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ABSTRACT

This study considered broadly the problem of homelessness by examining the housing difficulties of one at-risk population, the elderly, who presented needs to one city emergency service agency. A random sampling of some 500 emergency case files identified the prevalence of a wide range of emergency situations affecting the city's elderly. At least 50 percent had problems immediately related to housing: evictions, landlord-tenant disputes, utility shutoffs, deplorable housing conditions, need for temporary or emergency shelter, and being chronically undomiciled. From 126 cases involving either need for shelter or deplorable housing conditions, researchers were able to develop 91 case studies. Three risk factors for homelessness were found to be: (1) living alone and lacking social supports; (2) diminished mental functioning; and (3) having very low incomes. Coping patterns which were identified included daily life pattern, degree of autonomy, nature and meanings of attachments, denial, lifestyle theme, external factors, and overall ability to cope. The study revealed the magnitude of the deprivation some elderly individuals endure; the extent to which agency workers' behaviors, options, and interests are limited due to finite resources; and the importance of informal, long-term, often mutually satisfying helping relationships maintained by people in neighborhoods. (ABL)

# PERSONAL COPING STRATEGIES OF THE ELDERLY IN HOUSING EMERGENCIES: CLUES TO INTERVENTIONS TO PREVENT HOMELESSNESS AND INSTITUTIONALIZATION

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City agencies which provide emergency services rather than housing itself have a particularly constrained, yet pragmatic view of the problem of homelessness, given what they have capacity to do. Played out around homelessness and their workload are all the processes of urban community development imperatives, agency resource limits, and the reality of staggering unmet needs among certain vulnerable populations, including the elderly. In the 1980's these interfacing processes have devolved into a vicious vortex, recirculating as public policy poorly framed definitions of problems, responses to the wrong ones, redefinition, blaming the victims, and deterrence of the very clients programs claim to serve. Eventually government can't even account for the magnitude of homelessness with any credibility. Indeed, the definition of "homelessness" has been narrowed such that lack of "a decent home and living environment" is no longer of as much concern to government as is managing persons who make their homes inconveniently in public places. All persons who somehow cope outside of public view are expected to continue doing so, regardless of the personal risk.

This paper will consider broadly the problem of being without a home by examining the housing difficulties of one at risk population, the elderly, who present needs to one city emergency service agency. We use as a proxy definition for homelessness the agency's own problem descriptors: need for temporary or emergency shelter or living in deplorable housing conditions. In order to better identify the kinds of help elders themselves would find truly useful in housing crises, we present the clients' own perceptions of their needs as contrasted with those of other informants and city agency records. We start with a brief description of the overall research design.

## The Usefulness of City Emergency Service Agency Data

In summer 1987 I conducted a study through the Gerontological Society of America for the Chicago Department of Aging and Disability (DAD) of the needs of the homeless elderly (Keigher, 1987). DAD was being asked by the city's Department of Human Services Emergency Service program to provide more services to the homeless elderly, and in effect wanted a feasibility study about what it might do. The task was to identify who the ES program considered homeless, and

what was being done for them. ES responds to some 125,000 calls per year, and has six radio-dispatched mobile units on the street 24 hours per day which provide emergency services. Interviews with ES workers, police, outreach workers and other social service agency workers revealed a wide range of circumstances that could lead to a DHS call and referral to programs serving the homeless elderly or placement of a senior in a public shelter. The ES case files were the logical repository of data for identifying the contingencies present at the point when elderly people experience an emergency and are offered help by ES.

Data for the present study were gathered in summer and fall 1988, under auspices of the Metropolitan Chicago Coalition on Aging. A resarch staff consisting of both quantitative and qualitative methodologists (two social worker/researchers and two anthropologists), plus several coder-interviewer-investigators, would draw a large random sample of cases of elderly persons from the DHS ES files to identify a subpopulation that appeared to be at significant risk of losing their housing. We hoped to locate and interview some of these people (and others who knew them), to check the veracity of the available agency file data and to assess what had happened to these clients since their emergencies.

The random sampling of some 500 emergency case files at DHS identified the prevalence of a wide range of emergency situations affecting the city's elderly. At least 50 percent had problems immediately related to housing: evictions, landlord-tenant disputes, utility shutoffs, deplorable housing conditions, need for temporary or emergency shelter, and being chronically undomiciled. Others (fires, being lost or "wandering and confused," and need for food) appeared to also be housing related. (Figure 1 shows all types of emergencies experienced by the elderly and DHS' increasing workload. Figure 2 depicts the particular problems included in Basic Needs.) ES handled these crises also in a wide variety of ways ranging from doing nothing to moving clients from home or street, or placing them in shelters. From the case file records we found that those "in need of temporary or emergency shelter" and those "in deplorable housing conditions" were particularly likely to have had repeat contacts with DHS and evidence of multiple serious problems. Typical interventions ("transported client to bus stop," "provided a food box," "placed client in

shelter") suggested the complex of problems probably present, but also the unlikelihood that they had been resolved by the emergency intervention. Such data offered an extraordinary window on a random sample of older persons who had at least once exhibited need, but had not necessarily sought assistance. Recontacting such clients offered the chance to see the impacts of ES intervention and the coping strategies the elderly had managed on their own.

One-hundred twenty-six cases involving either need for shelter or deplorable housing conditions were selected from the random sample for more in depth study and interview. We then searched aggressively for each person and any informants (agencies, neighbors, relatives, friends) who could provide information about them. An average of over eleven hours were spent searching for each client. After six months of investigation we had completed a case history on 91 clients, including for most at least one interview with a knowledgeable informant. (Approximately 20% of the 91 had died and another 20% were sufficiently unable to communicate that client interviews could not be completed.) Clients we were not able to locate were largely men, had needed shelter, and were more likely to have been called "chronically undomiciled persons" in the ES record. Thus, the clients about whom we now know the most are ones whose housing dislocation or problem may have been less severe or of shorter duration than those we did not find. Presumably their needs are even greater than what we did confirm.

All data gathered on all 91 clients was analyzed by comparing their circumstances at the time of the emergency with their situation six months to three years later when we located them. This both corroborates and raises questions about situations at the time of the emergency relative to the very sketchy information in the case record. It adds data about their current situation, including an ordinal scale from the Duke University OARS resource assessment instrument and an unstructured discussion of their housing history which was a part of the interview. Quantitative analysis of these data identified three risk factors on which the clients who had ever been without a place to live were significantly deficient compared to the others. These findings are consistent with other research on homelessness and need for protective services, and are common predictors of institutionalization. These factors included living alone and lacking social supports, diminished mental functioning, and

having very low incomes. In addition, the mortality rate among those who had ever been homeless appeared to be significantly higher than ar ıg the others. In the whole sample, there were a substantial number of placements in emergency shelters and eventual institutionalization.

The Qualitative Analysis of Coping Strategies

We are now engaged in qualitative content analysis of some 30 cases on which client interviews have been transcribed and extensive supplementary data are available. Significant discrepancies in the accounts of events provided by clients versus neighbors, relatives, and agencies are noted. The client's own language and feelings, meanings, and persistent themes reveal how each, facing variously threatening circumstances, has mobilized resources to maintain or relinquish personal autonomy. It is this persistence or abdication of autonomy and control in ho\ the client copes that becomes the key issue in power struggles between agency and client. Understandably, the clients' need to maintain autonomy and control and the ways he or she asserts it allows us to better identify interventions elderly clients will find truly helpful.

By coping is meant the client's ability to live independently in the community, to assert preferences, and retain personal control over their circumstances. A strong coping strategy can be dysfunctional in a larger sense, but for the client is basically neutral, allowing her to maintain homeostasis. A sufficiently strong drive for independence and self-control can lead to minimization of other values, outweighing even health and death itself. Effective intervention programs respective of client self-determination will build upon the strengths of client coping strategies.

Current data analysis has identified seven dimensions of client self-management that seem to be particularly salient to an understanding of coping patterns. These include:

1. Daily life pattern and the extent to which it appears to be organized or disorganized.
2. Degree of autonomy (independence or dependence) and control.
3. Nature/meaning of attachments (to things, place, memory, people, past, events).
4. Denial, evasiveness, fantasy.
5. Lifestyle theme and preoccupations.
6. External factors affecting coping ability.

7. Overall ability to cope in the face of threatening housing situations.

The coping capacities and strategies identified via these dimensions appear to have been variously effective in terms of situational outcomes, although environment and circumstances largely beyond the clients' control also play a major role. Preliminary data review has identified two distinct outcomes at the time of our investigation some six months to three years after the emergency: some are in institutional placements and slightly more than half have remained in the community. Coping patterns during the intervening period can be distinguished relative to (a) the degree of personal autonomy and independence that continues to characterize the client's life and (b) the uses clients make of formal, organized service systems. Table 1 categorizes the 17 cases analyzed so far by the degree of dependency in their outcome status (at the time of our interview), noting also their degree of dependency at the time of the emergency. Type A denotes maximum independence and contentedness, while Type D indicates abdication of virtually all personal autonomy.

Those who remain in the community (Types A through C) include both those who, by our standards, are coping either satisfactorily or poorly, but nevertheless continue to live independently and retain autonomy over their every day lives. Some receive varying amounts of assistance from informal sources and, less frequently, formal sources.

The self-sufficient (Type A) are elderly clients who managed in the emergency essentially without formal help and continue to do so, although they sometimes rely extensively on friends or family. Note only two of the 17 cases analyzed thus far could be considered self-sufficient , and one of these continues to be highly dependent upon a family (not his own) which he lives with. The other, a well organized, relatively young senior, was offered shelter after his apartment fire, but determinedly insisted upon staying in his badly damaged apartment "to protect his belongings." He managed to move on his own to a better place where he remains.

The next set of clients continue to cope independently but less contentedly or effectively than this. Those in category B are coping alone, but something in their situation remains seriously wrong. This may or may not be acknowledged directly by the client who has either rejected or not

been offered help. Several were offered shelter and refused. Those who did accept help geting to shelter generally continue to receive services later. Formal agencies may or may not have offered any assistance or the kind of or comprehensiveness of help the client really needs. It may not be coincidental that most of the institutionalized clients (category D) at the time of the interview had been in category D at the time of the emergency. On the other hand, many others who were coping alone at the emergency had begun to get some agency help by the time of the interview, especially those who had been in shelter.

Those in category C are getting some kind of formal help. They generally exhibit less personal drive to control their situations and are reliant upon formal supports (agency services) they have usually chosen or found and requested themselves. Most have come to utilize external help since the emergency, although none appear to be substantially dependent upon it. Those in the community vary in the extent to which they are accepting of formal help, however. The men, for example, seem more likely to be getting homemaker service or home delivered meals, while the women are not. The women are suffering substantial amounts of depression and inertia about their inability to organize their surroundings. The men also are more likely to be accessing concrete benefits like free food banks or meal sites. The bulk of assistance provided, however, to both men and women is coming from relatives or nearby friends, rather than agencies. The two clients getting regular outreach medical care expressed particular gratitude for it.

Finally, the largest group are those who were coping poorly enough to have been effectively institutionalized (Type D) since their emergency. Most are now in nursing homes, but some are in agency operated board and care, and mental health facilities. One woman had remained in a senior shelter for over a year. Only one (#846) in this set actually died at a county extended care facility during the course of our investigation, but mortality is a common outcome in the larger data set. In being placed, they have virtually lost all personal control over their situations (by choice or by having been overpowered), exactly the situation that evokes expression of grave fear from those who assert they will not give up so easily. Having determined these clients require substantial protection or supervision, social service agents have typically removed them completely from their

previous environment. Several of those institutionalized had already wandered away from nursing homes or treatment programs (#2267, 2004, 918), and many appeared to be sufficiently aggitated or confused to be in danger of doing so again. Their anger, confusion, and frustration suggested that they had not accepted their current residence as being their home. On the other hand, among this population who were not adjusting well to loss, we could hardly contend that acceptance of so much loss would be a good thing either. Indeed, for those without strong social supports available, loss and even trauma is probably a rather predictable lifestage event, certainly not suggestive of pathology or human failing. Passivity and dependence appear to be an adaptive response, however, in view of the lack of alternative housing options.

Certain variations or themes characterize the coping pattern for each individual as they compromised their independence and daily activities. Most clients went from type B to Type D without intermediate assistance of any kind. While some rejected help, normally help simply wasn't offered. The variations reveal both the substantial dislocations that sometimes result from interventions (like placement in temporary shelter or involuntary hospitalization) and alternatives that might have been more acceptable. They also reveal the apparent insignificance of some routine assistance provided by ES. More effective and genuinely facilitative interventions for extremely resource poor and "resistant" clients might include the services used by those who were maintaining with help (type C) at the time of the interview. Since we had an average of ten times more investigative time per client than the ES workers had originally, however, we naturally discovered factors ES workers could not. This indicates the kind of service intensive work necessary to be truly responsive and helpful to such needy clients.

Implications for Programming and Public Policy

The implications of this ethnographic analysis for public policy are several. The first, of course, is the magnitude of the deprivation some elderly individuals endure, given that the options they perceive are worse. Such persons are not irrational, but rather feel caught in a Catch-22. In many cases substantial improvements in their life quality would cost little if provided where they currently live.

Several clients expressed firm willingness to move from what are clearly fragile circumstances if an affordable or more satisfactory apartment could be found (#953, 567, 44). Most would require assistance in searching and moving because of mobility problems, inability to organize, fears, or cognitive impairment. Note that those who had relocated to CHA or to a congregate living facility, where personal choices and autonomy are preserved, were mostly men, were relatively satisfied, and generally appeared likely to remain there.

Those who had not moved but wanted to felt trapped without options. One (#953), mutually dependent upon her granddaughter and greatgrandaughter, insisted on moving with them, but CHA senior housing does not accept multigeneration families, and the wait for other CHA housing is long. Other examples of multigeneration families, all African-Americans in similar straits, showed in our larger interview sample. One was a diabetic amputee living with and dependent upon her drug-addict daughter and teen-age grandson, known to ES for over a year, who fell in the night going to the bathroom in a strange apartment, was comatose for two months, and died. An improved living standard is secured by staying together, but overcrowding, domestic disputes. illness, and violence can all lead to dissolution. Loss of one income-contributing member can force the whole family to move, as happened with the bedridden son-in-law of this client was finally placed in a nursing home. They can no longer afford the $350 rent, but by November had not yet found alternative quarters.

The remaining two appeared to be less amenable to help with relocation. The elderly sisters (#86 & 87) were understandably attached to their life-long home. Yet, after the death of her sister, the younger one's contention that she had substantial savings and friends conflicted sharply with the deteriorated condition of her home, health and surroundings. Living in a racially changed and increasingly threatening neighborhood, hospitalizations, and growing inability to repair her vandalized home contributed to her tenacity and fierce protection of her privacy. Her complaint to the city about our investigators could be interpretted as a cry for assistance as much as a rejection of it. The other client had moved several times in eight months since returning from Arizona and her ES paid shelter stay. With no apparent attachements to place, her independence expressed itself in

continuous disatisfaction with where she was staying. Having formed no bonds with any friends or neighbors, she may well end up without a place when she can no longer afford one she likes. All of these clients who remain independent, whether accepting of help or not, will easily slip through the cracks of the service system which simply does not do outreach with persons in their own homes unless they request it.

Secondly, the data reveal the extent to which, because agency resources are finite, agency workers' behaviors, options, and interests are as painfully limited as are those of the clients they are serving. Lipsky and Smith (1989) note that emergencies are socially constructed concepts. Lacking the capacity (resources) to really resolve social problems, human service agencies make emergencies out of them in the face of a systemically inadequate supply of the basic necessities of life: food, clothing, shelter, and health care. Human service agencies always must ration their provision of such. Yet, frequently (or consequently) the ES records said the client had "refused service." For example, since a medical clearance is required before admission to the senior shelters, workers frequently leave elders in the hospital emergency room awaiting an examination, with transportation to be provided by the next shift. But, not suprisingly, a substantial proportion of clients disappear before the next team arrives. Seniors who are ambivalent about going to shelter, and can do so, have the option to walk away. It is no wonder that referrals to other agencies rarely work any more effectively. The worker's incentives work to encourage self-sufficient, especially demanding, or troublesome clients, to go away. The passive, uncertain client is simply overlooked, as seen in the number who refused shelter and appeared to get no other followup assistance from DHS at all.

Thirdly, the data reveal over and over the importance of informal, long-term, often mutually satisfying helping relationships that are maintained among people in neighborhoods all over the city. Sometimes such arrangements are viewed with suspicion by agencies, as in case #788, where the police found this dependent old man in a home raided for drugs. The assumption was, perhaps realistically, that he was being abused. In fact, however, when interviewed over a year later, he continued to live there and, although very dependent upon this family, was remarkably contented.

He had chosen to manage his own dependence by relying upon these people he trusted. The same was true of those who were physically disabled who carefully chose who they would rely upon. In-home medical care to #953 who gets no other assistance, and #2022 who is blind, is accepted gratefully and provides critical security to persons in fragile condition. It suggests what a proper means of outreach medical care would be. Except for those with severe dementia, several who ended up in category D would probably have benefited psychologically as well as physically from home health care outreach.

Other outreach programs also would be appropriate for those clearly unable to maintain their property. Homeowners (#86 & 87, and #834) have special problems both maintaining and trying to dispose of property, needing chore services and major maintenance, as well as legal and financial advice. Because their apprehension was so strong, special care and time would be required to gain trust and access. Others can be assisted simply by a homemaker, but serious consumer satisfaction problems occur in matching homemakers appropriately. Couple #72/73, for example had been sent a homemaker but refused to allow an African-American person into their home. In another case, the homemaker was nearly raped entering the neighborhood and refused to return. Unfortunately, the need does not fade away when the homemaker does.

Here we propose the need for old-fashioned, individualized casework when the routine agency response is not adequate. Outreach must address the specific problem as the client sees it and flexibly provide resources over which the client can assert the sometimes dormant urge for control. Agencies can hire someone the client knows and trusts, especially a relative or long-time friend, to provide needed regular care or services to the property. Acceptability to the client should be the bottom line.

A special case is presented by the dementia patient whose cognitive impairment is difficult to sort out and experiences are difficult to reconstruct. A most serious finding to us was the extent to which intervention by a mental health agency appears to sever the client's continuing contact with support systems that have been in place until he or she is placed in a facility. Nursing homes we visited had absolutely no idea where some clients had come from and the clients had had no visitors

since admission, even though DHS records indicated they had previously been staying with neighbors or friends. Informants we spoke with told of relatives who had completely disappeared since their admission to the local mental health system. Maintenance of social networks is challenging enough, and critically important, but too many interventions had simply destroyed them, failing apparently to acknowledge that they had ever existed.

Finally, policies and procedures of some city agencies aggravate rather than resolve already unmet human needs: confiscating a home for payment of delinquent taxes, granting tax breaks to developments which result in dislocation of low-income persons, redlining a neighborhood that results in racial transformation and fear, lack of maintenance and enforcement of payment schedules by public housing authorities. The clients who have become institutionalized (category D) exemplify this: #834 was living in her home, which the city had boarded up, with no gas or electricity; #8687 also in the home of her birth, was a frightened white woman remaining in a neighborhood transformed by white flight; #567, living in SROs, will eventually run up against Chicago's shrinking supply of SROs and steeply rising rents of such. With a pattern of instability and unpredictable behavior, she will be on the short list when residents are asked to move.

Emergency services can expedite referrals to other agencies who might advocate for resources, but in the face of a continual onslaught of newly dislocated clients and the recycling of some "uncooperative" elderly who never make it to the service systems of other agencies, ES has also become vital to the maintenance of certain persons on the streets.

In addition to all these implications, we would add an important methodological post-script. We have cast a wide net in order to capture a population of elderly at high risk of losing their homes. The persons we found were largely unknown to any service systems at the point of their initial emergency and as time elapsed most of their circumstances deteriorated significantly, accompanied by grave loss of personal autonomy and situational instability. While only some actually lived on the street or in shelters, such that the term "homeless" would normally be applied to them, most did in fact lack an objectively decent or secure place to live for some period of time.

It is important that public policy discourse on homelessness be more inclusive and that

popular images of who is in need be expanded. We must not allow eligibility for public programs and services to be restricted to only the narrowly proscribed population who make their homes inconveniently in public spaces. Qualitative analysis of individual needs, such as we have presented here, begins to clarify what little difference exists among the needs of the homeless, the near-homeless and those homeless in their own homes.

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The preliminary study Relocation, Residence and Risk (1989) may be ordered from the Chicago Metropolitan Coalition on Aging, 53 W. Jackson, Suite 1632, Chicago, IL 60632. telephone (313) 922-5890. Price of $15 includes shipping cost. The ethnographic study described above will be available in the form of an addendum to this report in late Spring 1990.

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DHS PROVISION OF SERVICES TO SENIORS BY TYPE. JAN 86-JULY 87

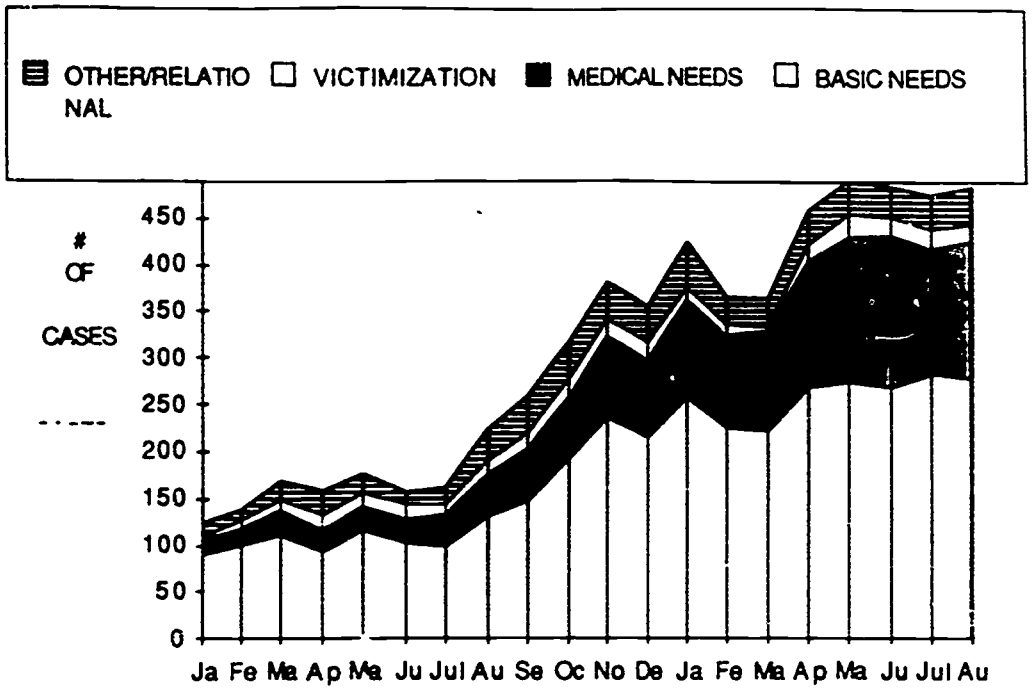


FIGURE 1

DHS PROVISION OF BASIC SERVICES TO SENIORS BY TYPE. JAN 86-AUG 87

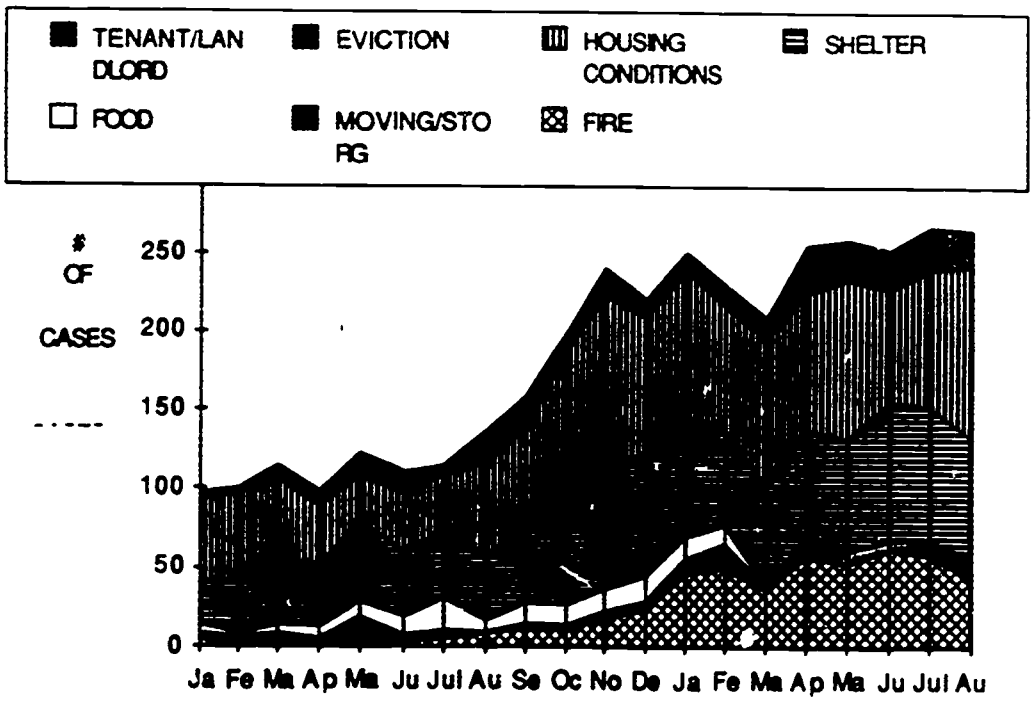




FIGURE 2

TABLE 1. EMERGENCY CLIENTS' COPING PATTERNS & CIRCUMSTANCES

| | Sex Race Age at T1 | Dep. Time 1. Type | Emergency | ES Immediate Intervntn | Months Elapsed T1-T2 | Dep Time 2. Type | At Interview |
|---|---|---|---|---|---|---|---|
| **IN COMMUNITY** | | | | | | | |
| **Coping well on own** | | | | | | | |
| 852 | MB 70 | A | Fire, stayed in burnt bldg to protect prop. | Offer shltr, ref'd | 9 | A | Moved self to better apt |
| 788 | MW 76 | A | Dependnt, living w friends busted for drugs | Refused shltr offer | 14 | A | Still w same family, seems happy, dependent on them |
| **Coping Poorly** | | | | | | | |
| 953 | FB 86 | B | No util; caring for stroke debled son-in-law, other ref's | HEAT asst, Ref to MD | 6 | B-C | Still frail, less income bec SIL to LTC, still no util; RNs visit. |
| 86 & 87 | FW 66&83 | B | 2 sisters can't go home from hosp bec. they turned off utilities before going to hosp; | Cits refused shltr, | 39 | B | In & out of hosp, motel for 9 mo.; home vandalized. Lived in destroyed home 2 yrs since older sister recently died; other in poor health. |
| 43 | MB 67 | B | Appeard to be without home (2 mo), in st & shelter; alc? | Transp to shltr? | 35 | C | Got aid from several ag's; has been in CHA since ES; was recently hit by car, has hmkr. |
| 212 | MW 79 | B | Evictd w 30 days notice, streets, hosp; alcoholism | To shltr | 8 | C | Fr shltr to hosp, then to congregate hm with meals |
| 2022 | MB 71 | B | Blind, evicted; says ref's won't help; his chldrn in Cleveland | Offered shltr, refused | 14 | C | Moved self to friends, to CHA 2 mo later. Sees Dr in bldg, friends help |
| 587 | FW 61 | B | Ref's fr Ariz "ran out of $"; on streets, "ref's won't help" | placed in shltr | 8 | B | Moved self to SRO, to apt, to better apt, seeking better apt MI? |
| 44 | FB 69 | B | Fire, rat bite, wants to move, no shelter needed | Refr to ag, helpd move | 21 | B | Ag. helped her move; in another v. poor apt, depressed |
| **REMOVED FROM COMMUNITY** | | | | | | | |
| **Coping Inadequately, No Longer Independent** | | | | | | | |
| 2004 | MB 73 | B | Living in abandoned bldg | Report to MH? | 13 | D | To MHosp, now at vendored MH board & care |
| 834 | FB 84 | B | Burned at her lg run down home, has derelict boarders | Placed at sr shltr | 17 | D | Ref'd home, friend dies, ref's to shltr where she's been 1 yr. |
| 2267 | FW74 (77?) | B | Asks police for shelter sevrl xs, in & out of SROs | Transp to shltr? | 10 | D | Placed at NH, AWOL, placed again by? |
| 491 | FW 70 | B | Confused, lost, hosp (8 mo.) Neigh's compln of son's neglect | To sr shltr, to home | 12 | D | Sev. strokes. Alt hosp, son agrees to NH |
| 73&72 | M&FW 78&75 | B | Deptor hsg cond, wife in wheelchair, refuse to go to shltr | Refr to services | 26 | D | Rec'd meals (refused hmkr); both hosp, husb dies, wife to NH |
| 121 | FB74 (72?) | B | Evicted, confused, stayed with friends | To hosp | 15 | D | In NH, no recall of past at all |
| 918 | MB 81 | B | In 1 yr: lost, evictd, on streets, to shltr, AWOL fr NH | Transp to these places | 5 | D | Still in NH, dementia |
| 846 | FW 61 | B | Raped, undomiciled, living in city park | To women shltr (?) | 8 | D | In county NH (died shortly after intrview) |