

Assisted Living in Public Housing: A Case Study of Mixing Frail Elderly and Younger Persons with Chronic Mental Illness and Substance Abuse Histories

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Abstract

Since the Fair Housing Act of 1988, younger chronically mentally ill and substance abuse residents have been admitted to subsidized senior housing. This policy's main purpose was to furnish housing for younger homeless individuals and to improve rental income streams for senior facilities. The policy was also meant to promote age integration, improve social engagement, and enhance informal support in these developments. Younger persons with chronic mental illness and substance abuse histories have proven to be incompatible neighbors, diminishing the quality of life for seniors and creating management problems for facility staff.

A Decatur, Illinois, case study covered three years of mixing younger individuals into a public housing facility for frail seniors. After the younger persons were admitted, quality of life diminished and management became difficult. Results indicate that careful tenant screening and sensitive and extended management are vital for any chance of successful age integration in subsidized housing.

Keywords: Low-income housing; Elderly; Disabled

Introduction

This article discusses the recent history of mixing younger disabled persons into federally subsidized housing for seniors, the extent of this trend, and how it has been studied to date. It also describes the impact on residents and staff and on the cost and quality of assisted living services.

The effect of this practice is examined in a three-year evaluation of a public housing facility in Decatur, Illinois, that was designed to provide assisted independent living for low-income and frail elderly persons. The facility began to admit younger persons nine months into the rent-up process. The younger residents included physically and mentally disabled persons as well as persons with chronic mental illness (CMI) and substance abuse

histories. The case study supports previous research showing that the inclusion of younger persons with CMI and substance abuse histories into senior public housing can severely diminish both quality of life and quality of care for the frail seniors and can complicate facility management. It is clear that this policy has not lived up to expectations.

Policy background

Under the Rehabilitation Act of 1973 (Section 504) (as amended) and the Fair Housing Act of 1988, all single persons who are income eligible, whether they are over age 62 or younger and disabled, are eligible to move into senior subsidized housing. For years, federal and local officials ignored this policy because they felt it would make marketing and management of senior housing more difficult. By the late 1980s, however, senior housing was opened up to younger, single individuals because it made fiscal and political sense.

The federal government had cut back all housing subsidies by 70 percent between 1978 and 1988, and pressure on the existing supply had grown tremendously (Levitan 1990). In contrast, some of the older public housing and Section 8 facilities for the elderly began to experience chronic vacancies. There was an oversupply of these units that had multiple market shortcomings: They were commonly small efficiency apartments (most people wanted at least one bedroom), and often the facilities were poorly designed, poorly maintained, and located in “bad” neighborhoods. The U.S. Department of Housing and Urban Development (HUD) filled these vacancies with younger, income-eligible single persons, addressing both issues of fiscal solvency and the pressing need for permanent affordable housing for younger singles.

By the 1990s, younger people with CMI and substance abuse histories presented the greatest need for housing (U.S. General Accounting Office [GAO] 1992). Once the doors to senior public housing were opened to single persons under age 62, aggressive advocacy by mental health case managers made this population the most popular applicant pool at several housing authorities.¹

People with CMI have been underserved in federal housing assistance programs, mainly as a result of the court decision

¹This observation is based on conversations the author conducted with six public housing authorities in the Midwest.

that “the Secretary of HUD and the PHAs [public housing authorities] can refuse to integrate CMI individuals in federally assisted developments with other eligible housing assistance recipients without violating the rights of the CMI to equal protection” (Newman and Struyk 1990, 452–53). The reason for the court decision, according to most mental health professionals, is that the support needs and supervision of people with CMI are distinctly different from those of all other groups (Newman and Struyk 1990).

Nevertheless, by 1990 HUD had been requiring for several years that public housing and Section 8 facilities designed for seniors fill prolonged vacancies with any and all income-eligible younger persons. In fact, HUD surveyed its 10 regional offices about whether the number of younger persons being admitted to senior facilities had increased and if this was causing any management problems (HUD 1990). All 10 affirmed an increase in senior facilities with mixed age groups. Nine of the 10 said that PHAs in their region reported increased management problems in senior facilities with younger residents.

In 1992, the GAO took note of growing management problems where younger persons were being mixed into senior housing. A GAO study of over one-third of all PHAs in the country reported that about 9 percent of public housing units for the elderly were occupied by nonelderly persons with CMI (GAO 1992); medium to large PHAs reported that management problems with chronically mentally ill persons had grown. About a third of the mentally disabled younger persons caused moderate or serious problems, according to the housing authority administrators. Findings indicate serious problems ranging from increased management burnout to declining quality of life and care for seniors (GAO 1992). In a 1993 survey by the Illinois Association of Housing Authorities, 29 percent of its membership reported that housing the chronically mentally ill with seniors was a problem for their agency (Crouch 1993). Most of the studies to date argue that, at the very least, mixing age populations in subsidized housing requires careful planning and more comprehensive and sensitive management (Burby and Rohe 1990; Cohen, Bearison, and Muller 1987; Kellam 1992; Massachusetts Department of Mental Health 1994; National Association of Housing and Redevelopment Officials 1989; National Resource Center on Homelessness and Mental Illness 1993; Normoyle 1988; Tanzman 1993).

Some reports suggest that mixing nonelderly persons into senior housing, even persons who have CMI and substance abuse

histories, is possible with proper support services, cooperative agreements between health service providers and housing authorities, and full cooperation between senior and mental health case managers (GAO 1992; Highrise Mixed Population Committee 1989; National Resource Center 1993). But this supposition remains largely unverified by the professional managers and service providers in the field. The specific conditions for successful integration are currently unknown. Meanwhile, the number of senior facilities with younger disabled residents has grown over the past decade, and problems for both management and resident care and safety continue to be reported (Bauer 1995).

Current conditions

The Housing and Community Development Act of 1992 was the first congressional recognition of a problem in mixing younger disabled persons into senior public housing. The Act called for “designated housing” solutions that allow owners and authorities of senior-subsidized housing to separate elderly and younger residents. In April 1994, HUD adopted a new regulation to implement the congressional mandate (HUD 1994); it ended HUD’s insistence on mixing younger disabled persons into senior housing as long as local authorities produce a plan to house both groups. Current policy allows all local authorities to separate senior and younger disabled persons currently living in mixed facilities with HUD approval of a designated housing plan. Relaxing the regulations, however, has not solved the problem.

According to HUD records, as of February 1996, only 41 authorities had submitted designated housing plans. Furthermore, only 25 of the 41 plans have been approved, and no new HUD funds exist to build housing to accommodate the separation of senior and younger persons. Of the 25 applications approved, almost all are in large cities that have a large stock of senior high-rises and can therefore designate one or more as younger disabled housing facilities. The voluntary compliance provision has caused a further complication: Persons who are in compliance with their current lease cannot be forcibly relocated. Thus the change will be slow, and most of these housing facilities will continue with mixed populations for some years to come.

The second most popular plan is to target rent voucher certificates so that younger persons leaving senior public housing are given preferential treatment. Once again, this process is voluntary and can be done only in cities that have large certificate

programs and the flexibility to allocate them in this way. Moderate to smaller cities with only two or three senior public housing facilities cannot designate an entire building to younger disabled persons and will find it hard to target the available certificates to younger disabled persons if they are in short supply for all needy households.

The problems created by mixing the age groups in senior subsidized housing will remain for many years. The following case study illustrates these problems in more detail. Previous studies have indicated that the problems lie in two major areas: resident quality of life and complex management issues. Presentation of the findings in this case study follows this two-part framework.

The Concord Congregate Care Program

The study, conducted between 1992 and 1994, was originally designed to be an analysis of the quality and effectiveness of a community-based congregate care program. Responding to the combined needs to modernize a facility and provide assisted living options for the most frail and low-income seniors in the city, the Decatur, Illinois, Housing Authority closed its oldest senior housing (the Concord), modernized it with federal funds, and reopened it in 1992 as congregate housing for frail seniors.

This case study reflects major trends in senior public housing, which is recognized as the most affected by mixing populations of all government subsidized housing (Crouch 1993; GAO 1992; HUD 1990). Within the universe of senior public housing, the Concord is near mean size (117 units), has a typical building layout (four-story, elevator-serviced efficiency and one-bedroom units), and is constrained by the same HUD program management regulations and resident eligibility criteria that all senior public housing must follow.

The remodeling of the Concord included a major first-floor addition of common spaces for dining, socializing, medical and daily living services, on-site management, and case-managed support, and won a national award for design and service creativity (Henry 1993). Key support services like congregate meals, housekeeping, transportation, and case management were provided from the start, but services were not designed to reach economies of scale that would be affordable to the residents until the facility was fully occupied.²

² The housing authority applied for and received a grant from the Retirement Research Foundation to fund start-up and initial operating costs for two years.

Table 1 shows the components of the community-based congregate care program and the initial subsidies. The combination of a site manager and a half-time case manager was designed to provide leadership for the service managers, who meet monthly to assess and coordinate individual resident support cases. These key managers and service providers were interviewed in person at the site in November of each year. The residents were interviewed every six months by mail. Those who could not respond on their own were interviewed in person.³ A reference group of seniors was also surveyed every year.⁴

Case study evaluation criteria

This article contributes several new dimensions to the debate on mixing seniors and younger persons. First, this case study is of younger persons introduced into a senior public housing facility designed to provide assisted living for the most frail elderly persons. Even while they are trying to accommodate all eligible single persons in senior housing, many housing authorities are searching for ways to help their frail but healthy seniors “age in place” and avoid a move to institutional care. However, seniors with failing mobility, eyesight, hearing, and the like could be

This study was a portion of the Retirement Research Foundation grant set aside to monitor and evaluate the congregate care program and appears in other papers (Heumann 1994a, 1994b).

³ To simplify the data tables and provide a clearer picture of changes and trends, the resident data are shown for every year, rather than every six months. Also, this article focuses on senior resident responses (1992, $n = 39$; 1993, $n = 50$; 1994, $n = 47$) rather than total resident responses. The younger residents were surveyed, but more of them had severe mental disabilities, resulting in a high percentage who were unable to participate in the survey in a meaningful way (in 1994, 18 percent of the younger residents ($n = 10$) were not competent to participate compared with only 6 percent of the seniors ($n = 3$)). For each year cross-sectional data are presented for each point in time. Because the Concord was still renting up throughout the study period, and because of a high turnover of residents of all ages (discussed in greater detail below), the size of the constant resident population was too small for longitudinal statistical analysis (of the 117 residents in the last year, 1994, only 21 seniors and 3 younger persons had lived in the facility for all three years). Finally, many seniors who might have grown unhappy with the mixed living or quality of life at the Concord moved with no exit interview, and the new group of recent residents comprises a sizable portion of each cross-sectional survey.

⁴ This reference group was composed of seniors in other high-rise public housing facilities in Decatur who had a similar age and income profile but had no pressing need or desire for the congregate services provided at the Concord (1992, $n = 80$; 1993, $n = 49$; 1994, $n = 43$). They are used as a point of reference with which changes in the Concord senior population can be compared.

Table 1. Components of the Concord Congregate Care Program

Position	Source of Support
Site manager (live-in, full-time)	Housing authority
Case manager (half-time social worker)	Nonprofit community
Program manager ($1/5$ time)	Housing authority
Meal service (2 meals/day, 7 days/week)	Private caterer
Medication management ($1\frac{1}{2}$ days/week)	Nonprofit community
Homemaker/chore service (hours as needed or by resident request)	Profit and nonprofit community
Van services (5 days/week purchased for the Concord but serves all senior facilities)	Housing authority
Beautician/podiatrist (half-time, 3 days/week)	Private for-profit
Social organizer (half-time, providing arts, crafts, recreation, etc.)	Nonprofit community
Subsidies (initially provided by a two-year grant)	
Case management	The cost of each full assessment per resident at three assessments per month.
Meals	\$2.00 of each breakfast and \$2.50 of each noon meal. This subsidy cuts resident meal costs in half and is the largest subsidy each year.
Van service	The salary of a half-time van driver.
Medication management	The full cost of \$35.00 per month for 35 to 45 residents. The need for this service occurs most among very frail residents and is vital if they are to remain out of institutional care.
Housing authority	One-time start-up funds for staffing and equipment.
Evaluator	The full cost of evaluating the program for the first three years.

adversely affected by the presence of younger persons. Second, this study is not a single-point-in-time evaluation but follows the history of mixed residency for three years after rent-up began. Finally, the majority of previous studies were limited to a few simple, often open-ended, questions about the problems of mixing age groups.

The following evaluation is divided into two broad issues: quality of life and management. Quality of life is measured by senior reactions to younger persons, changes in the number of friends and perceived isolation, changes in senior activities, and the problems and benefits of mixing. The management problems include staff burnout, resident incompatibility, failure to reach service cost economies, and high resident turnover and vacancy rates.

Quality of life issues

Reaction to younger residents

Responses from seniors to direct questions about mixing age groups are presented in table 2. They show increases in senior disapproval of mixing between the first two surveys and the third, which correlates with a sizable increase in younger residents from around 30 percent to 47 percent of total residents. While the percentage of younger persons as a whole increased in the third year, the proportion of younger persons with CMI and recovering from substance abuse held steady at about 18 percent. However, the absolute number of younger people with CMI and substance abuse histories was increasing as the facility reached full capacity.

The overall satisfaction of seniors with the facility and services is also presented in table 2. The seniors' perception that life is easier since moving to the facility or that the facility meets their needs did not change significantly between years. However, responses to specific questions about service provision, staff understanding of needs, whether they would recommend the facility, or if they wanted to stay, revealed significant increases in dissatisfaction in the third year when the younger resident population increased significantly (see table 7 discussed below).

Friends and perceived isolation

Another measure of quality of life is the number of friends seniors have and whether they feel they are becoming isolated.

Table 2. Senior Resident Approval of the Concord (Percent)

	After 1 Year	After 2 Years	After 3 Years	Chi-square
Younger residents (percent)	32.8	27.1	47.0	
Senior responses to mixing				
Disapprove of mixing age groups	41.7	31.4	64.5	0.10511
Feel socializing is more difficult	33.2	36.0	58.7	0.06712
Feel safer without younger residents	42.9	37.3	71.1	0.04594
Overall senior satisfaction				
Life is easier since moving here	83.8	76.9	78.2	0.30329
The Concord meets my needs	91.2	98.0	84.1	0.37034
Services are provided when requested	94.1	95.8	80.0	0.05039
Staff understand my needs	91.7	95.9	77.3	0.09344
Would recommend the Concord to friends	100.0	97.8	75.0	0.00163
Don't want to live here	2.8	8.3	19.6	0.09631

Friendships and acquaintances were measured four ways (table 3). The first three measures are the mean number of neighbors in the facility to whom the residents report saying "hello," the mean number of neighbors in the facility the residents report visiting, and the mean number of friends in the facility reported by each respondent. For all three, the percentage declined as the percentage of younger neighbors increased.

The reference group from other housing authority facilities had lived in their units for seven to nine years on average over the three surveys. When they were asked the same questions, the mean number said "hello" to stayed consistent at 31 percent for all three years. The mean number of visits stayed between 11 and 12 percent. The mean number of friends ranged from 23 to 40 percent. Thus, seniors living at the Concord and those in

Table 3. Friendship and Acquaintance Rates for Seniors at the Concord

	After 1 Year	After 2 Years	After 3 Years
Younger residents (percent)	32.8	27.1	47.0
Mean number of people say "hello" to (percent of facility population)	26.4	33.2	11.2
Mean number of visits among neighbors (percent of facility population)	8.6	10.7	3.6
Mean number of friends in the facility (percent of total friends)	29.6	32.4	26.7
Percent who agree "most of my friends are neighbors who live in this facility"	33.3	32.6	40.0

other facilities reported a similar percentage of friends and contacts until the third year, when the percentage of younger residents at the Concord rose appreciably. At this point at the Concord, the percentage of senior friends and contacts fell and senior isolation appeared to increase.

The fourth statistic in table 3 shows responses to a Likert-scaled question that asks if the respondent agrees or disagrees that most of his or her friends are neighbors in the facility. The percentage agreeing was similar for the Concord and the reference group for the first two years. In the third year, however, the reference group reported that only 31.4 percent of their closest friends lived on-site, while the Concord seniors reported 40 percent. Despite a declining percentage of acquaintances and friends on site, the low-income and frail seniors at the Concord depend on the facility to be a major source of friends, which results in a perceived lower quality of life for these residents.

Senior activity characteristics: A management perspective

Recording the social and recreational activities of seniors is a third way to measure quality of life. The 13 program managers and service providers were asked about the use of common rooms. Only six of the program managers could regularly observe tenant use of the social activities in the common rooms. All six noted the increasing danger to, and isolation of, the seniors as the younger resident population became more dominant.

According to the staff, negative contacts between the age groups increased in the common rooms during the third year. A younger resident slashed upholstered chairs and couches in the main lounge (an event witnessed by seniors), and a videocassette recorder was stolen. Staff reported more incidents of confused and incoherent younger residents disrupting activities in the common rooms. Both the site manager and the case manager reported that many seniors were too scared to participate in organized activities or even to use the common rooms as part of their extended living space. They both felt that seniors were becoming isolated in their apartments.

Responses from seniors about the use of social and recreational services are presented in table 4. Knowledge and use of activities decreased over time, although seniors who did participate in the activities rated them highly. The proportion of Concord seniors who reported not knowing about or not using social activities was 5.6 percent after year 1, 15.2 percent after year 2, and 25.0 percent after year 3. The reference group reported 24.6 percent, 23.7 percent, and 20.7 percent in similar time frames. The statistics moved in opposite directions over these three years.⁵

Table 4. Responses by Concord Seniors on the Use of Social and Recreational Services (Percent)

	After 1 Year	After 2 Years	After 3 Years
Recreational programs			
Don't know of or use it	17.6	26.7	30.2
Rate it poor or fair	11.4	15.5	16.3
Social activities			
Don't know of or use it*	5.6	15.2	25.0
Rate it poor or fair	19.4	17.4	15.9
Arts and crafts			
Don't know of or use it	20.6	26.7	28.6
Rate it poor or fair	11.8	13.3	7.2
Opportunities to worship			
Don't know of or use it	17.6	21.3	20.9
Rate it poor or fair	8.8	12.8	13.9

* $p = 0.05$, chi-square test over time.

⁵ The reference group does not always have equivalent social services or spaces in their buildings to accommodate these activities. Answers about the use of social activities in general, however, should be comparable.

Staff changes at the Concord explain part of this trend. The first social activity director lasted for a year and a half. She was replaced by a less competent person and, for a while, by no one. By the third year, a new social director was in place, but she was quick to note, as were other program directors, that by the third year the Concord had such a diverse population and so many seniors who did not like to socialize in the common rooms that there were not enough people to sustain some activities. The activities the younger people were interested in did not interest the elderly and vice versa. Many of the fully independent seniors and younger people tended to go outside the facility for their group activities and registered no demand at all.

Phantom and real benefits

The three surveys with the program managers and service providers indicated that mixing younger persons into senior facilities can produce some benefits. One benefit, which seems initially attractive to a housing authority with chronic vacancies or slow rent-up, is that younger residents represent an applicant pool, allowing the facility to fill vacant units and acquire a more manageable rental income stream. The larger rental income stream can, in theory, provide financial flexibility for additional services that benefit the seniors. Unfortunately, screening for compatible younger persons is time consuming. Even with extensive checking with former landlords, a higher probability exists that persons with CMI and substance abuse histories will not have a lengthy, stable, or compatible housing history and will have dysfunctional personalities that can further deteriorate after entering a new facility. Increased rental streams can be quickly absorbed by increased administrative costs, management turnover, and time-consuming eviction proceedings, which may even deplete resources that could have supported the senior population.

All the service providers said that there are real benefits of mixing in younger persons who do *not* have CMI or addiction problems—that is, the physically and mentally disabled, the terminally ill, and normal low-income single persons. The presence of these younger people can often lead to more socially active and engaged seniors as a result of the age integration. The younger people can provide more voluntary support services and even a blending of complementary physical strengths among all age groups.

Another presumed benefit is cooperation across community-based service pools for the younger and older residents. Unfortunately, even this benefit generates costs. At the Concord, problems arose in the early stages between vendors and case managers for the two age groups. While support service cooperation improved over time, potential conflicts should have been resolved before mixing the clients instead of making the Concord the testing and negotiating arena. Even with cooperation, the increased number and variety of client advocates and support staff visiting the site changed the look and atmosphere of independent apartment living.

Management issues

Site management burnout

The site manager is probably the most vital person to the coordination of services, the social bonding of residents, the feeling of security, the sense of trust and confidentiality among residents, and the overall administration of the facility and services. The site manager, more than any other person, sets the tone in a senior housing facility. He or she often serves as a “family surrogate” to the residents (Heumann and Boldy 1983). No other support worker engenders the trust of the residents and maintains the depth and breadth of knowledge about the residents and their ever-shifting support needs. When the younger disabled residents were introduced, the site manager became the primary intermediary and negotiator of all social interactions in the halls and common areas, at nights and on weekends, and when other support staff were off-duty.

Nine months into the rent-up, the housing authority hired a new site manager whom it judged as the best person to handle the influx of younger persons; she had the most experience in housing management and social interaction among tenants. At her first interview, four months after beginning the job, she stated that even without the younger people, a congregate facility meant more emergency calls, closer and more careful observation of changes in individual resident support needs, and more coordination between services and activities (the case manager coordinates most support but relies on the site manager for consultations on changing individual needs).

She stated that the inclusion of younger residents with varied mental capacities and substance dependencies expanded the workload significantly. The mentally ill residents became

confused and confrontational; the recovering substance abusers could be moody and even depressed, and they often relapsed or brought in friends who were addicts. Between the fourth and twelfth month of her tenure, she reported that 6 emergency calls per month had grown to 16 per month. The increase in calls resulted from actions by younger residents. These interventions were usually tense confrontations with younger residents, resulting in stressful and time-consuming eviction proceedings.

In the first interview, the site manager reported that 40 percent of her time was spent in basic physical management of the building (supervising maintenance, building administration, paperwork), 40 percent in basic tenant interaction (visiting and talking to tenants, addressing tenant needs and complaints), and 20 percent in intense tenant-focused activities (monitoring physical and emotional health, counseling, reviewing and assessing tenants for continued occupancy).

At the twelfth month of the site manager's tenure (in a second interview), she had cut physical management to 20 percent of her time, basic tenant management remained at 40 percent, and intense tenant-focused tasks had increased to 40 percent, all because of the younger tenants. She had to sacrifice care of the building to avoid shortchanging the senior residents. In actuality, the quality of time with frail seniors had been compromised. The twelfth-month interview turned out to be an exit interview. The site manager quit over the issue of managing the younger people. She felt overworked and overwhelmed by the management problems they presented and concluded that "it is a *disaster* to mix younger mentally ill people into a senior complex."⁶

The replacement site manager was a younger, more energetic person, hired so she could relate better to the younger people and take on the heavier workload. This second site manager did beautifully for about the same length of time (one year). Unlike her predecessor, however, she did not read the signs of her own rising stress level, and neither did the housing authority. In October 1994, while we were conducting the final evaluation of residents and service providers, she just walked away from the facility and the community, leaving a note stating she could no longer handle the stress caused by the mix of younger and older residents. Unlike her predecessor, her job performance had fallen dramatically and was reflected in the residents' evaluation

⁶ Because her specific problems were so like those found by her replacement and all the other service managers, they will be summarized in the final section.

of this pivotal management role. The results of the site manager evaluation by senior residents are shown in table 5.⁷

Table 5. Ratings of the Site Manager by Seniors at the Concord and in the Reference Group (Percent)

	After 1 Year	After 2 Years	After 3 Years
Concord seniors			
The site manager is			
Inefficient*	0.0	0.0	45.1
Unfriendly*	0.0	0.0	21.6
Unresponsive*	0.0	0.0	31.3
Unavailable*	0.0	0.0	45.2
Reference group			
The site manager is			
Inefficient	17.9	5.1	16.7
Unfriendly	5.0	0.0	12.5
Unresponsive	14.7	3.4	16.7
Unavailable	15.3	10.3	23.0

* $p \geq 0.0006$, chi-square test over time.

Within a month of hiring a third site manager in as many years, the community-based organization that provided the half-time on-site case manager withdrew that person because there were not enough frail seniors to warrant the position. They maintained an off-site case manager on a case-by-case need basis.⁸ The loss of this case manager put more pressure on the site manager, who no longer had a professional social worker on site half the week to discuss and evaluate changing needs of the frail senior population. The site manager was left with more responsibilities and stress.

Failure to reach cost economies in critical services

Staff working for the service agencies assumed a certain number of seniors would need high levels of congregate services once the facility filled with frail elderly persons in need of extremely high levels of support. However, the housing authority applicant pool

⁷ The first time period represents the evaluation of the first manager; the second and third time periods represent the evaluations of the second manager.

⁸ This is one example of service economies lost as a result of the large number of younger persons ineligible for this support service; other examples follow in the next section.

became dominated by younger disabled people and totally independent seniors who did not need or want congregate services such as meals, housekeeping, transportation, or medication management. The independent seniors had no support needs, while the younger population needed services totally different from those in the congregate care program. Some younger people needed psychological counseling for depression or confusion. Others needed help with job training, job hunting, budget management, substance addiction therapy, and a myriad of other services that were not part of the congregate care program. In fact, the site managers and case managers found that some of the services needed by younger residents did not exist.

Where such special services did exist, many providers were unwilling to coordinate with the delivery of the congregate services the younger people also needed. Eligibility criteria for congregate services that younger residents did need, such as medication management and homemaker services, limited use to persons over age 62. The vendors who were part of the congregate care program were also restricted to care of the seniors. Even basic case management, which younger people with multiple problems clearly need, could not be provided by the congregate care program social worker because she was trained and paid under a state Department on Aging grant to serve only seniors.

Even when seniors and younger persons could use the same services, the variations in demand introduced by the younger people often complicated service delivery and raised service costs. For example, some younger people worked outside the facility and had more requirements for daily bag lunches from the kitchen and rides from the van to different destinations than the seniors. The younger people had different tastes in food, hair care and styles, music, and television shows. The diversity of younger residents introduced more management costs to the Concord rather than creating cost economies and efficiencies.

As problems with the younger disabled persons increased, the housing authority sought to admit any and all senior applicants—even totally independent people who did not require congregate services. This practice further diminished demand for the senior congregate services. The biggest effort to fill the facility with any income-eligible seniors occurred between April and October of 1993. During those six months, the median age of the seniors dropped from 81 to 78. Almost all the new senior residents were younger and independent; the proportion who drove their own cars rose from 21.9 percent to 31.3 percent, and

the number who said they made all the most important decisions by themselves increased from 59.5 percent to 75.5 percent.

The combination of independent seniors and younger persons thwarted economies of scale in all the support services when the facility filled up in the third year. Demand for congregate meals, case management, transportation, and housekeeping services declined in absolute numbers even as the relative size of the resident population was increasing.

Congregate meals serve many purposes in this type of facility, despite constituting the single largest congregate cost. Congregate dining operates as the primary social event of each day and remains one of the best ways for staff to check on changes in daily health. Also, congregate dining functions as one of the only ways the most frail residents engage in social activities. Between 525 and 700 meals needed to be served each week in the Concord to lower meal prices and match the facility's initial subsidy (see table 1). However, as shown in table 6, the number of residents taking congregate meals lagged far below the required economy of scale in the third year with a full facility. The subsidy ran out in the spring of 1995, and scale economies were never achieved. Many of the lowest income and frail seniors could not reasonably afford these meals. The combination of not reaching scale economies on key congregate services and having some key services for the mentally ill and recovering substance abusers not available or not coordinated with the congregate services severely complicated site management. These problems also made the individual support needs of seniors and younger persons more difficult to monitor.

The trend in congregate meals over time (table 6) reveals that satisfaction with the meals remained high or went up. So the decline in the quantity of meals served, shown in the top half of the table, was not caused by a decline in their quality.⁹ Nevertheless, the average number of meals per tenant and the number of meals served per week (seniors and total residents) all declined even as the total number of residents living at the facility increased (table 6).

Another major congregate service element is homemaker/chore provisions. At the end of the first year, 47.2 percent of the seniors used this service; this rose to 51.1 percent at the end of the second year but fell to 50.0 percent at the end of the third

⁹ This observation is reinforced by the service managers and providers who occasionally ate in the dining room and reported that meals were very good.

Table 6. Statistics on Congregate Meal Services at the Concord

	After 1 Year	After 2 Years	After 3 Years
Percent of seniors taking no meals	33.3	32.0	42.6
Total senior meals served/week*	162	207	145
Total resident meals served/week*	240	325	230
Average number of meals/week for seniors taking congregate meals	6.2	6.1	5.4
total residents	2.7	2.4	1.2
Percent of seniors preparing their own meals	44.4	34.8	42.3
Satisfaction with meals (1 = excellent, 5 = poor)			
Taste of the food	2.6	2.4	2.2
Look of the food	3.5	2.3	2.2
Size of the portions	2.1	1.9	2.1
Choice of entrees	2.4	2.3	2.2
Day-to-day variety of menus	2.6	2.3	2.4

* $p = 0.0002$, chi-square test over time.

year. Average hours of service per week was 4.1 in the first year, hit an all-time high of 5.5 in April 1993, and was down to 3.6 as the facility reached full occupancy. Similar trends can be shown for every other service element in the congregate care program.

Apartment vacancy and resident turnover

When the Concord reopened as congregate care for seniors, the facility was expected to be fully occupied in nine months. In actuality, the facility was only 40 percent occupied after one year and only 82 percent occupied after two and a half years. The facility filled after three years, but since then capacity has been hard to maintain because of high turnover. As shown in table 7, seniors registered a bare majority by the third year (53 percent),

Table 7. Rent History of the Concord

	After 1 Year	After 2 Years	After 3 Years
Percent occupied	52	73	100
Percent seniors	67	73	53
Percent younger	33	27	47

and this residential mix affected the social atmosphere. The high turnover rate of all residents also undermined the social stability of the facility.

The reference group's behavior indicated no unique factors in the Decatur economy that might cause anomalous patterns in the senior population at the Concord. Past studies of both subsidized and market-rate housing for seniors show a steady turnover rate of 11 or 12 percent per year (Gayda and Heumann 1989; Heumann 1987), which mirrors the senior turnover rate in the reference group during the study.

Rate of turnover may be higher as a senior facility is renting-up because of uncertainty about who will occupy unrented units. If resident expectations about "tenant chemistry" are not met as newer residents move in, they may leave before investing much time in the facility. However, when the residents are very low income and frail seniors with relatively few affordable housing alternatives, we would not expect the turnover to be high.

Only a very conservative estimate of total turnover at the Concord during the three-year study is possible. The Concord was estimated to have a 28.9 percent turnover of seniors between the first and second year and a 36.5 percent turnover of seniors between the second and third year.¹⁰

The turnover of younger residents is even higher. Many of them did not like living in a senior facility. They found it imposed too many rules and was too quiet. The rapid turnover of younger persons can be confusing and certainly does not add to a sense of community for increasingly facility-bound seniors. Between the first and second years, there was a 69.2 percent turnover of younger residents, and between the second and third years the rate was 46.7 percent.

The senior turnover rate at the Concord reached three times that of the reference group in the third year, even using the conservative estimate of about 30 percent. Interviews with the site managers and case manager over the three years indicated that the high percentage of departures in excess of normal turnover was the result of two factors. First, the families of many departing seniors wanted them to move because the families did not like

¹⁰ This estimate covers population changes between annual surveys, even though there is evidence that some persons were admitted and then left between surveys without ever being counted in the study. This level of transiency was observed during the one month at the site when semiannual surveys of residents were being collected.

the presence of the younger mentally ill and recovering substance abuse tenants or the types of guests these younger residents invited into the building. They felt the safety of their relative was being compromised.

Second, many of the departing seniors were totally independent people who were not really candidates for a congregate care facility. The support service managers felt that the housing authority admitted these people to fill the facility with seniors so they would not have to take younger applicants. However, these functionally independent seniors tended to find the facility too restrictive for their independent lifestyles and were uncomfortable living with the younger mentally ill residents. According to the site managers, the independent seniors tended to stay only until they found more conventional affordable housing. Because these seniors were independent, they possessed more housing options than the frail seniors who needed on-site support services.

Summary of problems

The following problems were identified by the program managers and service providers as the results of mixing younger persons, particularly those with CMI and substance abuse histories, into a housing facility for the elderly. Many of the quality of life issues and management problems clearly belong in both lists; the problems that lower resident quality of life also complicate site management, and complicating site management takes staff time, which can lower resident quality of care.

Quality of life issues

1. Resident isolation increased, the residents' sense of community declined, and social cohesion and integration among residents were reduced when seniors retreated to their apartments out of fear of the more volatile younger residents.
2. Socializing opportunities dissolved when the facility became so diversified that there were no longer enough residents with common tastes and interests to provide a threshold for specific activities.
3. The involvement of friends and family visits to the facility (providing voluntary support to residents) declined. Younger persons tended to have less of a private support network

than seniors. When residents did have potential support, site staff lacked the time to guide and encourage it. In some cases, families were deterred from visiting the facility because of volatile or unpredictable younger persons.

4. Building safety suffered, mostly from friends the younger residents brought into the facility.
5. There was an increase in resident stress, mostly felt by the seniors, which resulted in increased resident turnover and a less stable population base.

Management problems

1. Staff stress and turnover increased as a result of problems managing mentally ill and emotionally unstable younger persons.
2. There was a loss in service economies of scale, especially for senior services, because most younger persons did not need congregate support services. The result was higher service costs for low-income seniors who needed the services.
3. The introduction of younger disabled persons created a more diverse support need base and a more institutional atmosphere, with more support providers coming and going in the facility.
4. There was a loss of on-site staff time and attention per resident because younger disabled residents were more likely than seniors to be disoriented, confused, depressed, and antisocial and required a higher rate of stressful evictions.

Conclusions

The Concord does not represent an isolated case, but this single case study cannot tell us if the problems and benefits of mixing uncovered in this study are comprehensive, universally applicable, or more or less severely felt in other settings. The Concord was designed as a congregate care facility for very frail seniors, which added a more severe test of mixing in younger persons and more costly repercussions from resident incompatibility.

Nevertheless, universal lessons can be drawn from this study. The most important stems from the inappropriateness of introducing younger people who have CMI or substance abuse histories into senior housing. These young people have volatile and chronic disabilities; no amount of prescreening can guarantee successful integration with seniors who are losing their physical dexterity, mobility, hearing, eyesight, and other skills necessary to cope with irrational and unreasonable behaviors and actions.

The policy question then becomes, What are we going to do with the facilities where these types of younger persons already live with seniors? The HUD policy of designated housing plans provides no real solution for most subsidized housing owners. Even increased funding for new housing to ease the demand among younger low-income individuals will not help their situations. In the short term, forcibly relocating tenants in good standing from existing mixed facilities is not a legal option. Meanwhile, many housing authorities need to keep their senior facility close to fully rented for financial reasons, but they can no longer attract senior applicants because of problems brought about by earlier mixing in of younger people. Therefore, most subsidized housing managers should look for strategies to minimize the tensions and conflict and improve the quality of life for all residents in these mixed facilities. Some simple management practices can be employed:

1. Improve applicant screening of all persons to eliminate incompatible residents and include younger persons who produce more benefits than costs.
2. In buildings with separate wings and entries, effective plans and programs of residential zoning by lifestyle, functional ability, and support needs can be created to minimize housing vacancies and maximize living conditions.
3. Much more local effort is needed to improve case coordination between mental health and social service agencies that provide exclusive services to either seniors or younger people. Also, federal funding streams should be coordinated to create effective and efficient integrated support programs.
4. Finally, new programs in staff training are clearly needed to teach staff to cope with, and be sensitive to, the diversity in living arrangements, to successfully monitor diverse living patterns, to accurately handle interpersonal relations and group dynamics, to call in the proper support services, and to provide sensitivity training for residents as well as their informal support networks.

The Decatur experience demonstrates that if, and only if, all this can be provided on site at an affordable cost to all residents will such mixing of age groups be potentially appropriate and beneficial.

Further research

The methodology needed to accurately test the national impact of mixing elderly and nonelderly persons in federally assisted senior housing will be complex and expensive. Every study published to date has serious limitations. When the samples have been large enough to suggest national trends, the surveys have been targeted to the administrative staff above the site level. The questions asked in these surveys were too basic to detail the scope or scale of site problems and did not provide a quality of service evaluation for new solutions. This study is one of four that have detailed problems and evaluated quality of services, but they have used small, nonrandom samples, making it difficult or dangerous to extrapolate national conditions or trends.¹¹

A national random sample of senior public housing and Section 8 housing facilities is needed. It must be large enough to establish the significant independent variables that discriminate between positive and negative mixing of age groups and must classify the facilities on these variables. The list of variables is likely to be large and should include the size of the facility, design layout and zoning options, demographic characteristics of the residents, disability characteristics of the residents, ratio of seniors to younger persons, ratio of staff to residents (especially security and support service staff), types of on-site and community-based services available, and degree of cooperation among mental health, social service, and housing agency staff.

Surveys should include residents, site management staff, and on- and off-site support staff using control groups of mixed and nonmixed senior facilities. To handle such complexity, the study should be staged so that an initial classification clusters facilities into types based on demographic and environmental variables along with types of age mixes, but it should not define positive or negative mixing. Facilities in each class can then be sampled with more detailed and controlled tests of residents and staff. The final stage requires an on-site observation by trained

¹¹ For other examples, see National Resource Center (1993), Massachusetts (1994), and Hornig (1990).

teams of analysts to determine with the greatest assurance and intercomparability which management schemes, support programs, training programs, site characteristics, and population characteristics produce successful age-integrated housing.

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