A Preliminary Study of Elderly Emergency Service Clients in Chicago and Their Housing-Related Problems

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Emergencies to which city agencies respond reveal a connection between homelessness and other housing hardships of the elderly. This study examines a random sample of 125 case records of elderly clients assisted by the Chicago Department of Human Services Emergency Services program between 1984 and 1987. The crises that lead to emergency services, the extent of clients' housing-related problems, and the needs that cluster around shelter placement and other housing related problems are analyzed. An extraordinarily broad range of problems and service needs are identified. The findings reveal the prevalence of housing problems for the elderly and the relationship between basic needs, patterns of services offered, and certain emergencies, including homelessness. They have implications for improving client services and underscore the importance of ongoing rather than emergency assistance with the elderly. Very old persons without kin who experience crises are at great risk and pose growing dilemmas for urban public agencies.

The number of elderly homeless persons is small in relation to the number of younger homeless people and families. But homelessness grew dramatically throughout the 1980s and continues to increase among the elderly (National Coalition of the Homeless, n.d.; U.S. Conference of Mayors, 1986, 1987; U.S. General Accounting Office, 1985). Little is known about the causes of homelessness among the elderly, its effects, or its magnitude (Aging Health Policy Center, 1988; Institute of Medicine, 1988).

The growth of homelessness is highly visible in Chicago. Like other major cities, its government provides emergency shelter services and has thus been

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concerned about homelessness as well as the management of problems among populations vulnerable to it. I examine the problems of urban elders related to homelessness and housing by analyzing a sample of case records of older Chicagoans who have experienced emergencies. Drawn from city agency data files, these client records reveal relationships between basic needs, patterns of services offered, and certain emergencies, including homelessness.

Introduction

Several recent studies have documented the growth of homelessness in Chicago (Chicago Coalition for the Homeless, 1983; Rossi, Fisher, & Willis, 1986; Sosin, Colson, & Grossman, 1988). The extent to which the elderly are experiencing homelessness is unknown, but these and other studies confirm that some older Chicagoans are certainly suffering it (Hannibal, 1984; Haslberger, 1987; Kutza, 1987). Their difficulties appear to be less with finding housing than with keeping and maintaining it independently. Declining physical mobility makes their plight less visible, and their higher rate of home ownership often masks the true proportions of their chronically marginal living conditions. Interventions that prevent housing loss among the elderly are not well documented.

Cities are concerned about elderly homelessness for several reasons. The average age in Chicago is increasing, putting a greater proportion of people at risk. People over the age of 60 represent a growing proportion of the city's population, and those over the age of 85—who are most vulnerable to loss of familial support, income, and health—are the fastest growing subgroup among them (U.S. Bureau of the Census, 1982). The population of older Blacks and other minorities, already poorer and in poorer health, is growing, and their proportion over the age of 85 is growing even more rapidly than that proportion of the White population (Kingson, Hirshorn, & Cornman, 1986; Squires, Bennett, McCourt, & Nyden, 1988).

Like the rest of the nation, Chicago is losing the very housing that low-income elders can afford (U.S. Bureau of the Census, 1989). In recent years a precipitous loss of affordable housing (market and subsidized) has occurred because of condominium conversions, gentrification, and razing by private developers (Hoch, Saffrin, & Spicer, 1985). The federal budget for Housing and Urban Development was reduced from $32 billion in 1981 to $7.1 billion by 1987. Even Chicago's supply of nursing home beds contracted dramatically in the 1980s. Finding affordable housing for the lowest income elderly is increasingly difficult.

For persons without family at extreme ages and in need, city agencies often intervene. Yet they are unable to intervene substantially with persons who do not ask for help themselves, who live alone or have no family, or who do not receive services from other social agencies. Increasingly such persons need multiple services and very basic resources (Butler, 1975; Butler & Davis, 1987). As a result, very old poor people present distinct problems to agencies charged with managing emergencies, while demand for such services is increasing. Between January 1986 and August 1987 the Chicago Department of Human Service (DHS) experienced a 400% increase in referrals of elders from its emergency service unit to its senior follow-up unit. The primary problems identified included basic needs (59%), need for medical treatment (29%), relational and other difficulties (9%), and victimization (4%). Basic needs included shelter or temporary housing and relief from deteriorated or deplorable housing conditions, fire, eviction, tenant-landlord disputes, and other situations.

DHS purchases emergency shelter care for the indigent from some 42 shelters as well as from motels, transient hotels, and two specifically designated "senior shelters." Its division of Emergency Services (ES) is the city agency most likely to deal with homelessness and has growing responsibility for housing services and relocation. Six radio-dispatched mobile response teams provide on-the-spot, short-term intervention 24 hours per day to persons referred by the police, fire department, citizens, shelters, and other agencies. Each team consists of two experienced workers trained on the job to respond quickly to a wide range of situations. Their task is to resolve problems quickly; they are not specialists in helping the aged but refer approximately one fourth of the senior cases to the DHS follow-up unit. Referrals are also made to other community agencies, with a small number being referred to a health care project for the homeless. Forty percent are also served by the city area agency on aging. ES handles over 100,000 cases per year between telephone and direct service of which about 1 in 9 are elderly. Resistant emergency clients usually do not become clients of other agencies although some may be seen again by the ES teams. Because of the scope of ES services, its records provide a unique source of data on crises encountered by older persons throughout the municipal area.

Methods

To examine the emergency needs of seniors and identify factors associated with persons who have been homeless, a random sample of 125 emergency case records of persons aged 60 and over was drawn from this agency's case

files in the summer of 1987 (Keigher, 1987). Each record contains demographic data, referral source, and a brief narrative description of the presenting problem and the service(s) provided. Such records provide evidence of clients' circumstances over time, the reasons for their encounters with ES, and their needs. In addition to the ES contact cards, supplementary client information was found in over two thirds of the 125 cases in the files of other city agencies, including the area agency on aging (42%), the follow-up unit (25%), and health care for the homeless (6%).

Case data are suggestive of the needs of the clients seen, but certainly not definitive of them, because notations are inherently subjective, incomplete, and selective of detail. The sample cannot tell who does *not* use emergency service and so cannot be used to extrapolate the actual prevalence of problems citywide. Given its small size and the frequency of missing data (e.g., race and age), tests of significance are only occasionally appropriate. However, this agency is a good source of data in that it is less selective of its clients than typical community service programs: It imposes no fees; its clients are referred by agencies and other people, especially the police; most clients are nonvoluntary; and it responds to virtually every referral it gets. The agency's recognition of needs and problems is simply filtered by the repertoire of services it offers (Lipsky & Smith, 1989).

The variety of needs presented to this agency makes it a source of unusually comprehensive data. The sample includes a wider cross section of the elderly than street surveys that have limited the definition of homelessness to persons literally on the street (Douglass, 1988; Rossi et al., 1986). The study also encompasses a broader population than surveys of clients at social agencies providing specific services, such as food and shelter (Kutza, 1987; Sosin et al., 1988). ES clients may have used city paid shelter, other shelter or no shelter, used many social services or none at all. Great variation is seen in their problems.

Results

Sample Demographics

Distinctly needy subgroups emerge from the random sample on the basis of age, number and intensity of contacts with ES, concentration in certain communities, and problems presented. The sample is not significantly different statistically from the city population demographically. Ages range from 60 to 100 at the time of the first ES contact, with the average being approximately 69. About half of the sample were over the age of 73, with

42% over the age of 75 and 14% over the age of 85, making it somewhat older than the aged population of the city.

Older Black men were much more likely and older White women much *less* likely to be referred to ES than their respective populations would predict. Older Hispanic males were more likely and older White males were *less* likely to use ES, and Hispanic females seemed to use ES in proportion to their representation in the population. ES senior contacts were well distributed around the city. Districts with the most referrals generally included neighborhoods with the highest proportion of seniors. Those living alone were also more likely to be referred.

The majority (66%) had had only one contact with ES, although multiple contacts were recorded over a period of from 1 day to up to 5 years. Only 10% had 4 to 14 contacts, and 4% had from 18 to 35 contacts. Thus, although most clients had very minimal contact with ES, a distinct subgroup appears to have had substantial unmet needs. The five clients having 15 or more contacts had all been served for at least 3 years, were described as chronically undomiciled, and had stayed in city-paid shelters.

The problems presented in the ES contact are not always easily delineated, although descriptive information from other agencies supplements this. Table 1 presents a complete listing of problems from *all* the data available. The problems recorded often reflect more than one encounter with ES or other agencies and multiple interrelated conditions for each client, but the number of problems identified per client suggests their severity. The average senior had at least two problems, but 23% had four or more. Certain problems appear to cluster, for example, simply having, or not having, a residence delimits a distinctive pattern of problems. Some ES clients were clearly very needy, especially those who were older, Black (and consequently poor), and living alone. A substantial proportion who were helped repeatedly had multiple problems, including serious medical or psychological ones. They resemble the high-risk population that Butler and Davis (1987) describe as old, alone, and poor who are at risk of self-neglect and institutionalization. The problems presented by seniors with needs for shelter or temporary housing or who were ever "undomiciled" are distinctly complex. Analyses of these problems are especially important given the expense and complexity of shelter provision.

Characteristics of Elders Needing Shelter

At least 31% of the ES clients needed shelter at some point. These persons were only somewhat younger than those who did not need shelter, with substantially fewer in the group aged 85 and older (5% vs. 19%). This

Table 1. Problems Presented by ES Clients Needing Shelter and Not Needing Shelter

Problem Type	Total ES Sample			Clients Needing Shelter			Clients Not Needing Shelter		
	n = *125*	*Percentage*	*Rank*	n = *39*	*Percentage*	*Rank*	n = *86*	*Percentage*	*Rank*
Medical/health	52	42	1	19	49	3	33	38	1
Lost/wandering	41	33	2	16	41	5	25	29	2
Needed shelter	39	31	3	39	100	1	0	0	0
Psychological problems/intoxicated	34	27	4	19	49	3	15	17	6
Uncooperative	31	25	5	14	36	6	17	20	5
Fire	23	18	6	1	3	14	22	26	3
Undomiciled	22	18	7	22	56	2	0	0	0
Bad housing conditions	21	17	8	3	8	11	18	21	4
Needed food	21	17	9	7	18	8	14	16	7
Evicted	14	11	10	10	26	7	4	5	10
Crime victim	12	10	11	6	15	9	6	7	8
No utilities	9	7	12	5	13	10	4	5	10
Domestic violence	7	6	13	2	5	13	5	6	9
Other	4	3	14	3	8	11	1	1	12
Total number of problems	330			166			164		

difference is not statistically significant ($p < .24$), although generally the chronically undomiciled are younger, "age faster," and die earlier on the streets (Cohen & Sokolovsky, 1989; Institute of Medicine, 1988). As will be shown, "need for shelter" does not necessarily mean "homeless" in this sample, and on many characteristics the shelter clients are more similar to than different from the other ES clients.

Of the shelter need group, 62% were men, as were 43% of those who did not need shelter ($p < .10$); Whites and Hispanics were overrepresented among those who have needed shelter ($p < .15$). Neither of these are statistically significant differences, however; and race is unknown for fully 26% of the sample. Of those needing shelter, the men were evenly split between Blacks and Whites (42% White, 42% Black, 17% unknown), whereas the women were more often White (47% White, 33% Black, 20% unknown). In general, those in need of shelter were more likely to be White and male when compared to those who did not need shelter. The other ES clients, who usually presented other needs, were more often Black and women.

Over half of the shelter need group were described in the record at least once as being undomiciled, including most of those clients who had been served four or more times and all of those having 15 or more contacts. They tended to live in the city districts having the highest incidence of homelessness. Three types can be discerned among these 39 clients: persons who appeared to have (a) barely used shelter, if at all; (b) used shelter only briefly; and (c) been chronic shelter users.

Elders Needing Shelter Who Barely Stayed at a Shelter, Including Transients

About one fourth of those in need of shelter (10 of 39) did not actually stay in shelter or did so only for one or two nights as they traveled through Chicago. It was not unusual for ES "shelter cases" to be resolved without a shelter placement, although alternative resolutions usually required extensive telephone contact, transportation, and worker time. Some clients relocated with friends or relatives, were admitted to hospitals, were referred to agencies serving the aged, or disappeared before the ES team arrived.

This category includes transients who had only recently arrived in Chicago who used a shelter for a night or two. They were habitual itinerants who become lost or confused at transport stations, individuals who had gotten lost or run out of money after coming to Chicago for some purpose, and persons who had recently moved to Chicago but became confused or victimized. All cases involved intense ES interventions for up to 3 days and sometimes a

great deal of follow-up. These individuals were not typically considered "homeless," although they could have been, and they often appeared to have moved immediately.

Short-Term Shelter Use

About three fourths of those who needed shelter actually stayed at one. Records usually do not indicate how long or how often they stayed, but about half were listed as "undomiciled." Several more used free shelters regularly, and a few lived at least intermittently at cheap hotels, YMCAs, or motels. Persons with only one or two contacts with ES may actually have been chronically homeless persons who avoid agencies.

Of the 29 who used shelter, about two thirds (18) had only one to three contacts with ES. Their circumstances varied widely; for example, at least 2 were placed in shelter because of deplorable housing conditions, another because of a utility shutoff, and 5 had recently been evicted. Some were lost, wandering, or without identification. Some had medical conditions that necessitated transport to a hospital, and many had situations complicated by medical, psychological, or alcoholism problems. Some had listed an address but went to a shelter anyway, and at least half apparently had no place to live. It appears that a sizable proportion of the "low-contact" shelter users were very briefly homeless and that housing problems and/or inability to manage contributed to this.

Such persons were usually taken to a senior shelter because only limited alternatives were immediately available. In a crisis, temporary shelter seemed appropriate, although, typically, only action by other social supports and kin really precluded further ES contact. This short-term shelter use resulted from a complicated array of acute problems and precipitating situations, urgent needs for assistance, and having no safe place to go. Shelter use resolves only such imminent dilemmas.

The Chronically Undomiciled

Of those who used shelter, almost one third (11) had four or more contacts with ES. These included the chronically, long-term or high-use shelter users as well as the intermittently homeless. These persons ranged in age from 60 to 83 and had from 6 to 35 contacts with emergency services over periods of 1 to 4 years. Nine were listed as undomiciled, including five who had been evicted. Both Black and White, most were very well known to ES staff.

More information is available about the chronically undomiciled women whose notably aberrant behavior attracted substantial attention. The records

indicate that these women were substantially mentally impaired, uncooperative, aesthetically unpleasant, and possibly suffering from dementia. They fit a "bag lady" stereotype, but they "lived" in abandoned buildings, on bus benches, sometimes with friends, and intermittently in shelters. Their health problems included lice, incontinence, leg ulcers, alcoholism, and paranoid schizophrenia. ES interventions were typically limited to transporting them for a medical clearance and then to a shelter, and they were more likely to be placed in a transitional shelter than in an overnight one. Sometimes they were not admitted because of disruptive behavior, general offensiveness of odor or habits, or refusal to leave their bags and belongings outside.

The men in this group were seen less frequently by ES than were the women and were more inclined to stay regularly at overnight shelters (possibly because more shelters serve men than women). They were somewhat younger and their problems were often related to alcohol abuse as well as to dementia. Some had been refused admittance to shelters because of intoxication or violent or offensive behavior. ES usually transported them to the nearest bus stop rather than providing rides to shelter.

In sum, nearly a third of the ES seniors had needed shelter at some point in the past four years. These clients had many more contacts and longer histories with ES, and more known problems than did the others. They included regular and irregular shelter users sometimes living in marginal conditions on the streets and, occasionally, in their own residences. Of all ES clients, 5% were basically transients using shelter, 14% (about whom little is known) had used shelter for a variety of reasons and durations, and at least 9% could have been considered chronically undomiciled, regularly living in shelters and on the streets.

Differential Needs of the Shelter Users and Nonusers

Elderly emergency service clients experience very serious problems. Some of these are short-lived crises, possibly amenable to emergency intervention, but others are deep-seated social problems that can be resolved only with resources and carefully orchestrated social interventions over a long period of time (Lipsky & Smith, 1989).

Clients in need of shelter are clearly in this latter category. Aside from needing housing, their main problems are similar to those who do not need housing—having medical conditions or poor health, being lost or wandering, and being uncooperative—but they have much higher rates of these problems. They are almost three times as likely to suffer from psychological or alcohol problems, over twice as likely to have been a victim of a crime, five times more likely to have been evicted, and almost three times as likely to

have had their utilities shut off. They are also more likely to have been uncooperative with agencies.

On the other hand, those who did not need shelter were almost 10 times more likely to have had a fire and 3 times as likely to be living in unsafe or unhealthful housing conditions, problems that only persons with homes could have. (Both groups have similar incidence of medical problems, being lost, and being victim of a domestic dispute). Those housed appear to have the same threats as those living on the streets, but they evoke less public concern. Seniors seem to be handled in different ways if ES workers view them as homeless, especially if they are lost or hungry.

Being lost. Recording a senior as "lost" is a polite way of handling a routine difficulty of some frail elderly persons. Seniors who become lost usually suffer from dementia, psychosis, or situational confusion. They are not recognized by neighbors, wandering in a public place, or lost on public transportation. They are reported to ES by police, emergency rooms, shelters, neighbors, or others concerned about them. Typically the lost senior is taken by a concerned citizen to a police station, found to have no identification, and turned over to an ES team. They are sometimes suspected of being missing persons or intoxicated.

However, the urgent needs noted when a senior is confused and lost are different if that person appears to have a residence. When need for shelter was associated with (or necessitated by) being "lost," myriad other complex problems were usually identified. For example, lost seniors who were taken to a shelter were more likely to be listed as having psychological problems or being intoxicated, uncooperative, or difficult to get information from. They were usually taken to unpaid shelters or to the nearest bus stop to find their own way to shelters. Typically, the senior who had no place to live and became "lost" was seen repeatedly by ES until, or unless, disposition to a more controlled setting finally occurred. Indeed, more of the shelter users tended to get lost, and they did so more often.

Some were placed temporarily in senior shelters because of psychological or health problems or inability to cooperate or communicate, but these usually had minimal contact with ES. Worried family members usually came forth quickly so that no further agency intervention was required. These differential dispositions are based on largely subjective distinctions between the "chronically undomiciled" and those genuinely deserving of help. Elderly women were more often in the latter category.

Being hungry. Similar proportions of those needing and not needing shelter needed emergency food. With those in need of shelter, workers usually

left a food box after the client was relocated in transitional housing at a YMCA, a single-room occupancy (SRO) facility, or with a neighbor. Occasionally, they actually took the client to a cafe to obtain a meal. At regular shelters, however, food boxes are unnecessary.

The need for food by persons in their own homes was usually accompanied by problems such as utility shutoffs or deteriorating housing conditions, evidence of poverty, and inability to manage. Of the 14 who received food boxes in their own residences, 12 were women, usually following some crisis such as domestic violence, a diabetes attack, or other health problems.

Transitional states and becoming undomiciled. As noted above, most older ES clients, even those who were placed in shelters, had intermittent and even regular addresses. Of those who used shelters, over half also listed a local address, although some of these addresses were actually shelters. Many addresses were transient hotels or SROs. About a third of the clients who resided in shelters were actually transported to homes at least once, over half were transported to shelters, and at least 15% were transported to hospitals. This indicates that some literally lived in public shelters on a semipermanent or permanent basis, many were intermittantly housed, and, for some, transitional states were a permanent life-style.

Problems Leading to Loss of a Home

Shelter use is only one indication of desperate need presented in these records. Additional need is suggested by the fragility of the housing conditions where many older persons live. Upkeep of personal surroundings reflects mental and physical health as well as financial capacity so that frequently deterioration is evidence of psychological, organic brain, or physical decline. Neglect of housing maintenance is often directly precipitated by loss of mental and/or visual acuity. Yet, even if the condition of home, apartment, or room is thoroughly inadequate, its loss is a major disaster having significant implications for life-style and security.

Most of those in need of shelter were living in marginal housing that was lost when some crisis occurred. Being completely without a place may actually be a shorter step toward getting assistance than is remaining in one's own privacy, because the public generally finds it unacceptable to allow impaired elderly persons to live in public places. Owning or living many years in a permanent residence may subject an older person to as marginal and fragile a life as being homeless, because only major emergencies draw sufficient attention to force relocation.

The emergencies experienced only by persons living in homes or apartments (residential fires, poor housing conditions, loss of utilities, and evictions) affected about half of all the ES samples. Of those who did not need shelter, 23% had suffered fires in their residences (including three married couples), and 25% had housing problems other than fire. This suggests that the shelter clients have experienced as many housing-related difficulties as those who have never needed shelter, especially evictions and utility shutoffs, which may have directly necessitated the shelter use. These occurrences, each of which lead to potentially devastating outcomes, are discussed below.

Evictions. Shelter users were four times more likely to have been evicted than those who did not use shelters. Five of the eight who had been evicted in the shelter use group were men, and several had been evicted repeatedly. Most had histories of short-term residences, often in SRO buildings, transient hotels, or other units where rent is paid on a daily or weekly basis. Most had "streetwise" life-styles, psychiatric difficulties and hospitalizations, or had been committed to detoxification programs. Multiple difficulties with coping are common.

Although several had obvious psychological difficulties, only one was mentioned to have medical problems. Either ES workers are unlikely to recognize health problems or landlords are reticent to evict older ill persons with nowhere else to go. (Landlords and hotel clerks had often provided extraordinary help to frail older residents, such as regularly delivering meals, even to persons who had not paid rent for a long time.) Many of those finally evicted were aged mentally ill persons who had become disruptive or very sick, whose landlords were no longer comfortable managing them.

To the regular shelter users, eviction was simply one more adaptive step in a continuing cycle of transitory living. Workers who distinguished among those needing assistance on the basis of potential responsiveness expected such persons to continue to fend for themselves and appeared more sympathetic toward persons who were evicted because they were ill. Evicted clients avoided public shelter either through adamant refusal to go, because relatives offerred to take them in, or because some agency helped locate alternative housing. Effective assistance at the first eviction deterred further loss of valued possessions, burdens on families, and a cycle of residential instability.

Utility shutoffs. Utility shutoffs affected only 7% of the ES clients, including mostly those who also needed shelter. Lack of utilities accompanied very few of the reports of deplorable housing conditions, perhaps because housing conditions are usually investigated in summer and utilities

are needed mainly in winter. Two of the four shelter users without utilities were living in deplorable conditions when ES placed them in shelter for their safety. This suggests the importance of whether the older person owns or rents his or her home, and if renting, the permanence of the lease and the supportiveness of the landlord. Clients with permanent homes usually return to them after a few days in shelter; otherwise they risk losing them altogether on going to a shelter.

Utility shutoffs, like nonpayment of rent and eviction, impose immediate negative consequences. Persons lacking utilities, even those who owned their homes, often needed food deliveries, too (symptoms of poverty), although they sometimes also displayed declining mental and physical capacity. Without ongoing case management, their situations often deteriorated, as described below.

Poor housing conditions. Poor housing conditions are much more prevalent among elders who have never used shelter, have their own residence, or have family members who provide assistance. The client is unable to maintain the home, which has become hazardous or unhealthy with accumulating garbage or debris. ES intervention may be precipitated by landlord neglect, poor pet maintenance, living in abandoned buildings, or owning or inheriting buildings that the elder could not maintain. At the extremes, the clients' situations had already led to illness or caused fires. Sometimes ill or demented persons were found lying in their own excrement, or the Department of Streets and Sanitation had to be called to fumigate a residence for vermin or sewage.

Persons living in deplorable conditions usually required assistance more than once, but records indicate they rarely get follow-up. Although serious housing problems and utility shutoffs were experienced by about twice as many who did not need shelter, equal numbers of shelter users and nonusers — all elderly women living alone — reported utility shutoffs. Often no follow-up or formal assistance was provided in these cases at all, sometimes despite the knowledge of several agencies. Often at least a year elapsed between the first ES contact and the second, as in the following chain of events reconstructed from case records from several sources.

> Mrs. R., an 82-year-old Black woman, was referred to ES by the agency for the aging. She reportedly had three elderly persons living with her who were defecating in the alley behind her home. On investigation, the ES team learned that the woman had taken in boarders after her husband was placed in a nursing home. Living on public aid, she was unable to maintain the house. The toilet broke and she could not afford a plumber. It was doubtful that she was collecting rent from the boarders. Yet, the Visiting Nurse Association had

recently closed her case because "she didn't need nursing service." At the time of the ES investigation, the renters were evicted and ES suggested that Mrs. R.'s stepson take guardianship and place her in a supervised living arrangement.

Apparently this did not happen because she was still in the house 15 months later when it was largely destroyed by a fire. At that point, relatives came from California and moved her in with the stepson, at least temporarily. The agency for the aging case management unit opened her case 9 months after she was moved out of the house. Subsequent contact by researchers revealed that Mrs. R. later moved to a nursing home in California to be near her sister. She stayed about a year, but then returned to her home in Chicago, which has been repaired. She continues to reside there with her stepnephew's young family. They attend to her daily needs, because she is nonambulatory and somewhat confused.

Like most reports of "deplorable" housing conditions, Mrs. R.'s problems appear to have been preventable. Agency actions might have corrected the plumbing problem, as well as prevented the conditions that lead to the fire. It is unclear why the agency took so long to respond. The tenuousness of available family assistance and lack of timely agency follow-through (despite her home's being a worry to her neighbors) appears to have allowed her situation to deteriorate. Similar cases of very poor, confused, and sometimes isolated individuals often involved couples or elderly sisters found to need nursing services, food, and shelter (or other multiple kinds of help) and complex but attenuated family ties. Such clients usually continued to live in their homes, as does Mrs. R., without any agency assistance.

Fires. The culmination of deteriorated housing circumstances were residential fires, which comprised over 18% of the emergencies. The victims included three married couples (two Hispanic, and one aged 91) and a woman who spoke no English. Several fire victims lost all their personal belongings, their pets, or their relatives. At least four had had significant encounters with ES *before* the fires occurred, and building fires frequently started in the elderly victims' apartments. With forgetfulness, confusion, or accumulation of combustible possessions, aging persons can be the cause as well as the victims of fires.

Only one of these 23 cases required placement in city shelter. Most victims quickly moved in with relatives or friends or were assisted by the Red Cross, requiring little DHS follow-up. Those who remained in their dwellings after fires were at great risk, because of their own incapacity and the danger posed by the property. However, some, without relatives or friends, with poor judgment, or without resources continued living there. ES investigates fires and housing conditions far more often than it actually relocates people or otherwise intervenes. But the most perilous circumstances do not improve on their own, and these situations usually deteriorate further.

Discussion

Agency client records of emergencies are a rich source of data on the housing needs and risks of the elderly. As noted at the outset, these data confirm that when housing is lost to the elderly, it is extremely difficult to replace. Most elderly who experience emergencies, however, have grave difficulty keeping and maintaining it because of physical and cognitive impairment. Homeowners are least likely to lose their housing or to receive any follow-up services after an emergency. Extreme poverty stands out as a precipitating factor in most emergencies to which the city responds.

Although the incompleteness of these data limits the generalizability of the findings, they confirm some disturbing realities in how cities deal with housing problems of older people. Two especially intransigent problems, isolation and poverty, need further attention from researchers and policymakers.

First, although approximately 80% of the ES clients apparently lived alone, most coped with the assistance of family, neighbors, and friends. Note, for example, that all but one of the fire victims were immediately taken in by relatives or friends, such that they never needed shelter. In contrast, only 20% of the case records of the shelter clients mention names of relatives or friends, and many indicated that fires had been experienced by these individuals in the past. The latter group appear to lack reliable social supports with resources to share, and the seriousness of their dislocations suggest that they had no housing alternatives. For some, their isolation appears to be an even greater deficiency than their lack of money.

Elderly persons found by ES to need shelter are not necessarily "homeless," but certainly are vulnerable to it. Persons who have lived a marginal life-style for any period of time (having been institutionalized, suffered chronic mental disorders, or paid rent on a week-to-week basis in transient hotels) are occasionally or intermittently *un*housed, because they have particular difficulties managing on little money or living a precarious life-style. ES is somewhat likely to encounter such persons a second time, unless they have a permanent or secluded living arrangement not likely to attract attention.

The second critical problem is extreme and insidious poverty. Kutza (1987) found, for example, that although most elderly clients at Chicago's health care for the homeless project had some source of regular income, it was typically less than $350 per month, an amount insufficient to sustain adequate housing when living alone. Older persons who own their homes have some distinctive protection, becoming vulnerable to homelessness only when beset by overwhelming personal and cognitive losses or threats to their homes. The domiciled may become vulnerable if they are relocated to shelter

temporarily and thus lose their personal and housing resources. Traditional street people may be more or less "homeless" at different points in a year or in the cycles of their conditions.

Homelessness is only the tip of the iceberg of housing problems of elderly Chicagoans. Poor older persons who lack social *and* housing alternatives and cannot afford available single unit housing are at risk. Shelter users lack trusted friends and relatives to "double up" with, obtain advice from, or turn to for help in an emergency. This includes not only men who have experienced lifelong estrangement from family, alcoholism, or other problems, and who live semipermanently in the city's shelters, but also an increasing number of women. This corroborates Sosin's (Sosin et al., 1988) findings about the isolation of younger homeless people and other findings that older people lose their housing largely because they desperately lack social resources (Bachrach, 1987; Cohen, Teresi, Holmes, & Roth, 1988). The near homeless and undomiciled become increasingly vulnerable as their personal resources are lost. Homelessness appears to be not so much a permanent condition as it is a permanent threat for a significant proportion of the very poor and very old who are without family; a problem surely amenable to planned solutions.

Services. These data can suggest ways to improve certain interventions, service delivery priorities, and prevention. A sizable proportion of those sampled had problems related to losses that predated their emergencies. Nearly a third of these were complicated by stays in shelters. Clearly, some of these tragedies might have been prevented by more timely, better coordinated, and more appropriate formal interventions. Effective social services must replace vital personal resources and contain counterproductive housing patterns that have led to hazardous conditions or evictions.

In the long run, efforts to keep elders in their homes, even marginal efforts, are less expensive than shelter placement. Provision of the basic necessities of life, decent medical and psychiatric diagnoses, treatment, and assistance in managing personal space and finances to prevent evictions are prerequisites. Having informal nonrelative caregivers available is also vital. Landlords, for example, must know what assistance and resources are available. When medical problems or dementia exist, informal helpers often need support and information to offer effective assistance. Informal caregivers need to know about and be encouraged to become legal guardians or representative payees.

Housing alternatives for the most difficult and habitually undomiciled among the elderly, those with the fewest physical and social resources,

require aggressive and consistent long-term assistance, for even when referrals are made under optimal circumstances, these clients often cannot follow through alone. But ES's experience confirms that elders with such needs are proportionately few. All tragedies cannot be prevented, but, clearly, some of the emergency situations reported here could have been. Most needed only a bit more help and follow-through. Without resources, decent housing alternatives, and reliable, appropriate assistance, many of the urban elderly will continue to suffer serious emergencies unnecessarily.

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