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HOUSING ENVIRONMENTS FOR ELDERLY PEOPLE IN THE UNITED STATES

Ageing demographics, older people's preferences, and public policy trends have affected the way elderly people are housed in the United States. Longevity continues to increase, greater numbers of older people are living longer periods of time with frailties, and a cost-containment shift in public policy has promoted the delivery of long term care via community-based alternatives and decreased the proportion of older people living in institutional environments. This shift supports older people's strong preference to stay where they are and age-in-place when frailty compromises independence. The policy shift and consumer preference behaviors underlie the rapid growth in the number and variety of community-based services available to allow older people to successfully age in place, as well as the development of many types of purpose-built senior housing alternatives that integrate housing with activities, supportive services, personal care, and health care.

As the locus for long term care has shifted, the role that the housing environment plays in the lives of older people has grown in significance. For older people, their housing cannot be considered in isolation, but must be considered part of their wider physical and social environments (Sherman, 1990). Both the physical and social environments have an impact on the mental and physical status of older people (Gutheil, 1990; Bechtel, 1997) and, therefore, on their well-being. Aspects of the housing environment must be considered when seeking to influence the well-being of elderly persons.

ENVIRONMENTAL THEORIES

Researchers have developed environmental theories that provide frameworks for social workers, other practitioners, and family caregivers for understanding the implications of attending to or ignoring the housing environments of older people. These theories provide principles to undergird interventions, programs, and policies to improve older people's housing environments as a means for improving well-being.

Sherman (1990) describes several theories that explain the dynamics of aging and environment: (1) Lawton and Simon's environmental docility hypothesis asserts that the less competent the individual, the greater is the impact of environmental factors on that individual. The more vulnerable a person is, the greater he/she is affected by even a small negative or positive environmental change. (2) Lawton and Nahemow's adaptation model (environmental press) purports that an individual at a given level of competence will be optimally adjusted at a given level of environmental demand. (3) Kahana's person/environment congruence theory stresses that environments do not have a uniform effect on all persons, that a given environment is not good for all persons. A person can be characterized by the types and strengths of his/her needs, the environment can be characterized by the extent to which it is capable of satisfying those needs, and optimal adjustment is achieved by matching the individual with the appropriate environment.

Cox (1990, 1993) describes environmental theories that explain how older people strive to maintain consistency in their environment and how frailty can result through older people's interactions in the social environment: (1) Atchley and Bultena describe continuity theory, which views old age not as a distinct phase of life but as a natural continuation of earlier periods and proposes that older people seek to maintain their earlier life styles, roles, and activities even in the face of opposing social forces seeking to discourage this continuation. (2) Mead's symbolic interaction theory posits that a person's identity is developed and maintained through interactions and reinforcements with others around him/her. (3) Bengston's social breakdown and reconstruction theory proposes that many factors in the environment act to both threaten and destroy an older person's competence and that as abilities decline with age, the person is labeled impaired and becomes vulnerable to dependency, a label which tends to be fostered by the existing services system. (4) Similarly, according to Seligman's learned helplessness theory, when those around the individual focus on the older person's frailties and disabilities rather than

on his strengths, helplessness and passivity develop as the impaired person begins to accept the loss of control over his own life and loses confidence in his ability to function.

Langer's theory of psychological control (Bechtel, 1997) is based on evidence that elderly persons who were given mindful decision-making responsibility over their own care were more active, healthier, were in better spirits, and lived longer than those whose care decisions were put in the hands of others. Bechtel also describes Lawton's environmental proactivity hypothesis, which is a counterpart of his environmental docility hypothesis and is an explanation of growth throughout the lifetime. This theory asserts that as personal competence increases, the variety of environmental resources that can be used satisfactorily by the person also increases and that if the environment is made proactive, the elderly will respond.

PERSON/ENVIRONMENT INTERACTIONS

Researchers have studied several elements that are related to well-being. Findings help clarify the effect of housing-environment decisions on older people. The studies show that, for an older people, the elements of *choice* in decisions about their living environment and the amount of *change* experienced by an older person are critical factors in determining well-being.

Relocation: Findings indicate that relocation itself is not the critical variable affecting the well-being of elderly people, but that the context within which the move occurs, the extent to which the relocation was voluntary or involuntary (choice), and the amount of life change that occurs as a result of the relocation are the critical factors related to positive or negative outcome. Work by Borup, Gallego, and Heffernan (1979) and Lieberman and Tobin (1983) shows that involuntary relocation (lack of choice) has a negative impact on older persons' physical and mental conditions. Sherman (1990) reports on Lawton's 1980 summary of several studies which concludes that there is a risk of physical health deterioration as a result of older persons' relocation within the community. Lawton finds no deterioration in social or psychological functioning or mortality, but finds that this is dependent upon perceived choice in the decision

and upon the quality of the new environment. Schultz and Brenner's 1977 research (Sherman, 1990) concludes that choice and the quality of the new environment are important determinants of positive outcome. Schooler's stress-theoretical model separates the effects of a residential relocation itself from the effects of the changes the relocation event brings to the older person's daily life (Sherman, 1990). The findings of others support Schooler's theory, indicating that choice in decision-making and the amount of change or degree of instability in a person's environment resulting from the relocation are the sources of the impact (Mirotznik and Ruskin, 1985; Borup, 1983). Mirotznik and Ruskin concluded that relocation involving radical environmental change tended to be deleterious, moderate change had no effect or a positive effect on psychosocial status, relocation to environments that encouraged dependency resulted in declines in psychosocial dimensions, patients relocated to environments that encouraged independence improved physically and cognitively, and involuntary relocation was more likely to result in more distress or in increased mortality and morbidity.

Perception of Well-Being: A broad base of research consistently finds that subjective well-being (morale, happiness, life satisfaction) remains stable during later life and is not subject to the effects of aging, but that perception of well-being among adults is sensitive to changes in life circumstances or life patterns (life events). Change increases the risk of negative outcomes in physical and mental health and perceptions of well-being, and the degree to which a positive or negative life event is subjectively experienced as stressful is strongly related to the negative impact of that event on the individual (George, 1990). Perception of well-being, and the impact of events as stressors, is strongly related to socioeconomic position, health status, amount of family and friendship interpersonal ties, access to informal social networks and social support structures, and predictability of social interactions (Baur and Okun, 1983; Ward, LaGory, and Sherman, 1988; George, 1990). Stability in these factors lessens the impact of change due to life events. In addition, older persons do not react to objective situations in identical ways, but

each person's own life experiences in the process of reaching old age affect how each will subjectively react to life changes (Lindberg, Hartig, Garvill, and Garling, 1992; Ardel, 1997).

Autonomy and Competence: Altholz (1989) defines autonomy as the quality of being self-governed, and defines competence as a person's capacity to interact effectively with his/her environment. The burden of maintaining competence does not rest solely with the person, but is a transaction between the person and the environment (Gutheil, 1990). Altholz' research review concludes that both the external environment and the people in the environment are critical to an older person's maintaining autonomy and competence, that environments which do not allow opportunities for autonomy and competence can lead to frustration, depression, helplessness and apathy in elderly people, and that both autonomy and competence are basic motivators for both independent and frail older people. Bechtel's (1997) review determined that loss of autonomy and control over one's life caused deterioration and even death, while gaining control brought improved health and outlook.

Perception of Environment: Most people view their home as a personalized place that expresses their identity, and the concept of "home" overlaps the physical dwelling and the neighborhood (Bechtel, 1997). Ward, LaGory, and Sherman (1988) found that general satisfaction with one's neighborhood is correlated with morale and that happiness is related to perceived safety/security of the neighborhood, the kind of people who live there, the ability to visit with friends, the amount of peace and quiet, accessibility to shopping, traffic patterns, and neighborhood upkeep and repair. These authors draw a distinction between (1) the neighborhood of the mind, which is a place where people feel some degree of affiliation or an area defined by a mental connection with the others who share the defined space, and (2) the neighborhood of use, which is a place whose facilities and services are used by people. Both must be considered to achieve a balance between the individual's perceived fit (mental congruence) and his/her actual fit (behavioral congruence).

As environmental experiences and choices are reduced by physical, social, and economic losses during the aging process, the importance of the living environment in maintaining well-being grows, and a close fit between the characteristics of the residential environment and the personal characteristics and preferences of the resident becomes critical.

HOUSING PREFERENCES OF OLDER PEOPLE

The importance of providing older people with choice in their living environment decisions underscores a need to understand the housing-related preferences of older people. Some common preferences have remained consistent over time, reflecting many of the elements that researchers have found to have an impact on older people's well-being: continuity in place and in life styles; familiarity; maximized privacy, stability, and independence; choice in options; autonomy in decision-making; and control over day-to-day living activities.

The desire for continuity and familiarity is illustrated by older people's relocation patterns and the extent to which the older population does age in place. Many studies (Flynn, Longino, Wiseman, and Biggar, 1985; Orange County Office for the Aging, 1986; Golant, 1987; Stein, 1987; Parr, Green, and Behncke, 1989; Sherman, 1990) echo the findings of AARP's four nationwide surveys of the housing preferences of older people. AARP found that 78 per cent (1986), 84 per cent (1989), 84 per cent (1992), and 83 per cent (1996) of older people agreed with the statement, "What I'd really like to do is stay in my own home and never move." Among those aged 75 and older, 88 per cent agreed with that statement (AARP, 1996). In 1996, AARP found that 40 per cent of older people aged 50 and over have lived in the same residence for over 20 years and 50 per cent have lived in the same geographic area for over 30 years. Among those aged 75 and over, 40 per cent have lived in the same residence for over 30 years and 64 per cent have lived in the same geographic area for over 30 years. Between two and five per cent of older persons move intra- or inter-state each year compared to 9 - 20 per cent of the general population, with the greater majority of relocating older persons staying within their own

communities (Alba and Batutis, 1984; Flynn, Longino, Wiseman, and Biggar, 1985; Golant, 1987; Regnier and Pynoos, 1987; Lavenhol and Horwath, 1988, Parr, Green, and Behncke, 1989; Hunt, Merrill, and Gilker, 1994; Longino, 1994; Johnson-Carroll, Brandt, and McFadden, 1995; and AARP, 1996). The older a person becomes and the longer a person has lived in a community, the less that person prefers to move upon retirement (Johnson-Carroll, Brandt, and McFadden, 1995; AARP, 1996).

The preference for familiarity in living environments is reflected in the primary relocation sites older people choose when moving: near to their children or family, back to where they grew up, back to where they spent a significant portion of their lives, or to a favorite vacation spot (Litwak and Longino, 1987; Lavenhol and Horwath, 1988; Longino, 1990, 1994; AARP, 1996; Stoller and Longino, 2001). Prosper's (1990) review of research findings concluded that the three major reasons elderly people relocate are because they can no longer afford their present residence, they cannot physically continue home upkeep, or they have the need for supportive services or health care.

Privacy is cited as the most frequently liked living environment design feature (Nasar and Farokhpay, 1985). The strong desire to maximize privacy and personal control in the living environment is revealed by the housing options in which older people currently live. A rank ordering, from most used to least, reflects the descending levels of privacy and personal control that characterize the ordered options: single family homes, age-integrated multiunit apartments, age-segregated (senior) retirement housing, shared living alternatives, institutional facilities (Prosper, 1990; AARP, 1996). Jenkins' (1997) survey of older people's concerns about assisted living facilities showed that, when given a choice between a small private room and a larger room shared with another person, 87 per cent chose the smaller private room.

Many preference items underscore the desire for continued independence and life style continuity. For example, Prosper's (1990) review of research findings on multiunit housing

concluded that older people's preferences are for complete one- and two-bedroom apartments rather than studio apartments, for a full kitchen, for voluntary rather than mandated participation in a dining/meals program, as well as a preference to entertain friends in their own apartments rather than in common rooms, a preference by the majority of women and married couples to cook and eat in their own apartments, and that small intimate common rooms used for specific functions get greater use than a large generic common space.

The elderly population is the most diverse of all age groups, reflecting differing cultural, educational, and socioeconomic backgrounds, as well as differing patterns of life experiences. While common preferences apply across the elderly cohort, it is important to understand that specific preferences characterize subsegments of this population, affecting their behavior patterns and perceptions of their environment.

Diversity among subsegments is often overlooked and preferences incorrectly assumed. For example, for programmatic and policy purposes, ethnic and minority elderly people are often not distinguished by type, but are aggregated into one subsection of the total elderly population (Stull, 1993). However, within the total elderly population, ethnic and minority elderly subgroups exhibit the greatest diversity compared to the Anglo-Saxon majority core (Markides, Liang, and Jackson, 1990; Espino, 1993). Variations in language, cultural norms and expectations, acculturation patterns, and life experiences have an impact on ethnic individuals' quality of life, perceptions of their own health status, and attitudes about various housing alternatives and about using supportive services and health care. For example, various studies report low social services use (Kulys, 1990; Cox, 1993; Simmons, 1997), low participation in senior centers (Kulys, 1990), and low residence in senior housing alternatives (Prosper, 1997) by ethnic elderly persons compared to white elderly people. Cox (1993) admonishes that it is generally believed that family support networks among ethnic groups are strong and provide all of the caregiver assistance that a frail elderly individual requires. She further admonishes that the fact that

minority elderly are underrepresented in the formal services network is continually used as evidence of their lack of need. In support of Cox's caution, Wood and Wan (1993) found that where culturally compatible services have been developed, ethnic elderly utilization rates for social services are comparable to whites.

Research studies that do not adequately distinguish among subgroups can provide misleading outcomes about the needs and preferences of these subgroups. For example, in reviewing caregiving studies, Janevic and Connell (2001) suggest that there may be differences in stress and psychosocial outcomes and service utilization among caregivers of different racial and ethnic groups, but that differences are unclear because "the research paradigm of the 'primary caregiver' may not be equally applicable in all cultures."

The traits and preferences characterizing individual ethnic and minority subgroups is illustrative of the need to clearly understand the differing characteristics of other elderly subgroups, such as never-married men, lesbian and gay elderly people, childless single women, rural elderly farmers, and others, in order to shape the nature of the housing environment to best respond to those differences.

EVOLVING PREFERENCES AND TRENDS

Evolving cultural and social trends, as well as historical events, have an impact on the experiences and life styles of each age cohort, coloring both their preferences and expectations.

For example, the great depression and World War II were major influences in the lives of the current elderly group aged 80 and over. In contrast, the large baby boomer group, which are about to enter the elderly cohort, were heavily influenced by the post-war boom, the social upheaval of the 1960s, the Internet, and economic globalization. Compared to the current elderly cohort, a greater proportion of baby boomers are more highly educated, technologically sophisticated, mobile, cosmopolitan, and healthier; more will delay retirement, will have more buying power, and will continue to stay connected and integrated with the wider community

during their elderly years (Prosper, Sherman, and Howe, 2000). While basic living environment preferences will remain, interpretation of those preferences will change. For example, more baby boomers, compared to previous age groups, will travel and live in more locations throughout their lives, expanding their choices for a familiar living environment in the elderly years. Too, because of mass communication and globalization, changes in location will not seem as extreme to upcoming cohorts. While Longino (1994) reported that ten per cent of all older movers said they relocated just to have a change, this proportion will increase in the future because change will have less of an impact on this more cosmopolitan, mobile group. The strong preference among elderly people to stay living where they are (age in place) will continue, but the traits of future elderly groups will reshape the concept of "staying where they are" to mean staying in their latest housing of choice.

Evolving social trends continue to result in changes in the composition of many older households, changing the traditional responsibilities of people in their elder years, and requiring housing environment features to support the viability of these households. Future elderly cohorts will include significant proportions of grandparents rearing grandchildren, requiring a housing environment that supports both the needs of children and the aging grandparent; young-elderly and old-elderly children caring for an oldest-elderly family member, with the multiple generations requiring support or assistance; elderly parents caring for aging adult children with developmental disabilities who have not traditionally lived into old age; increasing numbers of single older people who lack familial caregivers; and emerging subgroups requiring housing with specialized care, such as older people with AIDS or Alzheimer's Disease, or aging prisoners (Prosper, Sherman, and Howe, 2000).

HOUSING TRENDS

The evolution of senior housing development underscores the consistency of older people's strong preferences for aging in place, privacy, and autonomy in daily living decisions.

The overwhelming majority of older people continue to remain living in their own homes (single family, mobile homes, semidetached homes, age-integrated apartment buildings) (AARP, 2000). While longevity continues to increase and vulnerability to physical and mental decline increases with advancing age, the estimated proportion of older people living in purpose-built senior (age-segregated) housing has remained consistent over the years at between six and ten per cent (Donahue and Thompson, 1977; Hunt, Feldt, Marans, Pastalan, and Vakalo, 1984; AARP, 1986, 1992, 1996, 2000). The average entry age into senior housing models has steadily risen over the past 40 years (now, between 80 and 85); those who seek senior housing are searching for a supportive living environment because of frailties that make independent living unmanageable; increasingly, Alzheimer's and other dementia conditions are the reasons for making a relocation; and growing numbers of relocation decisions are made by the adult children of older people rather than by the older people themselves.

The proliferation of community-based services and care programs support the preference of older people to remain living in their own homes for longer periods of time, often until death. Such programs include home modification and repair, installation of universal design features to improve safety and prolonged self-management as frailties are incurred, home maintenance services (lawn mowing, snow shoveling, painting, etc.), shopping services, transportation, training for using all manner of technology, home-delivered meals and dining packages, care management and coordination, technology-based in-home medical assessment and diagnosis, personal care services (help with bathing, dressing, eating, etc.), home health care, nursing services, and others.

As the opportunity to "stay where you are" has become a tenable option for longer periods of time during the later years, the nature of purpose-built senior housing has changed to accommodate the frailer nature of newly entering tenants. Various models of "supportive senior housing" exist, which are known by many different names and which include one or more of the

following: a meals program, housekeeping assistance, transportation service, educational and socialization activities, a services coordinator who informally monitors the welfare of the elderly tenants and assists them in contacting and using additional services and care that are available in the wider community, and management and other housing staff that are trained in aging issues. Increasingly, older senior housing developments built initially as an alternative housing option for independent older people have evolved into supportive senior housing by incrementally adding supportive activities, services, and staff to address the needs of their aging tenants and their frailer new entrants. Newer senior housing developments are purposely designed to provide such supportive activities, services, and staff upon opening.

The term Naturally Occurring Retirement Community (NORC) was coined by Hunt (1984), referring to geographic areas or discrete multiunit apartment buildings that were not initially planned, designed, or marketed for only older people, but which gradually evolved into retirement communities as significant proportions of residents (often, over 50 per cent) were over the age of 60. Until very recently, NORCs were the most overlooked form of retirement housing for elderly persons in the United States (Hunt and Gunter-Hunt, 1985; Hunt, Merrill, and Gilker, 1994; Lanspery, 1997). Twenty seven per cent of older people live in NORCs (AARP, 1992). These elderly tenants often prefer the age-integrated environment of multifamily housing or experience the strong desire to age in place, while some can find no suitable housing alternative. NORCs have now begun emulating the incremental approach of older senior housing models to address the needs of long time, now-aging tenants by adding activities, services, and aging-trained staff.

In response to increasing frailty (particularly dementia) as the major underlying reason for relocation, the past five years has seen rapid growth in the development of various "assisted living" senior housing models. In addition to the supportive services listed above, assisted living also provides assistance with personal care (help with bathing, dressing, grooming, eating,

transferring, toileting, supervision, and medication management). Some models also provide more intensive care, such as physical and occupational therapy, health-related services such as dressing wounds, and intermittent nursing care; some have been designed (physical layout, programming, staff skills) specifically to care for elderly persons with Alzheimer's Disease or other dementia conditions. Increasingly, assisted living models are created to provide a community-based alternative to institutional nursing home care.

Certain housing models and features that have had limited use by the current older population can be expected to gain in recognition and receptivity by the emerging baby boomers because they reflect the personal, social, and cultural traits of a significant portion of the boomer cohort (Prosper, Sherman, and Howe, 2000). These include: (1) Active adult community, which is an age-segregated enclave of large single-family homes targeted to those aged 50 to 70. Counter to the traditional relocation behavior of elderly people to choose smaller living quarters (for ease in maintenance and reduced living expenses), baby boomers have produced a market for larger homes during the retirement years to accommodate room for second careers, hobbies, fitness activities, technology, visiting grandchildren, and to accommodate caregiving responsibilities for aging parents. (2) Shared living residence, which is a single family home or an apartment unit in which several unrelated older people live together, sharing expenses and upkeep. Among the baby boomers, who perceive communal living in a more favorable light than the current elderly generation, shared arrangements will provide opportunities for mutual support and companionship, particularly for those who are single or have no available familial caregivers. (3) Elder cottage, which is an apartment-sized home sited temporarily in the backyard of a son's or daughter's home for use by a frail, aging parent. The close proximity provides privacy for both the older person and the younger family; convenience for younger family members who are providing caregiving assistance to the elderly family member; and the emotional security, familiarity, and social interaction available to the elderly person from being physically close to

family members. (4) Accessory apartment, in which is a single family home is modified to incorporate a private, full apartment for use by an elderly family member. Accessory apartments provide the same conveniences and benefits as an elder cottage. (5) Senior housing cooperative, which is a multiunit building or complex in which residents retain an ownership interest. Cooperatives provide residents with the feeling and benefits of homeownership, as well as the decision-making opportunities for managing their own housing complex and designing their own arrangements for amenities, recreational activities, and supportive personal and health-related services.

ROLE FOR SOCIAL WORK

The shift to providing long term care in a variety of community settings has expanded the number and types of professional opportunities for social workers. The flexible nature of the social worker's profession (the job description), together with the escalating cost of community-based services and supportive housing models, have made social workers a desirable, cost-effective staffing choice by housing providers, service agencies, and others. Examples of expanding opportunities include:

(1) Community-based service agency staff: As longevity continues to increase and the greater majority of frail older people remain living at home, greater numbers of social workers are hired for a variety of tasks and responsibilities to address the needs of these older people and their families, including creating and directing new agencies, conducting in-home assessments, providing case management, educating and training informal caregivers, counseling, discharge planning, organizing community educational forums and conferences, grant writing, program development and implementation, program evaluation and outcomes measurement, research, advocacy, legislative lobbying, and as specialized adjunct staff in offices of elder law attorneys and consultants.

(2) Housing staff: Traditionally, housing management and operations staff had little or no training in aging issues or in the specialized skills associated with the human services (Prosper, 1997, 2000). The need for such training and skills has increased in tandem with increasing longevity, prolonged aging in place by existing housing residents, and the changing frailty profile of new housing residents. As one cost-savings strategy, many senior housing developments now hire managers who are trained in both traditional management skills and in social work skills. As another cost-effective strategy, in both senior housing and age-integrated multiunit housing, the function of a services coordinator is most often filled by a social worker. A services coordinator, hired as an adjunct to a traditional manager, informally monitors elderly residents, plans social and educational activities, helps residents with instrumental activities of daily living, helps residents identify and access needed services and care from the wider community, and coordinates the provision of these services in the building. Social workers are also hired as housing staff to carry out the interviewing and rent-up process, conduct eligibility assessments, help new residents through the relocation-transition process, provide counseling, coordinate discharge procedures, plan programs, act as a liaison between residents and the manager and between the manager and residents' families, implement conflict resolution protocols, and many other resident-related activities.

(3) Consultant: Increasingly, gerontological social workers are hired by senior housing developers as expert consultants during the development process to apply their specialized knowledge in designing the housing project's overall conceptual model, explaining the proposed project to community officials and citizens, conducting feasibility studies and marketing focus groups, reviewing architectural plans for aging-appropriate physical design features, interfacing with potential residents, and taking charge of public relations and advertising activities.

(4) Community-based housing counselors and housing-related case managers: At one time, living with family members or in a nursing home were essentially the only alternatives for elderly persons whose independence was compromised by frailties (Prosper, Sherman, and Howe, 2000). These options did not respond to the living environment preferences of older people or adequately address the diversity of their needs and traits, but neither elderly people nor their families were confused about the available options. The proliferation of community-based services to support aging in place at home and the development of myriad alternative housing types for elderly persons created an extensive pool of options from which an elderly person can match his/her own set of needs and preferences. However, these expanded choices have generated inordinate confusion among older people, their families, and many professionals.

Consumers do not have sufficient knowledge of programs and housing types to understand their differences. Little educational resources are available for consumers; both services and housing types continually change and new ones are added; and consumers often begin their search for a service or housing type during a crisis situation. Functional, age, and income eligibility criteria differ among service programs and among housing types; pricing and reimbursement guidelines vary; and all service programs and all housing types are not equally available in all communities. Among housing types, any single type is called by various names; varying versions of each type exist; and there is overlap in design among the different housing types, in the services and activities provided in each, and in the functional profiles of residents living in each.

For consumers, other service provider professionals such as discharge planners, and for advisers such as elder law attorneys who are increasingly consulted by older people and their families, housing counselors and housing case managers can educate about service programs and housing types, can help people differentiate among the differing types, can assist people

through the decision-making process to determine the most appropriate living environment choices, and can maintain an on-going relationship with an elderly person to facilitate necessary living environment changes as personal and familial circumstances evolve.

CONCLUSION

Demographic and social changes have been a compelling force for change in how the role of housing is perceived in the lives of elderly people. Researchers have documented the effect of the living environment on residents' physical, social, and mental well-being; have concluded that an older person's housing must be considered part of that person's wider physical and social environments; and have raised awareness of the how the environmental preferences of older people are a critical element in shaping the impact of the living environment on their well-being. A variety of environmental impact theories provide a framework for human service professionals and family caregivers to understand the effect of the environment and to develop interventions, service programs, and housing environments that best respond to both the needs *and* the preferences of older people and, thus, address issues of well-being.

Demographic, social, and policy trends have resulted in a proliferation of community-based services, programs, and housing models to support the capacity of older people to successfully age in place in community settings. This has significantly increased the number and variety of professional opportunities available for social workers.

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