

Social Segregation: Barriers To Mobility In Urban Domiciliary Care

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This paper reports the conclusions from a secondary analysis of a project, utilizing survey and ethnographic methods, to study communication activities of the aged; outlines barriers to external mobility for the elderly residents of domiciliary care facilities.

Our focus is on the factors which can be minimized or negated by careful planning of the neighborhood location of such facilities. Maintaining independence and privacy for older adults makes such residences a viable option for the aged with minimal loss of mobility. Careful location of such housing should be emphasized to avoid making the residents involuntary social segregates within their residences. Communication activities are also discussed.

Where do older adults live when they are unable to maintain a house or apartment, but do not want to become dependent upon their relatives nor need the health care provided in a nursing home? One possible answer is moving into a domiciliary care facility (DCF), also known as a home for adults, congregate care residence, or

retirement hotel. A domiciliary care facility is not an "institution," but is analogous to a college dormitory or residential hotel.¹ In a DCF, meals are served in a central dining room and all housekeeping chores are done by the staff. Residents are also helped with bathing, dressing, and mobility; recreation materials for hobbies and other activities are also provided (Moos and Lemke, 1980). Residents come and go as they please, just informing the DCF if they will miss a meal or stay out overnight. Part of the management role in a DCF is insuring that no resident is neglected or forgotten in the event of sudden illness or accident. In effect, a domiciliary care facility is a residential hotel with some special accommodations to the health needs of elderly people.

The interior design of domiciliary care facilities for older adults incorporates internal aids to accommodate the special needs of the elderly residents, facilitating their mobility within the build-

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ing. This concern with internal mobility is illustrated by the presence of handrails in hallways and bathrooms, multiple elevators, low-pile carpeting, ramps, and so on. In addition, the environment in which the DCF is located should facilitate external mobility — the ability to transport oneself to locations outside of the residence. Problems of neighborhood location, which may be aggravated by a transportation system geared to more agile individuals, can hinder if not bar elderly residents' access to religious, cultural and other resources, (e.g. museums, free concerts, ethnic and religious organizations). Limited mobility infringes upon independence and autonomy, crucial values for older adults (Atchley, 1977).

An important part of the American dream is the ideals of self-reliance and independence. The socialization of children includes experiences to make them independent adults; the dependent role is appropriate only for the sick, children and misfits (Atchley, 1977). Personal control, autonomy and independence (perceived and actual) can be important for both psychological and sociological perspectives on behavior. Butler and Lewis (1973: 224) suggest that autonomy “. . . may be more decisive as a determinant of human behavior than identity at various ages . . .,” particularly old age. Similarly, Atchley's (1977) review of the research on independence emphasizes the norm of adult independence in our society and the older adult's fear of dependence — both in terms of their fear of societal disapproval as well as their own personal disapproval. One of the key dimensions of adult independence is that of mobility and autonomy. With advancing age, a crucial question to an older person is “can I survive independently without being a burden” (Butler and Lewis, 1973: 234)? There is a strong desire for independence in older people. The issue of control is not an unrealistic one especially when considering the related issue of loss in old age, for example, income, career, physical functions, significant others, etc., (Bennett, 1973; Butler and Lewis, 1973; Schwartz, 1976). Other people have

been found to be unreliable due to death, moving, disputes, etc. Therefore, the aging process is accompanied by changes that influence an individual's ability to be independent. Independence in old age, nevertheless, is a source of pride, and is highly prized in terms of personal needs and perceived social demands (Atchley, 1977).

Independence is most influenced by finances, housing and mobility. Mobility and self-reliance are strongly related to morale and self-esteem (Clark, 1976). Without mobility, one can become dependent on relatives and friends; it may become a precipitating factor in eventual institutionalization (Clark, 1976). Home represents where one lives independently, in control and with autonomy. “In human terms, the issue of housing for older people is far more than simply providing a roof over their heads” (Butler, 1975: 13). Therefore, “home” in an institutional or congregate setting should continue to allow for mobility and independence, and facilitate access to cultural and social activities as well as needed health and social services. Losses in mobility, which diminish potential social interaction and mental stimulation, have a great impact on the mental and physical health of the aged (Clark, 1976).

The purpose of this paper is to report their findings from a case study which examines the barriers to external mobility and independence for the elderly residents of two DCFs in New York City. Our focus is on the factors which can be minimized or negated by careful planning of the neighborhood location of such facilities. These factors include: the fear of assault and robbery, heavy vehicular and pedestrian traffic, inclined sidewalk construction and difficulties using mass transit.

It is difficult to predict what activities within the neighborhood, community or city will attract the residents of facilities for older adults. A residence typically contains people from different backgrounds and generations (e.g. ages 60 to 94) who will be succeeded by still other generations of

elderly people from a variety of sociocultural backgrounds. Therefore, it seems practical to focus on the maximization of external choices. This will allow the individual to choose among many activities, and to satisfy personal tastes and needs. Furthermore, this minimizes the paternalistic bias so offensive to older adults — doing things for them instead of enabling them to do things for themselves if, when, and how they opt to do so.

The Study

This secondary analysis utilizes survey and ethnographic data from a study of communication activities by the aged residents (ages 60 to 94) of two DCFs in NYC.² The survey was done during February and March in 1976; observations and semi-structured interviews were conducted from October 1975 to May 1976. All 140 interviews were administered by social scientists or allied health personnel in a location chosen by the respondent — usually a recreation area in the residence. The age and sex distribution for the sample reflects the age and sex composition of the residences. The integrated sample of 140 older adults represents a stratified (by sex) random sample of 76 residents from Wilson Hall⁴ and a volunteer sample of 64 residents from Cornell House.³

Population

The 140 respondents include physically and mentally vigorous adults as well as physically and/or mentally frail people with handicaps ranging from blindness to severe depression. Table I outlines the social and demographic characteristics of the respondents in our sample, and a representative sample of older adults in the United States (during the same time frame) conducted for the National Council on the Aging (NCOA), (Harris and Associates, 1976). The DCF residents are generally: older, unmarried or single, white, and childless; they are also far more likely to be SSI (Supplemental Security Income) recipients.

Table I. — Social Demographic Characteristics of Respondents

	Integrated sample (N=140)	NCOA study (N=2797)
	% of sample	% of sample
Age		
60-69	26	37
70-74	51	27
75+	23	36
Sex		
Female	62	59
Male	38	41
Marital Status		
Married	6	55
Widowed	45	38
Separated or divorced	14	3
Single, never married	35	4
Education		
Grade 8 or less	32	46
Grade 9 to 12	41	17
High school grad plus	27	37
Race		
White	98	90
Other	2	10
Social Contacts		
Have friends	86	94
Have children	43	81
Live alone	78	—
See children weekly or more often	12	—
SSI Recipient		
Yes	36	10

The Settings

Cornell House and Wilson Hall, the two DCFs studied, are in the same borough in New York City, both are located in an inner city area characterized by decaying buildings, social disorganization and poverty in spite of attempts at urban renewal (Wilker and McGloin, 1975).

The two communities which contain Cornell House and Wilson Hall, like many communities in New York City, are home to a range of individuals and families from the very poor to upper middle class professionals. Luxury apartment buildings with uniformed doormen are across the avenue from decaying tenements. Disoriented individuals, derelicts, vagrants and ex-mental patients are common sights on the main avenues located in front of and on either side of the residences. Both areas have been characterized as a "dumping ground" for deinstitutionalized mental patients. Eight to ten percent of the families in both districts have a median income below the federal poverty level and more than 18 percent of the people living alone or with non-relatives have incomes below the federal poverty level (NYC-Community Planning District Profile I and II, 1973).

Cornell House is a proprietary domiciliary care facility. During the original study its total clientele was comprised mainly (90+ percent) of people over age 60. It is a refurbished residence that was formerly a hotel. Cornell House has rooms for 350 residents, though its population ranged from about 190 to 220 residents during the course of the study. It provides three meals each day and all housekeeping services in addition to a range of recreational activities.

Wilson Hall, a voluntary non-profit facility, is in a physically attractive pre-World War II structure with a carefully tended interior. It provides lunch and dinner for the approximately 350 residents over age 60. Most of the rooms have a kitchenette area or a separate kitchen so that the residents may prepare their own breakfasts or snacks. Breakfast can also be purchased, for

those who opt to do so. All housekeeping services are provided, as well as a range of recreational activities. Vacancies are infrequent and there is a long waiting list for people who want to move into Wilson Hall.

Both communities offer a range of cultural attractions, but the residences are located within and adjacent to concentrations of the pathological elements in the community. For example, Wilson Hall is one block from a "famous" hangout for drunkards and other derelicts.

Kleemeir (1961) stressed the need to study the impact which a residence has on the lifestyle of the people who live there. This is particularly important because the residents are not temporary clients or visitors; the DCF is their *home*. The following discussion outlines specific barriers.

Barriers to External Mobility

Physical Limitations

The physical capability of transporting oneself outside the residence is a necessary condition for external mobility. Even those who merely want to walk around the neighborhood must be able to walk across wide streets with rapidly changing traffic signals, and to negotiate the curbs. To utilize mass transit involves the ability to walk up and down steep stairways leading into and out of the subway stations, and the steps at the entrance and exit of the buses. All of these actions require some degree of agility.

Only six percent of the respondents report severe difficulty in leaving the residences. Therefore, at least 94 percent should be physically able to venture into their neighborhoods. The ability to use stairs is a prerequisite for using the mass transit system to go beyond the immediate locale of the DCF. Half were able to use stairs without difficulty and unaided. Another 19 percent could use stairs but with some difficulty. The remaining residents, less than one-third of the total, found a great deal of difficulty or required help to use stairs. Given the steep, long flights of stairs lead-

ing into subway stations near both residences, and the high first step on the buses, those in this last group are very unlikely patrons of mass transit. (In addition, the need to step up quickly onto a bus or off of it, may preclude mass transit use for even more people.)

This leaves 69 percent who probably could use some part of the mass transit system. Yet observations of people leaving both residences in the morning or returning at dinner time never found more than 15 percent of the senior citizens entering or leaving. While this does not preclude coming and going at other times, these periods were the "rush hours" at the DCFs as well as for the neighborhood, and it is unlikely that more than 25 percent of the residents were in the habit of leaving the residence daily or several times a week. This then suggests that physiological factors are not the only inhibitors of external mobility.

Physical Barriers

Traffic, both pedestrian and vehicular, is another factor that limits external mobility of the residents. Both residences face wide avenues with a constant flow of two-way auto traffic. The residents often complained that the traffic lights changed too quickly, that cars would begin moving in front of them and behind them, something they found frightening. Others feel that they could not see well enough to cross such busy streets unaided. The residents typically did not get more than two-thirds of the way across the avenue before the lights changed and traffic began moving again.

The sidewalks adjacent to the DCFs are heavily utilized by pedestrians, especially during the morning and evening rush hours; ". . . people rush by and knock old people down." While that was not observed, there was a frequent use of a sidewalk maneuvering pattern by the residents of Cornell House that seemed to prevent accidents. Frail elderly people tend to be aware of their susceptibility to injury and are fearful of being injured on the street. In an apparent effort to avoid such

injuries, the residents stay close to the buildings as they walk away, avoiding the "fast lane" of pedestrian traffic closer to the curb. People seem to walk more carefully near the entrances. This avoids collisions with anyone rushing out of a building and older adults may also use the buildings as a secondary source of support. The pattern was regularly observed, though mainly during the rush hours.

The physical structure of the sidewalks can also inhibit the external mobility of older adults, particularly the frail elderly. The side streets directly adjacent to the entrance of Wilson Hall are on an incline, and must be used to get to the business and shopping avenue, and mass transit. The residents walking up the incline to the shopping area (during favorable weather conditions) were clearly straining, generally stopping and resting along the way. Rain makes the sidewalks slippery; the slush and ice remaining after a snowstorm make those streets dangerous for anyone. Residents who can afford to use mass transit may be physically unable to get there, even if they are physically able to utilize it.

Once at the bus stop or subway station, further obstacles must be overcome by these elderly people. The first step onto a bus is approximately two feet above the street. Even if the bus stops near the eight inch curb, the passenger must step up and out across the curb to the bus steps. There are some buses with steps that can be lowered ("kneeling buses"), but very few are being used, and many problems with their use remain (e.g. mechanical breakdown, inattentive drivers).

Steps leading to and from subway stations could easily be mountains to many old people. The steps are steep, slippery when wet, and often littered with trash; there are typically more than two dozen steps between the street and the subway platform.

The fare for using the mass transit system does not guarantee a seat. Most bus stops lack a bench, few have an enclosure, and many subway stations also lack benches. Trains and buses are often crowded. If an elderly person has to stand on the

bus or train, irregular stop-and-go motion creates a danger of falling. Crime and victimization of the elderly also occur in the mass transit system, particularly in the subways. Yet there really is no alternative to mass transit, because the cost of taxi service is prohibitive for the average senior citizen in New York City.

Poverty

Some older adults are physically able to walk to the mass transit and to use it, but cannot afford to do so. Even with reduced fare cards, mass transit is very expensive for the low-income elderly. The SSI recipients at Cornell House report a discretionary income of \$11.50 per month. If they make one round trip each week, 25 cents each way, they spend just under 20 percent of their monthly budget. SSI recipients at Wilson Hall tend to have more discretionary income. There are very few SSI recipients there; and the management does not accept new residents who are SSI recipients.

Fear

Fear is one of the key factors limiting senior citizens' access to the community beyond the walls of the residence. This fear often makes them veritable shut-ins because they are too afraid to leave the DCF unless they are in a group or there is someone to protect them. The main reasons for their fear are certainly realistic: the pervasive street crime in the community and in the city, the knowledge that old people are easy prey for criminals, and the shared experience of being a victim that is so common to senior citizens who live in the inner city. The residents are all too aware of the risks they take each time they venture beyond the residence. Typical expressions of this fear include:

"This is a high crime area, you know . . ."

". . . I love to walk in the fresh air, and look at the shops. But I'm afraid; I was mugged several times."

". . . I worry about mugging."

There is also the fear of sudden illness, disorientation, falling in a crowd, etc.; however, such sources of apprehension were rarely noted. Fear of criminals seem to occupy the forefront of their anxiety.

Most of the residents want to leave the confines of the DCF; 85 percent indicated having a favorite outside (the DCF) activity. They enjoy meeting with old friends, visiting art galleries and museums, going for a walk, window shopping, etc. Many find a walk is quite therapeutic when they feel emotionally distraught. All of this intensifies their sense of injustice. They postponed much pleasure earlier in their lives, and now they find they must either continue postponing or risk injury to enjoy themselves. Obviously, it is difficult to enjoy doing anything when you are afraid.

Spring and autumn (when the extremes of winter and summer that limit mobility are gone), are the times when the most visible remainders of street crime appear; as soon as winter departs, the various and sundry derelicts come out on the streets near both facilities. Nearby block associations regularly complain to the local police and have done so for years. Younger neighborhood residents refer, rather caustically, to the derelicts as harbingers of spring and draw analogies to the swallows returning to Capistrano.

Why Go Out?

The emphasis on external mobility for these people stems from its importance to them. They desire it; this is not just a fringe benefit or an ideal that they *should* have. We asked the respondents to tell us what they enjoyed more than anything else. Most of the answers concerned activities that *could* be done in the facility, but 35 percent mentioned going for a walk (see Table II). We also asked about their favorite activity outside of the residence and only 15 percent did not specify one. The most popular outside activities are hobbies and walking. As a point of comparison, it is noteworthy that 23 percent had no favorite in-residence activity; hobbies, television, talking

Table II. — Favorite Activities (N=140)

What activity, that you do in the hotel, is your favorite?		What do you enjoy more than anything else?		What activity, that you do outside the hotel, is your favorite?	
	%		%		%
hobby	36	walking	35	hobby	29
TV	11	friends	18	walking	24
talking	11	reading	11	visiting	22
reading	9	family	10	movies	5
eating	5	TV	6	other	5
other	5	movies	5	none	15
none	23	music	4		
		other	9		
		none	2		

and reading were the most popular indoor activities.

The ability to move about in the wider community is usually taken for granted and not regarded as significant. Barriers to external mobility can limit access to visitors as well, particularly friends who are senior citizens too. Fear of crime, and the difficulty in finding a parking place, can hinder younger visitors.

Summary and Recommendations

A series of physical and social factors act as barriers to external mobility for the residents of two domiciliary care facilities in New York City. The physical barriers include: wide avenues with fast-changing traffic signals, fast-moving pedestrian traffic, sidewalks on a sharp incline, high steps leading onto buses, and steep stairwells leading into and out of the subway stations. Social factors include: inadequate levels of income that severely limit any consumer activity even when the physical barriers can be surmounted, and fear of being the victim of a mugging or being accosted by one of the disoriented individuals who are commonplace in the surrounding communities. These barriers limit access to the community and foster a reliance on resources that can be used inside the

safety of the residence (e.g. hobbies, mass media).

The problems and predicaments delineated here are not atypical of adult homes in New York City, or other urban areas. Wilson Hall and Cornell House are providing a very necessary *home* for people who have few (if any) viable alternatives.

Careful neighborhood location of such housing should be emphasized to maximize the aged residents' access to the community. The following issues should be considered before domiciliary care facilities are planned or licensed.

1. Is the DCF close to shopping areas, religious and cultural facilities?
2. Does the facility exit onto a street that is free of fast-moving, high-density pedestrian traffic?
3. Do the traffic signals on adjacent streets allow sufficient time for the (potential) residents to cross the streets?
4. Are there bus routes nearby that utilize kneeling buses or other vehicles which the (potential) residents will be able to use?
5. Is the facility in a high-crime zone?
6. Is an easy-to-read mass transit schedule available?

Urban life has always presented obstacles to the mobility of older adults (Clark, 1976). How-

ever, people should not be involuntary shut-ins in their retirement homes; their "captivity" makes the idea of the golden retirement years truly a "tarnished myth."

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Notes

1. The U.S. Bureau of the Census also places DCFs in the same category as a residential hotel or college dormitory.
2. For a description of the original study, see Paul A. Salisbury, *Aging and Communication: An Exploratory Study of Mass Media Uses and Gratifications in Later Life*. Unpublished dissertation, (New York: Columbia University, 1979).
3. Pseudonyms are used to protect the anonymity of the residents, as per an agreement with the managements of the residences. The management at Cornell decided *not* to provide the project director with a list of residents for the purpose of drawing a sample. Since this report focuses on the environment in which the DCFs are located, rather than the characteristics of the residents, the potential inadequacies of the sample for this exploratory study are not major points.
4. Wilson Hall is partially subsidized by a charitable organization; otherwise both DCFs are maintained by the monthly fees paid by the residents.