An Administrator's Perspective on Mental Health in Assisted Living

Deborah B. Wagenaar, D.O., M.S.
Maureen Mickus, Ph.D.
Clare Luz, Ph.D.
Michelle Kreft, B.S.
Julie Sawade, B.S.

Administrators of 94 assisted living facilities in Michigan completed a 19-item survey about the extent of mental health problems of residents and how such problems were addressed. In 45 facilities more than half of the residents were reported to be cognitively impaired. The two most common problems were dementia and depression. The most common problematic behaviors were resistance to care and wandering. Two-thirds of the facilities conducted some type of mental health evaluation at admission, and two-thirds conducted evaluations as needed. The most common treatment barriers were patient refusal and family refusal. Results of the study suggest that there may be a significant need for mental health services in assisted living facilities. (*Psychiatric Services* 54:1644–1646, 2003)

Approximately 6.5 million older people need assistance with activities of daily living. Nursing homes have historically been the primary place where this type of care has been provided (1); however, assisted living facilities are rapidly growing as an alternative to the high labor costs and heavy regulation faced in nursing homes and to the feelings of stigmatization nursing home patients may have.

The term "assisted living facility" is not exclusive; some interchangeable terms include "supportive care," "residential care," "homes for the aged," "foster care," "board and care homes," and "group homes." Each state may use a different definition to describe these facilities, with no specific definition a gold standard (2). In the state of Michigan, assisted living facilities are defined as 24-hour residences that provide assistance with activities of daily living, meals, laundry, and dispensing of medications.

Despite the growing popularity of assisted living facilities in the United States, we know virtually nothing about the prevalence and types of mental illness that exist in these facilities. Unlike nursing homes, assisted living facilities do not have mandatory licensing mechanisms in place nationally and are largely unstudied in terms of mental health issues (3,4). Because of these factors, our survey sought to delineate the extent of mental health problems and behaviors in assisted living facilities, to identify the types of resources commonly used to provide access to mental health care for residents of assisted living facilities, to identify barriers to treatment for residents of assisted living facilities, and to determine whether admission and discharge policies were in place to address behavioral problems and mental illness.

The authors are affiliated with the department of psychiatry at Michigan State University, A231 East Fee Hall, East Lansing, Michigan 48824 (e-mail, wagenaar@msu.edu).

Methods

This study took place from June 2001 through August 2001. A list of 156 administrators of assisted living facilities, each from a separate assisted living facility, was obtained from the state of Michigan. A 19-item survey was mailed to each administrator; after one month a duplicate survey was mailed to nonresponders. The Michigan State University institutional review board approved the project.

Results

Of the 156 administrators surveyed, the response rate was 60 percent (N=94). Table 1 describes key characteristics of the facilities, including ownership, location, and affiliations, as reported by each survey respondent.

Thirty-six facilities (38 percent) had a dementia unit. Sixty-six administrators (70 percent) reported a daytime staffing ratio of less than one staff member for ten residents. With respect to nighttime personnel, 67 administrators (71 percent) reported staffing ratios of less than 1:10.

In assessing mental illness, 62 administrators (66 percent) reported that they performed some type of mental health evaluation when residents were admitted into the assisted living facility. Thirteen facilities (14 percent) noted that mental health was evaluated only at admission, nine (10 percent) had monthly evaluations, 26 (28 percent) had quarterly evaluations, and 24 (26 percent) had yearly evaluations. In addition to their scheduled evaluations, 63 facilities (67 percent) had evaluations "as needed."

Forty-five administrators (48 percent) estimated that nearly half of all assisted living residents were cognitively impaired. Administrators also ranked the three most common types of mental illness encountered among their residents. The most commonly reported illness was dementia (reported by 56 administrators, or 60 percent), followed by depression (24 administrators, or 26 percent), hallucinations or delusions (four administrators, or 4 percent), anxiety (three administrators, or 3 percent), and alcohol use (one administrator, or 1 percent). Likewise, administrators ranked the three most problematic behaviors they had experienced with residents; patients' resistance to care was found to be the most common problematic behavior (39 respondents, or 42 percent), followed by wandering (24 respondents, or 26 percent), verbal abuse (eight respondents, or 9 percent), screaming (three respondents, or 3 percent), paranoia (three respondents, or 3 percent), sexually inappropriate behaviors (two respondents, or 2 percent), and physical abuse (two respondents, or 2 percent).

Administrators ranked primary care physicians as the most common type of provider of mental health services in assisted living facilities (56 administrators, or 60 percent). Psychiatrists were ranked second (45 administrators, or 48 percent), followed by community mental health agencies (40 administrators, or 43 percent), private therapists (27 administrators, or 29 percent), and friends (five administrators, or 5 percent).

To explore the types of mental health resources available in the community, we listed various therapy options—including family, individual, and group therapy as well as spiritual counseling, medications, and electroconvulsive therapy—and asked administrators what types of therapy options were available to their residents. Unfortunately, we did not inquire about how many residents actually needed or used each service. Given this limitation, we were not able to calculate which types of therapy were underused.

To understand the discrepancy between treatments available and treatments used, we inquired about barriers that may prevent a resident from receiving mental health care. Resident refusal ranked as the most common treatment obstacle (62 respondents, or 66 percent), followed by family refusal (52 respondents, or 55 percent). Cost (23 respondents, or 25 percent) and stigma of mental illness (25 respondents, or 27 percent) were ranked higher than lack of transportation (16 respondents, or 17 percent), unavailability of treatment (13 respondents, or 14 percent), or confidentiality concerns (three respondents, or 3 percent).

Mental illness may be a barrier to admission or a reason for discharge within the long-term-care continuum. A total of 75 facilities (80 percent) had a written discharge policy; 16 facilities (17 percent) did not, and two administrators (2 percent) did not know whether a policy existed. Physical abuse ranked as the most likely reason for denial of admission (71 administrators, or 76 percent), followed by sexually inappropriate behaviors (48 administrators, or 51 percent), screaming (44 administrators, or 47 percent), wandering (40 administrators, or 43 percent), verbal abuse (32 administrators, or 34 percent), paranoia (19 administrators, or 20 percent), and resistance to care (16 administrators, or 17 percent). Every administrator endorsed at least one behavior.

The reasons for premature discharge parallel those related to the denial of admission. Physical abuse again received the highest ranking (73 respondents, or 78 percent), followed by sexually inappropriate behavior (55 respondents, or 59 percent), screaming (44 respondents, or 47 percent), wandering (40 respondents, or 43 percent), verbal abuse (39 respondents, or 42 percent), resistance to care (23 respondents, or 25 percent), and paranoia (19 respondents, or 20 percent). Verbal abuse and the patient's resistance to care were more likely to be reported as reasons for denial of admission than as reasons for discharge.

Discussion

The results of this survey suggest that mental illness is an issue in assisted living facilities. More than 60 percent of the 94 administrators viewed dementia as problematic and 26 percent endorsed depression as an issue, which suggests that there may be a significant need for mental health services in assisted living facilities. It is not surprising that mental health services are needed in these facilities, because similar results have been seen in nursing homes (3). However, unlike in nursing homes, mental illness in the assisted living facility setting is largely unstudied (5).

Our results imply that of the treatments available, medications and supportive therapies are the most likely treatments to be endorsed by administrators. However, because we did not survey administrators about how many residents actually needed or used each service, we were not able to calculate which types of therapy were underused.

From this study, it appears that the largest barrier to obtaining services may be related to the attitudes of patients and families themselves. The stigma of mental illness, lack of understanding of the etiology of mental illness, or previous negative experiences may fuel these attitudes.

Although each of the facilities in this study was licensed in the state of Michigan, policies and procedures varied among institutions. Twenty percent of all facilities did not have a written discharge policy. Not surprisingly, physical violence and aggression were the likely reasons for admission refusal and for discharge.

Our research has limitations. For ex-

Table 1

Facility characteristics reported in a survey of 94 administrators of assisted living facilities in Michigan

Characteristic	N	%
Ownership		
Not-for-profit	45	48
For-profit	41	44
Other	11	12
Location		
Suburban	39	42
Urban	28	30
Rural	17	18
Affiliation		
Skilled nursing facility	30	32
Hospital	6	6
No affiliation	57	61

ample, only licensed assisted living facilities were surveyed. Also, although administrators were asked about mental health service access and use, we did not include definitions of each service provided. In addition, we do not know whether services were actually needed. These questions suggest that further research on mental health is needed in this arena. ♦

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A Quality Improvement Process for Implementing the Texas Algorithm for Schizophrenia in Ohio

Naakesh A. Dewan, M.D.
Douglas Conley, L.I.S.W.
Dale Svendsen, M.D.
Steven P. Shon, M.D.
John R. Staup
Alexander L. Miller, M.D.
M. Lynn Crismon, Pharm.D.
A. John Rush, M.D.
Madhukar Trivedi, M.D.
Tracy Skale, M.D.
Paul E. Keck Jr., M.D.
Stephen M. Strawkowski, M.D.

Medication algorithms developed in Texas are being implemented in a number of states in the United States and internationally. This report describes a quality improvement process adapted from the Texas Medication Algorithm Project that was used to implement the Texas algorithm for schizophrenia in Ohio. A total of 38 physicians were surveyed about their perceptions of barriers to implementation of the guidelines. The physicians generally thought that the schizophrenia algorithm was good, current, and applicable. Although they did not perceive barriers to its implementation, they did not seem to alter their practices to a great extent in response to the algorithm. The results of the study may guide other states in their implementation of algorithms. (*Psychiatric Services* 54:1646–1649, 2003)

Unnecessary variability in the quality of health care and the consequent unpredictability of costs have led to the development of numerous guidelines (1,2). However, despite laudable dissemination efforts, the implementation of such guidelines is the primary barrier to improving the quality of care (3,4). A recent systematic review of guideline implementation efforts outlined a number of key barriers—both environmental and physician-specific—to physicians' acceptance of guidelines (5). The six main physician-level barriers are lack of awareness, lack of familiarity, lack of agreement, lack of self-efficacy, lack of outcome expectancy, and inertia. External barriers include patient-related