Depression in Assisted Living Facilities

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I. **SETTING:**

An assisted living facility (ALF) is a senior living option for those with minimal needs for assistance with daily living and care. ALFs are residential settings which are midway on a continuum of independent living to nursing homes. They provide or coordinate room and board, personal care, 24-hour supervision, scheduled or unscheduled assistance, social activities, and health-related services. ALFs have served as a cost-effective solution for older adults who do not need institutionalization, but cannot live on their own in the community. The ALF philosophy emphasizes independence, autonomy, and privacy which appeals to many older adults and their families, and has become a popular housing option. As of 2002, there were approximately 36,400 licensed ALFs with more than 910,000 beds in the United States, which reflected a 48% increase since 1998. California, Pennsylvania, and Florida are the states with the largest number of ALFs.¹

The purpose of an ALF is to help adults live independently in a safe environment. There are currently no federal standards and regulations for assisted living facilities. Each state defines assisted living and sets the regulations for the entity. Some federal laws impact assisted living communities, but most oversight occurs at the state level. Most states are moving towards defining their ALFs as such, whereas other states use different terms such as residential care facilities or personal care homes. Two-thirds of states currently use the term assisted living.

More than 900,000 Americans live in an estimated 36,000 ALFs in the United States.¹ ALFs, promise supportive care where older adults can maintain a level of independence and age in place even when physical function declines. Several reports clearly indicate that older adults do not want to go to nursing homes, due to the high cost of care, loss of individual freedom, and an institutional/hospital-like setting.⁸ Despite the rapid growth in ALFs, there has been a paucity of research on ALFs and their residents. Particularly, there are compelling needs for research on mental health in ALFs among older residents in ALFs.
II. CURRENT PERSPECTIVES ON MENTAL DISORDERS IN THE SETTING:

The rising popularity of ALFs reflect their philosophy of care. These facilities market themselves as non-institutional, homelike environments with a philosophy of “maximizing autonomy, choice, privacy, well-being, independence, and continuation of normal life styles.” Seniors have repeatedly cited these principles as important factors in housing, and such policies may serve to maintain a good quality of life and prevent conditions such as depression. The elderly view depression as the most debilitating and most costly of health problems they face. Many residents in ALFs believe it is associated with mortality and adverse outcomes. Furthermore, the overall cost of health care for individuals with depression is significantly higher than for those without depression. Reports vary widely regarding the prevalence of depression among individuals residing in ALFs. Seligman developed a theory of depression based on the similarity that he saw in individuals with depression to animals who were unable to control aversive outcomes in their environment. Similarly, Lewinson’s perspective of depression is that it is a result of a failure in the environment to positively reinforce an individual’s behavior.

A) EPIDEMIOLOGY OF MENTAL DISTURBANCES ORDERS IN THE SETTING:

In the limited literature, available on ALFs and mental disturbances, it has been shown that older adults in ALFs exhibit impaired psychological well-being as compared with community-dwelling older adults. Recent studies suggest that a significant proportion of ALF residents, ranging from 13% to 25%, exhibit signs of depression. The prevalence rates of depression vary depending on the selected measures of depression, however, they are consistently higher than those of community-dwelling older populations, which is around 10%. Unrecognized and untreated depressive symptoms in older adults are closely associated with increased personal and family suffering, health care utilization, disability, and even mortality. It is thereby important to identify risk and protective factors for depressive symptoms.

Studies of depression in ALF have found that 20% to 24% of AL residents have symptoms of depression (women more so than men), which translates to 20 to 24 residents in a typical 100-bed facility. Depression is often related to greater levels of functional disability, poorer self-rated health, a lower sense of mastery, less religiosity, and less positive attitudes towards aging. In one
study, among those with dementia, 25% had comorbid depression. Other studies have reported depression rates of 24.5% to 54.4% among people with dementia.\textsuperscript{3}

Researchers have found that depression among AL residents is not only common, but also undertreated.\textsuperscript{4} This may contribute to morbidity and interfere with the ability of residents to age in place. The profiles of residents with depression in ALFs share common characteristics with others suffering from depression and profiles such as functional impairment, poor health, female gender, and perceived lack of social support. These 4 characteristics that are common in people with depression are also common in ALF residents which are predominantly female (more than 75%).\textsuperscript{5}

Seniors who have moved into ALFs have done so because health and functional impairments have limited their ability to live independently. The move to an ALF often triggers among residents a perceived lack of social support from those who previously were their neighbors, friends, and family within the community. Further, if residents feel they have been forced to move into an ALF or if they worry about being able to afford their ongoing care needs, depression is more likely. Widowhood, especially by female residents, also increases the risk for depression. By helping residents adjust to their new ‘home’ and providing or encouraging the social support they need are areas in which ALF staff can help the most in preventing or alleviating depression among elders.\textsuperscript{5}

III. CURRENT PROGRAMS RELATED TO MENTAL HEALTH IN THE SETTING:

There are currently no mental health programs that are implemented in ALFs due to lack of robust quantitative evidence. In the limited literature, it has been shown that older adults in ALFs exhibit impaired psychological well-being as compared with community-dwelling older adults. Recent studies suggest that a significant proportion of ALF residents, ranging from 13% to 25%, exhibit signs of depression.\textsuperscript{6} The prevalence rates of depression vary depending on the selected measures of depression, however, they are consistently higher than those of community-dwelling older populations, which is approximately 10%.\textsuperscript{6} Unrecognized and untreated depressive symptoms in older adults are closely associated with increased personal and family suffering, health care utilization, disability, and even mortality. It is thereby important to identify risk and protective factors for depressive symptoms.
IV. **SPECTRUM OF PREVENTION AND TREATMENT:**

Although ALFs do not have mandated programs to prevent and treat depression within their facilities, there are services that are available to identify and treat depression. The need for these mental health services fall into two groups. One includes those who have been diagnosed with a mental illness sometime in their lives. The other group includes those who develop a mental illness later in life. They have always been mentally healthy, until a chronic illness, such as hypertension or diabetes, affects the brain structure, contributing to late-onset mental illness.³

Mental support is offered through senior housing staff learning how to recognize symptoms of mental illnesses especially depression and respond appropriately. When the staff speak with physicians or nurse practitioners, they can speak in more clinical terms, so they get better responses and results and are better equipped to deal with troubled residents.⁹ Mental health training for staff is just the start. Staff can also take advantage of lunch-and-learn seminars on mental health topics and apply it to the ALF setting. The idea is to build awareness and convey the message that residents with mental health problems should not be treated any differently from those who have physical ailments or mobility impairments. Although they have depression, they can still be active participants in the community and be treated.

Posters and contact numbers for help and assistance are placed in ALFs for the residents to reach out for assistance.⁹ Outside mental health service providers visit residents in the ALFs and this partnership with mental health services is essential in prevention and treatment with residents struggling with mental health issues.
V.  BARRIERS TO DETECTION, TREATMENT AND PREVENTION:

Barriers to proper diagnosis and treatment include: attributing depressive symptoms to “normal” aging or physical illness, masking the effects of coexisting medical problems, self-medication (e.g., alcohol use), prescription drug use, low socioeconomic status (which restrict health care access), bereavement, social isolation and lack of family support, misdiagnosis of depression as dementia, cost issues, time constraints, and the stigma associated with mental illness. Barriers to detection, treatment and prevention can be divided as follows:

A) UNDETECTED AND INADEQUATELY TREATED:

There is currently no mandated oversight for the screening and treatment of depression or other mental disorders in AL settings. Only a few states require AL staff to be trained in information about mental health disorders such as depression. Very few ALFs screen residents for mental health problems besides dementia, and few states require that information about emotional and mental health be included in training programs for AL staff. Several key stakeholders in AL have pointed out that a greater effort should be made to detect and treat depression in this setting, both to reduce suffering and prolong the resident’s ability to remain in their preferred environment.

Beyond the lack of regulatory requirements to manage depression among AL residents, there are several other barriers that contribute to the lack of appropriate and timely diagnosis. For one, elderly patients with depression may not report depressed moods but instead may present with less specific symptoms such as insomnia, anorexia, and fatigue. Medications used to treat chronic diseases may also mask depression symptoms and it can go untreated. Although recent evidence indicates that antidepressant use is increasing among Medicare patients, most depressed elderly do not receive antidepressant treatment. Few depressed older medical patients receive antidepressants in the hospital and even fewer are treated after discharge or in home health care. Elderly persons are also less likely to receive an adequate course of psychotherapy compared to younger adults and the elderly with a poor socioeconomic status are also disadvantaged with Medicaid. Efforts to increase access to care and to improve the quality of depression care for older adults will need to address important patient, provider, and health system barriers to care.
B) **PATIENT BARRIERS:**

Elderly persons sometimes dismiss less severe depression as an acceptable response to life stress or a normal part of aging. Additionally, many elderly patients do not have major depression, but instead have “minor” depression, that is not thought to be a single syndrome, but rather a heterogeneous group of syndromes that is characterized. This lack of reporting symptoms and attributing them to a ‘normal part of aging’ leads to poor detection and little to no treatment. Other challenges also include resident attrition and dwindling staff participation. Older patients are less likely to voluntarily report depressive symptoms, may view depression as a moral weakness or character flaw, not an illness, and may be more likely to ascribe symptoms of depression to a physical illness. Perceived stigma of depression has been associated with treatment discontinuation among older patients and treatment non-adherence. Nonadherence to treatment among the elderly is common which can be due to doubts that medication is helpful. Depressed older adults are less likely to use specialty mental health care, preferring to use the general health care system and may be reluctant to attend group psychotherapy, but more willing to attend psychoeducational therapy formats.6 Culturally based preferences for depression care can become a barrier to care if the preferred mode of care is not available. Personal culturally based explanations for depression symptoms may influence symptom expression and patient provider communication. Patient perceptions of bias and cultural competence in health care, family perceptions, and practical barriers such as cost and transportation to therapy may impede receipt of care.6

Other barriers such as the elderly being particularly vulnerable to feeling powerless to influence and to control environmental reinforcements of their behavior.8 Being unable to do so may have negative consequences, whereas maintaining a sense of autonomy and control may protect against the development of depressive symptoms. There is great importance older adults place on having choice and control over matters such as bedtime, rising time, food, roommates, care routines, use of the telephone, and trips in ALFs and maintaining autonomy is crucial in prevention of depression.
C) PROVIDER BARRIERS:
Most older adults on ALFs receive antidepressants from primary care physicians and it is likely that physician attitudes and experiences may affect depression treatment more than knowledge. Clinical experience suggests that physicians who look carefully for symptoms of depression rather than relying on the patient to report mood changes have higher rates of recognition and response to therapy. Physicians may miss depression because they assume it is a ‘natural’ consequence of aging and associated physical illness, or fail to initiate treatment due to doubts about the efficacy of treatment. Primary care physicians may be more likely to detect depression in older women compared to men since women are more likely to report affective symptoms. Physical problems compete with depression for physician attention potentially decreasing the chance of pharmacological or psychotherapy treatment. As a result, they may inadequately manage depression, and underestimate symptoms in the most severely depressed.

Many primary care physicians significantly underestimate the extent to which depressed, elderly patients will respond to treatments such as antidepressant medication. The appropriate use of psychiatric medications in ALFs has been a long-standing quality of care issue. Inappropriate prescribing has been identified as that aimed at addressing behavioral symptoms by using antidepressants and sedating medications, partly to compensate for poor staffing levels. This inappropriate prescribing of antidepressants to those not depressed leads to a vicious cycle of higher doses leading to relapsed depressive disorders.

D) HEALTH SYSTEMS BARRIERS:
Organizational system barriers may limit implementation of depression guidelines or quality of care improvements. These include lack of coordination and collaboration between providers in primary care, long-term care and specialty mental health providers and shortages of nursing and social service professionals who have training and expertise in geriatric mental health. In addition to this, there is a lack of communication within staff and primary care physicians and with neighboring ALFs. This results in a disjointed information flow and a fragmented service landscape. Inadequate or discriminatory financing of mental health services for older adults may defer care. Inadequate drug coverage and the high cost of drugs may deter elders using antidepressants or taking less than recommended doses to reduce costs.
VI. OPPORTUNITIES FOR DETECTION, TREATMENT & PREVENTION:

Future research in this setting should include a focus on understanding how the presence and severity of even a few depressive symptoms may alter the course and quality of residents’ lives. Assisted living promotes community involvement in a home-like environment and may therefore afford novel interventions to alleviate the compelling prevalence of sadness, worry, and disinterest. Effort should be made to detect and treat depression in assisted living, both to reduce suffering and prolong the residents’ ability to remain in their preferred environment.

VII. RECOMMENDATIONS FOR A PREVENTION PROGRAM:

The targeted mental health disorder will be depression specific to assisted living facilities. The intervention will include selected and indicated prevention levels to encompass all those affected by depression in ALFs. In selected prevention, all clients in ALFs will be targeted and in an indicated prevention, those residents that have shown depression symptoms but have not yet met depression criteria will be included. Older individuals with a sense of mastery or feelings of control over life are known to be less likely to experience depressive symptoms when faced with adversities such as functional impairments and other forms of life’s stressors. Another important factor is the attitude towards aging. Positive self-perceptions or attitudes towards aging are beneficial for physical and emotional well-being in older populations. The foundation of the intervention program will be positive thinking and engagement. Direct Care Workers (DCWs) and other staff in the ALF will be interventionists. DCWs are resident assistants in assisted living facilities. They are responsible for major issues among most residents and solving communication barriers through language gaps or through simple miscommunication.

The prevention program will be called H.O.P.E. It is an acronym for Having Optimal Positive Engagement. The intervention will seek to encompass positive engagement in the facility through active learning, care management, referral, social interaction and behavioral management. H.O.P.E. will be a 5-day program that will reach all ALF residents on entering an ALF. It will not be limited to only the 5 days, if residents need a refresher or seek additional assistance, have queries or need clarification, DCWs and staff will be available to assist. Further referral and intervention will be given to those experiencing depressive symptoms.
**Education:** Education will provide the foundation for introducing other elements of the intervention. It enhances readiness of individuals to address emotional concerns. Education will specifically be provided on recognizing depressive symptoms, how to approach the primary physician about symptoms, the relationship of depression to activity and negative cycle of disengagement and informing family members and all staff members. This education will occur through live talks from primary physicians and DCWs, modules and videos.

**Care management:** Stressors can lead to depression and effectively identifying these stressors and caring for them is care management. Care management has been found to be more effective than therapy or medication alone for low income elders for whom financial, functional disability and lack of social resources may contribute to depressive symptoms. This will specifically involve assessment, coordination with other services/care management, problem identification and resolution. A wide range of care needs will be considered such as financial concerns, community safety, family conflict and legal concerns. Based on these concerns, referrals and linkages will be made.

**Referral and Linkage:** Referrals and linkages are derived from the care management assessment and may include 1) physician referral for medication review and management, 2) link to psychiatric/psychological follow-up, link to physician for chronic disease management and 3) referral and linkage to other services (e.g. legal advisors).

**Social Interaction:** Loneliness is a predictor of depression and by providing immediate, measures to reduce loneliness and introduce relationship of action and mood change, it can be prevented. Specific measures include, pet-assisted therapy buddy linking and volunteering in the community. In pet assisted therapy, the ALF brings in an animal, usually a dog to visit. The residents meet in a recreational room for one hour a day, with the dog and its trainer. They can engage in a variety of activities including feeding, petting, grooming the animal, socializing with the trainer, and walking the dog as part of a physical activity routine. Pet therapy has been known to increase physical activity, aid in weight maintenance and cardiovascular function, improve social behavior and decrease loneliness in nursing homes and can similarly reap the same benefits in ALFs. If allergic, buddy linking or volunteering can be done. In the buddy linking system, each ALF resident is paired with common interests and they can perform these activities together. Aside from this, volunteering can be done in a local school or spiritual center such as a church or within the
ALF itself. Volunteerism for all older adults has been associated with numerous benefits including: longer lifespan, slower functional decline, less depression, and better quality of life. The psychological and health benefits of volunteering are even more pronounced for older adults with multiple chronic conditions and functional limitations. These techniques include using: highlighting successful volunteer activities, verbal encouragement to encourage participation, sharing successful experiences and eliminating of fear associated with volunteering. Use of these techniques can strengthen resident volunteers’ confidence and help sustain their participation in the volunteer activities over time.

**Behavioral management:** helps participants reengage in self-identified meaningful activities and to have autonomy in decision making processes within the facility. Staff and DCWs review daily routines and help participants select a goal and specific activity to add pleasure and personal satisfaction. Active problem solving and motivational interviewing techniques help participants achieve identified activity goals. Reinforcement of activity engagement, identification of new activity goals and specific steps to help in developing a sense of purpose.

### VIII. EXPECTED RESULTS:

The above interventions have been efficacious and effective in other settings when used separately. It can be hypothesized that similar findings will also be present in ALFs. Education will raise awareness to not just residents, but family members and staff and recognition of signs and symptom of depression should be identified. Stigma associated with depression will decrease and residents will come forward and seek help. Care management will reduce stressors that are associated with depression and novel ways of managing them through referrals. Primary care physicians will build on their knowledge on depression especially in this target population and medications will be reviewed and managed frequently thereby creating less room for error, and non-compliance. Loneliness will also be reduced through the above interventions. Residents can actively engage in pet therapy, buddy linking and volunteerism accordingly to their needs. Behavioral management will help to assess their needs and goals and to work effectively towards them to eliminate feelings of melancholy. It is expected that a combination of all these activities encompassed as part of the H.O.P.E program will prevent and holistically heal depression in ALF.

Table 1: H.O.P.E Intervention Component, Content, and Activity for Target Population
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| **Education**      | Education provided on: 1) depressive symptoms, 2) how to talk to doctor about symptoms; and 3) relationship of depression to activity Provided to 1) Residents 2) Family members 3) Staff members                                                                                       | 1) Modules  
2) Brochures  
3) Talks by DCWs and physicians                                                                                                                                                                                                                                                                                   |
| **Care management**| Care management has been found to be more effective than therapy or medication alone for low income elders for whom financial, functional disability and lack of social resources may contribute to depressive symptoms. This includes: 1) assessment 2) coordination with other services/care management; 3) problem identification and resolution | 1) Considered a wide range of care needs most relevant to this population including, financial concerns, neighborhood safety, family conflict, death and loneliness                                                                                                                                   |
| **Referral and Linkage** | Referrals and linkages are derived from the care management assessment and may include: 1) physician referral for medication review and management; 2) link to physician for chronic disease management; 3) referral and linkage to other services (e.g., financial or legal advisors) | 1) Referrals to community-based service providers who are sensitive to participants' resources.  
2) For individuals identified as in need of more mental health support, helped bridge these services                                                                                                                                                                                                                      |
| **Social Interaction** | Provides immediate social interaction to reduce loneliness. Specific activities include: 1) Pet-Assisted Therapy 2) Buddy Linking 3) Volunteering                                                                                                                                                                                                 | 1) Use of a pet to aid in loneliness and improve physical activity  
2) Paired with another resident to participate in these activities.  
3) Volunteering in the ALF, schools or faith based organizations.                                                                                                                                                                                               |
| **Behavioral Management** | Approach is designed to provide positive reinforcement and engagement. Self-identification of goals/action plan promotes behavioral management. The approach involves: 1) identification of valued activities and goals; 2) establishment of plan of action for goal attainment; 3) monitoring and adjustment of plan/goals; and 4) identification of new goals and steps to attain them. | 1) Awareness and identification of appropriate community-based programs and services that could help participants link to meaningful activities.  
2) Use of motivational interviewing to reach feasible goals.  
3) Link individual to community to enable continuation of activity participation in a safe and structured setting.                                                                                                                        |
IX. CONCLUSION:

In the recent past, depressive symptoms were considered a natural consequence of aging, but depression is never normal and is a cause of significant functional decline in the elderly. Fortunately, it is also one of the most treatable chronic diseases in this population. The diligent monitoring of this disease and treatment often produces a good prognosis and an improved quality of life. Healthcare providers in the assisted living setting need to acknowledge that improved recognition and treatment of depression provides an opportunity to increase their quality of life despite the presence of other medical problems. As the aging population becomes increasingly diverse, there is a pressing need for culturally competent geriatric mental health care that addresses stigma. As stigma inhibits mental health help-seeking, little is known about the relationship between the spaces used for mental health care and stigma. By removal of the stigma associated with depression, the elder can learn to recognize signs of symptoms of depression and progress forward towards adequate treatment. Through education and consistent referrals, primary care physicians can build on their knowledge to empathize with the growing needs of the elderly and mental health challenges that they face. Further exploration is necessary in the mental health and aging domain to encompass multi-faceted approaches towards prevention and treatment of depression and other mental health disorders. By engaging in an active social life, exploring novel extracurricular activities, setting attainable goals and having day to day responsibilities, the importance of purpose and ‘mattering’ creates an overall sense of well-being. By having optimal positive engagement (H.O.P.E.) through the above interventions, depression can be conquered.
REFERENCES: