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Mental Illness in Assisted Living: Challenges for Quality of Life and Care

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Abstract

An unknown number of mentally ill elders in the U.S. receive care in assisted living [AL], along with persons facing physical or cognitive challenges. While dementia is familiar in AL, our data indicate that neither staff nor residents are prepared to work or live with the mentally ill. Challenges are created for professionals, since these residents bring diverse needs. Daily inter-resident interactions are also disrupted or stressful. Qualitative data describe the impacts on quality of resident life as well as care and management dilemmas identified within five assisted living settings having varying presence of mental illness among residents.

Keywords

Mental illness; assisted living; ethnography; quality of life; health care

INTRODUCTION

The closing of large-scale psychiatric hospitals in the U.S. in 1963 brought large numbers of people with severe mental illness [SMI] (including major depression, schizophrenia, bipolar disorder) into communities (Bartels, Miles, Dums & Levine., 2003; Hudson, Erickson, Lyon, Grauerholz & Herrity, 2013). Since that time, adults with SMI have received care in nursing homes, become homeless, resided in the community with family or other informal caregivers or, in some states, resided in assisted living [AL] or board-and-care homes specializing in the needs of those with SMI (Gilmer et al., 2003; McGrew, 1999). With advancing ages of this deinstitutionalized population, adults with SMI residing in community venues (i.e., not in psychiatric hospitals, other formal care settings, or prisons) may lose key caregivers or face age-related physical or cognitive challenges requiring care beyond the capacity of their current residential arrangements (Cohen et al., 2003; McGrew, 1999). The choice of an AL designed to serve older adults becomes an option for their housing and care.

The population of older adults with SMI is large, with approximately 8.6 million people age 65+ with SMI, either long-standing or of recent onset (Institute of Medicine, 2012; Kaskie, 2013). About 3% of older adults faced serious mental illnesses in 2012 (Karel, Gatz &

Smyer, 2012; Substance Abuse and Mental Health Services Administration, 2014). This figure jumps to 31.5% of older adults in all types of residential care (Karel et al., 2012), and was estimated at 38% for assisted living residents by the American Association of Homes and Services for the Aged [AAHSA] (2009). Recent national data show that 77.8% of residential care settings report offering some mental health or counseling services (Harris-Kojetin et al., 2013), yet the AAHSA study's data showed that only 5% of AL residents had received mental health services in the prior 90 days (2009). Despite a notable presence of SMI in AL, relatively few studies have focused on this topic to date.

Assisted living [AL] communities were developed to care for older adults with limited need for support and oversight in a less medically-focused environment than a nursing home (Becker, Schoenfeld & Stiles, 2002; Chapin & Dobbs-Kepper, 2001; Wilson, 1990); not all ALs have a full-time, licensed nurse on staff (Beeber et al., 2014; Hawes 2003). However, intentionally or not, many ALs also house persons with SMI (McGrew, 1999). Over recent years multi-state studies of AL have shown that aging in place has resulted in higher acuity resident populations, increasing the demands on care staff and affecting quality of care (Caffrey et al., 2012; Harris-Wallace et al., 2011; Hawes, Rose & Phillips, 1999; Morgan, Gruber-Baldini & Magaziner, 2001). Adding persons with SMI to the resident population, with their greater requirements for medical and behavioral supervision, further challenges ALs' original "social model" of care, intended to provide greater privacy and autonomy (Hudson et al., 2013; Wilson, 1990).

MENTAL ILLNESS IN ASSISTED LIVING

Little is known about psychiatric conditions or diagnoses for most older AL residents, except for two "expected" conditions (i.e., depression and anxiety), which often co-occur with dementia or serious physical health problems (Boyle, 2005; Hudson et al., 2013; Kaskie, 2013). Depression is the most prevalent mental health problem among AL residents, one of the top five chronic conditions in AL overall (Boyle, 2005; Dobbs, Hayes, Chapin & Oslund, 2006; Harris-Kojetin et al., 2013; Wagenaar, Mickus, Luz, Kraft & Sawade, 2003). About one in three residents takes medications for a mental health condition (American Health Care Assn, n.d.; Hyde, 2001). In addition, Lindsey (2009) points out increased risk of adverse outcomes or side-effects of psychoactive medications in adults over age 70. Detailed psychiatric evaluations in a Maryland-based AL sample (N=198) found dementia (67%) as well as mental illnesses (26%), sometimes co-occurring (Rosenblatt et al., 2004). Among mental illnesses reported in that sample were mood disorders (71%), anxiety (13%), and psychotic conditions (12%). Yet only half of those identified as having mental illnesses were deemed to be receiving adequate care (Rosenblatt et al., 2004). Several behavioral symptoms linked with both dementia and mental illness (agitation or aggression, depression, apathy, and irritability) have also been associated with AL residents' lower quality of life (Samus et al., 2005). While clearly establishing SMI as a challenge in ALs, less attention has focused on the quality of life of persons with SMI within these settings or on its impact on other residents.

While some U.S. experts advocate AL as a useful option for care of older adults with SMI, neither the AL's staff nor other residents are prepared for their presence (Becker et al., 2002;

Cohen et al., 2003; McGrew, 1999; Rosenblatt et al., 2004). Dobbs and colleagues (2006) reported both insufficient staff training and poor screening at admission for mental illness in ALs. Cadena (2007) examined a small sample (N=58) of AL residents with schizophrenia; her findings identified current use of multiple medications and notable unmet needs relating to care of their mental illness.

Lane and colleagues (2010), examining how ALs decide whether to admit persons with SMI, reported that dangerous or problematic behaviors, a concern shared for some applicants with dementia, often resulted in an AL's rejection of mentally ill applicants. A multi-state AL sample found 34% of residents evidencing one or more challenging behaviors due to mental illness, dementia or both (Gruber-Baldini, Boustani, Sloane & Zimmerman, 2004). The presence or emergence of problematic behaviors has been identified as precipitating residents' transfers out of AL, but the extent to which these behaviors overall were due to dementia vs. SMI is unknown (Ball et al., 2004; Bernard, Zimmerman & Eckert, 2001; Hawes et al., 2003; Sloane et al., 2011, Zimmerman et al., 2001). Dobbs and colleagues (2006) found, however, that having a diagnosis of mental illness was associated with lower odds of a resident aging in place in AL.

Despite best practice recommendations from the Committee on Aging of the Group for the Advancement of Psychiatry published over 10 years ago for ALs' care of residents with SMI (Cohen et al., 2003), there has been limited success in achieving these broad goals. Some states have regulations for care of persons with SMI in AL, but concerns remain regarding the implementation and quality of these services (Becker et al., 2002; Lane et al., 2010). This gap is especially troubling, considering that AL settings are not legally required to identify, treat, or refer persons with mental health issues to appropriate, specialized services (Hudson et al., 2013). Clearly the issue of staff training and awareness regarding mental illnesses of those in their care, including attention to administration and supervision of psychoactive drugs, remains insufficiently addressed in research or policy (Dobbs et al., 2006).

While issues of policy and AL operation regarding staff training and management of illness have been addressed to some degree in prior AL-based research, there has been limited attention to the effects of SMI on other residents or on the staff charged with their care.. Given this limited attention to outcomes relating to other residents, and in light of the broad-based social stigma toward those with SMI (Goffman, 1968; Hayward & Bright, 1997), this analysis has two objectives: a) clarifying the challenges from SMI to resident quality of life, and b) identifying challenges faced by AL staff who care for residents with SMI

STUDY DESIGN AND METHODOLOGY

Data for this analysis are derived from a study addressing the experience of autonomy in the daily lives of AL residents. This qualitative study, conducted sequentially in five diverse, purposively sampled AL settings in the mid-Atlantic region, generated data through both: a) participant observation, and b) semi-structured interviewing of AL residents, their family members, and a range of staff and managers. The AL sites for the project were selected to exhibit diversity on AL traits including size, cost, location, for- or non-profit status, and

independent or chain membership (See Table 1). Walden was distinct from the other ALs in that its mission explicitly included the provision of care to older adults with psychiatric needs in addition to those requiring primarily physical and cognitive support. This contrasted sharply with the other study settings, where disruptive behaviors arising from SMI were more often surprising to residents, staff at all levels, and visiting family members. Walden sensitized us to the issue of mental illness, which we began to observe arising regularly in the other AL settings as well. While this focus on mental illness was not an aim of our study, the impact of SMI became apparent from the data we collected in terms of both the operation of ALs and the quality of residents' lives.

Data Collection

Using ethnographic methods, studying individuals and groups within their own environments, the research team observed interactions among residents and with their family members, frontline staff, and managers. Intensive fieldwork in each site involved a minimum of two ethnographers over nine to twelve months. Narrative data were collected through participant observation and in-depth, reflexive interviewing. Visits to the research sites, occurring at various times of the day and days of the week, generated descriptive and interpretive fieldnotes. Through the intense immersion in these settings, ethnographers, as observant participants, engaged in daily activities to more clearly understand the meanings behind interactions through the eyes of those participating in its daily life. Fieldnotes sometimes captured specific language use or detailed descriptions of events. Ethnographers working at each site cross-checked their ideas and experiences during data collection to clarify themes and trends in the events and routines that appeared to be of importance within each site.

In addition, open-format, in-depth interviewing provided essential information from the perspective of individuals living, working, or visiting in the settings (Roulston, 2010). The ethnographers conducted reflexive interviews with 62 residents, 39 family members, and 55 staff and managers using questions adapted to their roles. None of the questions addressed mental illness, but instead inquired about transitions into AL, choices residents have in AL, and how residents navigate daily life in the setting. Responses relating to mental illness appeared in the context of these broader discussions and specific questions such as "Do residents make friends here?," "How are the activities here?," or "Do you keep your door closed/locked?," among others. Interviews were recorded (with permission); lacking this, extensive notes were taken. The study was approved by the Institutional Review Board (IRB) at the [blinded], and all names of ALs and persons are replaced with pseudonyms.

Data Analysis

Interviews and fieldnotes were transcribed verbatim, checked for accuracy, and entered into the text base (Atlas.ti 7.1.8) for coding and analysis (Muhr, 2013). Validation of data was achieved through multiple, established processes including: (1) memoing, (2) triangulation, (3) pattern saturation, (4) member checking, and (5) searching for "disconfirming evidence" (Birks, Chapman & Francis, 2008; Cresswell & Miller, 2000; Miles & Huberman, 1994; Richards & Morse, 2007; Seidel, 1998). We also employed a system of "collaborative coding" whereby codes were derived inductively by the entire research team's examination

and discussion of a series of fieldnotes and interviews early on in the fieldwork. A codebook of thematic categories was gradually developed through ongoing discussions and continually tested throughout the coding process (Eckert et al., 2009). This systematic process included considerable team-coding (rotating teams of two members independently coding transcripts and reconciling differences; no ethnographer coded his or her own materials) as well as individual coding once the code set was well established. In total our database at the time of manuscript preparation contained 370 fieldnotes and 156 interview transcripts across the five research sites. The time spent at the field sites, as well as the flexibility inherent in using an interview guide (as opposed to a structured instrument), produced a volume of data that extended beyond the fundamental questions relating to autonomy, including data presented here on SMI.

This paper's analysis specifically employed both ethnographer-identified case materials and word searches of the database (using terms such as "crazy," "mental," "nuts/nutty," "bi-polar," "hoard," and "psych") to generate relevant narrative material. This narrative data was systematically reviewed, leading to identification of themes relating to the experiences of mental illness for residents' autonomy/quality of life and to staff challenges managing behaviors and caring for residents with SMI.

FINDINGS

Since our study aims did not address mental illness, we did not directly seek information on SMI diagnoses or attempt to estimate its prevalence in our sites. A number of residents revealed their diagnoses to ethnographers, while interviews or observed conversations revealed that some residents were, regardless of diagnosis, labeled by peers or staff as mentally ill and treated differently on that basis. Nonetheless, we learned at a staff meeting that one third of the Chestnut Creek AL residents were on medications related to psychiatric diagnoses; rates were even higher in their dementia unit. Presence of mental illness, while largely unexpected by managers, staff, and other residents in all but one of our settings, appeared in all of the settings. This is demonstrated by Maureen Durke, a resident of Cedar Grove, who estimated 3–4 persons living there had mental illness.

I was not aware that mentally ill people, violent people, lived here – and I'm still trying to get one of the violent people out. And it hasn't worked yet, but I'm still trying. She's - she just hits. She hits herself or she hits other people. And she's very unpredictable.

A wide range of recognized conditions were mentioned by staff, residents, family members, and those with SMI, including eating disorders, schizophrenia, bipolar disorder, severe cyclical depression, and hoarding. Our analysis identified two focal areas: 1) effects of mental illness on resident's quality of life, including thematic elements of stigmatization (via language and labels), shunning or self-isolation, and the implications of behavioral issues for social relations, and 2) challenges faced by the ALs and staff to manage behaviors of, and provide care for, residents with SMI.

Resident Quality of Life

Three specific themes emerged relating to the impact of residents with SMI on other residents' daily lives. First, we saw notable evidence of social stigma manifested through labeling and language. Related to this was the confusion/conflation of dementia with SMI. Second, we observed shunning of, or self-isolation by, those with SMI. Our third theme describes the effects of problematic behavior on the quality of everyday life and autonomy of residents.

Stigmatizing Labeling, Language, and Conflation—For this theme we relied upon examination of utterances from residents and staff. Our word searches uncovered colloquial expressions using some mental illness terms to refer to everyday life (e.g., having a “crazy” day); we focus on use of these terms when directed at persons or groups. At Walden, the site that intentionally served those with mental illness, language about SMI was more direct and appropriate than elsewhere. One Walden resident, introducing herself, said, “I’m bi-polar, manic depressive, and schizophrenic, and my life’s been hell.” Her proactive self-identification stood in contrast to sometimes-hidden SMI at other sites, where few residents knew the specifics of others’ SMI diagnoses. An exception is a resident at Cedar Grove, who unashamedly told our researcher that, prior to moving there, she lived “at a mental health home for ten years.”

More typical were negatively-inflected usages to describe or label individuals or groups. Dominic Gervasi, a resident of Cedar Grove, indicated that there were special rules for “the crazy people - I mean handicaps,” both labeling others and intending tolerance toward them. Another resident, Steve Black, describing peers at Cedar Grove, said that one was “on another planet” and another was “nutty as a box of rocks.” Penelope Truman at Fairview described many residents as “only half-way normal.” Such disparaging comments were far from rare.

Language, including some examples above, may reflect the conflation of mental illness with dementia, since both are associated with some forms of disruptive behavior. Peggy Bennett, a resident of Walden who had bipolar disorder, distanced herself from others there, both because she was younger and because, in her words, “Half of them are....” and then she made a well-understood gesture [an inward-pointing index finger circling near her temple]. Peggy added, “They’re nuts!” a term she ironically directed at her fellow-residents with dementia. This conflation by residents, family members and staff could work in both directions, with dementia labeled as mental illness and mental illness branded as dementia. In either case, the potential for inappropriate or inadequate responses by others in the AL may result from this conflation.

Shunning and Self-isolation—Social distance (self-isolation or shunning) was initiated either by residents with SMI or by others, who were distancing themselves from real or perceived mental illness. Such separations amongst residents or groups can contribute to diminished quality of life and emotional health. According to Laura (Executive Director at Walden), Ruth Miller was “a good example” of shunning. “When she’s manic, she sometimes drives some of the residents a little bit nuts.” According to fieldnotes, residents

frequently were disturbed enough to flee to their rooms to escape her during these episodes. In a resident council meeting at Fairview, several cognitively intact residents, potentially combining reactions to SMI and dementia, complained about intrusions into their rooms. This group expressed their dislike for living with such residents, suggesting that “they” be moved elsewhere or locked into their rooms to lessen interruptions of others’ privacy.

Self-isolation of those with SMI is also a concern. A striking example, Peggy Bennett, a long stay resident at Walden noted above with multiple diagnoses including bipolar disorder and paranoid schizophrenia, remained in her room during a difficult episode. She told us that her dead brother had been visiting her during the night. Her right arm, which she rubbed during this account, was sore from him “shooting me up with dope.” She stayed in her room, trying to avoid him by locking her door, and claiming not to know how he found his way into her room. She then added that she knew that “people think I’m crazy, but I’m not.”

Behavioral Issues—Perhaps our most significant findings regarding mental illness’ impact on other residents relate to behavioral issues, ranging from aggressive behavior and delusions involving others to hoarding. Mentally ill persons sometimes become verbally or physically aggressive toward residents or staff, as reflected in the earlier quote about the woman who hits herself and others. Penelope Truman, a resident of Fairview, also spoke about another resident who “got into her face” and demanded that Penelope not “talk about her.” Penelope replied that she wasn’t talking about the woman, who then began vigorously pushing Penelope’s chair back and forth. “[S]he pushed the hell out of me.....She was really off; definitely off.” She added that the woman “scared [me] to death” that night; when she inquired later, the perpetrator had no recollection of this incident.

During an episode related to her multiple diagnoses of mental illness, JoAnn Richardson at Walden called the police repeatedly over several weeks, accusing her long-time friend Peggy of stealing her luggage. Mutual threats by JoAnn and Peggy to sue each other ensued. Meals and informal social activities were stressful for everyone spending time in the public areas of Walden during this rift. JoAnn persistently made comments under her breath about the luggage and glared at Peggy, who requested that their seats in the dining area be separated. Everyone else hoped to escape more explicit conflict and were vigilant to avoid saying or doing things that might bring the dispute to a boiling point. JoAnn continued to speak about the theft to other residents over several weeks, making them very uncomfortable, trying not to upset JoAnn while also supporting Peggy. Eventually, with adjusted medication and a piece of substitute luggage brought to the AL by her daughter, JoAnn’s accusations ceased, but not before many weeks of very stressful interactions among the Walden residents.

A third example involved Tillie who slept in Walden’s Dementia Care Unit (DCU) among higher-acuity residents, but preferred the more active daily life in the AL, where she was permitted to spend her days. While apparently high functioning, her divided days were due to mental illness. Her hoarding manifested itself through accumulation of boxes of paper and books in her room, as well as in her management of incontinence. The Director of Social Services told us, “We...and I fought the battle to keep her over here [the AL], and then every time I was even close, somebody would really open my eyes....” Cutting to the heart of the matter, she added, “[T]his is perhaps the psychiatric part...She hides her wet diapers.....

She's going to reuse them, she's going to dry them out, and she has boxes and boxes and BOXES of unused diapers. So it's a sickness." Tillie's hoarding, largely invisible to the residents in Walden's AL with whom she spent her daytime hours, required her to sleep in the DCU to ensure greater supervision and oversight for hoarding.

Staff & Nursing Challenges

Lack of Awareness and Training—In most of our study sites there was little or no training regarding the special medical and social needs of persons with SMI. Ms. McNair, a retired nurse and resident at St. Hildegard, noted that many residents there had psychological issues, and noted that the staff was not equipped to handle these residents. Added efforts required to supervise their medical needs and manage behavioral issues also impacted the staff at many levels. We observed, for example, that staff members also conflated dementia and mental illness. When asked whether mental illness had increased among residents, one caregiver at Chestnut Creek said that it was more mental than physical care required as resident acuity grew. However, she subsequently referred to residents with such mental needs who "may need to go to [the DCU]," clearly suggesting she did not distinguish between dementia and mental illness.

Denise, who described her job at Chestnut Creek as "Medication Technician," discussed her lack of training for mental illnesses. "[M]y main goal and my main job is med tech, just making sure that my residents get their medicine...in the allowable time that they give us, to make sure that they're safe with their medicine, make sure that it goes down properly." When asked about training, she said staff received limited training in understanding dementia, but as to training for mental illness, "Not too much, no, no." According to both Denise and the Director of Nursing there, paperwork arriving with new medications advised when the drugs were for mental illness, but other care staff did not know these diagnoses or that specific medication were for mental illnesses. In contrast, two Walden residents with SMI were highly familiar with and vigilant about their medications being administered correctly and on time, nagging Hilde, the responsible AL manager, if drugs were incorrect or late.

Added oversight for mental illness was not addressed either. Denise was typical in following a standard protocol reporting resident changes at Chestnut Creek, regardless of whether these episodes relate to physical conditions, dementia, or mental illness. "[I]f we....see something that's really, really changed or that person has gone down....I will talk to the nurses, I'll talk to the assisted living coordinator, I'll talk to the director.... I'll just let them take it from there." In contrast to this general approach, the relatively-larger care staff at Walden was aware of diagnoses and seemed to be better prepared to manage and supervise medications and disruptive or aggressive behaviors.

Limited awareness of SMI often extended to managers, raising the question of whether care for SMI can be effectively managed in AL. The administrator at Cedar Grove, for example, told us that the residents there were "like children;" she treated them accordingly in her interactions and by encouraging child-like crafts and activities. There was no talk among staff of specific diagnoses or special needs that residents might have relating to mental illnesses, although there was some staff awareness regarding dementia. In other settings we

saw nurses who were aware of SMI diagnoses and special needs, but not all ALs have on-site nursing staff. Formal rules or mentions of mental illness in most sites were rare at all staff levels.

Management of Problematic Behaviors—No single pattern emerged regarding how the sites managed the problematic behaviors evidenced by residents with SMI. Two of our sites, St. Hildegard and Fairview, showed distinctive patterns. When complaints arose about persons entering private rooms at night, the AL manager at Fairview offered those complaining the option of locking their own doors against unwanted intrusions; in doing so, she opted to support the autonomy of one resident group over another. The same pattern appeared at St. Hildegard, despite some residents' objections to locking their doors at night. In addition, floor supervisors at St. Hildegard targeted residents with behavioral problems for intensified oversight, limiting staff time for care of other residents. This approach was sustained up to the point where the resident was excessively disruptive or aggressive, at which time they were transitioned. At the other site, Fairview, resident Donna Cooper struggled with SMI from the beginning of her stay, and was discussed as being on "suicide watch" at one point. She, as well as residents in other settings, were "sent out" for "psych evaluations" when their mental health issues flared. One such stay for Donna Cooper was described by a disapproving staff member, as intended to get her "happy pills." Being "sent out" recurred for residents in three sites; this suggested that it may serve as a pressure valve, removing a resident during an acute episode with the option of retaining them afterward. For residents of other settings, such as Chestnut Creek, a pattern of challenging behaviors and "psych evals" often initiated steps toward relocation, either to their in-house DCU or a mandatory move-out. ALs varied in how long and hard they worked to retain individuals with SMI, some sustaining their efforts longer—not necessarily due to a commitment to a particular resident but often to keep the resident census at a desired level.

At times staff also needed to negotiate care issues and provisions for SMI with family members, physicians, and residents. Ruth Miller at Walden had been on psychoactive medications for many years. When she complained bitterly to her son about medication side effects, both of them lobbied the AL staff to have her medication levels reduced. With her physician's approval, the change was made, leading to a serious, disruptive SMI episode with mania that impacted both staff and other residents. Clearly AL staffers caring for those with SMI have many pressures to manage medications, address health or behavioral changes through time, and to manage outcomes from changes such as these. AL staffers and residents bear most of the brunt of difficulties arising in AL from SMI or its medications.

DISCUSSION

Given the limited staff and nurse availability in many ALs (Beeber et al., 2014), the difficulty of managing daily life and care for an aging resident population, and the housing of persons with serious, ongoing mental illness may present challenges. While U.S. health privacy policy forbids discussing others' diagnoses or health conditions with residents, mental illnesses create challenging experiences that can diminish the quality of life of other residents. SMI also challenges staff and managers, who are obligated to handle and explain

unexpected behaviors, such as aggression and delusions, and ensure privacy, while protecting other residents from danger or distress engendered by those with mental illness.

In reacting to and stigmatizing mental illness, most of our AL settings mirror the larger society by labeling and shunning persons with SMI. These negative dynamics may involve other residents, managers, staff, and visiting family members. Not all residents or staff were equally insensitive to these dynamics; some evidenced tolerance and understanding. ALs must be concerned about maintaining a safe and positive image in their communities. They wish to be seen as competent, comfortable, and supportive environments; these images may be disturbed by the actions of mentally ill residents. ALs are also businesses, which need to maintain occupancy levels to remain financially viable, and to afford sufficient staffing on each shift. Yet the obvious presence of residents with SMI may affect an AL's capacity to attract new residents.

The apparently unexpected yet increasingly likely presence of residents with SMI (Cohen, 2003), paired with most of our ALs' unfamiliarity with their care needs, risks disruption, distress, and harm, particularly for those spending much time in the setting's public areas. Problematic behaviors may also compromise resident autonomy, enjoyment, privacy. As described in prior work and discussed by the Director of Nursing at Chestnut Creek, the safety of all residents is compromised when staff must monitor and control behaviors about which they lack training (Dobbs et al., 2006; Hudson et al., 2013). Also problematic is the apparent lack of disclosure of SMI by family members prior to admission, and the absence of screening questions for admission relating to mental illness (Lane et al., 2009). Consequently, ALs may encounter recurrent problems in adequately responding to SMI; these are the stressors that caught our attention during the study. While most ALs we studied addressed issues as they arose and in an ad-hoc fashion, whether due to SMI or dementia, a contrast appeared at Walden, which intentionally served those with SMI. There attitudes and openness regarding SMI differed dramatically. Despite this greater awareness, however, problematic behaviors relating to SMI still sometimes disrupted everyday life and work there.

These findings, focusing on multiple groups of actors within the AL settings, confirm concerns identified in prior research regarding the personal/interpersonal challenges of inclusion of those with SMI in senior housing environments (Bartels et al., 2003; Cadena, 2006; Dobbs et al., 2006; Lane et al., 2006). Yet much of the extant literature focuses on SMI prevalence or policies at the local organizational or higher levels, rather than examining the issue in terms of the lived experience of those working, visiting, or living in the settings (Hudson et al., 2013; Institute of Medicine, 2012; Rosenblatt et al., 2004). These serendipitous findings of our research regarding SMI in assisted living point to both its limitations and to needs for future research. Given that our work was undertaken in a single region and was not designed to investigate mental illness or its implications, these findings remain preliminary. The topic of SMI's impact within assisted living clearly warrants further study. Future research might focus attention more directly on existing AL processes or care for SMI and on evaluation of best practice options to manage SMI. Outcomes should extend beyond retention of those with SMI to include quality of life for all residents and consequences for AL staff. Research examining the efficacy of training, environmental or

other programmatic interventions for improving resident outcomes would be a valuable addition.

Given the original intent of AL to address physical health and dementia care, the addition of persons with SMI creates dilemmas. Mental illness is not yet treated as equal to other health needs of residents in AL, since there remains little training. SMI is largely ignored, despite the existence of “best practice” guidelines (Cohen et al., 2003). Future research findings will enable appropriate changes to training, practice, and environments to best manage SMI in AL.

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Table 1

Research Site Information

Site Pseudonym	Established	Business Model	Capacity	Geographic Area
Cedar Grove	1970	Owner Operated	50	Rural
Walden	1990	Non-Profit with Board	15	Suburban
St. Hildegarde	2000	Religious, non-profit	60	Urban
Fairview	2010	For-profit, regional chain	100	Suburban
Chestnut Creek	1995	For-profit, national chain	60	Suburban