A NEEDS AND READINESS ASSESSMENT OF ASSISTED LIVING FACILITIES TO ADDRESS DEPRESSION AMONG ELDERLY CLIENTS

By

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ABSTRACT FORM

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Abstract

The purpose of this study is to explore the availability of mental health caregivers working within assisted living facilities for the elderly. The goal is to establish a link between theory and care facility practice. This study also explores the hypothesis that personal care workers (PCWs) have the most contact with residents as compared to all other assisted living staff. Therefore, PCWs would be the most logical candidate to observe the early warning signs of depression. Furthermore, this study describes to what extent assisted living directors are interested in training and requiring PCWs to conduct a brief assessment to help detect and report the early warning signs of depression among clients. In addition, this study investigates how receptive PCWs are to being trained and conducting brief assessments of clients to help determine if they are exhibiting any signs of depression. Data were gathered by telephone and/or by face-to-face structured interviews with directors of elderly assisted living facilities. This investigation is a

census of all such facilities within the tri-county area (Dunn, Chippewa, and Eau Claire). Findings will be utilized to design and direct future interventions aimed at training personal care workers to detect and report assisted living clients who are exhibiting signs of depression. In addition, findings will be utilized to promote further research.

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CHAPTER ONE

The older population, persons 65 years and older, numbered 34.4 million in 1998. Currently, they represent about one in every eight Americans (U.S. Bureau of the Census, 1998). The older population has grown and will continue to grow significantly in the future. Because of this growth, disorders which currently have high incidence and prevalence rates, such as depression, are projected to even more severely impact individuals and society (Bromberger & Costello, 1992). Currently, the National Institute of Mental Health estimates that "depression affects more than 17.5 million adults each year and costs society about $43 billion annually" (Wood, 1999, p. 51).

Depression is not an inevitable part of aging. Despite the fact that more losses are experienced in the later years-deaths, declining health, and loss of social roles-it is not "normal" to feel depressed all the time when one gets older. In fact, most older people feel satisfied with their lives (Smith, 1999).

Despite the publicity given to Alzheimer's Disease, depression is the most common psychiatric disorder in old age (Davis, 1996; Hughes, 1992; Snowdon, 1987). Overall, estimates suggest that between 20% and 25% of the adult population will experience an episode of depression at some stage in their lives (Falloon & Shanahan, 1992). Furthermore, epidemiological estimates have reported that 10-15% of individuals of 65 years experience significant depressive symptoms (Davis, 1996; Katona, 1989). In addition, after hospitalization and treatment of most major medical illness--e.g., hip fracture, myocardial infarction, stroke etc.--about one-third of elderly patients will develop depression (Smith, 1999). Research strongly suggests that the severity of depressive episodes may be greatly reduced if depression is recognized and treated early

(Bromberger & Costello, 1992; Falloon & Shanahan, 1992; Falloon, 1988). A disorder with such high rates of incidence and prevalence, associated with substantial emotional and economic costs, would seem to be an excellent target for prevention.

Problem Statement

This study explores the availability of mental health caregivers working within assisted living facilities for the elderly. In addition, this investigation explores the hypothesis that personal care workers have the most contact with clients. It is assumed that those having the greatest contact with clients would be best able to attest to changes in their mental health status. Furthermore, this investigation explores to what extent assisted living directors are interested in training and requiring personal care workers to conduct a brief assessment to help detect and report the early warning signs of depression among clients. Also, this study attempts to determine how receptive directors believe personal care workers would be to being trained and to conducting a brief assessment to help determine if clients are exhibiting any signs of depression. The earlier depressive symptoms are recognized, the earlier steps can be taken to combat the depressive episode. Early recognition and appropriate action increases the possibility of reducing the severity of depression or perhaps aborting the depressive episode entirely. With the interdependence of the above-mentioned factors in mind, it is important to have a profile of older Americans and to understand what depression is and how it impacts individuals and society.

Definition of Terminology

- Activities of daily living (ADL): The term ADL includes physical care needs such as toileting, dressing, and eating.
- Assisted living facilities (ALF): Assisted living facilities are apartment-style housing for elderly who want or require assistance with the activities of daily living. Assisted living facilities are not licensed by the state so there is no standard definition.

- Certified based residential facilities (CBRF): The term certified based residential facilities are intended for elderly who need assistance in completed the activities of daily life, but do not yet need the skilled nursing care provided by a nursing home. Usually, CBRFs offer each resident a room, but not an apartment.

For the purpose of this paper both types of facilities will be called assisted living facilities.

- Depression: Depression refers to a set of symptoms, low mood states, and syndromes. In this paper, depression includes the presence during the previous two weeks of a group of symptoms, such as the loss of energy and feelings of worthlessness, in conjunction with a depressed mood or the loss of pleasure or interest (American Psychiatric Association, 1994).
- Incidence: The term incidence refers to the frequency of a disease or disorder.
- Instrumental activities of daily living (IADL): The term IADL includes complex care needs such as shopping, meal preparation, and managing finances.
- Prevalence: The term prevalence refers to the total number of cases of a disease or disorder in a given population at a specific time.
- Risk factor: Risk factors are factors of characteristics in the individual or the environment that are known to be associated with an increased change of a person developing a disorder (Bromberger & Costello, 1992).

CHAPTER TWO

Profile of Older Americans

The older population, persons 65 or older, numbered 34.4 million in 1998. They represented 12.7% of the United States population, and about one in every eight Americans. The number of older Americans increased by 3.2 million or 10.1% since 1990, compared to an increase of 8.1% for the under 65 population. In 1998, Wisconsin had 690,786 persons aged sixty-five and older residing within its borders. When compared to all other ages, this population was 13.2% of the total state (U.S. Bureau of the Census,1998).

People are living longer. In 1998 the 65-74 age group (18.4 million) was eight times larger than in 1900, but the 75 to 84 group (12.0 million) was sixteen times larger and the 85 and older group (4.0 million) was 33 times larger. In 1997, persons reaching age 65 had an additional average life expectancy of 17.6 years (19.0 years for females and 15.8 years for males). A child born in 1997 could expect to live 76.5 years (U.S. Bureau of the Census,1998).

The older population will continue to grow significantly in the future largely due to the Baby Boomers. In the first half of the 20th century, the annual number of births in the United States remained fairly steady, at 2.7 million to 3 million a year. Then, about nine months after the end of World War II, the number of births began a quick, steep climb. It rose from 2.9 million in 1945 to 3.4 million in 1946 to 3.8 million in 1947. The boom continued for 19 years, with 4.3 million babies born in the peak year of 1957. Births remained above 4 million until 1965 when they dropped to 3.8 million. When it was all over, a grand total of nearly 76 million baby boomers had arrived. In addition, the 72 million children of Baby Boomers form a huge generation that will come of age in the next five years. Overall, these large booms in the number of births coupled with medical advancements will secure the growth continuation of the older population

(Mitchell, 1999).

It is estimated that there will be 34.7 million people over the age of 65 in the year 2000. By 2020 that number is estimated to increase to 53.2 million people over the age of 65. By 2030, there will be 70 million older persons, more than twice the number in 1998. People 65 and over are projected to represent 13% of population in the year 2000 but will be 20% by 2030 (U.S. Bureau of the Census,1998).

In 1998, older men were much more likely to be married as compared to older women -- 75% percent of men, 43% percent of women. Almost half of all older women in 1998 were widowed (45%). There were four times as many widows (8.4 million) as widowers (2.0 million). Although divorced older persons represented only seven percent of all older persons in 1998, they're number (2.1 million) had increased five times as fast as the older population as a whole since 1990 (U.S. Bureau of the Census,1998).

In Wisconsin, there are 148,556 people 65 and over residing with their spouse, while 218,670 people 65 and over are either single, divorced or widowed (U.S. Bureau of the Census, 1990).

Approximately 1.43 million (4.2%) of the 65 and older population lived in nursing homes in 1996, the percentage increases dramatically with age, ranging from 1.1% for persons 65 to 74 years to just over 4% for persons 74 to 84 and nearly 20% for persons 85 and older (U.S. Bureau of the Census,1998). In Wisconsin, there are approximately 46,000 people 65 and older institutionalized, while 36,927 people are residing in group quarters (U.S. Bureau of the Census, 1990).

The median income of older persons, in the United States, in 1998 was $18,166 for males and $10,504 for females. For all older persons reporting income in 1998 (31.7 million), 36% reported less than 10,000. Furthermore, only 22% reported $25,000 or more. The median income was $13,768 per year (U.S. Bureau of the Census,1998).
In Wisconsin, 119,772 people over the age of 65 made less than 10,000, while 119,638 people made more than 25,000 (U.S. Bureau of the Census, 1990).

About 3.4 million elderly persons were below the poverty level in 1998. Another 2.1 million or 6.3% of the elderly were classified as "near-poor". One of every six older persons was poor or near-poor in 1998. In Wisconsin, over 7% of those 65 and older were below the poverty level from 1995 to 1997 (U.S. Bureau of the Census,1998).

Health and Health Care among the Elderly

Limitations on activities because of chronic conditions, such as, dementia, arthritis, Cushing's Disease, diabetes, and Parkinson's Disease increase with age. In 1996, over one-third of older persons reported they were limited by chronic conditions. Among all elderly, 10.5% were unable to carry on a major activity. Approximately 10% of the population under 65 years old were limited in their activities, and 3.5% were able to carry on a major activity. In 1994-95 more than half of the older population reported having at least one disability. One-third had at least one severe disability (U.S. Bureau of the Census,1998).

In 1996, over 4.4 million had difficulty in carrying out activities of daily living (U.S. Bureau of the Census,1998). More specifically, 48.7% of those 65 and older needed assistance with instrumental activities of daily living while, 35.3 needed assistance with basic activities of daily living (U.S. Bureau of the Census, 1990). The term activities of daily living (ADLs) encompasses basic physical care needs, such as toileting, dressing, and eating, as well as more complex care needs referred to as instrumental care, which include shopping, meal preparation, and managing finances. The instrumental ADLs (IADLs) are the complex activities that allow an individual to survive independently. Overall, activities of daily living are influenced by a variety of factors, including cognitive factors, affective state, social supports, behavior, and degree of physical functioning. For example, although an older adult may appear to functioning independently in the community, this may be due to the involvement of a spouse or other caregiver who has assumed many of the ADLs for that person (Branch, 2000).

Affective status can significantly influence functioning in the activities of daily

living. Research suggests that depression may have more of an impact on ADLs than cognitive status. Among depressed participants, those able to engage in ADLs had higher mini-mental status exam scores than those who were unable to perform ADLs. Likewise, among non-depressed participants, those able to perform ADLs had higher mini-mental status scores than the more disabled participants. When controlling for the level of cognitive function, the single most important predictor of functioning in ADLs was the presence or absence of depression. In other words, depressed patients will have higher rates of impairment in their ADLs, regardless of cognitive functioning (Branch, 2000).

Older people accounted for 36% of all hospital stays and 49% of all days of care in hospitals in 1997. The average length of a hospital stay was 6.8 days for older people, compared to only 5.5 days for people under 65. Older persons averaged more contacts with doctors in 1997 than did persons under 65 (11.7 contacts vs. 4.9 contacts). These statistics greatly support the need for specialized facilities to assist elders who need an increasing amount of care but are not yet in need of the constant skilled nursing care offered by a nursing home (U.S. Bureau of the Census,1998).

When a loved one can no longer live at home independently, but does not need or want to move into a nursing home, other residential options do exist. Living arrangements that maximize a person's independence while providing necessary support and care are available in many communities. Assisted and residential living facilities are two options that provide alternatives to more intensive and costly nursing home care.

Assisted living facilities (ALFs) maximize independence by providing apartment-style living with services designed for older persons. ALFs are often marketed as "upscale" living. However, there is no standard definition for assisted living. Also, aside from standard safety and fire codes, there are no federal regulation regarding the operation of ALFs (McGannon, 1993). In other words, these facilities are unlicensed. Residences vary as to the type of services they provide .

In general, assisted living facilities fall into three categories: 1) The hospitality

model provides hotel-like services such as meals, housekeeping and laundry. These facilities are suitable for healthy older persons with minimal service needs. 2) The personal care model provides personal care assistance for persons in frail health or in situations where the well spouse and the impaired spouse wish to continue living together with onsite support services. 3) The aging-in model offers onsite care for chronic conditions (McGannon, 1993). These are equipped to provide some skilled nursing services and can accommodate the changing needs of residents. For example, a client suffering from dementia may have only needed help taking medication upon admittance but as the illness progressed, the client's needs have increased to requiring assistance getting dressed and mild behavioral redirection. Furthermore, these facilities are personally paid and are generally more expensive than certified based residential facilities (McGannon, 1993).

Assisted living facilities range in size from small homelike environments of 3-12 residents to large full service communities with 600-800 residents. Services within ALFs vary, but usually are facilitated by personal care workers'(PCWs) and include: 1) 24-hour security, 2) emergency call systems for each resident's unit, 3) housekeeping and laundry services, 4) transportation, 5) assistance with bathing, grooming, dressing and toileting, 6) medication management, 7) social and recreational activities. The level of assistance can be minimal to comprehensive (McGannon, 1993).

Certified Based Residential Facilities (CBRFs) are intended for individuals who are unable to live alone but who do not warrant skilled nursing services. They provide individual rooms, but not apartments. Unlike ALFs, CBRFs must be licensed by the state (McGannon, 1993).

Many people who live in certified based residential facilities are fairly independent and require only minimal supervision. However, CBRFs are also appropriate for mildly to moderately confused people with few or no medical needs. A residential care home provides social interaction, activities, has staff present 24 hours a

day in case of emergencies, and supervision for those with mild physical or cognitive impairments (McGannon, 1993).

Similar to ALFs, CBRFs employ personal care workers to provide assistance with personal hygiene, grooming, and bedside care, dressing, meals, and other typical daily activities including recreational and social activities. Housekeeping services are included. In addition, some CBRFs offer optional services for an additional fee, for example, transportation to shopping centers or to other outings, cable TV, newspaper delivery or religious services (McGannon, 1993).

Certified based residential facilities differ from assisted living facilities in several ways. CBRFs offer rooms, where ALFs typically have apartment units. Also important is the CBRFs are state licensed. Persons moving into a CBRF must complete a pre-admission appraisal to assess the individual's care needs. CBRFs are subject to regulations for admissions agreements, theft and loss policies, and eviction procedures, as well as periodic inspections by the Department of Social Services (McGannon, 1993). Assisted living facilities can provide more autonomy to healthier residents, but they are generally more costly than CBRFs. Those persons with care needs may receive similar services to those offered by a CBRF, but there is no government oversight. It is important to note that both ALFs and CBRFs are included in this investigation. For the purposes of this paper both types of facilities will be called assisted living facilities.

As mentioned above, personal care workers may assist clients in virtually all activities of daily living. Logically, one may conclude that they spend the most time with clients, thus making them the most likely candidate to attest to changes in the mental condition of clients on a regular basis.

Definition of Depression

The label of depression has commonly been given to symptoms and low mood states, as well as to clinical syndromes. Although these symptoms, mood states, and syndromes may overlap to some extent and may be related, they often reflect

qualitatively and quantitatively different phenomena. Major Depressive Disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition includes the presence, during the previous two weeks, of a group of symptoms, such as the loss of energy and feelings of worthlessness, in conjunction with a depressed mood or the loss of pleasure or interest (American Psychiatric Association, 1994).

Whatever definition is preferred, depression is one of the most common mental disorders in western societies, and its frequency appears to be increasing (Bromberger & Costello, 1992). It has been suggested that Western societies are entering an age of melancholy--an observation fueled by recent epidemiological studies that have found an increasing incidence and prevalence of depressive disorders (Hagnell, Lanke, Rorman, & Ojesjo, 1982).

Epidemiology of Depression Among the Elderly

Despite the publicity given to Alzheimer's Disease, depression is the most common psychiatric disorder in old age (Davis, 1996; Hughes, 1992; Snowdon, 1987). Even the most conservative epidemiological estimates have reported prevalence of depression at twice that of dementia, and it is reported that 10-15% of individuals of 65 years experience significant depressive symptoms (Davis, 1996; Katona, 1989). The extended lifespan of the population, combined with the high prevalence of depression in elderly people, means that depressive illness is a major public health problem. Overall, estimates suggest that between 20% and 25% of the adult population will experience an episode of depression at some stage in their lives. A disorder with such high rates of incidence and prevalence, associated with substantial emotional and economic costs, would seem to be an excellent target for prevention (Falloon & Shanahan, 1992).

Impact and Consequences of Depression

Depression threatens a significant portion of the population (Bromberger & Costello, 1992). It is often a reoccurring illness that appears to be increasing in frequency and that brings with it great economic and emotional costs. Depression has no

respect for race, class or gender. We know that 22 percent of women and 13 percent of men will suffer major depression in their lifetimes (Wood, 1999). The National Institute of Mental Health estimates that "depression affects more than 17.5 million adults each year and costs society about $43 billion annually" (Wood, 1999, p. 51). The impact of depression on individuals, families, and communities is more difficult to measure. There are no accurate estimates of the effects of depression on "productivity, absenteeism, family relationships, or physical health" (Bromberger & Costello, 1992, p. 124). Yet, one may logically conclude that a link between depression, an illness that affects people physically, emotionally, behavioral and mentally, would impact virtually every aspect of a persons life and the various systems in which they interact (Bromberger & Costello, 1992).

According to Davis (1996), depression is associated with a marked increase in the use of primary care, hospital and social resources. The excess use of general health services resulting from inadequately treated depressive illness is "not surprising considering the common symptomatology of depression in elderly people, e.g. loss of appetite; weight loss; loss of interest in life leading to self-neglect" (Davis, 1996, p. 23). Apart from the problems mentioned above, there are a range of other complications that can accompany untreated depressive illness in elderly people. These complications include suicide (Katona, 1989): non-compliance with prescribed medications; overdosing, leading to drug toxicity; delusions and/or hallucination; somatic reoccupation (e.g. with bowel function in the absence of functional abnormality) and increased risk of falls and domestic accidents (Davis, 1996). Both trader-dosing and over-dosing can result in a need for hospitalization. Drug toxicity frequently results in severe cognitive impairment (McMinn, 1995).

Depression and Health

A two-way interaction exists between both depressive syndromes and declining function and health status and disease. After hospitalization and treatment of most major

medical illness--e.g., hip fracture, myocardial infarction, stroke etc.--about one-third of elderly patients will develop depression (Smith, 1999). Similarly, 15 to 25 percent of nursing home patients meet criteria for major depression while many others experience some significant depressive symptoms. Yet, many people who suffer from depression are not diagnosed and do not receive treatment for their illness (Smith, 1999).

There are many reasons why depression in older people is often missed or untreated. As a person ages, the signs of the disease are much more likely to be dismissed as crankiness or moods of "old age." Depression can also be tricky to recognize. Confusion or attention problems caused by depression can sometimes mimic the symptoms of Alzheimer's Disease or other disorders of the brain (Friedrich, 1999). Mood changes and other common symptoms of depression are sometimes the result of side effects from drugs commonly taken by older patients for high blood pressure and heart disease. Depression in late life also frequently occurs with other chronic disease, making diagnosis difficult and treatment challenging. Depression in older people may not be easy to diagnose, but it should not be ignored because it typically responds to appropriate treatment (Friedrich, 1999).

Despite being very treatable and a largely reversible condition, clinical depression in older people is frequently misdiagnosed, under-treated and/or untreated by their primary caregivers. Research indicates that approximately 15% of independent older adults, 20% of older hospitalized patients, and 25% or more of nursing home residents suffer from depression (Smith, 1999). Yet, more than 60% of depressed older adults are not being treated for this disabling illness, which can became life-threatening. The suicide rate for older people is high, with males over age 65 committing suicide at three to four times the rate of the general population (Smith, 1999).

Although there have been significant advances in psychiatric treatment for depression, there has been a well-reported laissez-faire attitude towards active treatment for depressed elderly people. A study of mental health services in Sydney nursing homes

confirms that depression is a problem. It revealed that "30% of nursing home residents surveyed were significantly depressed, while 59% took one or more psychotropic medication on a regular basis" (Davis, 1996, p. 24). A disturbing finding was that despite its high prevalence of mental disorder in Australian nursing homes, 21% of directors of nursing in the same study did not believe it was necessary to involve mental health professional in the management of any of their residents (Davis, 1996). Given that untreated clinical depression can lead to serious life-threatening complications, particularly suicide in elderly males, this lack of referral for specialist psychiatric intervention suggests that there is a lack of knowledge and awareness regarding mental illness and treatment.

Risk Factors for Depression Among Elderly

Stressful life events include the loss of a job, a move to a new neighborhood, or a change in the health of a family member. In general, depressed patients experience more stressful life events in the six months prior to being diagnosed (Smith, 1999). Other risk factors include:

- Being female, though males are more likely to commit suicide.
- Living alone, divorced or widowed.
- Alcohol abuse("secondary alcoholism" due to depression is also common).
- Lower socioeconomic class.
- Family history of affective/mood disorders.
- Major medical illness.
- Personal history of prior depressive episode.
- Anxiety disorder or panic disorder.
- Placement in a long-term care facility

Logically the more risk factors for depression one has the greater the probability of the individual developing this common and often devastating illness. Furthermore, the greater the probability of depression, the greater the need for monitoring for depressive

symptoms (Smith, 1999).

Signs of Depression

Older people experience more events and problems that might cause one to become “depressed” - deaths of loved one and friends, being unsure of what to do in retirement, or coping with chronic illness. Usually, though, after a normal period of time grieving or feeling troubled, people resume their daily lives. When a person is clinically depressed, his or her ability to function both mentally and physically is affected and the trouble may last for weeks, months, or even years (Penninx & Leveill, 1999).

Families, friends, and health professional must look carefully for the signs of depression in older people. Symptoms vary widely among people and, sometime, depression can hide behind a smiling face. For depressed people who live alone, for instance, feelings of despair or loneliness can change briefly when someone stops by to say “hello” or during a visit to the doctor. The person may get such a boost from the contact with another individual that, for the moment, the depressive symptoms subside. Access to appropriate psychiatric care is therefore in the hands of primary caregivers. It is essential that primary health care workers understand when it is appropriate to refer their clients for specialist psychiatric assessment and treatment. If the “symptoms are recognized early in the course of the illness and if appropriate help is obtained, many of the complications of depression - along with their accompanying human and material costs -- can be prevented” (Davis, 1996, p.25).

A list of the most common signs of depression can be found in Appendix B.

Prevention

In some cases, major depressive illness can be greatly reduced in severity or even avoided. This is especially true when depression is linked to life events, such as widowhood and retirement, which occur more often with age (Falloon & Shanahan, 1992). For instance, fostering and maintaining relationships over the years can help

lessen the effects of losing a spouse. Developing interests or hobbies, staying involved in activities that keep one in touch with family and friends are all ways to keep major depression at bay (Eaton & Badawi, 1995). Research strongly suggests that the severity of depressive episodes may be greatly reduced if depression is recognized and treated early. The benefits to sufferers, careers and the service providers are likely to prove substantial (Falloon, 1988).

The association between environmental stress factors and depressive disorders has a long history (Brown & Harris, 1978). They have provided compelling evidence that "environmental stress coupled with psychological vulnerability tends to enhance a person's risk of succumbing to a depressive condition" (Falloon & Shanahan, 1992, p. 54). The stress factors tend to be either life events that are perceived as threatening by the person and remain unresolved after a week, or enduring stressors such as persistent financial hardship or grossly inadequate housing that provoke a sense of hopelessness and helplessness in the vulnerable person (Falloon & Shanahan, 1992). The vulnerability factors that have been most clearly implicated are lack of employment outside the home, having three or more children under 14 living at home, loss of a mother before the age of 11, or the absence of a close, confiding relationship (Falloon & Shanahan, 1992, p. 54).

Efficient early intervention requires close collaboration with those agents in the community to whom persons turn when experiencing the earliest features of depressive disorders. A pilot study of early detection and intervention with depressive disorders seems to suggest that such methods may abort the development of the more severe presentations of these conditions and the burdens they cause to sufferers, caregivers and community services (Falloon & Shanahan, 1992).

The items discussed thus far appear to suggest that depressive symptoms may actually contribute to the need for assisted living facilities. In fact, residing in a long-term care facility is considered a risk factor for depression (Smith, 1999). Considering that every person residing within an assisted living facility exhibits at least one risk factor

for depression further reinforces the need to monitor for depression within these agencies. In other words, depression may contribute to a variety of physical, emotional, mental, and behavioral difficulties leading an elder to reside in a long-term care facility and a perceived loss of autonomy may further exacerbate the depressive symptoms (Smith, 1999).

Hypothesis

A telephone or face-to-face structured interview of directors of assisted living facilities, that house elderly populations, was conducted in an attempt to demonstrate five hypotheses.

- First, that there is a lack of mental health caregivers working within assisted living facilities.
- Second, personal care workers are the staff members that have the most contact with clients.
- Third, based on contact, personal care workers would be the staff member best able to attest to changes in the mental condition of clients.
- Fourth, that assisted living directors are interested in training and requiring personal care worker to conduct a brief assessment to help detect and report depressive symptoms.
- And finally, that personal care workers are interested and willing to learn about depression among elderly and would be willing to conduct a brief procedure to help determine if clients are exhibiting any symptoms of depression.

CHAPTER THREE

Methodology

Participants

This study involved interviewing directors of assisted living facilities located in a tri-county area in the mid-western part of Wisconsin. Although materials used in this study did not gather specific demographic data on participants, all participants were female. The counties included in this investigation are Eau Claire, Chippewa and Dunn counties. Eau Claire County has the largest population followed by Chippewa and then by Dunn. Each county's resident population is primarily Caucasian.

Eau Claire County hosts eleven assisted living facilities and currently has another under construction. Within Eau Claire County there are approximately two-hundred elderly persons residing in assisted living facilities. Chippewa County hosts three assisted living facilities with a combined elderly population of approximately forty-five clients. Chippewa County also has another assisted living facility currently being constructed. Dunn County hosts four assisted living facilities with a combined elderly population of approximately eighty clients. On average, clients are in there 80's and require assistance with the activities of daily living.

Materials

A nineteen-item, researcher-developed, survey located in Appendix A was utilized to gather the desired data from the directors of the assisted living facilities. Question one investigates the mission of the agency. Questions two and three ask how many clients the facility serves and "approximately the average age" of clients. This was followed by questions regarding funding, and exact type (i.e., assisted living facility or certified based residential facility) of facility. Question six asks if the facility is "physically connected to any other care facility." This question is followed by a series of questions about the caregivers working within the facility. More specifically, question seven asks if the "agency employs any mental health caregivers." Questions eight and

nine ask about what job titles used by the facility and who on staff, spends the most time with clients. Questions ten through thirteen address how much time PCWs and/or other caregivers interact with each client and any given day. Questions fourteen and fifteen ask if the "agency attempts to address any of the mental health needs of clients" and does the facility "have any training sessions/programs for staff regarding depression in the elderly." And finally, questions sixteen through nineteen attempt to determine the extent to which assisted living directors and personal care workers are interested in being trained to implement an assessment and to report the early warning signs of depression.

Procedures

A list of assisted living facilities targeting the elderly population in Eau Claire, Chippewa and Dunn Counties was gathered using the telephone directories that encompass each of the counties. Once the list was compiled, a face-to-face or telephone interview was arranged between the director and researcher. All face-to-face interviews were conducted on-site at the assisted living facilities. Opening statements varied slightly dependent upon the type of interview. Participants who were interviewed face-to-face were first verbally informed that they had been selected to participate in this investigation because of their position within the agency and that they possess particular knowledge of interest to the researcher. More specifically, directors were chosen because of their unique awareness of the mission and purpose of the agency. Furthermore, directors interact with all staff within the agency on some level. Upon completion of the introduction, participants were asked to sign an informed consent form. Participants who had a telephone interview were verbally informed about the study and notified that by continuing the interview they were demonstrating their consent to participate.

All directors then participated in an interview lasting approximately 20 minutes. Upon completion of the interview, participants were debriefed and thanked for their time and cooperation.

CHAPTER FOUR

Results

Results in the following section will be organized around the specific questions that were asked in the structured interviews. Data will be presented collapsed across all counties. Written description of the results will often be accompanied by a graphic depiction of the results to ease interpretation.

"As director, what do you see as the mission of this agency?"

Figure 1 – Mission of Assisted Living Facilities

Figure one is a graphic depiction of the mission of assisted living facilities within Eau Claire, Chippewa, and Dunn Counties. As the graph depicts, people most frequently expressed providing quality care and promoting independence and dignity to be the mission of the facility. More specifically, sixteen out of the eighteen facilities in the tri-county area expressed that providing quality care was seen as a mission of their facility. This was followed closely by promoting independence and dignity, which was expressed by fifteen facilities as being a part of their mission. Furthermore, ten facilities expressed providing choice in living arrangement for seniors as a part of their mission. Three facilities expressed promoting wellness as a part of their mission.

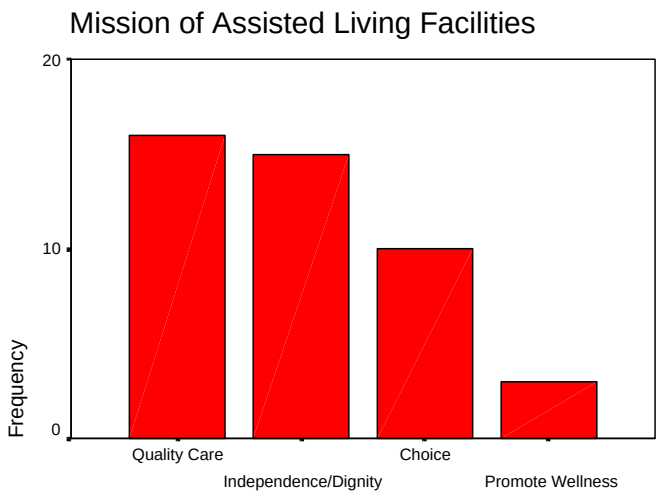

Figure 1

"How many clients are you currently serving?"

Of the eighteen assisted living facilities located within Eau Claire, Chippewa and Dunn Counties, the average number of clients was eighteen per facility. The facility with the fewest clients has 3 residents and is located in Eau Claire County. The facility with the most clients has 48 residents and is also located in Eau Claire County.

Figure 2 – Number of Assisted Living Clients

County	Population	Average
Eau Claire County	202	18.36
Chippewa County	43	14.33
Dunn County	82	20.50
Collapsed Across Counties	327	18.17

" Approximately what is the average age of your clients?"

Figure 3 – Average Age of Clients

Figure three is a graphic depiction of the average age of clients residing in assisted living facilities. As the graph depicts, most clients are in there eighties. More specifically, thirteen assisted living directors expressed the average age of their clients to be between eighty and eight-nine years of age. Five facility directors expressed the average age of their clients to be between ninety and ninety-nine years of age.

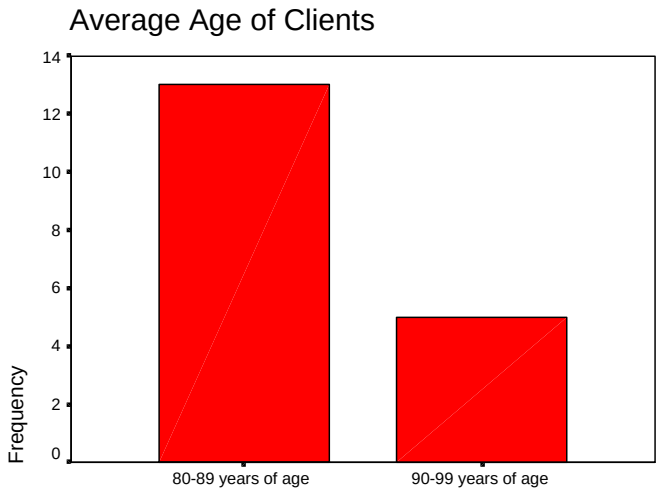

Figure 3

"How is this agency funded?"

Figure 4 – Agency Funding

Figure four is a graphic depiction of how the assisted living facilities are funded. As the graph depicts, most assisted living facilities in Eau Claire, Chippewa and Dunn Counties are funded through private pay and are for profit facilities. More specifically sixteen out of the eighteen facilities are private and for profit while only two directors expressed their agency as being a not for profit organization.

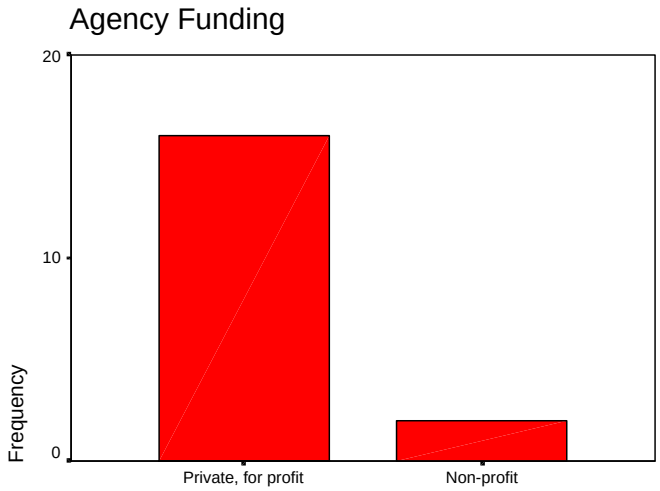

Figure 3

"Is this a community based residential facility or an assisted living facility?"

Figure 5 – Type of Facility (CBRF or ALF)

Figure five is a graphical depiction of the exact type of facility. As the graph, depicts, twelve of the facilities are certified based residential facilities. Six of the facilities are assisted living facilities.

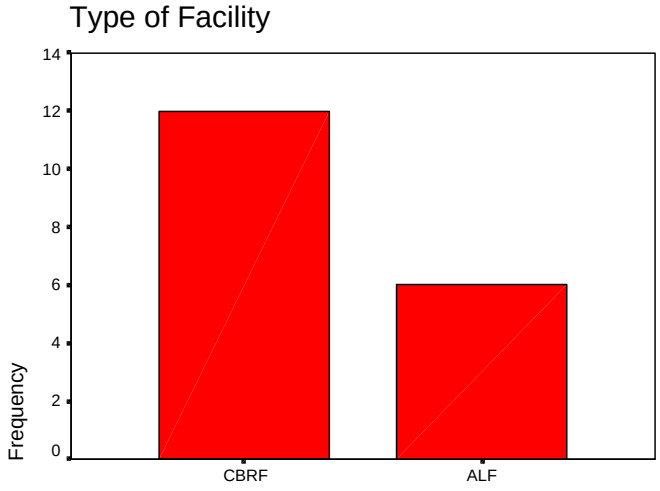

Figure 5

"Is this facility physically connected to any other care facility?

Figure 6 – Physical Connection to Another Care Facility

Figure six is a graphic depiction of assisted living facilities that are physically

connected to another care facility. As the graph depicts, four assisted living facilities are physically connected to another care facility, while fourteen are not physically connected.

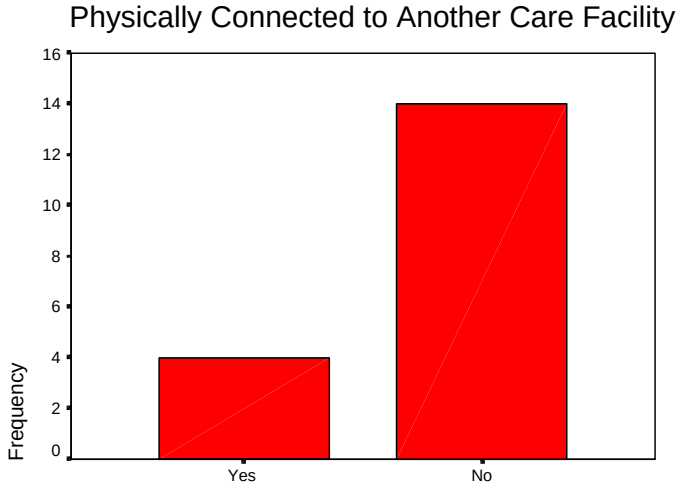

Figure 6

"What type of care facility?"

All four facilities that are physically connected to another care facility are connected to a nursing home.

"Does this agency employ any mental health caregivers?"

Directors of all assisted living facilities within Eau Claire, Chippewa, and Dunn Counties expressed having no mental health caregivers on staff. Because of this, no data could be gathered regarding exact job title or amount of interaction with client as requested on the structured interview survey.

"What are the job titles that you employ?"

Figure 7 – Job Titles Used by Facilities

Figure seven is a graphic depiction of the job titles utilized by assisted living facilities. As the graph depicts, all eighteen facilities employ a director and personal care workers. Fourteen of the facilities employ at least one nurse. Eight of the facilities employ clerical staff while five facilities employ maintenance personnel. In addition, four facilities employ activities staff, while three employ a program coordinator.

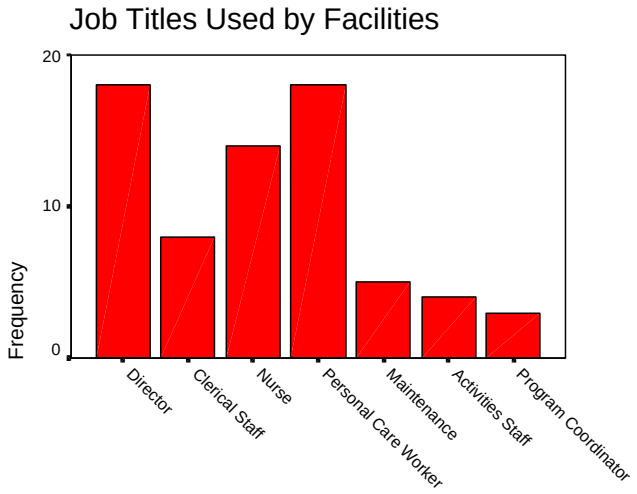

Figure 7

"Who, on staff, do you estimate spends the most time with your clients?"

All directors estimated that personal care workers are the staff members who spend the most time with clients.

"On average, how much time do you estimate PCWs interact with clients on any given day? (all clients)"

Figure 8 – Estimate of Personal Care Worker and Client Interaction (all clients)

Figure eight is a graphic depiction of the estimated amount of time personal care workers interact with all clients on any given day. As the graph depicts, personal care workers spend, on average, between seven and eight hours a day interacting with clients. More specifically, fourteen directors expressed that personal care workers spend between seven and eight hours interacting with clients. Four directors expressed that personal care workers spend between six and seven hours interacting with clients.

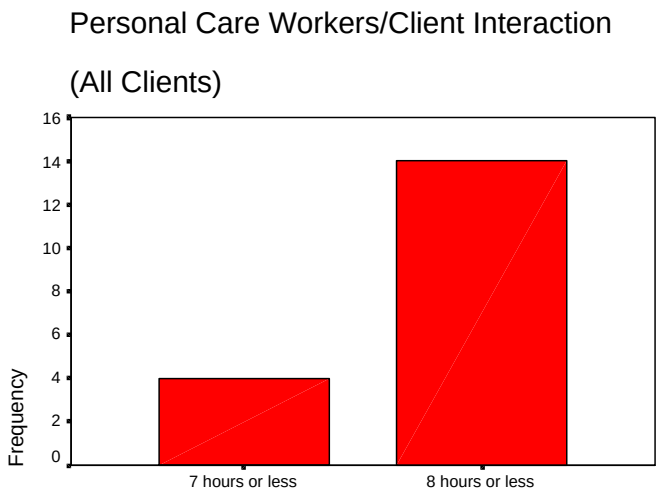

Figure 7

"On average, how much time do you estimate each client spends interacting with a personal care worker on any given day? (one-on-one)"

Figure 9 – Estimate of Client and Personal Care Worker Interaction (one-on-on)

Figure nine is a graphic depiction of the estimated amount of time clients interact with personal care workers one-on-one. As depicted in the graph, ten directors estimated that clients and personal care workers interact one-on-one, on average, one hour or less. Eight directors estimated that clients and personal care workers interact one-on-one, on average, between one and two hours a day.

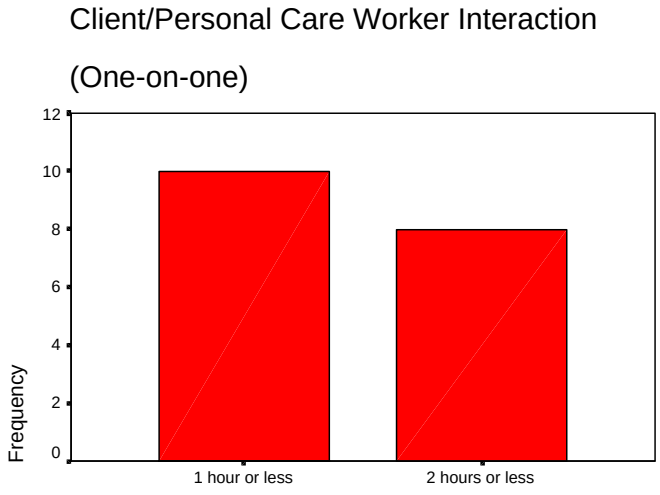

Figure 9

"On average, how much time do you estimate a nurse interacts with clients on any given day? (all clients)"

Figure 10 – Estimate of Nurse and Client Interaction (all clients)

Figure ten is a graphic depiction of the average amount of time directors estimate nurses interact with all clients. As depicted in the graph, five of the fourteen directors which expressed having a nurse on staff estimated that a nurse, on an average day, had no client contact. Three directors expressed that nurses spend, on an average day, between one and two hours interacting with clients. Similarly, three directors expressed that nurses spend on an average day between three and four hours interacting with clients. Two directors expressed that nurses on average interact with clients one hour or less a day. Furthermore, one director expressed that nurses on average interact with clients between five and six hours on any given day. Results vary widely because of the number of nurses that are employed by the agency either part-time or do not work on-site at the facility. This variation will be discussed further in the researcher observation section.

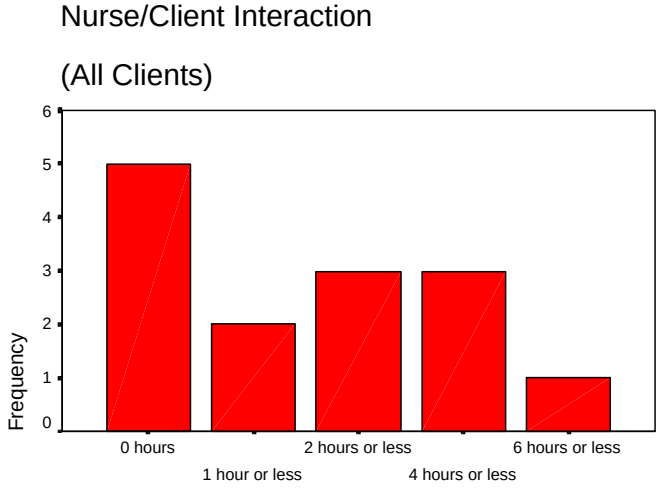

Figure 10

"On average, how much time do you estimate each client spends interacting with a nurse on any given day? (one-on-one)"

Figure 11 – Estimate of Client and Nurse Interaction (one-on-one)

Figure eleven is a graphic depiction of the average amount of time directors

estimate clients interact with nurses one-on-one. As depicted in the graph, ten out of the fourteen directors that expressed having a nurse on staff, reported that on an average day clients received zero hours of one-on-one interaction with a nurse. Four directors expressed that clients spend one hour or less interacting with a nurse one-on-one.

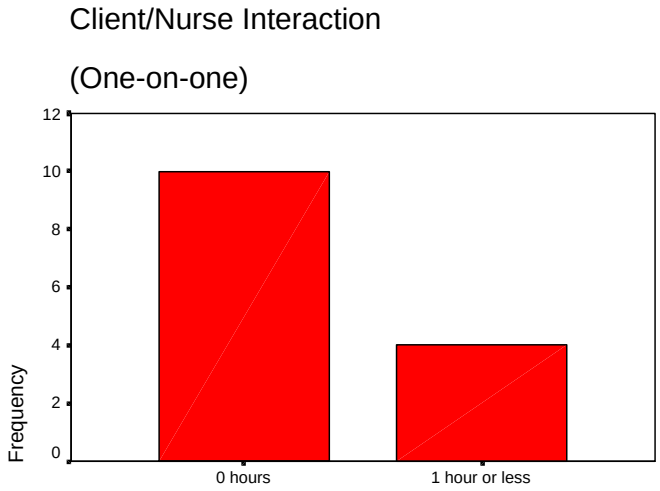

Figure 11

"Does this agency attempt to address any of the mental health needs of clients?"

Figure 12 – Attempt to Address Any Mental Health Needs of Clients

Figure twelve is a graphic depiction of the number of directors that attempt to address the mental health needs of clients. As depicted in the graph, fifteen directors expressed that they attempt to address the mental health needs of clients, while three did not.

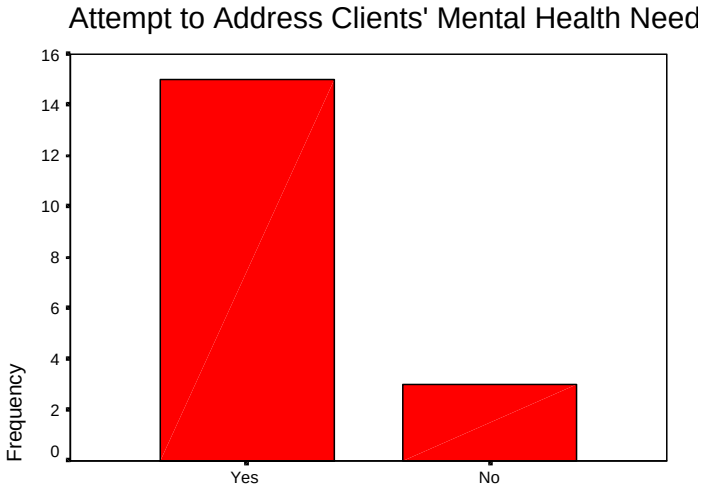

Figure 12

"How does this agency attempt to address the mental health needs of clients?" (i.e., referrals to mental health agencies, mental health assessments)

Figure 13 – Facility Initiated Ways of Addressing the Mental Health Needs of Clients

Figure thirteen is a graphic depiction regarding the fifteen directors that expressed an attempt to address that mental health needs of clients. More specifically, figure thirteen depicts the exact ways in which directors expressed addressing the mental health needs of clients. As depicted in the graph, thirteen facilities refer clients to their physician if concerns arise regarding mental health. Ten directors expressed that they conduct a mental health evaluation to address the mental health needs of clients. Five directors expressed that they address the mental health needs of clients by referral to mental health agencies. In addition, five directors expressed that they promote social interaction as a way of addressing the mental health needs of clients.

Figure 13

"How often are mental health assessments conducted?"

Figure 14 - Frequency of Mental Health Evaluations

Figure fourteen is a graph depiction of the frequency of the mental health evaluation conducted by ten of the assisted living facilities in the tri-county area. More specifically, four of the facilities conduct an evaluation only upon admittance to the facility. Six facilities conduct a mental health evaluation upon admittance and as needed (PRN) thereafter.

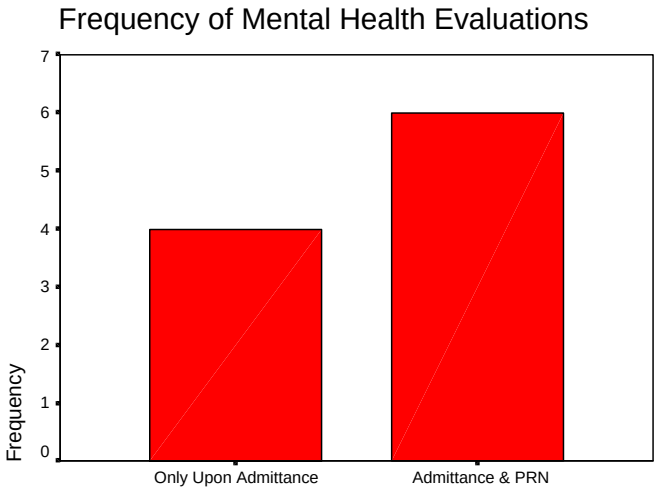

Figure 14

"Who conducts these mental health assessments?"

Figure 15 - Facilitator of Mental Health Evaluations

Figure fifteen is a graphic depiction of the title held by those who conduct mental health evaluations within assisted living facilities. More specifically, of the ten facilities which conduct mental health evaluations, five directors expressed that they conduct the evaluations. Four directors expressed that a nurse conducts the evaluation. In addition, one director expressed that they were physically connected to a nursing home, thus enabling them to have a social worker complete their mental health evaluations.

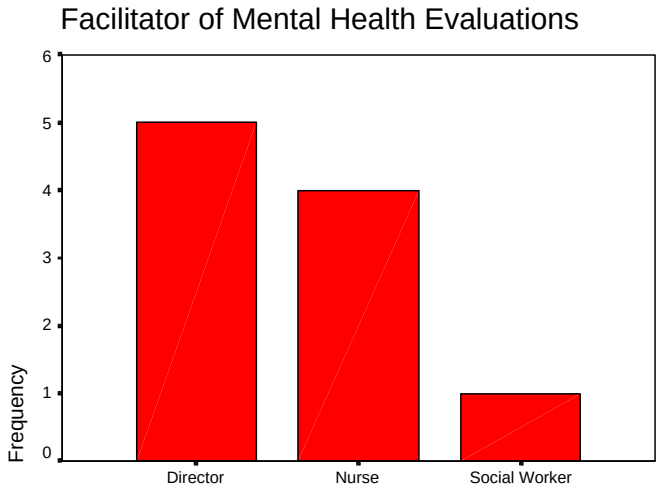

Figure 15

"Do you have any training session/programs for your staff regarding depression in the elderly?"

Figure 16 - Training Programs for Staff on Depression in the Elderly

Figure sixteen is a graphic depiction of the number of assisted living facilities which offer training for staff regarding depression among the elderly. As the graph depicts, five facilities offer training for staff on depression, while thirteen facilities offer

no training in this area.

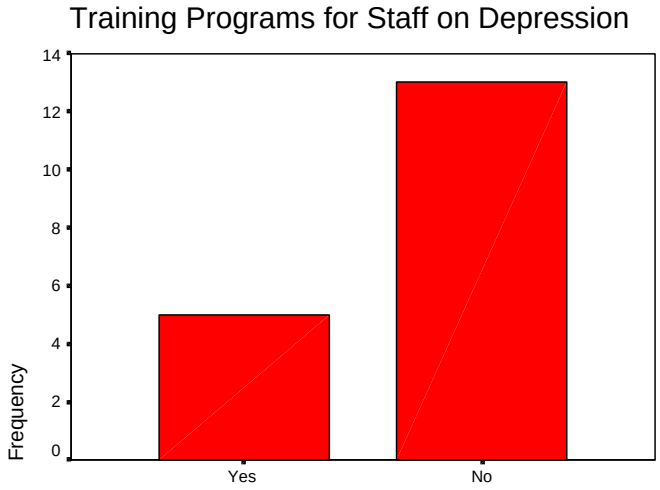

Figure 16

"What does the training involve? Please elaborate:"

Figure 17 - Characteristics of Depression Training

Figure seventeen is a graphic depiction of the characteristics of the depression training that is offered by five assisted living facilities. As the graph depicts, two of the directors were not aware of the exact nature of what the training involved. Two directors expressed that the training was conducted upon hiring and involved informing staff members about what depression is and a discussion about the signs of depression. In addition, one director, described the training as a "brief overview of the signs of depression."

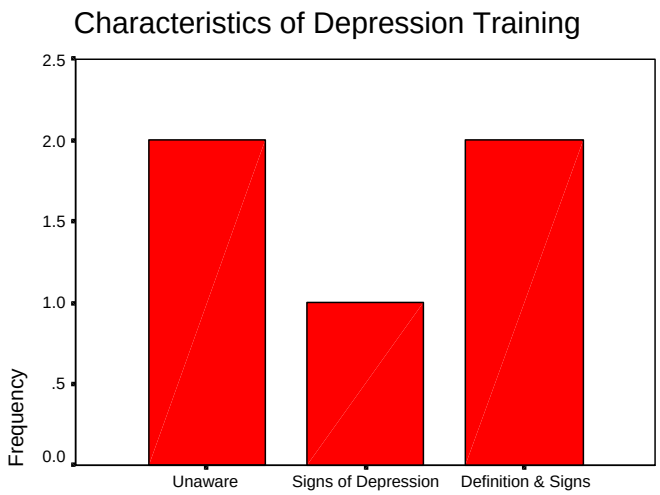

Figure 17

"On a scale from 0 to 10, 0 being no interest and 10 being extremely interested, how interested are you in the implementation of a PCW training session for you staff on detecting the signs of depression among your clients?"

Figure 18 - Directors Level of Interest on Training Sessions

Figure eighteen is a graphic depiction of the level of interest directors expressed in offering a training session for staff on depression among clients. As the graph depicts, six directors expressed that they had an extreme level of interest in implementing a training session for personal care workers. In other words, they responded by describing their level of interest as being a ten. Five directors expressed that they had a level of interest of nine. Four directors expressed their level of interest as being an eight. And one director expressed their interest as being a six, one a five, and one a four. The mean level of interest is 8.44.

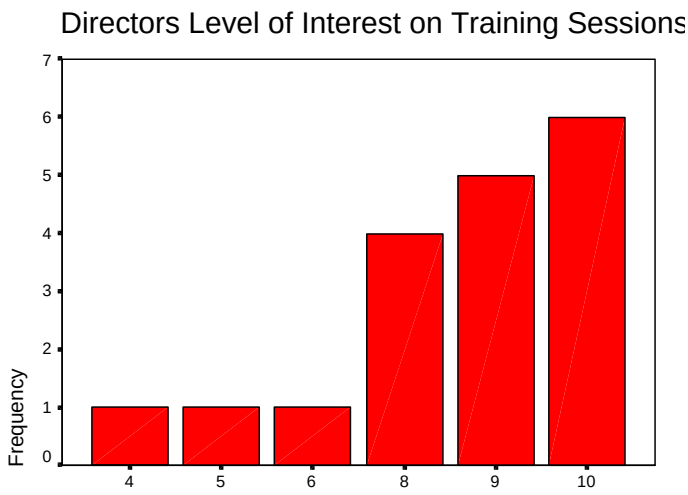

Figure 18 (0=No Interest, 10=Extreme Interest

"Using the same scale, 0 being no interest and 10 being extremely interested, how interested are you in implementing a procedure to help workers detect and report the early warning signs of depression?"

Figure 19 - Directors Level of Interest on Implementing a Procedure to Help Detect Depression

Figure nineteen is a graphic depiction of directors level of interest on implementing a procedure to help workers detect and report the early warning signs of depression. As the graph depicts, six directors expressed their level of interest as being a ten. Five directors expressed their level of interest as being a nine. Three directors expressed their level of interest as being an eight. One director expressed their level of interest as being a six. Two directors expressed their interest as being a five and one expressed their interest as a four. The overall, mean level of interest is 8.28.

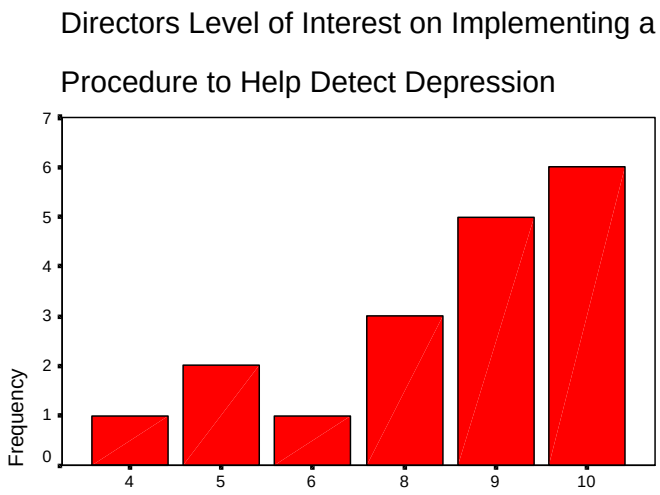

Figure 19 (0=No Interest, 10=Extreme Interest)

"Again, using that same scale, how interested do you think PCWs would be in being trained about the early warning signs of depression in the elderly?"

Figure 20 - Director Perception Regarding Personal Care Worker Level of Interest on Training Session

Figure twenty is a graphic depiction of directors perceptions regarding personal care worker level of interest on participating in a training session regarding the early warning signs of depression in the elderly. As the graph depicts, three directors perceive personal care workers level of interest to be at ten, meaning extremely interested. Two directors perceive the level of interest to be nine. Four directors expressed the level of interest as being an eight, while five expressed the level of interest as being at seven. One director expressed the level of interest as being a six, and three others expressed the level of interest as being a five. Overall, the mean level of interest is 7.56.

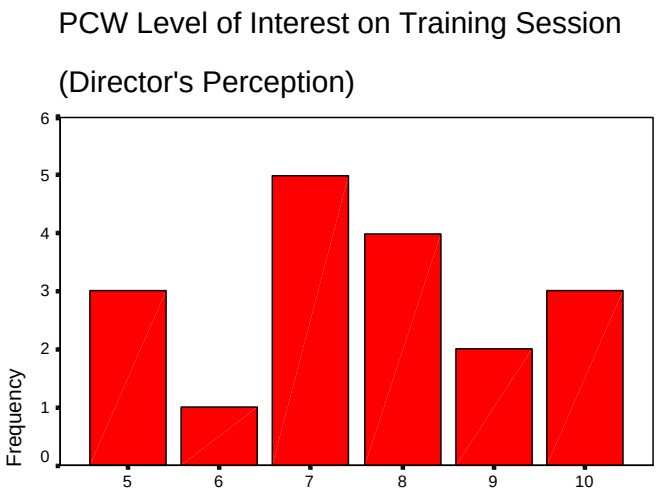

Figure 20 (0=No Interest, 10=Extreme Interest)

"Once again, using the same scale, 0 being no interest and 10 being extremely interested, how interested do you think PCWs would be in conducting a brief procedure to help determine if any of your clients are exhibiting signs of depression?"

Figure 21 - Director Perception Regarding Personal Care Worker Level of Interest on Implementing a Procedure to Help Detect Depression Among Clients

Figure twenty-one is a graphic depiction of directors perceptions regarding personal care worker level of interest on implementing a procedure to help detect depression among clients. As the graph depicts, two directors expressed the level of interest as being a ten, demonstrating extreme interest. Three directors expressed the level of interest as being an eight, while four described the level of interest as being a seven. Two directors expressed the level of interest as six, while five directors expressed the level of interest as being a five. And finally, two directors expressed the level of interest of being four. Overall, the mean level of interest is 6.50.

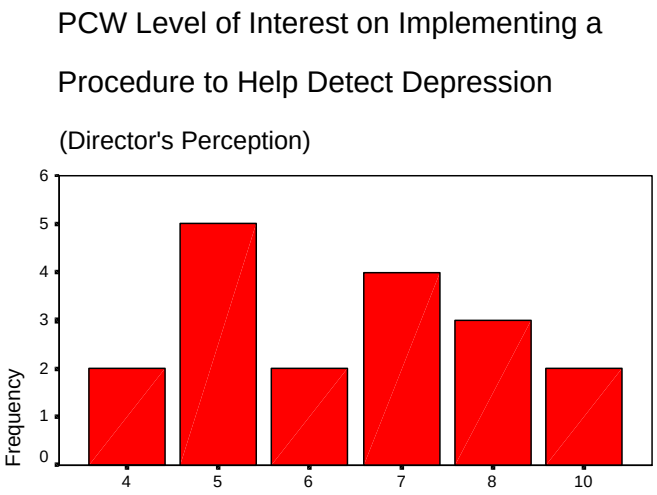

Figure 21 (0=No Interest, 10=Extreme Interest)

CHAPTER FIVE

Discussion

Conclusions

The overall mission of assisted living facilities is to provide quality care, to promote independence and dignity, and to offer a choice in living arrangements as people grow older. Assisted living facilities, in the tri-county area of Eau Claire, Chippewa and Dunn, on average, host approximately 18 residents in their eighties. Findings show that the overwhelming majority of facilities were certified based residential facilities and are private, for profit organizations. Four facilities are connected to nursing homes which may allow them to better serve the mental health needs of clients. For instance, one facility utilized a social worker who worked at a connected nursing home to conduct mental health evaluations upon admittance and as needed.

All directors expressed that there were no mental health caregivers working within the assisted living facilities. It seems clear then, that there is a lack of mental health caregivers working within these facilities. However, every facility employs personal care workers and it was found that PCWs spend the most time with clients. Most personal care workers spend more than seven hours, but less than eight hours interacting with all clients on any given day. Clients at eight facilities receive, on average, more than one hour, but less than two hours of one-on-one time interacting with a personal care worker. Clients at ten facilities receive, on average, one hour or less, but more than zero hours interacting one-on-one with personal care workers. Overall, it was found that based on contact, personal care workers would be the staff member best able to attest to changes in the mental condition of clients. More specifically, if trained on the warning signs of depression in the elderly, they would be the most likely staff member to recognize and report the signs.

Fifteen directors expressed that although no mental health caregivers are employed by their agency, attempts are still made to address the mental health needs of clients. Most directors expressed they did this by referring clients to their physician. Ten directors expressed that their clients received mental health evaluations. It is important to note, however, that four of the ten facilities conduct these evaluation only upon admittance. Furthermore, the other six facilities conduct the evaluation upon admittance or as needed. No facilities conduct a regular mental health evaluation. Also it is useful to note that the directors or nurses are the personnel who most often conduct the evaluations and yet they are not necessarily trained in this area and they spend less time with clients than personal care workers.

Only five facilities, out of the eighteen facilities, offered training to staff regarding depression. It is important to note that two directors had no knowledge of the training. Also, two directors stated it was conducted upon hiring, while one director expressed that the training was a "brief overview of the signs of depression."

Overall, directors appeared very interested in training staff on depression in the elderly. Directors also appeared very interested, although to a lesser degree, in implementing a procedure to help detect the early warning signs of depression. Directors also perceive that personal care workers are interested in being trained about depression in the elderly. Furthermore, directors perceive that personal care workers are somewhat interested in implementing a procedure to help detect depression among clients.

Implications

Limitations

The results of this investigation imply that not only do assisted living facilities lack mental health caregivers, but that they recognize this as a deficit within their agency. Furthermore, the results imply that personal workers are the staff members spending the most time with clients, thus making them the most likely to see changes in the mental health status of clients. In addition, interviews suggest that stakeholders within assisted living facilities are not only willing to train staff regarding depression but also willing to support a regular procedure to help detect clients exhibiting signs of depression. Since directors are in a decision-making role it seemed appropriate to focus the willingness questions on the perceptions of the directors themselves. Furthermore, findings from

directors appear to suggest that personal care workers are somewhat interested and willing to be trained regarding depression among the elderly. It is the belief of directors, that personal care workers are willing, although to a lesser degree, to conduct a brief assessment aimed at detecting the early warning signs of depression among clients. It is important to stress that data was gathered from directors, not personal care workers. In other words, findings may not truly reflect the thoughts of personal care workers and in this lies a limitation with this study.

Further Research

Though the results of this study were promising, additional research involving personal care workers may be needed to further reinforce these findings. It is not known if personal care workers would participate in training for the detection of depression or if they would conduct a brief procedure aimed at detecting the early warning signs of depression among clients. Also, research regarding the most feasible, valid and reliable tools to detect the early warning signs of depression must be conducted to apply the current findings.

Application

The results from this study indicate a need for mental health caregivers within assisted living facilities. Furthermore, this study supports the hypothesis that personal care workers are the staff members who spend the most time with elderly clients, thus making them a logical point of intervention. The results of this study clearly show that there is a need and willingness on the part of directors to address depression within assisted living facilities. Training personal care workers to detect and report depressive symptoms among elderly clients is clearly the most feasible application of the current

findings.

For facilities considering implementation of depression training and/or an assessment tool to recognize the warning signs of depression it is useful to note some hindrances to such an application. For example, with increased occupational responsibility comes at least the perception of more pay and/or other types of incentives. In addition, this intervention increases the workload of perhaps an already overworked group of employees, thus adding to job stress. Similarly, personal care workers may be reluctant to conduct evaluations for a variety of other reasons including lack of education and because it greatly impacts their job descriptions. Furthermore, assessing clients for depressive symptoms may completely change the dynamics of the relationships between personal care workers, clients and other staff. Assessing clients with whom they work so intimately with may be difficult for both the client and PCW. Also, this application may evoke a power struggle within an organization between PCWs and other employees. Having the ability to assess depressive symptoms may increase the internal and external power of PCWs, creating shift in the dynamics between themselves and other employees. In other words, there are ethical considerations that need to be addressed surrounding the application of these results. These are issues assisted living facilities need to be aware of and be prepared to address in an equalitarian fashion to facilitate effective and long-lasting change.

With increased emphasis put on detecting depressive symptoms among clients, one may find that many clients are exhibiting signs of depression. This presents a challenge to organizations to develop strategies to assist workers, clients and families in coping and preventing depression. These strategies may lead an organization to hire

additional staff, train existing staff or redistribute responsibilities all of which increase the cost of operation. Furthermore, if it is determined that a client needs mental health therapy, medication or both, the question then becomes how is the treatment going to be financed. It is imperative to stress the importance of addressing the varying thoughts and feeling of the clients and their families. Some clients may perceive being evaluated for depressive symptoms to be a part of a comprehensive care plan, and thus find it comforting. While others may view the evaluation as intrusive and believe that the care facility is overstepping their bounds. There are no clear-cut and definite ways to address these concerns that can be offered to all facilities. Before attempting to implement any changes within an organization, it is important to fully assess and address the persistence and resistance of stakeholders and consider all ethical issues.

Overall, each facility must consider the cost versus the benefits of such an application. More specifically, are the costs are worth reducing and/or eliminating depressive episodes among clients. Reducing or eliminating depressive episodes among clients could improve the quality of life for clients, their family, and workers. An improved quality of life may logically reduce sickness for both clients and workers, reduce worker absenteeism and offer a more comprehensive care package for clients. Furthermore, addressing depression among elderly assisted living clients may greatly reduce the economic and social burdens that depression costs society.

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Appendix A:

Structured Interview Survey

1.) As director, what do you see as the mission of this agency?

2.) How many clients are you currently serving?
_____# clients

3.) Approximately what is the average age of your clients?
[ ] 50-59 years of age
[ ] 60-69 years of age
[ ] 70-79 years of age
[ ] 80-89 years of age
[ ] 90-99 years of age
[ ] 100+ years of age

4.) How is this agency funded?
[ ] Private, for profit organization
[ ] Non-profit organization
[ ] Church funded
[ ] Other _____
[ ] Other _____

5.) Is this a community based residential facility (CBRF) or an assisted living facility (ALF)?
[ ] CBRF
[ ] ALF
[ ] Other _____

6.) Is this facility physically connected to any other care facility?
[ ] Yes (If yes, go to question 6a otherwise go to question 7)
[ ] No

6a.)What type of care facility?
[ ] Hospital
[ ] Nursing Home
[ ] Church
[ ] Other _____

7.) Does this agency employ any mental health caregivers?
[ ] Yes If yes, complete 7a and 7b, otherwise go to question 8.
[ ] No

7a.) What is their title?
_____

7b.) If so, on average how much time do you estimate, a mental health

caregiver interacts with each client during any given day?

[ ] 0 hours
[ ] 1 hour or less
[ ] 2 hours or less
[ ] 3 hours or less
[ ] 4 hours or less
[ ] 5 hours or less
[ ] 6 hours or less
[ ] 7 hours or less
[ ] 8 hours or less

8.) What are the job titles that you employ?

[ ] Director
[ ] Clerical Staff
[ ] Nurse
[ ] Personal Care Workers
[ ] Maintenance
[ ] Other _____
[ ] Other _____

9.) Who, on staff, do you estimate spends the most time with your clients?

[ ] Director
[ ] Clerical Staff
[ ] Nurse
[ ] Personal Care Workers
[ ] Maintenance
[ ] Other _____
[ ] Other _____

10.) On average, how much time do you estimate PCW's interact with clients on any given day? (all clients)

[ ] 0 hours
[ ] 1 hours or less
[ ] 2 hours or less
[ ] 3 hours or less
[ ] 4 hours or less
[ ] 5 hours or less
[ ] 6 hours or less
[ ] 7 hours or less
[ ] 8 hours or less

11.) On average, how much time do you estimate each client spends interacting with a personal care worker on any given day? (one-on-one)

[ ] 0 hours
[ ] 1 hours or less
[ ] 2 hours or less
[ ] 3 hours or less
[ ] 4 hours or less
[ ] 5 hours or less
[ ] 6 hours or less
[ ] 7 hours or less
[ ] 8 hours or less

If the agency employees a nurse, complete question 12, otherwise go to question 14.

12.) On average, how much time do you estimate a nurse interacts with clients on any given day? (all clients)

[ ] 0 hours
[ ] 1 hours or less
[ ] 2 hours or less
[ ] 3 hours or less
[ ] 4 hours or less
[ ] 5 hours or less
[ ] 6 hours or less
[ ] 7 hours or less
[ ] 8 hours or less

13.) On average, how much time do you estimate each client spends interacting with a nurse on any given day? (one-on-one)

[ ] 0 hours
[ ] 1 hours or less
[ ] 2 hours or less
[ ] 3 hours or less
[ ] 4 hours or less
[ ] 5 hours or less
[ ] 6 hours or less
[ ] 7 hours or less
[ ] 8 hours or less

14.) Does this agency attempt to address any of the mental health needs of clients?

[ ] Yes *If yes, complete 14a, otherwise go to question 15.*
[ ] No

14a.) How does this agency attempt to address the mental health needs of clients? (i.e., referrals to mental health agencies, mental health assessments)Please elaborate:

[ ] Referrals to mental health agencies
[ ] Referrals to physician
[ ] Conduct mental health evaluations *If checked, complete 14b and 14c.*
[ ] Promote social interaction
[ ] Other _____
[ ] Other _____

14b.) How often are mental health assessments conducted?

[ ] Upon admittance
[ ] Annually
[ ] Monthly
[ ] Weekly
[ ] Daily
[ ] Other _____

14c.) Who conducts these mental health assessments?

[ ] Director
[ ] Nurse
[ ] Certified Nursing Assistant/Personal Care Worker
[ ] Other _____

15.) Do you have any training sessions/programs for your staff regarding depression in the elderly?

[ ] Yes If yes, complete 15a, otherwise go to question 16.
[ ] No

15a.) What does the training involve? Please elaborate:

16.) On a scale from 0 to 10, 0 being no interest and 10 being extremely interested, how interested are you in the implementation of a PCW training session for your staff on detecting the signs of depression among your clients?

[ ] 0 [ ] 6
[ ] 1 [ ] 7
[ ] 2 [ ] 8
[ ] 3 [ ] 9
[ ] 4 [ ] 10
[ ] 5

17.) Using the same scale, 0 being no interest and 10 being extremely interested, how interested are you in implementing a procedure to help workers detect and report the early warning signs of depression?

[ ] 0 [ ] 6
[ ] 1 [ ] 7
[ ] 2 [ ] 8
[ ] 3 [ ] 9
[ ] 4 [ ] 10
[ ] 5

18.) Again, using that same scale, how interested do you think PCW's would be in being trained about the early warning signs of depression in the elderly?

[ ] 0 [ ] 6
[ ] 1 [ ] 7
[ ] 2 [ ] 8
[ ] 3 [ ] 9
[ ] 4 [ ] 10
[ ] 5

19.) Once again, using the same scale, 0 being no interest and 10 being extremely interested, how interested do you think PCW's would be in conducting a brief procedure to help determine if any of your clients are exhibiting signs of depression?

[ ] 0
[ ] 1
[ ] 2
[ ] 3
[ ] 4
[ ] 5
[ ] 6
[ ] 7
[ ] 8
[ ] 9
[ ] 10

Appendix B:

Signs of Depression

Physical

- Aches, pains, or other physical complaints that seem to have no physical basis
- Marked change in appetite (or weight loss or gain)
- Change in sleep patterns (insomnia, early morning waking, and sleeps more than usual)
- Fatigue, lack of energy, being “slowed down”

Emotional

- Pervasive sadness, anxiety, or “empty” mood
- Apathy (lack of feeling)
- Decreased pleasure or enjoyment
- Crying for no apparent reason
- Indifference to others

Changes in Thoughts

- Feelings of hopelessness, pessimism
- Feelings of worthlessness, self-reproach, inadequacy, or helplessness
- Inappropriate or excessive guilt
- Impaired concentration, slowed or disorganized thinking
- Forgetfulness, problems with memory
- Indecisive, unable to make decisions or take action
- Recurrent thoughts of death or suicide

Changes in Behavior

- Loss of interest or pleasure in previously enjoyed activities, including sex
- Neglect of personal appearance, hygiene, home, and responsibilities
- Difficulty performing daily tasks; ordinary tasks are overwhelming
- Withdrawal from people and usual activities, wanting to be alone
- Increased use of alcohol and drugs
- Increased irritability, argumentativeness, or hostility
- Greater agitation, pacing, restlessness, hand wringing
- Suicide attempts or talking about suicide

The more signs checked, the more likely the person is suffering from a serious depression and may need your assistance in seeking proper help.

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