

Families and Assisted Living

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Purpose: Despite growing research on assisted living (AL) as a residential care option for older adults, the social ramifications of residents' transitions to AL are relatively unexplored. This article examines family involvement in AL, including family structures of residents, types of involvement from family members living outside the AL facility, and outcomes for these family members. **Design and Methods:** We reviewed current literature utilizing the MEDLINE, PsycINFO, and CINAHL databases to identify AL studies that examined issues pertaining to families or informal care. Following the screening of abstracts, we retrieved 180 reports for further review and selected 62 studies for inclusion. **Results:** Families visit residents frequently and provide a wide range of instrumental assistance but provide only minimal personal care. Studies of family outcomes indicated relatively high satisfaction but potential care burden as well. **Implications:** How family care and involvement occurs in AL in relation to formal care provision and whether various types of formal/informal care integration influence family outcomes remains unclear. We suggest a research agenda that attempts to tease out causal relationships for family involvement, differentiate family roles, and implement longitudinal analyses for a range of family outcomes.

Key Words: Family caregiving, Residential care, Long-term care, Informal care

Two key sources supply long-term care in the United States: *formal*, or paid, care providers, and *informal*, or unpaid, care resources (e.g., family members). Many studies have treated the move of

a disabled older person to a 24-hr residential care setting as the termination of family care, assuming that all informal care responsibilities are substituted in favor of the services provided by the long-term-care facility. As a number of researchers have noted, such substitution does not occur across all care domains or all families; some families continue to provide a range of assistance to relatives living in nursing homes (NHs; e.g., Gaugler, 2005). Family involvement may be even more apparent in emerging residential milieus that are neither designed nor organized to provide intensive care assistance; in such environments families may provide more diverse forms of assistance when compared to skilled nursing facilities.

This article examines how informal help is integrated into an emerging model of residential long-term care: assisted living (AL). We begin with a conceptual exploration of how informal care varies in AL settings when compared to more scrutinized residential contexts where formal and informal care may interact—the licensed and/or certified NH. The second section of this article surveys the literature in order to ascertain whether current research findings support our conceptual model of informal care in AL. We conclude with a series of recommendations designed to guide future research on the interface of informal and formal long-term care in AL.

Conceptualization of Informal Care in AL

Domains of Family Involvement

Since the early 1970s, researchers have attempted to describe the care provision and general involvement of family members following a relative's move to a NH (see Gaugler, 2005, for a review of this literature). These studies identified several different types of family involvement. One way to quantify family involvement is in terms of visits. One can consider family visits to be a gross measurement of overall family involvement, but what family members actually do during a typical visit may entail one or several other dimensions of family involvement.

Family involvement in residential settings can both supplement and supplant the formal care offered. *Personal care* includes activity of daily living (ADL) assistance, such as grooming, caring for a relative's skin, assisting the relative to walk,

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Table 1. Formal and Informal Care Provision in Residential Long-Term Care: Assisted Living and Nursing Homes

Type of Care	Assisted Living	Nursing Home
Visits	Supplementation	Supplementation
Personal care		
Going to the bathroom, eating	Independence	Substitution
Grooming	Supplementation	Substitution
Ambulation, bathing, dressing	Independence → supplementation → substitution	Substitution ^a
Instrumental care		
Transportation	Supplementation	Supplementation
Shopping, finances	Kin dependence	Kin dependence
Medication administration	Supplementation	Substitution ^a
Laundry	Substitution	Substitution
Socioemotional support	Supplementation	Supplementation
Monitoring	Kin dependence	Kin dependence
Advocacy	Kin dependence	Kin dependence

Note: ^aFamily involvement potentially discouraged.

helping with eating/feeding, and providing aid in going to the bathroom or dressing (Maas et al., 2004). Family members may provide these services when they perceive that a facility is not doing so.

Families can also provide assistance with instrumental ADLs (IADLs), or *instrumental care*. Instrumental care provided by facility staff may supplant care that was once provided by families, such as assistance with laundry; cleaning or organizing the relative's room/apartment; preparing and storing food and beverages; and offering transportation (Maas et al., 2004). Other instrumental tasks are supplemental (both informal and formal care providers offer assistance), such as arrangement of, participation in, and follow-up of doctor's appointments and related services; assistance with financial affairs and bills; and health care decision making. Although residential facilities may vary in their provision of instrumental care, family members appear to continue to provide at least some supplementary services (Gaugler, Anderson, & Leach, 2003).

Other dimensions of informal care are of potential interest following entry into a residential setting. For example, one type of care that has received little attention in residential-based studies of family involvement is *socioemotional support*. Socioemotional support encompasses a number of activities, including talking with the resident, holding hands with the resident, reminiscing, and engaging in social activities (Maas et al., 2004). The need for socioemotional support is likely high given the challenges of moving from a familiar place into an entirely new setting, coping with change, reestablishing routines and relationships, and (as much as permitted by the setting) reorganizing personal belongings.

Additional dimensions of family involvement may highlight the ambiguous delineation of care roles between informal and formal care providers following residential care placement. For example, with the introduction of formal facility staff in the care system, many family members may feel the need to monitor care provision or advocate for their relatives. As Bowers (1988) noted with reference to NHs, family monitoring of facility care can encompass supervising or keeping a watch over nurse aides or other day-to-day care staff. Other aspects of monitoring may include coordinating with care staff in order to maximize the quality of care provided, such as sharing personal information about the relative to staff (Maas et al., 2004). Similarly, whereas personal and some forms of instrumental care may be relinquished to formal care providers, families may feel it necessary to either direct formal care provision or give a voice to the concerns of the relative or other residents. Advocacy can range from the actual direction of care provided by staff to working with an ombudsman or other facility officials in an attempt to improve the formal care delivered in a given facility.

Expected Family Involvement Across the Long-Term-Care Landscape

In hypothesizing variations of family involvement across AL and NH settings, we relied on prior work that specified formal/informal care patterns in community settings (Lyons & Zarit, 1999; Noelker & Bass, 1989). Litwak (1985) suggested that the type of task determines how older adults utilize formal and informal sources of care. For instance, formal providers usually carry out caregiving tasks that require specialized skill and are performed at predictable times, whereas informal caregivers perform tasks that require less skill and occur unpredictably. A model developed by Edelman (1986) stipulates that formal support is merely used to alleviate the burden and time demands of tasks already carried out by informal caregivers (i.e., *supplementation*); in residential care, supplementation may emerge when both informal and formal care providers provide assistance for some care need. Greene (1983) hypothesized that assistance once provided by informal caregivers is eventually replaced by formal care (i.e., *substitution*). Other models suggest that informal care providers continue to provide the bulk of assistance for certain tasks, even with the introduction of formal care (*kin dependence*; see Lyons & Zarit, 1999).

This framework of formal/informal care patterns may help to distinguish family involvement among various dimensions of support in AL. As Table 1 illustrates, the nature of formal care in AL and NH care may affect the informal personal care delivered to residents. Informal personal care is more likely to operate according to the substitution model in NHs; for the most part, family members relinquish ADL

tasks to facility staff. Due to regulatory concerns, NHs may discourage families from engaging in certain care responsibilities, such as bathing or ambulation, due to potential risk. Although there may be instances when family members still perform certain personal care activities on an intermittent basis in order to maintain intimacy in the care relationship (e.g., helping a relative eat during facility meal time), one can consider the overall pattern of formal/informal personal care in NHs to be substitution. In contrast, some AL residents are less likely to need such care. For those who do, informal care may supplement the formal care provided by AL staff (residents may rely on both family members and AL staff equally to perform certain ADL tasks such as grooming). In other instances, formal care by AL staff or other formal providers may substitute informal care (e.g., ambulation, bathing, dressing). Due to the heterogeneity of care needs and AL service delivery models (which may fluctuate according to various pricing levels), the range of informal and formal personal care in AL may vary considerably.

We expected instrumental assistance to demonstrate variable formal/informal care patterns across AL facilities and NHs. NH staff are more likely to assume several IADL tasks that fall under the instrumental dimension, such as medication administration and laundry. The regulatory nature of NHs and the emphasis on resident safety (based, in part, on the 1987 Omnibus Budget Reconciliation Act legislation and other policy developments) has meant that NHs are less likely to facilitate family involvement that involves potential harm to the resident, such as medication administration. In contrast, the stated emphasis on control, privacy, and autonomy in AL coupled with the less disabled nature of the clientele and the reluctance of AL facilities to provide intensive 24-hr supervision may lead many family members to continue to supplement formal instrumental care. For example, although AL facilities may offer some transportation services and some assistance with medication administration (e.g., reminders), they may encourage or motivate families to provide any additional instrumental help to their relatives in AL. For yet other types of instrumental care, families in both NH and AL facilities may provide the bulk of such assistance with little aid from formal care providers (e.g., shopping, finances).

Socioemotional support and, by extension, visits, are likely to assume supplemental patterns of formal and informal care across both AL facilities and NHs. Although there may be some variation in the amount of each provided by formal care staff (e.g., if certain AL facilities employ less staff at various shifts, this type of engagement may be offered less frequently), we assumed that regardless of regulatory environment, case mix, or care delivery schedules there would be staff in both types of facilities that provide

such support. Formal socioemotional support and visits may occur because they are encouraged by the facility environment (e.g., smaller, family-style types of AL settings) or because of particular staff in each type of setting who are caring and committed to engaging in meaningful relationships with their residents.

In contrast to the other domains of family involvement, we expected that monitoring and advocacy would be more likely to assume a kin-dependent structure. These types of assistance are based strongly in the concept of *preservative* care (Bowers, 1988), whereby family members play an integral role in attempting to maintain the identity of the relative via these activities. Whereas staff may monitor residents' care provision for reasons related to job responsibilities, families are likely motivated to engage in monitoring or advocacy due to their kin relationship with the relative and their more intimate knowledge of the person the relative is and was prior to entry into a residential setting.

Survey of the Literature: Families and AL

Methods

We attempted to identify research on AL related to family involvement or with some type of research focus on family-related variables. Because definitions of AL in the research literature have ranged from residential environments that are not NHs to more specific apartment-style settings, we conducted a particularly wide-ranging topical search of research databases. In December 2005 and January 2006, we searched the MEDLINE, PsycINFO, and CINAHL databases simultaneously using the following keywords: *assisted living* (1,705 abstracts), *adult family living* (123 abstracts), *congregate housing* (116 abstracts), *adult family home* (398 abstracts), *continuing care retirement community* (191 abstracts), *personal care home* (104 abstracts), *adult foster care* (176 abstracts), and *residential care and family* (603 abstracts). Joseph E. Gaugler screened each abstract and included any abstract that included some mention of family, family involvement, or family-related variables. We also considered larger scale national studies of AL to aid in the description of family structure. Following this review process, 180 reports were ready for further analysis and potential inclusion. Joseph E. Gaugler reviewed each report and selected articles for final review that provided information on the following extraction categories: (a) family structure in AL ($n = 10$), (b) types and predictors of family involvement in AL ($n = 49$), and (c) family-related outcomes ($n = 12$). This resulted in the selection of 62 reports for the literature survey (several reports provided information across two or more of the extraction categories). In all, we excluded 118 reports because their study content did not fall into one of the three review

categories ($n = 116$) or we could not locate the original report despite follow-up emails with study authors or interlibrary loan searches ($n = 2$). As the original inclusion criteria of the literature review were broad, we excluded a considerable number of articles. Joseph E. Gaugler reviewed and re-reviewed the content of each excluded article. Reasons for exclusion were as follows: the samples identified were either not based in AL or were pooled across residential settings ($n = 15$); articles included family members as proxy respondents for resident outcomes ($n = 9$); the focus of the analysis was on resident outcomes and not the family data included in this review ($n = 18$); articles were review papers and did not present pertinent family data in AL ($n = 15$); articles did not report family data ($n = 35$); the data presented were a subsample of a larger parent study already included ($n = 15$); the article was not in English ($n = 1$); and although they provided some data on family support in AL, articles were largely based on perceptions of residents and staff and thus not relevant for inclusion in the current review ($n = 8$).

Results

Family Structure in AL.—To examine family structure we limited our analysis to studies that included detailed sampling frames of AL facilities and residents at the national, multiregional, state, or regional levels. We excluded studies utilizing convenience samples of AL residents. We included those studies that reported data on at least two key family structure variables (e.g., marital status, living children, traveling distance of nearest family member) and summarize them in Table 2.

The data presented in Table 2 suggest two important trends related to the informal care potentially available to individuals in AL. First, approximately 70% or more of AL residents are widowed, and few AL residents (7% or less) are living with a spouse in AL facilities. For those who have no spouse or family support available within the AL setting, personal and instrumental care needs may be met either through the formal support available in AL or via informal care resources that are external to the AL facility. Second, most residents appear to have proximate family members who may serve as sources of informal support. It is important to note that a small proportion of residents (approximately 10%) have no proximal family member.

Table 3 provides additional information on three important need characteristics: resident age, cognitive impairment, and functional status. On average, residents in AL are 80 years of age and older, with some samples indicating that more than half of residents are 85 years of age or older (i.e., the oldest old; see Hawes, Phillips, & Rose, 2000; Hawes, Phillips,

Rose, Holan, & Sherman, 2003; Zimmerman, Sloane, & Eckert, 2001). Approximately 20% of residents suffer from severe cognitive impairment, with roughly an additional 25% suffering from moderate cognitive impairment. Similarly, roughly 20% of AL residents are dependent in three or more ADLs. These results suggest that although AL residents are not as functionally or cognitively impaired as NH residents (e.g., see Magaziner et al., 2000), for a segment of the AL resident population there are considerable care needs present.

Types of Family Involvement in AL.—A number of quantitative and qualitative studies examined family involvement in AL. Table 4 summarizes existing quantitative research on types of family involvement provided in AL settings. Few studies took a comprehensive approach to family involvement in AL; most quantitative research focused on either visits or contact frequency (i.e., telephone calls) as opposed to more intensive types of care provision. Nonetheless, the research appeared to emphasize the considerable degree of family contact AL residents experience via frequent telephone calls (often weekly or more) or in-person visits. Most residents across these quantitative studies indicated an average of once-weekly visits or more while living in various AL environments. Families are engaged most frequently with socioemotional help (e.g., R. A. Kane, Kane, Illston, Nyman, & Finch, 1991; Keating, Fast, Dosman, & Eales, 2001; Lough & Schank, 1996; Port et al., 2005; Stacey-Konnert & Pynoos, 1992; Thompson, Weber, & Juozapavicius, 2001). Instrumental assistance is provided consistently but on a more moderate basis; available reports indicated that families generally perform instrumental care one to three times per month. In contrast, families rarely perform personal care provision; several studies suggested that family members spend 1 hr or less per month providing ADL care (Abbey, Schneider, & Mozley, 1999; Gaugler & Kane, 2001; Newcomer, Breuer, & Zhang, 1994; Stacey-Konnert & Pynoos, 1992). Very few studies examined monitoring or advocacy performed by family members; Port and colleagues (2005) found that families engaged in relatively frequent medical and financial monitoring of relatives in AL (approximately 5 times in the past month), whereas another study in Canada suggested much less frequent monitoring or advocacy (0.27–1.63 hr in the past month; Keating et al., 2001).

Although these studies provided some description of family involvement in AL, the data make it difficult to determine how informal care is integrated with formal care delivery. Given the frequency of visits, socioemotional support, and instrumental care, it is likely that families are at least providing supplemental assistance with these dimensions in conjunction with the facility, if not outright kin-dependent care (e.g., see Newcomer et al., 1994). The low frequency of personal care implies that families may relinquish

Table 2. Family Structure Characteristics: Selected AL Studies

Study	Data Collection	Sampling Frame	Marital Status	Living Children	Distance of Nearest Family Member
National Survey of Assisted Living for the Frail Elderly (Hawes et al., 2000, 2003)	1998–1999 telephone survey of ALFs selected via multistage probability sampling; residents randomly selected within each high service–high privacy ALF (41% of eligible settings) and interviewed in person ($N = 184,558$)	National via 60 geographic areas/sampling units	12.1% married 70.8% widowed 7.2% divorced 9.9% never married	75.8% had living children	85.9% had a relative within an hour's drive
Collaborative Studies of Long-Term Care (e.g., Zimmerman et al., 2001)	1997–1998 telephone and in-person survey of AL/residential care facilities selected via multistage cluster sample of counties within 4 states (233 facilities). All eligible residents recruited ($N = 2,078$)	Counties in 4 states: Florida, Maryland, New Jersey, and North Carolina	11.3% married 69.6% widowed		9.9% indicated a “proximate” spouse; 85.5% reported a “proximate” family member or friend
Kane study (Levin & Kane, 2006)	1999–2000 telephone survey and in-person interviews with 60 randomly selected apartment-style ALFs in multicounty, urban geographic hubs. 10 residents randomly selected within each ALF ($N = 600$)	Multicounty, urban geographic hubs in 6 states	7.3% married 79.0% widowed 5.8% divorced 8.0% single	76.5% had living children	65.5% had a child within an hour's drive; 5.6% lived with a spouse
California residential care survey (Newcomer et al., 1994)	1993 mail and in-person survey of a multistage, stratified random sample of 386 residential care facilities and 1,051 randomly selected residents	Statewide sample of facilities in California	63.8% married 11.7% widowed		75.6% had a relative within an hour's drive
Kane Oregon study (e.g., Frytak et al., 2001; Gaugler & Kane, 2001)	38 of 39 ALFs in Oregon in 1995 were recruited; one third of residents from each ALF randomly selected and interviewed in person ($N = 605$)	ALF population of Oregon	10.6% married 80.3% widowed 5.0% divorced 4.1% single	84.5% had living children	7.1% lived with spouse
Maryland Assisted Living Study (Burdick et al., 2005; Rosenblatt et al., 2004)	Stratified sample of small and large facilities in central Maryland; residents randomly sampled within each ALF ($N = 198$) and interviewed in-person and over the telephone	Urban and rural regional area of central Maryland	6.6% married 70.7% widowed 9.1% divorced 13.6% never married	$M = 1.5$ ($SD = 1.53$)	3% lived with spouse
Los Angeles–Orange County study (Mitchell & Kemp, 2000)	Stratified random sample of 55 residential care facilities; cognitively alert residents randomly sampled within each facility and interviewed in person	Los Angeles and Orange counties, California	69% widowed		$M = 2.7$ ($SD = 3.2$) family members were within an hour's drive

Note: Three larger scale studies (American Seniors Housing Association annual report, AARP survey, and National Investment Conference survey) were not included as they were not publicly available and the costs to obtain these reports were deemed prohibitive. AL = assisted living; ALF = AL facility.

Table 3. Need Characteristics of Residents: Age and Functional Status

Study	Resident Age	Cognitive Impairment	ADL Dependence
National Survey of Assisted Living for the Frail Elderly (Hawes et al., 2000, 2003)	10.9% younger than 75 34.8% 75–84 54.3% 85+ 96% 65+	11.9% moderate 13.0% severe	12.7%, 1–2 ADLs 8.1%, 3 + ADLs 19.3% required help with dressing
Collaborative Studies of Long-Term Care (e.g., Zimmerman et al., 2001)	52% 85 and older	28.7% mild/moderate 24.7% severe	25.9%, 3 + ADLs 58.1% required limited to total assistance with bathing M = 1.96 ADLs; range = 1–6
Kane study (Levin & Kane, 2006)	M = 86 years		
California residential care survey (Newcomer et al., 1994)	M = 78.9 years	39.7% mild/moderate 18.3% moderate to severe MMSE M = 20.33; range = 0–30	30.7%, no ADLs 23.8%, 1 ADL 18.9%, 2 ADLs 9.5%, 3 ADLs 17.1%, 4 + ADLs M = 1.74 ADLs; range = 1–6
Kane Oregon study (e.g., Frytak et al., 2001; Gaugler & Kane, 2001)	M = 84.61 years (SD = 7.06)	MSQ M = 5.99 (SD = 3.38); range = 0–10	M = 16.88 ADLs (on magnitude estimation scale of 0–100; see Frytak et al., 2001)
Maryland Assisted Living Study (Burdick et al., 2005; Rosenblatt et al., 2004)	M = 85.6 years (SD = 8.2); range = 58–104	67.7% were diagnosed with dementia via consensus conference decision MMSE M = 18.2 (SD = 8.8)	M = 12.3 ADLs (SD = 8.5); range = 0–39
Los Angeles–Orange County study (Mitchell & Kemp, 2000)	M = 81 years (SD = 9.6); range = 56–100		70%, 1 + ADL 21%, 3 + ADLs M = 1.6 ADLs (SD = 1.64); range = 1–7

Note: ADL = activity of daily living; MMSE = Mini-Mental State Examination; MSQ = Mental Status Questionnaire.

these care responsibilities to the facility, which one could consider a substitution formal/informal care pattern. The lack of studies or consistent findings on monitoring and advocacy makes it difficult to ascertain how families and formal care staff interact to offer these types of care assistance.

Several quantitative studies also attempted to identify correlates or predictors of family involvement in AL (Gaugler & Kane, 2001; Gaugler et al., 2003; Hopp, 1999; Port et al., 2005; Pruchno & Rose, 2002; Zimmerman et al., 2003). Of particular interest in these studies were comparisons between various types of AL settings and NH environments. For example, some studies suggested that family members of AL residents are more likely to engage in instrumental/IADL assistance (Gaugler & Kane, 2001; Leon et al., 2000); family interaction (Pruchno & Rose, 2002); and monitoring of cognitively impaired residents' medical, emotional, and financial well-being (Port et al., 2005) when compared to informal care providers of NH residents (although a statewide study of adult foster care found no such differences; see R. A. Kane et al., 1991). Other efforts examined correlates or predictors of family involvement in AL; variables that are consistently associated with greater family visits and more personal/IADL family care include geographic proximity of a family

member to the facility (Gaugler & Kane, 2001; Gaugler et al., 2003) and residents who are women (Gaugler & Kane, 2001; Hopp, 1999; Zimmerman et al., 2003). Other variables with significant but diverse effects on family involvement across studies include race/ethnicity, resident length of stay, functional and cognitive status, and age (Gaugler & Kane, 2001; Gaugler et al., 2003; Hopp, 1999; Pruchno & Rose, 2002; Zimmerman et al., 2003). Beyond facility type, no studies examining correlates of family involvement assessed facility-level characteristics in reliable fashion when ascertaining the influence of facility environment on informal care provision (e.g., Gaugler & Kane, 2001; Gaugler et al., 2003).

Although the majority of quantitative studies focused on different types of family involvement once a relative had moved into an AL facility, single studies examined other potential dimensions of family involvement. These included analyses of family members' influence over relatives' decisions to move to apartment-style AL settings and their preferences (Reinardy & Kane, 2003; see also Hawes et al., 2000; Krout, Moen, Holmes, Oggins, & Bowen, 2002; Sales et al., 2005; Silverstein & Zablotsky, 1996; Tornatore et al., 2003). Specifically, family dimensions appear to play an important role as to whether an older adult

Table 4. Types of Family Involvement in AL: Review of Quantitative Research

Study	Design	Visits	Personal Care	Instrumental Care	Socioemotional Support	Monitoring	Advocacy
Hawes et al. (2000, 2003)	1998–1999 telephone survey of ALFs selected via multistage probability sampling; residents randomly selected within each high service–high privacy ALF (41% of eligible settings) and interviewed in person ($N = 184,558$)	9.3% none 26.7% once or twice 27.6% once a week 30.1% more than once a week 6.3% daily in past 30 days					
Port et al. (2005)	Telephone interviews with family members of 353 residents with dementia in 34 AL/residential care settings in 4 states (see Zimmerman et al., 2001, 2003, below)	9.72 (0.68) times per month	2.10 (0.56) times per month (ADLs)	1.58 (0.39) times per month (laundry) 2.14 (0.25) times per month (IADLs)	4.69 (0.86) times per month (call on phone/write letters)	5.81 (0.86) times per month (medical) 5.27 (0.44) times per month (finances) 6.25 (0.53) time per month (well-being)	
Zimmerman et al. (2001, 2003)	1997–1998 telephone and in-person survey of AL/residential care facilities selected via multistage cluster sample of counties within 4 states (233 facilities). All eligible residents recruited ($N = 2,078$)	69.4%–83.3% of residents visited with family/friend in prior 2 weeks (M contacts = 3.2–4.3)			52.6%–59.8% of residents telephoned family/friends in prior 2 weeks (M contacts = 3.6–5.2)		
Gaugler & Kane (2001)	440 residents from Kane Oregon AL study interviewed at baseline, 6 months, and 1 year (see Table 2)		0.37 types of “personal care” assistance in past few months from family/friends at baseline 11 hr of IADL help during an average month	2.68 types of “instrumental” assistance in past few months from family/friends at baseline			
Leon et al. (2000)	2 ALFs from a sample of 13 sites in 9 states; telephone interviews with 161 family caregivers of residents with dementia in AL						

(Table 4 continues on next page)

Table 4. (Continued)

Study	Design	Visits	Personal Care	Instrumental Care	Socioemotional Support	Monitoring	Advocacy
Keating et al. (2001)	Telephone interviews with 19, 21, and 39 family members of 2 adult family living programs (1 ALF and 1 dementia care settings, respectively) in Canada		In past month: 0.96 hr on personal care 0.73 hr on skilled care	In past month: 6.22 hr on transportation 2.00 hr on housework 1.88 hours on shopping 1.57 hr on financial management 0.16 hr on arranging appointments	23.25 hr on "enhancing well-being" in past month	1.63 hr on "keeping on eye on things" in past month	0.27 hr in past month "speaking up for resident"
Gaugler et al. (2003)	In-person resident and telephone family interviews with 34 AL and 38 family care home dyads randomly selected from 5 ALFs and 16 family care homes in Kentucky	11.76 (9.78) and 3.09 (3.41) family visits in AL and family care homes in past month; duration of typical visit = 61.81 min (51.18) in AL and 71.47 min (97.88) in family care home					
Newcomer et al. (1994)	1993 mail and in-person survey of a multistage, stratified random sample of 386 residential care facilities and 1,051 randomly selected residents	57.6% of residents visited with relatives/friends 3 or more times in prior month	For those who needed help with dressing, eating, or bathing, family helped 1.1%, 2.2%, and 3.1% of residents in prior 7 days, respectively	For those who needed help with medications, managing money, or travel outside facility, family helped 0.9%, 39.6%, and 30.4% of residents in prior 7 days, respectively	49.9% of residents had telephone conversations with relatives/friends 3 or more times in prior month		
Mitchell & Kemp (2000)	Stratified random sample of 55 residential care facilities; cognitively alert residents randomly sampled within each facility and interviewed in person	77% of residents indicated monthly family contact					
Pruchno & Rose (2002)	51 AL residents in a Cleveland, Ohio, facility; assessed on time use during the prior day	M = 75 min "interacting with family" M = 209 min "with family"					
Thompson et al. (2001)	Interviews with 30 residents from 5 ALFs in Oklahoma	1.8–43.6 visits from others per month M = 14.3		Frequency: 9 = shopping 1 = laundry 6 = family takes care of "business" 6 = family brings items that resident needs	Frequency of 1–28 for a number of activities inside and outside ALF (e.g., playing games, reminiscing, dining out)		

(Table 4 continues on next page)

Table 4. Types of Family Involvement in AL: Review of Quantitative Research (Continued)

Study	Design	Visits	Personal Care	Instrumental Care	Socioemotional Support	Monitoring	Advocacy
Abbey et al. (1999)	Mail survey of 228 visitors ($n = 216$ family members) of residents in 17 residential care homes in the United Kingdom	89 visits per year (range = 1–365)	7% assisted residents with “personal/physical” care during typical visit	28% took the resident “out and about” and 10% helped with “chores” during typical visit	94% “socialized” with residents during typical visit		
Erickson et al. (2000)	Interviews with 101 individuals in a CCRC in upstate New York; interviewed pre-move (1995) and post-move (1997)	51.9% of parents ($n = 88$) visited with children several times a year in 1995–1997 27.8% visited with children less than several times a year in 1995–1997			86.3% of parents had weekly telephone contact with children in 1995–1997 10.0% had less than weekly telephone contact in 1995–1997		
Stacey-Konnert & Pynoos (1992)	50 randomly selected residents in a CCRC interviewed		0.56 family members provided “assistance” for 25 residents	2.10 family members “loaned money” to 14 residents	0.06 family members “socialized” with 36 residents 1.43 family members served as “confidant” for 44 residents		
Hopp (1999)	In-person interviews of 617 randomly selected residents of nonrandomly sampled board and care homes from urban areas in 7 states	Visit frequency of family members: 22.7% weekly 14.2% 2 to 3 per month 8.2% monthly 17.7% less than monthly 25.9% no visits 11.3% no available family member	For those with ADL limitations ($n = 206$), 5.8% received informal (family, friends, or other residents) help with 1 ADL	For those with IADL limitations ($n = 519$), 26.4% received informal help with 1 IADL, 10.4% with 2 IADLs, 4.6% with 3–4 IADLs			
R. A. Kane et al. (1989; 1991)	1988 mail survey of all licensed adult foster homes in Oregon and in-person interviews with 400 randomly sampled residents	228 residents indicated regular visits with relatives or friends outside of care setting (57%) 36% indicated weekly or daily visits during past few months			32% of residents indicated weekly or daily telephone contact during past few months		
Lough & Schank (1996)	In-person interviews with 47 older women in 6 congregate housing units in midwestern United States	44 respondents visited relative/close friend in past month			92% reported feeling “close” to a relative; 93% received 5 or more calls from family/friends in past month		
Adams, Sanders, & Auth (2004)	Mail survey with 234 residents in 2 independent living apartment units in northeastern United States	3.13 (0.94) visitors per week					

(Table 4 continues on next page)

Table 4. Types of Family Involvement in AL: Review of Quantitative Research (*Continued*)

Study	Design	Visits	Personal Care	Instrumental Care	Socioemotional Support	Monitoring	Advocacy
Mullins & Dugan (1990)	Mail survey with 208 residents of 10 independent living facilities in Florida	70% of those with children saw a child monthly 51% of those with grandchildren saw a grandchild monthly 27% of those with siblings or other relatives saw either monthly					
Hellström et al. (2004)	Mail survey of 523 residents in "special accommodation" in southern Sweden		97 (18.5%) reported help from informal and formal sources				

Note: Data are means (standard deviations), percentages, or ranges. AL = assisted living; ALF = AL facility; ADL = activity of daily living; IADL = instrumental ADL; CCRC = continuing care retirement community.

moves to an AL-style setting, as these various analyses indicated that older adults who are unmarried (Sales et al., 2005), proximal location to family and friends (Krout et al., 2002; Silverstein & Zablotsky, 1996), family preferences for AL (Reinardy & Kane, 2003), and even family abuse (Weatherall, 2001) are all variables that positively influence relocation to AL. As with predictors of NH admission (e.g., see meta-analysis by Gaugler, Duval, Anderson, & Kane, 2007), informal support appears to influence older adults' entry into residential long-term care.

In addition to several case studies (Baldwin & Shaul, 2001; R. L. Kane & West, 2005; Pitts, Krieger, & Nussbaum, 2005), various qualitative efforts explored the process of family involvement in AL. These studies included anywhere from 6 to 78 family members in various types of residential care settings. Seven of these studies took place in the United States (Ball et al., 2004; Carder & Hernandez, 2004; Mead, Eckert, Zimmerman, & Schumacher, 2005; Perkinson, 1995; Sanderson & Meyers, 2004; Schmidt, 1987; Wellin & Jaffe, 2004) and four took place in the United Kingdom (Roe, Whattam, Young, & Dimond, 2001; Seddon, Jones, & Boyle, 2002; Train, Nurock, Kitchen, Manela, & Livingston, 2005; Wright, 2000). Five of these studies relied on semistructured interviews with either family members or residents to inform the process of family involvement in AL, whereas the other six studies relied on multiple informants or participant observation/ethnographic approaches (Ball et al., 2004; Carder & Hernandez, 2004; Mead et al., 2005; Perkinson, 1995; Train et al., 2005; Wellin & Jaffe, 2004). The themes derived from these various qualitative studies overlapped with those of the quantitative studies: Family members remain engaged in socioemotional forms of assistance such as visits and regular contact and are active in monitoring and attempting to preserve the well-being of AL residents. However, family members tend to relinquish more personal forms of care assistance to AL or other formal care providers, implying a substitution model of formal/informal care integration. However, other themes emerged in these qualitative analyses that have been relatively unexplored in quantitative research efforts, such as the importance of prior family-resident relationships in dictating the quality and type of family involvement (Sanderson & Meyers, 2004; Seddon et al., 2002); the role of family-oriented facility characteristics, environment, and policies in affecting family inputs in care planning and decision making (Carder & Hernandez, 2004; Wright, 2000); and "deviant" family caregivers, or those who prefer to operate outside of group norms of family involvement and care (Perkinson, 1995).

Several qualitative studies moved beyond family roles in AL to explore family involvement at various transition points during a relative's stay in AL. A recurring theme in several qualitative studies was the importance of family roles and history prior to

admission, such as the role of health problems, emotional stress, and psychological upheaval related to at-home care provision as triggering the need for AL and potentially continuing after entry (Liken, 2001a, 2001b, 2001c; Russell, 1996; Sanderson & Meyers, 2004; Seddon et al., 2002; Wright, 2000). Other qualitative inquiries examined family involvement and transitions from AL; analyses suggested that family intervention and involvement in monitoring care, administering medications, collaborating with staff, and purchasing external formal care services (i.e., home health aides) was key to allowing residents to age in place in AL facilities. However, family members also suggested a degree of comfort in allowing AL directors to make final decisions and judgments in determining whether a relative could remain in the AL setting; families also indicated a lack of formal discussion regarding such matters (Ball et al., 2004; Cartwright & Kayser-Jones, 2003; Mead et al., 2005). Additional qualitative research examined interaction of families with interdisciplinary geriatric care teams at the onset of Alzheimer's disease in AL (Liken, 1999) and with physicians in general (Schumacher, Eckert, Zimmerman, Carder, & Wright, 2005); both studies suggested the need for continuity of physician care in the context of chronic illness in AL, as well as the need to enhance communication in the long-term-care environment between staff, physicians, and family members to improve the delivery of chronic care.

Two additional qualitative studies explored marital status in AL-type settings as dictating the type and degree of social contacts with other residents (Perkinson & Rockemann, 1996) and attempts of married AL residents to continue to maintain their spousal roles when entering a residential care setting (Schmidt, 1987). An ethnographic study of 47 older adults in a continuing care retirement community examined the onset of care provision in such settings. Semistructured interviews and field notes revealed that older residents were active participants in initially eliciting informal care from family members and then engaging in negotiation and evaluation with family caregivers throughout the informal care process. The findings suggest a more dynamic role for the resident than conceptualizations of the passive care recipient that dominate much of the family caregiving literature (Russell, 1996).

Family Involvement and Family Outcomes

Table 5 summarizes available quantitative research on family outcomes in AL. A handful of studies attempted to examine family members' satisfaction with various aspects of the AL environment. Of the four studies that compared resident and family ratings of satisfaction, all but one found that residents reported lower overall satisfaction with the AL environment as well as with specific aspects of

the AL environment, AL staff, and AL care provision (Buelow & Fee, 2000; Gesell, 2001; Sloane et al., 2003). The one exception was the work of Levin and Kane (2006), which incorporated ratings of importance for various aspects of AL (e.g., control, care, programs) as well as satisfaction with these dimensions. Levin and Kane found that family members alternatively rated importance as higher on resident control, care provided, and programs offered and satisfaction as lower when compared to residents. Overall, the trend of findings suggests that families and residents view satisfaction and quality of care differently on a number of important dimensions in AL, with residents' satisfaction often lower when compared to that of family members.

A few other analyses examined family members' emotional responses to informal care provision in AL. Studies of various dimensions of caregiver burden (or the financial, social, emotional, and physical load of informal care) suggested that although community caregivers may experience greater work-related strain than AL family members (Leon et al., 2000), family members in AL indicate more burden than families of NH residents, due perhaps to the frequency of informal care provision in AL (Port et al., 2005). In the one longitudinal analysis of stress in AL, Seddon and colleagues (2002) found that feelings of guilt (i.e., "I feel I have failed my relative in some way") remained for family members over a 10-month period, whereas perceived stressfulness on items related to visits and interactions with staff decreased. The scarcity of empirical analyses of emotional distress makes it difficult to discern overall trends of stress and adaptation for family members in AL.

Available qualitative research on family outcomes in AL suggests a process based in preadmission experiences and also indicates important psychosocial outcomes for future consideration. Both positive and negative emotional outcomes for family members may follow a relative's move to an AL facility. For example, in an interview of 20 family members of AL residents, Liken (2001a) indicated that the move resulted in relief for 15 family members due to greater supervision and emotional/personal care provided by the AL facility. Similarly, in their analysis of open-ended responses, Seddon and colleagues (2002) reported that stress decreased due to religious coping, attempts by family members to make each visit as stimulating as possible, and a sense of freedom on the part of family members. Across each of these studies, sustained guilt following a relative's move to AL consistently emerged (Liken, 2001a, 2001c; Sanderson & Meyers, 2004; Seddon et al., 2002). Other negative responses were based in feelings of loneliness and increased strain in the relationship with the relative (Sanderson & Meyers, 2004; Seddon et al., 2002).

A pair of studies examined family members' reactions to end-of-life care in AL. As shown in Table 5, one quantitative study suggested that many family

Table 5. Family Outcomes in AL

Study	Design and Family Sample	Family Outcomes Assessed	Predictors/Correlates of Family Outcomes (effect size; <i>p</i>)
Dobbs & Montgomery (2005)	Mail survey of 260 family members from 83 ALFs in Kansas	Facility rating, overall satisfaction with ALF, satisfaction with AL staff	Age of family member → facility rating (.14; .0051) Age of family member → satisfaction with staff (.05; .0051)
Buelow & Fee (2000)	Mail survey of 113 family members from 3 ALFs in metropolitan area	Single-item ratings of overall care, "residents generally like staff," "residents are comfortable in ALF," "staff are interested in residents," "complaints are acted upon," "aspects of care could be improved"; open-ended responses	Family members rated satisfaction higher than residents on "staff are interested" (3.28 vs 2.89; $\leq .001$) and "aspects of care could be improved" (3.06 vs 2.61; $\leq .001$).
Marsden (1999)	In-person interviews with 100 family members of residents in ALFs in New York and Michigan, recruited from support groups	Rating of "homeyness" following view of pictures of various models of AL; open-ended responses	Across various facility categories, families tended to rank 2-story environments as more "homelike" ($p < .05$) when compared to residents.
Gesell (2001)	Mail survey to all family members of 12 ALFs in 8 states; $N = 350$	Multidimensional measure of satisfaction with activities, personnel, aides, apartment, facility, and management	Overall, residents indicated lower ratings of satisfaction than family members ($p < .05$).
Levin & Kane (2006)	1999–2000 telephone survey and in-person interviews with 60 randomly selected apartment-style ALFs in multicounty, urban geographic hubs. 10 residents randomly selected within each ALF ($N = 600$)	Multidimensional measure of importance of and satisfaction with control, household services, care, programs, dining, and living situation	Family members' ratings of importance regarding control (16.76 vs 14.97), care (18.02 vs 16.85), and programs (15.78 vs 14.29) were higher than residents' ($p < .01$). Family members' satisfaction with control (16.74 vs 17.59), household services (7.29 vs 8.73), care (15.81 vs 17.91), programs (13.45 vs 14.87), and dining (7.57 vs 8.33) was lower than residents' ($p < .01$). Community caregivers reported greater work-related strain than AL family caregivers (2.1/2.0 vs 1.7; .001)
Leon et al. (2000)	2 ALFs from a sample of 13 sites in 9 states; telephone interviews with 161 family caregivers of residents with dementia in AL	Multidimensional measure of caregiving burden: mastery, health change, relationship strain with care recipient, social activity restriction, work strain	Means adjusted for resident cognition, function, caregiver health, and sociodemographics found that family members of AL residents indicated greater burden than family members of nursing home residents (1.13 vs 0.80; .015).
Port et al. (2005)	Telephone interviews with family members of 353 residents with dementia in 34 AL/residential care settings in 4 states	Single-item reports of preferred level of involvement and burden in caring for resident	Feelings of guilt remained "very stressful" or staff became less stressful.
Seddon et al. (2002)	Telephone interviews with family members of 353 residents with dementia in 34 AL/residential care settings in 4 states	Single-item reports of perceived stressfulness of various care responsibilities recently after admission and 10 months thereafter	Family members of AL residents were less aware of resident's approaching death (64.7% vs 87.0%; .011); overall family satisfaction was higher for family members of AL residents than nursing home residents (32.1 vs 41.2; .016). (Note: Lower score represents higher satisfaction on scale.)
Sloane et al. (2003)	Telephone interviews with family members of 353 residents with dementia in 34 AL/residential care settings in 4 states; 224 family members of 73 AL residents who died	Single-item reports of perceived stressfulness of various care responsibilities recently after admission and 10 months thereafter	

Note: AL = assisted living; ALF = AL facility.

members appeared unaware of a resident's approaching death when compared to families of NH residents (Sloane et al., 2003). Qualitative focus group work indicated a number of concerns family members held regarding palliative care in AL, such as doubts that AL staff could handle the complex personal care and disease management requirements and a perceived lack of communication. However, family members were also vocal in expressing satisfaction with the individuals who provided care for their relatives at the end of life (Dixon, Fortner, & Travis, 2002). These quantitative and qualitative findings suggest important barriers to end-of-life care in AL, as well as the need for greater research in this area.

Research Recommendations

Although this article is the first to synthesize quantitative and qualitative research results on family involvement in AL, there are several important limitations to note. Due to available resources, only Joseph E. Gaugler was able to conduct the literature review, screen for inclusion, and extract data. As existing guidelines note, assessing the interrater agreement of multiple reviewers enhances the rigor of the data extracted and reported for the purposes of a systematic literature review (Petitti, 2000; Stroup et al., 2000). Also, due to the relatively nascent literature on families and AL, the sampling strategy adopted in the literature search was necessarily broad; in addition to AL settings, we included other environments such as board and care homes, residential care settings, and adult foster care homes in the review. Family involvement may operate differently across these settings due to facility-level diversity or other important environmental factors.

Although prior work on informal and formal care in the community has emphasized the complex relationships between these two sources of assistance (Lyons & Zarit, 1999), quantitative and qualitative research has just begun to explore family integration in AL. As the survey of the literature suggests, families of relatives in AL appear to contribute considerable amounts of instrumental, socioemotional, and monitoring support (along with frequent visits) when compared to other residential settings such as NHs. However, the relationship of facility-level characteristics to family involvement and activities, the longitudinal ramifications of family involvement, the causal processes of family involvement, and effective assessment tools to capture various forms of family involvement are less apparent in the literature. Similarly, few studies have begun to examine the impact of the AL experience on family outcomes beyond ratings of satisfaction. This concluding section offers recommendations designed to guide future research and conceptual work on the process of family involvement in AL.

Nonsimplistic Causal Models of Family Involvement in AL

The review of the literature, particularly the quantitative research, revealed rather simplistic causal models of family involvement in AL. For example, several studies have attempted to determine correlates or predictors of family involvement in AL, such as resident functional status, family members' geographic proximity, and similar characteristics. However, a more dynamic process may influence motivation for involvement on the part of family members. For example, family members could be motivated to provide increased involvement (such as monitoring) because the facility is not offering adequate care or is providing much technical care at the expense of residents' emotional well-being. In other instances, the provision of certain types of assistance (such as socioemotional support) at the expense of more hands-on types of care (i.e., personal, instrumental) may suggest that families are content or comfortable enough to engage in psychosocial forms of support as they relinquish responsibilities related to technical hands-on care to the care facility. Overall, it is difficult to identify the causal direction of family involvement and potential predictors, given the lack of longitudinal research and conceptual models. For example, some studies have indicated that AL resident length of stay and family visits are negatively correlated (Pruchno & Rose, 2002), implying that as AL residents remain in their respective settings for longer periods of time families are less likely to remain involved. However, it may also be the case that family members who are more involved with residents in AL may be more likely to facilitate an earlier move out from AL back to the community or some other setting (as some NH studies have found; see Gaugler, 2005).

Stronger conceptual models are needed to guide the process of family involvement in AL. Some of this work has begun in qualitative research, which has suggested the importance of factors that can influence family involvement and are subject to family involvement (see above). However, quantitative studies have not addressed why various types of family involvement do or do not occur. Incorporation of conceptual models may begin to better address the issue of how families are integrated within the formal care service systems of AL settings (e.g., Gaugler, 2005, p. 114).

We also argue that the consideration of formal/informal care patterns when examining family involvement in AL is useful, as this conceptual approach may acknowledge the place of AL in the long-term-care landscape. As presented in the literature review, how formal and informal care is arranged in AL is dynamic. But are these formal/informal care patterns similar to care arrangements in NHs? It may be that formal care provision in AL is more analogous to that in home care settings, where

family members arrange for some formal assistance on certain care tasks (e.g., bathing) and continue to provide considerable informal support for others. The difference in AL is that the resident and/or family has purchased systematic assistance for housekeeping and meal preparation and may negotiate at move in and during the resident's stay for additional types of formal care services (provided by either the facility or some external, contracted organization). Subsequent research that examines the expectations of AL facilities for family care, whether family-level assessments are conducted, the involvement of family members in formal service planning, and programmatic efforts on the part of AL to support families would help to ascertain how formal and informal care in AL operate in relation to home- and community-based settings or more traditional residential contexts.

Differentiating Family Involvement in AL

Quantitative research on family involvement has relied largely on task-based approaches to assessing frequency and type of informal care in AL. However, such approaches may obscure the overlap of certain types of family assistance in AL. For example, the provision of instrumental types of support may be integrated with socioemotional forms of help such as reminiscing with a relative while the family member takes him or her to an appointment. The segmentation of family involvement into various types may increase the risk of double-counting informal assistance.

Reviews of the family caregiving literature suggest that, in comparing various methods of assessing informal care inputs, calendar- or diary-based approaches may most effectively capture the amount and dimensions of informal help provided to disabled older adults (Gaugler, Kane, & Kane, 2002; for an example in AL, see Pruchno & Rose, 2002). For example, a calendar type of instrument can collect information on a daily basis regarding family visits and what occurred during each visit; moreover, administering these measures over time can capture periods of intensified family involvement due to particular crises the AL resident may experience (e.g., the resident falling). Although data monitoring is critical to ensure complete data, the incorporation of these assessment tools (as opposed to forcing respondents to choose categories of family involvement *a priori*) may capture the empirical richness of family involvement implied in qualitative research.

It is also apparent that few studies have examined family involvement in AL from a dyadic or systems-level perspective. There may be family-level assessment techniques that are important to consider when examining the integration of formal and informal care in AL (e.g., such as those used in family systems theory development and family social science). These approaches may better incorporate the perspectives

and importance of the resident in family involvement in AL; as was evident in our review of the literature, the voice of the resident is conspicuously absent from most analyses of family involvement (see Russell, 1996).

Incorporation of Facility-Level Characteristics Associated With Family Involvement

As suggested in the survey of the literature, there are differences in the amount of family support provided to AL or NH residents. Although much of this variation may be due to variations in resident function and cognition, few studies have adequately controlled or adjusted for heterogeneity in samples. Moreover, the examination of facility type, given the extensive diversity in size, staffing, environmental amenities, and other characteristics within and across AL facilities and NHs, may make such comparisons simplistic. There may be a range of facility-level characteristics that could potentially influence or facilitate family involvement in residential settings, such as the *family orientation* of facilities, or the degree to which facilities encourage family involvement via specific policies and programs (e.g., flexible visiting hours, family participation in service planning; see Friedemann, Montgomery, Maiberger, & Smith, 1997).

Ethnographic studies have explored whether skilled nursing settings such as NHs are able to overcome the notion of institution and instead create a community-oriented context that is integrated within and outside facility walls (Rowles, Concotelli, & High, 1996). Building on this work, research in alternative residential environments has examined factors related to perceptions of AL as home; among these factors is attachment to AL of which perceptions of family involvement in AL is an important factor (Cutchin, Owen, & Chang, 2003). The promotion of these blurred boundaries appears to result in greater resident adaptation to lives in the facility as well as continued connection to roles and lives outside the residential care setting. Beyond facility size and other basic characteristics, no study to date has similarly examined the environmental context of AL and its potential effects on family involvement. One could hypothesize that AL facilities, which actively market amenities such as choice, individuality, and control over one's environment, may facilitate greater family involvement when compared to NHs, even when adjusting for the myriad differences between such settings. However, we argue that such comparisons are not illuminating; more rigorous descriptions of AL facility environment (e.g., via a tool such as the Multiphasic Environmental Assessment Procedure; see Moos & Lemke, 1996) would allow researchers to pinpoint those characteristics and policies that may best influence family integration and resident well-being across the long-term-care landscape.

Family Structure and its Potential Effects on Family Involvement

An additional conceptual limitation in family involvement research is its general focus on available family members. Most research has tended to examine family involvement from the perspective of a *primary family member*, or that person who is most involved or who feels most responsible for the relative in AL. However, as Table 2 suggests, there are various other configurations worthy of analysis in future research. For example, up to 10% of residents in AL are living with spouses in the facility. How family involvement operates in instances where spouses are living in the AL unit, and presumably providing considerable informal care to each other, may be an important variation of family involvement to explore. Moreover, the general underlying assumption of much of the research is that residents have available family members to rely upon. Some residents have no available family members to provide informal support, and it is not clear whether existing studies of family involvement in AL exclude or consider these individuals in analyses. How formal/informal care patterns operate in situations in which residents have no family members at all would contribute to researchers' understanding and conceptualizations of family involvement across various family structure types.

Longitudinal and Transitional Nature of Family Involvement in AL

The large majority of research on family involvement in AL is cross-sectional. Whether family involvement changes over time, and how such changes are related to facility-level factors or resident function, is relatively unknown. A longitudinal perspective is important; as noted in research on family care in NHs, early cross-sectional studies suggested a negative correlation between family visits and resident length of stay. In contrast, prospective longitudinal designs have suggested more variable and dynamic patterns of change in family visits and involvement than earlier cross-sectional research implied (e.g., Yamamoto, Aneshensel, & Levy-Storms, 2002). Similarly, as the qualitative research highlighted in this review emphasizes, the degree and type of family care provided appears strongly associated with family-resident relationships prior to admission. However, no quantitative study to date appears to have considered family caregiving patterns prior to a relative's move to AL, or the how quality of family-resident relationships during and prior to admission influences family members' involvement or other outcomes. Adopting a transitional perspective in future quantitative research would provide greater insight on the process of family involvement in AL and other long-term-care settings, in contrast to

simply describing types and frequency of informal care. Along with providing longitudinal description, researchers should incorporate strategies to address the complications of attrition (see Gaugler, 2005).

Family Outcomes and Intervention in AL

Of the three areas surveyed, family outcomes in AL was the most underdeveloped. It remains unknown how family caregiving roles change prior to and after a relative's admission to AL. The greater family care burden in AL compared to NHs suggests that increased or continued family involvement in various care domains (such as IADLs) may exacerbate caregivers' perceived stress following the care recipient's move to AL. Family stress and other negative outcomes often do not abate with placement in NHs (Schulz et al., 2004). In addition, the care expectations of families or AL facilities themselves (e.g., supplementation care patterns for instrumental or personal care domains) may stress caregivers. It is also possible that family outcomes in AL may require measurement approaches that move beyond traditional domains of stress. For example, assessment of family members' perceptions of role continuity as caregiver or more AL-specific types of family outcome measures (understanding of and satisfaction with disclosure and communication regarding the extent of resident care in AL) may better describe family members' acclimation to AL. Subsequent research examining change in caregiver outcomes across the AL transition could shed greater light on families' adaptation and may also point toward interventions designed to assist families during the AL experience.

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