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Aging in Place vs. Relocation for Older Adults with a Neurocognitive Disorder: Applications of Wiseman's Behavioral Model

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Abstract

Some older adults are more vulnerable to housing concerns due to physical and cognitive challenges, including those with a neurocognitive disorder who need extensive support. Environmental gerontology frameworks, including Wiseman's (1980) Behavioral Model of Elderly Migration, have informed scholarship on aging in place and relocation. It remains unclear, however, the extent to which this conceptual work informs services and supports for older adults, and the Wiseman model has not been applied to people with a neurocognitive disorder. Understanding Wiseman's model, including considerations for working with families confronting a neurocognitive disorder, can help practitioners ensure that older clients live in settings that best meet their wants and needs.

Introduction

Demographic and societal changes over the past three decades are bringing greater attention to where older adults live, as well as the informal and formal supports available to them. An overwhelming majority of older adults would like to age in place, defined as "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level" (Centers for Disease Control and Prevention, 2013). Furthermore, an increasing number are able to do so; in the United States, for example, the proportion of those 85 and older living in long-term care institutions has declined from about 26% in the 1970s to 14% in the 2000s (Hayutin, 2012). Although decreased fertility, fewer women staying at home, and the geographic dispersion of families have reduced the availability of families to help older loved ones with their daily activities (Spillman & Pezzin, 2000), an expansive continuum of home and community based services and other supports are available to help people of all ages to live as independently as possible in the community. Both formal and informal community-based supports, however, may be ill-

equipped to provide the needed assistance to some older adults who are more vulnerable to housing concerns due to physical and cognitive challenges.

Older adults with dementia, which is currently conceptualized and labeled “neurocognitive disorder” (Sibersky, 2012), have a particularly high need for informal and formal support and are at an increased risk for institutionalization (Banaszak-Holl et al., 2004). Over 44 million people worldwide are currently living with a neurocognitive disorder, and this number will more than triple to above 135 million by 2050 (Alzheimer’s Disease International, 2013). A projected rate of about 1,000,000 new cases of Alzheimer’s disease (AD) diagnoses per year by 2050 translates to one new case diagnosed every 33 seconds (Alzheimer’s Association, 2014). This suggests that a growing number of older adults with a neurocognitive disorder will need to assess, often with assistance or direction from their friends and family, whether aging in place or relocation will best meet their care preferences and needs.

Frameworks from the field of environmental gerontology have informed much of the scholarly work on aging in place and relocation. One particularly promising framework is Wiseman’s (1980) Behavioral Model of Elderly Migration, which explicates the process of residential relocation in later life, viewing it as an interaction between triggering mechanisms and personal resources. It remains unclear, however, the extent to which this conceptual work informs services and supports for older adults, and to our knowledge the Wiseman model has not been applied to people with neurocognitive disorders. To address this gap, this article has two specific aims: 1) propose ways in which Wiseman’s model can inform interventions for older adults with a neurocognitive disorder, and 2) suggest additional considerations of the needs of older adults with a neurocognitive disorder to inform further development and empirical testing of this model. To address these aims, we developed three case vignettes that draw from our social work professional experiences. Understanding Wiseman’s model, including the additional considerations potentially needed when working with older adults diagnosed with a neurocognitive disorder, can help future practitioners ensure that their older patients and clients live in settings that best meet their care preferences and needs and inform future empirical studies on this topic.

Background and Literature Review

Neurocognitive Disorder

Neurocognitive disorder is an acquired and persistent clinical syndrome caused by brain damage or disease. It involves multiple cognitive impairments that lead to dysfunction and disability (Qui, de Ronchi, & Fratiglioni, 2007), loss of independence with activities of daily living (Neundorfer et al., 2001), depressive symptoms (Stroud, Steiner, & Iwuagwu, 2008), and premature institutionalization and death (McClendon, Smythe, & Neundorfer, 2006). General categories of symptoms of neurocognitive disorder include difficulty remembering (amnesia), difficulty performing routine activities (apraxia), difficulty perceiving the environment (agnosia), and difficulty communicating (aphasia). As a result of these cognitive impairments, people with a neurocognitive disorder also experience significant functional impairment, unpredictable personality changes, psychiatric features like hallucinations and delusions, and emotional irregularities like depression and anxiety (Zarit

& Zarit, 2007). In total, more than 60 different diseases and conditions can cause neurocognitive disorder (American Psychiatric Association, 2013), with each having a distinct profile of pathology and resulting symptoms. Alzheimer's disease is the most common cause of dementia, with AD alone accounting for 50% to 70% of dementia cases and combinations of AD and other brain diseases responsible for up to 90% of cases (Weiner & Lipton, 2012). The progressive impact of the vast majority of neurocognitive disorders is increasingly devastating, as are the effects on family members and friends, especially those involved in care (Toseland & Parker, 2006).

Researchers and practitioners have long recognized that social and physical environments are key factors in the quality of life of older adults with a neurocognitive disorder, and influence where these elders live. The social environment has typically been examined in terms of the informal support system, and approximately 70% of all the care for people with dementia is provided in private homes by family and friends (Alzheimer's Study Group, 2008). As a neurocognitive disorder advances it is important to assure that the family care team is well educated and prepared for the cognitive and behavioral issues that may arise. A difficult aspect of care provision for individuals with a neurocognitive disorder is the increasing need for direct engagement and supervision. Medicare and other forms of insurance do not routinely reimburse for companion care that would help to support optimal adaptation to gradual losses of independence, so much of the responsibility for this type of care falls on the informal support system including spouses, siblings, and adult children. There are evidenced-based interventions that address caregiver needs (e.g. psychoeducational-skill building interventions and cognitive-behavioral therapies), and research has shown that psychosocial interventions can improve outcomes such as improved caregiver knowledge, coping skills and social support; improved patient skills, cognition, activities of daily living, and mood; and reduced patient depression and agitation (Brodaty, Green, & Koschera, 2003; Gallagher-Thompson, & Coon, 2007; O'Connor, Ames, Gardner & King, 2009a, 2009b; Olazaran et.al., 2010).

Though receiving less attention than the role of caregivers, a burgeoning literature also recognizes the influence of the physical environment on safety and health outcomes for those with a neurocognitive disorder, including the impact of wandering behaviors, cooking hazards, medication mismanagement, access to firearms, and improper space design (Horvath et al., 2013; Horvath, Harvey, & Trudeau, 2007; Lach, Reed, Smith, & Carr, 1995; Van Hoof, Blom, Post, & Bastein, 2013). Numerous complications threaten the safety and appropriateness of remaining in the home as symptoms worsen and stresses mount. For example, both social scientists (e.g., Lawton, 2001) and architecture and planning experts (e.g., Calkins, 1988) have written about designing residential environments for persons with dementia, frequently focusing on an institutional setting. Home environments have also received attention; for example, the typical home is rife with environmental hazards, such as loose stair rails and bathrooms lacking grab bars, which should be proactively addressed to avoid accident and injury (Rowe, & Fehrenbach, 2004; Horvath et al., 2013). Many people with a neurocognitive disorder and their family caregivers, however, lack awareness of these risks, the strategies to mitigate the risks, and the resources available to learn about these issues.

One promising intervention that targets both the social and the physical environment involves occupational therapists providing intensive in-home training to enhance caregiver's abilities to manage neurocognitive symptoms (Gitlin, Corcoran, Winter, Boyce, & Hauck, 2001). In this intervention, caregivers learn about environmental effects on their care recipient's behavior, identify hazards in the home (such as throw rugs or shaky stair railings), and devise strategies to enlist help from informal and formal sources of care. Randomized control trials indicate that caregivers participating in this program experience a reduction in emotional distress and an increase in self-efficacy, while their care recipients have fewer behavioral problems and slower declines in instrumental activities of daily living (Gitlin et al., 2001). Thus, meaningful benefits related to home safety and caregiver abilities can be realized through existing interventions and adaptations in the home setting.

Because a large number of people with neurocognitive disorders live in the community and prefer to receive care in the home, it is critical to understand both the individual and environmental implications of the disorder in order to effectively design appropriate assessment and intervention protocols, and determine the optimal living setting. Given the complexity of diagnosis and prognosis with neurocognitive disorders, including bio-psycho-social factors, sophisticated multidimensional evaluations conducted by expert providers are typically required to assure home-based safety, care, and quality of life. We propose that incorporating ideas from environmental gerontology can enhance the acceptability, effectiveness and person-centeredness of such evaluations and interventions. This includes, for example, knowledge of residential safety enhancements (e.g., monitors and grab bars) and knowledge of the built environment (e.g., the particular benefits of community-based services such as adult day care centers, home care services, and respite programs to assist working caregivers).

Wiseman's Behavioral Model of Elderly Migration

Environmental gerontology is a small but growing area of the theoretical and empirical literature that describes the relationship between older adults and their environments (Wahl & Wiseman, 2003) and the implications of this relationship for a variety of outcomes, including quality of life (Golant, 2003). The most-cited framework in the field is the Ecological Model of Aging (also called the Press-Competence Model), first introduced by Lawton and Nahemow in 1973. This model proposes that late life health and well-being are the result of the interaction between individual competence (e.g., cognitive and physical functioning) and the press of the surrounding environment both objective (e.g., the physical layout of the home) and subjective (e.g., perceived expectations of friends and family) (Lawton, 1982; Lawton & Nahemow, 1973). This model describes the aging process as one of "continual adaptation" (Lawton & Nahemow, 1973, p.619) to achieve person-environment fit.

Influenced by this model, in 1980 Wiseman developed the Behavioral Model of Elderly Migration to explain the process by which older adults relocate or remain in their current home and community, which he viewed as driven primarily by housing satisfaction. As shown in Figure 1, several late life issues may trigger older adults to evaluate their satisfaction with the home environment, including expected changes (e.g., lifestyle

preferences such as continued workforce participation vs. retirement and pursuit of leisure activities) and unexpected major life events that demand rapid adaptation (e.g., serious injury from a fall). Triggering events can be either push or pull factors that encourage older adults to consider relocation. Examples of push factors include environmental stressors, functional decline, and the death of a spouse or caregiver. Pull factors inspire moves by attracting older adults to desirable settings, such as appealing amenities for recreational activities or a pleasant climate. Furthermore, triggering events may be endogenous, emerging from the individual (e.g., a change in income), or exogenous, emerging from the environment (e.g., increased cost of living).

In Wiseman's conceptualization, residential relocation results from the interaction between these triggering mechanisms and personal resources (Wiseman & Roseman, 1979). Wiseman (1980) recognized that triggering mechanisms provide the initial motivation to consider a change in residence, but actual relocation depends on individual needs, preferences, and resources. Personal resources such as money, confidence in one's ability to move, and social support play a role in whether a triggering mechanism leads to relocation. Furthermore, an important contribution from Wiseman is the distinction between involuntary and voluntary relocation or staying in one's current home. For example, involuntary movers may be forced to relocate because of losses in their functional capabilities or care supports, while involuntary stayers may wish to relocate but lack the financial resources to do so.

Theoretical and empirical work that has emerged since the publication of Wiseman's model has helped to clarify and refine its concepts. Studies on relocation in later life, for example, have identified additional push factors, such as problems in urban areas (e.g., crime, congestion, pollution) and the absence of family members who live with or close to the elder (Haas & Serow, 1993). Researchers have also uncovered more information about the emotional motivation of older adults who voluntarily relocate, including perceptions of the ways a move may affect their kin network. For example, avoiding or delaying relocation to live with family because of a desire to not be a burden has emerged in several recent qualitative studies (Jennings, Perry & Valeriani, 2014; Jungers, 2010).

Concomitant with this growing literature on relocation in later life is a rise in scholarship examining the causes and consequences of aging in place. A number of scholars, for example, propose that aging in the same home and neighborhood contributes to a sense of attachment, identity, and familiarity (Burns, Lavoie, & Rose, 2012; Rowles, 2003; Sixsmith & Sixsmith, 2008; Wiles, Leibing, Guberman, Reeve, & Allen, 2012) and ultimately can lead to such positive outcomes as better physical health, improved mental well-being, and a high quality of life (Sixsmith & Sixsmith, 2008). Indeed, surveys indicate more than 80% of older adults wish to age in place (AARP Public Policy Institute, 2005; Feldman et al., 2004), and a variety of public initiatives (e.g., Money Follows the Person, Program of All-Inclusive Care for the Elderly) and non-profit programs (e.g., Villages, NORC Supportive Service Programs) aim to help older adults remain in their home and community. Furthermore, over the past few decades the availability of residential alternatives to nursing homes, such as assisted living, has increased dramatically, providing a variety of settings in which older adults can age in place (Zimmerman et al., 2003). There is clearly a great deal of enthusiasm

both inside and outside of academia to design, implement, and evaluate interventions that could help older adults, including those with cognitive limitations, age in place.

By synthesizing the theoretical and empirical literature, Wiseman provided a detailed framework from which to understand the process of relocation in later life, as well as the potential consequences of such relocation. However, advances in our theoretical and empirical understanding of relocation and aging in place highlight the complexity of this process and the need for further refinement of the foundational model to enhance professional practice with particular populations. Here we offer the novel application of Wiseman's model to the unique housing-related challenges of persons with neurocognitive disorders. Wiseman's model offers several general considerations that are relevant to older adults experiencing cognitive impairments, but has not yet been applied to the specific challenges of neurocognitive disorders in order to examine where the model offers sufficient guidance and where further refinements are needed. Social workers and other community care professionals interact with families experiencing uncertainty about when moves or adaptations are needed, and may benefit from a deeper, disease-specific understanding of how to match interventions to illness conditions. For example, the dynamic nature of Wiseman's model could be particularly useful if applied to cases where the intensification of symptoms cause unpredictable overlapping changes in issues of safety, familiarity with the environment, caregiver fatigue, and decision-making ability. In the next section, we illustrate the ways this model can inform relocation decisions for those with a neurocognitive disorder and identify some potential gaps in our understanding of the relocation process with this population.

Case Vignettes

Due to the paucity of relevant research studies on this topic, we constructed three case vignettes for this article to provide a basis for exploring the conceptual relevance of Wiseman's theoretical framework for understanding and informing interventions for older adults with a neurocognitive disorder. Through these vignettes we highlight additional considerations of these older adults' needs and identify promising areas for future development and empirical testing of this model, as well as provide a valuable teaching tool for future geriatric practitioners. The vignettes are composites of actual cases seen by the first and second authors in clinical settings where older adults with neurocognitive disorders seek consultation and treatment, which we purposefully crafted to present a diversity of neurocognitive disorders and issues relevant to Wiseman's model.

Case Example 1: Mrs. Harrison

Mrs. Harrison is a 76-year-old woman with moderately severe symptoms of Alzheimer's disease. She was diagnosed 5 years ago, and continues to live with her husband who is her primary caregiver. They live in a rural agricultural community in the Midwest. Their only child passed away several years ago and they have no support from the extended family. Mrs. Harrison is experiencing increased difficulties with all of her activities of daily living. She has recently begun to exhibit numerous behaviors which threaten her safety, including burning pots on the stove and wandering away from the home and becoming lost. She frequently

has feelings of anxiety and paranoia, causing her to rummage through household drawers and closets, hide her possessions in new locations, and then later forget these actions and make accusations that someone stole her belongings. Mr. Harrison has cardiovascular disease, diabetes, and mobility limitations. He is overwhelmed with managing his wife's increasing care needs. This couple has limited income and they are enrolled in both Medicare and Medicaid programs. Despite the additional coverage for supportive services offered through Medicaid, accessing home-based care is difficult due to their remote location and the sparse availability of service providers in the region. Similarly, the nearest residential care facility is more than 25 miles away.

Application of Wiseman Model—Mrs. Harrison's progressive loss of independence in routine functioning represents the prototypical push factor that triggers a need for relocation. The diagnosis of Alzheimer's disease, a well-known terminal illness, may also be considered a critical life event that ushers in an unanticipated and undesirable shift in the life cycle from healthy older adult to disabled and dependent care recipient—a transition typically expected at a more advanced age. Neurocognitive disorders shorten life expectancy while extending the years spent living with serious illness. This scenario also highlights the challenges of supporting this individual's wish to age in place. Cognitive impairment and associated changes in judgment can lead to surrogate decision making that may directly contrast the abilities and wishes of an individual with a neurocognitive disorder.

Mrs. Harrison's dementia-related wandering behavior and difficulties using appliances not only threatens her safety and the safety of her husband, but also may signal the exogenous push factor of environmental incongruence. She and her husband have not made any environmental adaptations, likely because they have been trying to cope with each new problem as Mrs. Harrison's condition gradually worsens. Both of the hazards facing Mrs. Harrison can lead to tragedy through just a single episode, and yet her husband's physical limitations and their lack of access to formal care services suggest that supervision alone cannot be relied upon to avoid disaster.

This married couple is both impoverished and elderly, representing the dual eligible beneficiaries who are the focus of so many health and social policy debates. Their low income is an indigenous factor which has both positive and negative effects. Their Medicaid coverage offers greater resources to pay for in-home and facility-based care, while their limited income reduces the range of housing options and ability to relocate to a different community with greater access to informal and formal supports. In addition, the lack of nursing homes in the region is an exogenous factor that further limits their available options for responding to Mrs. Harrison's unmet needs. This couple will face difficult decisions about the safety of the home, the husband's capacity to provide comprehensive care, and the implications of placing Mrs. Harrison in a far-away care facility that may become inaccessible to Mr. Harrison as his conditions worsen. This couple also needs to consider the serious implications for care and housing when one member of the dyad outlives the other.

Case Example 2: Mr. Lopez

Mr. Lopez is a 56-year-old man who has been diagnosed with frontotemporal lobar degeneration. He was diagnosed one year ago after a series of behavior and personality changes that were initially thought to be unrelated to neurological disease. One of Mr. Lopez's first symptoms was a dramatic dietary change involving frequent carbohydrate binging and excessive alcohol use. He now also exhibits poor impulse control and has been cited for shoplifting on two occasions. After working as a regional sales manager for a pharmaceutical company for many years and earning a good income, Mr. Lopez was fired from this position because these behavioral disturbances made him unable to fulfill his responsibilities. He has recently hired an attorney to assist with his application for Social Security Disability Insurance. Mr. Lopez lives alone in an apartment in an urban community. He has two siblings living out of state who are concerned about Mr. Lopez and routinely request more frequent contact and encourage his relocation to one of their communities. In addition, his landlord has initiated eviction proceedings after a number of tenants filed complaints about multiple instances of inappropriate social behaviors including aggression and sexual overtures. As is common among people with frontotemporal dementias, Mr. Lopez's impaired insight and judgment are related to his resistance to accepting help.

Application of Wiseman Model—Mr. Lopez's impending eviction serves as the current triggering mechanism in this vignette. However, Mr. Lopez suffers from sufficient frontal lobe disease, which impairs his ability to engage in rational evaluation of his housing situation. The core symptoms of this disorder dramatically impair judgment, reasoning, self-awareness, awareness of disability, and ultimately decision making capacity. While he may view his current housing satisfaction as favorable, both indigenous and exogenous factors have shifted the ultimate decision as to whether he can age in place to surrogate decision makers. His diagnosis, behavioral problems, and alcohol use are indigenous factors which may significantly limit his access to relevant housing and care options. His loss of employment will likely also lead to a significant loss of financial resources, an important indigenous factor, and social network connections, an exogenous factor. In Mr. Lopez's case, his termination abruptly affected connections with his peers and his ability to pursue disability benefits through his employer.

For Mr. Lopez, who has neither formal nor informal assistance to help manage this rare disease, the array of symptoms caused by frontotemporal dementia will not only make it difficult to overcome the legitimate concerns of the landlord and neighbors, but will also limit his institutional care options, since complex cases of neurodegenerative disease are known to demand excessive time and effort on the part of direct care personnel. Mr. Lopez will likely experience rapid losses over the coming year, and his care needs will increase dramatically. Experts would advise that Mr. Lopez gain access to a comprehensive care setting before his symptoms further escalate, and yet his memory, communication capacity, age and physical independence will cause a poor fit with care environments catering to the needs of older adults with disabilities. Mr. Lopez's resistance to offers of help from family and others is an indigenous factor that significantly impedes his ability to engage in

meaningful lifestyle and environmental adaptations. From Wiseman's model, Mr. Lopez would be considered an involuntary mover. His emotional volatility would likely interfere with interventions made by family to find a more suitable living situation and may necessitate legal guardianship to facilitate his involuntary move.

Case Example 3: Mr. Watts

Mr. Watts is a 79-year-old male who has been diagnosed with Lewy body disease. Mr. Watts initially sought help two years ago for losses in cognition and memory. He has since developed tremors and an unsteady gait, yet does not use the recommended walker due to his dementia-related forgetfulness and confusion. Recently he suffered a fall down the stairs and received medical treatment in the emergency department after breaking a hip. Upon discharge from the hospital, an in-home occupational therapist identified multiple high-risk conditions, including loose handrails on the stairs, numerous small rugs and tall door saddles, thresholds too narrow to accommodate a standard wheelchair, and a lack of grab bars in the bathrooms. In the past three months, Mr. Watts has been experiencing hallucinations where he sees children in his yard, as well as disturbing delusions that people are trying to poison him. Mr. Watts is married, and his wife has a history of cancer which is now in remission. However, she is suffering from fatigue due to the increased care struggles with her husband's condition. They have a son who lives out of state, and he helps by visiting monthly. Mr. and Mrs. Watts both receive retirement income and Social Security benefits, and own the two-story row home in which they have lived for the past 44 years. Mr. Watts has been vocal about his strong desire to remain in his home, and has asked his wife to promise that she will work toward this goal. Their son, however, is concerned for both parents and has been insistent upon his father's nursing home placement.

Application of Wiseman Model—A fall precipitated by the environmental incongruence of the multilevel home for an elderly person with gait disturbance is a triggering mechanism that has inspired Mr. Watts, his wife, and their son to evaluate the possibility of relocation, albeit with different conclusions. This couple has financial comfort, which will allow for adaptations to the home and ongoing supportive care services. They have an involved and caring son, but his priorities differ from those of Mr. Watts. In Wiseman's model, the son has already engaged in destination selection by deciding that the best place for his father is a long-term care facility. However, his father's self-concept appears to be related to remaining in his home with his wife.

Mr. Watts is living with a common cause of neurodegenerative disease, but one which is accompanied by Parkinsonism and psychiatric features early in the course of illness, while his communication skills and orientation will be relatively spared until later stages of decline. He is fortunate to have a dedicated spouse as a care partner, but the home environment must be adapted to reduce the risks identified by the occupational therapist. Remaining in the home is a personal goal that is challenged on multiple fronts: his mobility issues place him at heightened risk of additional falls, his hallucinations increase his anxiety

and impair his ability to be reassured or redirected, and the cumulative impact of Mr. Watts' care places burdens on his wife.

Discussion

In these three vignettes, we have demonstrated the challenges related to housing for persons with a neurocognitive disorder. The details of each case would be gathered by comprehensive biopsychosocial assessments, typically facilitated by social workers in collaboration with interprofessional team members. These assessments collect information on diagnoses and symptom progression, informal and formal supports, medical and psychiatric histories, and relevant social and financial resource profiles. With Wiseman's model as a framework, there are important points that can be taken from the complexity of the situations described in the vignettes. The solutions to housing concerns vary according to individual choice, support networks, resources and, as demonstrated above, type of neurocognitive disorder. No single setting is optimal for everyone. When older adults and their families select relocation, in addition to considerations for resources and the timing of the relocation, the progression of neurocognitive disorders should factor into the decision making process.

Older adults do not just react to their environment (e.g., triggering mechanisms), but act on their environments as well. Many settings could be altered to promote aging in place given adequate resources and knowledge about ways to improve the safety and navigability of a space. The possibilities for alteration of home spaces are expanded by finding opportunities to educate older adults and family members before safety concerns related to neurocognitive disorder have developed. Such education is an essential component of proactive dementia care and can be offered by clinicians and other professionals. Social workers, nurses and other health professionals employed in memory clinics or neurology centers, Alzheimer's service and counseling organizations, and any of a number of home and community based service agencies often encounter families confronting the earliest stages of cognitive decline or at the time of diagnosis. They have opportunities, therefore, to discuss proactive dementia care strategies, sources of information, and potential referrals for home assessments. This type of support aids families in completing care plans (Andersen & Kaplan, 2014), and while we do not yet understand the long-range impacts of such interventions on the ability to live in settings that best meet the family's wants and needs, this is an important and suitable area for longitudinal trials.

Practitioner assessments provide a snapshot as of the time of evaluation, but many conditions contributing to neurocognitive disorder are progressive and their impacts continue to evolve over time. The case vignettes above offer succinct case histories that feature different profiles of older adults with neurocognitive disorders in order to demonstrate the complex array of challenges requiring assessment and intervention, which varies dramatically from disease to disease. While depicting such variability was more important to support the purposes of this paper, we acknowledge that the assessment of the suitability and safety of one's housing occurs *periodically* for those in late life and this is particularly salient for those living with a neurocognitive disorder. Wiseman's model incorporates the individual's periodic reassessment of potential triggering mechanisms. This

assessment/adjustment cycle can be characterized, for some, by periods of little to no decline and interspersed with acute episodes of disorientation or punctuated with unpredictable and precipitous losses. Although the timeline of reassessment and adjustment will differ for each older adult with a neurocognitive disorder, researchers and clinicians working to consider housing needs and solutions should be aware of how these disorders typically develop. Practitioners with ongoing or episodic access to people with dementia and their families over the course of illness, such as social workers in home health and primary care settings or geriatric care managers, can facilitate interventions involving education, counseling, and referral to inspire reassessment in light of evolving needs and preferences.

Older adults often consult and collaborate with family members and health care providers to make decisions about housing, a consideration that is particularly important for people living with a neurocognitive disorder. While distinguishing between involuntary and voluntary stayers and movers, Wiseman also acknowledged that his model had limited utility for understanding the relocation process of older adults who are excluded from the decision making process (Wiseman & Roseman, 1979). Given the anticipated increased prevalence of those with neurocognitive disorders in coming decades, strategies for working in partnership with older adults and their family members must be developed for this population. We must also acknowledge that the speed or order of symptom progression is not the only factor in housing decisions for individuals with a neurocognitive disorder. For example, in many cases, caregivers will experience a change in their ability to provide instrumental and emotional support due to their own decline in health and/or mental health, including losses that are caused by fatigue and burden associated with the demands of providing such intense assistance. Practitioners may then misread these difficulties as an indicator of the decline of the older person with a neurocognitive disorder, and subsequently recommend a housing transition rather than additional supportive resources for the caregiver. Thus, interventions need to be tailored based on careful evaluations of the needs of both older adults and their family members as these families attempt to navigate highly unpredictable futures.

Conclusion

By applying Wiseman's model of relocation to persons living with a neurocognitive disorder, we contribute to a more nuanced understanding of issues of aging in place and relocation for specific disease trajectories, particularly those with resulting multidimensional disabilities. One of Wiseman's contributions was recognizing the role of the elder's decision-making process with regard to relocation. Further conceptual development and related research are needed to explore the utility of this model for understanding relocation among people who cannot participate in the decision-making process. Similarly, Wiseman and other environmental gerontologists describe an adaptation process (e.g., person-environment fit) where either the elder experiences some internal change in thoughts and behaviors or takes action to adapt the home environment. We have offered examples and raised issues salient to those older adults who are unable to perform adaptation tasks. Future studies in environmental gerontology can integrate theories of the relationships between older persons and their environments with advanced knowledge of progressive neurocognitive disorders.

Mental health clinicians and other healthcare practitioners with access and opportunity to interact with families confronting neurocognitive disorders can work to understand the complex array of personal, familial, social and environmental factors potentially influencing decisions to relocate or age in place. Families struggle to understand how to assess the appropriateness of the home when loved ones experience neurocognitive disorders. Social workers are trained to complete biopsychosocial assessments. However, social workers have historically lacked education on neurocognitive disorder and on housing changes for older adults. We offer case studies presenting a diverse array of challenges associated with different neurocognitive disorders, as well as their related environmental implications. We therefor make explicit linkages between Wiseman's framework on housing appropriateness and the unique array of challenges associated with neurocognitive disorders. We hope that this informs assessments and interventions.

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From: Robert F. Wiseman (1980), Why Older People Move: Theoretical Issues

Figure 1.
Wiseman’s (1980) Model of Relocation found in “Why older people move” published in Research on Aging