

11

Case Management for Older Persons in Disasters

MICHAEL B. FRIEDMAN AND KIMBERLY A. WILLIAMS

In the aftermath of a major disaster, most people experience emotional distress, some people experience an exacerbation of an existing mental disorder, and a few people develop new mental disorders, such as depression or PTSD. Contrary to common expectation, older adults often weather a disaster better than younger people. Frequently, they have had experiences that have prepared them to deal with difficult events and, therefore, may be more resilient than expected. In fact, older adults can be an important source of comfort and support to those experiencing significant emotional distress (Brown, 2007). However, older adults with mental disabilities—such as dementia, schizophrenia, major depressive disorder, anxiety disorders, substance abuse problems, and/or PTSD—are a particularly vulnerable population (Kessler, 1999).

An adequate response to the mental health needs of older people in the aftermath of a disaster must, of course, include concrete services such as a safe place to live, food, clothing, money for necessities, reunification with family, and so forth. But it also must include mental health services such as mental health education, brief counseling, and treatment for those with either ongoing mental disorders or atypically severe emotional reactions to the disaster. These services are provided by various types of mental health professionals and paraprofessionals, including psychiatrists, psychologists, clinical social workers, psychiatric nurses, and case

managers. This chapter provides an overview of the critical role of case management in helping older adults with mental disorders or troubling emotional reactions in the aftermath of a disaster.

There are four underlying assumptions for this chapter.

1. Most older persons are not disabled—either mentally or physically (Geriatric Mental Health Alliance of New York, 2007). Many are highly resilient, have survived difficult times in the past, and have developed coping skills that many younger people have not developed.
2. Needs for services and supports vary depending on whether the older adult is disabled, has a history of serious mental illness, has a severe psychological reaction to a disaster, or is having a *normal* difficult emotional reaction to a disaster (Brown, 2007).
3. Needs also vary depending on where the older adult lives—independently in the community, with caregiving family, in senior housing, in special needs housing, in a nursing home, and so forth (Brown, 2007).
4. Disasters unfold in stages:
 - a. Preparing for the disaster
 - b. Coping with the immediate crisis
 - c. Reconstructing day-to-day life for self, family, and community
 - d. Dealing with long-term mental and substance use disorders

WHAT IS CASE MANAGEMENT?

There are many definitions and models of case management (Naleppa, 2006; Roberts-DeGennaro, 2008; Rose & Moore, 1995; Rosen & Teeson, 2001; Vanderplasschen, Wolf, Rapp, & Broekaert, 2007).

Sometimes the term *case management* is used, particularly by social workers, to distinguish providing services to address the concrete needs of clients for shelter, food, clothing, income, and so forth from providing clinical social work services that often include some form of psychotherapy.

At other times, case management is used to refer to a combination of activities that include concrete services as well as linkages to services and supports and coordination of care.

It is important to note that most discussions of case management assume an ongoing relationship between case manager and client. But some-

times, case management is provided on a one-shot basis. For example, in the aftermath of a disaster, a case manager may be temporarily available to help an individual or family to meet their basic needs as quickly as possible and to develop a plan to meet their longer term needs later on. That case manager often is not available for ongoing interaction and assistance.

Despite the variety of definitions and models, there are several core functions of case management even when provided on a one-time basis:

- Assessment and screening
- Case planning
- Addressing concrete needs, especially helping establish eligibility for and linkages to shelter, cash relief, medical care, and so forth
- Seeking and linking to services and benefits
- Providing mental health education
- Providing emotional support

Ongoing case management also may include the following:

- Following up to be sure linkages are successful
- Reaching out to clients who have not connected with services to which they were referred and/or who have not stayed in contact with the case manager
- Negotiating on behalf of the client
- Coordinating services and supports
- Providing crisis response
- Providing ongoing emotional support
- Taking overall responsibility for helping the client meet his or her needs

THE EFFECTIVENESS OF CASE MANAGEMENT

A ProQuest search revealed no studies regarding the effectiveness of case management with older persons experiencing emotional distress or mental or substance use disorders in the aftermath of a disaster. However, there has been considerable research about the effectiveness of case management (Rosen & Teesson, 2001; Smith & Newton, 2007; Vanderplassen, et al., 2007). Unfortunately, this research is of limited value for the purposes of this chapter because of the highly varied meanings of case management; because the populations studied—people with severe, long-term mental illness and people with severe substance use disorders—are not typical of the population needing help after a disaster; and because

different studies have looked at different outcomes ranging from clinical improvement to stabilized housing.

In addition, research findings have varied considerably. For example, according to Smith and Newton (2007), two Cochrane systematic reviews in the 1990s focusing on case management for severe mental disorders were published. The first review found little evidence for benefits of case management with regard to clinically significant improvement, social functioning, or quality of life (Marshall & Lockwood, 1998). The second review showed more positive outcomes generally, especially for assertive community treatment (Marshall, Gray, Lockwood, & Green, 1998). This study concluded that the question of whether case management works is too imprecise to be answered and that each type of case management needs to be assessed separately. It is important to note, as well, that the Cochrane reviews focused on people with severe long-term mental disorders. Thus, their findings have very limited applicability to people who need emotional help in the aftermath of a disaster—most of whom do not have a severe, let alone a long-term, mental disorder.

The effectiveness of several different complex interventions to help frail older persons remain in the community has been studied recently. A meta-analysis indicates that addressing multiple dimensions of need in frail older persons produces better outcomes with regard to community tenure and quality of life than standard care, even though it does not appear to increase life expectancy (Beswick, et al., 2008). Complex interventions generally include case management in one form or another. Thus, these studies suggest that case management is a useful component of efforts to improve the quality of life of frail older persons.

In the absence of definitive studies regarding the effectiveness of case management with older persons with complex needs, it is not possible to identify evidence-based approaches. However, based on experience and anecdotal evidence, it is reasonably clear that it is simply not possible to help older persons experiencing dislocation and emotional distress in the aftermath of a disaster without providing services that fall within one or another of the many definitions of case management.

THE POPULATION IN NEED

Most older persons do not need special assistance regarding mental health in the aftermath of a disaster. The assumption that they do reflects our society's inherent ageism. In fact, many older persons are more resilient

and better able to cope with disasters than are younger people (Brown, 2007).

However, many older persons do need special attention to their mental health. These can be categorized in the following ways:

1. On the basis of their psychological history and current psychological needs, including whether they were receiving mental health services prior to the disaster
2. On the basis of where they live

The role and availability of case management varies depending on these factors.

Psychological History and Need

Some older persons have significant mental problems prior to a disaster for which they may or may not have been getting treatment, including the following:

- Dementia (usually Alzheimer's disease)
- Long-term psychiatric disabilities such as schizophrenia or treatment-refractory affective disorders
- Recent disorders resulting in ongoing mental disability
- Long-term or recent mental disorders interfering with social functioning but not severely disabling
- Lifelong or late-life substance use problems, especially overuse of alcohol and prescription and over-the-counter medications
- Emotional difficulty managing the developmental transition to old age

Some older persons experience psychological difficulties in the aftermath of a disaster, including the exacerbation of mild mental problems that have existed, often untreated, for years, including the following:

- Acute psychosis
- Anxiety states
- Depressed mood or diagnosable minor or major depression
- PTSD
- Difficult-to-manage stress reactions

- Increased substance abuse, especially alcohol abuse
- Normal emotional turmoil

Residential Status

The need for, and nature and availability of, case management services varies depending on where people live, what supports and services are there, and whether case management is built in or not.

Community-Dwelling Older Persons

Most older persons live independently in the community in their own homes.

Although upwards of 30% of older persons live alone, this is not a problem for many because they have significant personal relationships and engage in satisfying activities—vocational, communal, recreational, and social. Some, however, live in *social isolation* without relatives or friends with whom they have regular contact. Disasters pose serious problems for those who are socially isolated.

Many, probably most, older persons who live independently in the community get no special assistance in the home other than ordinary domestic help or minor support from family.

However, quite a number of older persons—a higher and higher percentage as they age—are disabled to some degree and need, and sometimes get, support in the home, mostly from family caregivers with whom they often live. Often family caregivers can themselves benefit from supportive care because they are at high risk for depression, anxiety disorders, and physical illness.

Older persons may also get help in the home from personal care workers, home health workers, case managers from the aging services or mental health systems, or elder care managers. Sometimes, disabled older persons get mental health treatment in their homes.

Naturally Occurring Retirement Communities (NORCs)

Many older persons live independently in apartment buildings or neighborhoods in which a majority of residents are older persons. Some of these communities have supportive service programs (NORC-SSPs), which can include case management as well as health services and volunteer, recreational, and social activities.

Older Persons in Special Housing

A relatively small proportion of older persons live in settings that specialize in serving people with mental or physical disabilities or who are older and need some degree of assistance. In some cases, such as community residences for people with mental illness or mental retardation, older persons have lived in these settings much of their lives. In other cases, older persons have chosen, or been forced, to move to these settings. Older persons live in the following settings:

- Senior housing, which provides apartments for independent living but often includes on-site social and/or medical services; many of these housing complexes are subsidized by governmental entities
- Supportive housing, which is designed for people with low incomes, histories of homelessness, or serious illnesses or disabilities such as HIV/AIDS or mental illness
- Mental health housing, which is funded and overseen by the mental health system and includes supervised group residences, apartments with visiting case management, and single-room occupancy dwellings with on-site supports
- Housing for people with mental retardation or developmental disabilities, which includes intermediate care facilities, community residences, and supported apartments
- Residences for older persons with substance abuse disorders
- Residences for people who cannot live independently but do not qualify for nursing home care, which provide a place to sleep, meals, and very limited case management services often combined with on-site or nearby mental and physical health services
- Nursing homes, which provide skilled nursing care 24 hours per day, 7 days per week usually in institutional settings but sometimes in smaller, more homelike facilities using a *greenhouse*¹ or similar model

CASE MANAGEMENT ROLES IN DIFFERENT STAGES OF RESPONSE

Preparatory Stage

The stage of preparing for disasters is divided into two parts—the period of preparing for disasters generally and the period of preparing after it

is known, or is strongly believed, that a disaster will strike soon, such as when a hurricane is on the way.

General Preparation

Every community should have a disaster plan that includes identifying and assigning responsibility for helping vulnerable older persons in the community. This plan should include outreach to warn these individuals and save them if necessary. It should also include shelter, food, medical care, and so forth. It is particularly important to have a plan to retrieve or replace critical medications. The plan should also include identifying older persons with current mental problems and anticipating that some older persons will develop mental health problems. Cadres of people need to be trained to provide intervention in disasters and should include people trained in case management. Necessary skills include engagement, assessment, triage, how to develop a service plan, knowledge about resources and how to access them, negotiation on behalf of clients, and how to provide mental health education and emotional support. Connection to case management services and case management services themselves should be available via telephone and Internet as well as face-to-face.

In addition, service programs, whether community based or residential, should have specific plans for how to help the people for whom they are providing services. Responsible case managers should be designated for those who do not currently have case managers, and case managers should be trained and prepared to do assessments, to develop service plans, to provide concrete services, to link to services and benefits, and to provide emotional support. A backup plan is also needed because some assigned case managers will be directly affected by the disaster and will not be available to help their clients.

It is important not to assume that older persons who need help will welcome it. Help may be rejected for any number of reasons such as fear of where one will be taken, suspiciousness sometimes of paranoid proportions, desire for stability, or desire to stay with one's pets or with the important material things accumulated over a lifetime such as family photographs. Disaster planning needs to anticipate such problems.

Preparation for a Specific, Anticipated Disaster

Once a disaster is anticipated, the people who are expected to provide services, including case managers, need to be mobilized, reminded of their

responsibilities, and asked to begin the process of preparing those for whom they are responsible for during the disaster. This often will include outreach, making an effort to persuade those who are living independently to take appropriate precautions, providing them with transportation to safe places, assuring they have adequate provisions if remaining in their homes, providing emotional support if they need it, and so forth.

Similar arrangements need to be set in motion for those who live in special residential settings.

Crisis Stage

Disaster Response Centers

In the aftermath of severe disasters—when people lose their homes and electricity and telephone service may be disconnected, leaving them without food to eat, clean and dry clothing, and so forth—much of the immediate response will be provided in service centers and temporary shelters operated by the Red Cross; other not-for-profit organizations; or local, state, or federal governments. Crisis teams will be assembled in these settings, and one of the central functions of these teams is helping people get what they need to survive and begin to reconstruct their lives—case management by any other name. For everyone whose life has been disrupted by a disaster, recovering stability is a critical need. This is particularly true for people with pre-existing mental conditions such as dementia, schizophrenia, serious depression, or mental retardation, who tend to become extremely anxious and confused when their routines are disrupted.

The job of the case manager in these settings includes the following:

- Rapid assessment
- Triage
- Arranging immediate services
- Determining eligibility for services and benefits
- Providing information and referral
- Providing immediate linkage to needed services
- Assisting to get information about missing family members and facilitating family reunification
- Providing emotional support
- Providing education for parents and grandparents about how to manage their own and their families' emotional distress.

It is generally believed to be important to combine emotional support services with the provision of concrete services rather than to refer people to a mental health professional in a separate part of the emergency response center or shelter. In general, people do not want and do not need to have separate psychological services during the phase of immediate crisis. What is important to them is getting their lives together. Treatment can wait.

The exception is those people exhibiting severe psychological symptoms, some of whom will need immediate outpatient treatment or to be hospitalized. One of the key roles of case managers is to determine who needs treatment and who can wait until a later phase. When treatment is necessary, case managers need to not just make a referral but also provide a real linkage to assure those who need treatment get it. This is often easier to arrange for people who need inpatient care than for those who need outpatient care. Those who provide mental health treatment in the community may have had their services disrupted, and many of them may have become the temporary case managers helping manage the immediate crisis. In some communities, telephonic and Internet services are available to connect people to the care they need.

Older Persons Who Remain at Home

Many older persons who are adversely affected by disasters will not go to disaster relief centers or shelters. They will remain in their own homes unless it becomes absolutely impossible, even at the risk of their own lives. For these people, outreach is critical. Case managers need to be available to go into their homes as soon as possible. Arrangements also have to be made for animal companions. The preceding section describes the function of case managers.

Older Persons in Special Housing

Hopefully, residential settings for older persons are adequately prepared to protect and meet the basic needs of their residents. The case management role in these facilities is essentially the same as that described earlier. However, all too frequently plans break down. Improvisation becomes necessary—an important skill of case managers in these kinds of situations.

Reconstruction Stage

Community-Dwelling Older Persons

Once survival and basic safety are assured, the stage of immediate crisis response phases into the stage of reconstructing lives and includes the following steps:

- Returning to, and often rebuilding, existing housing or arranging for new permanent housing
- Establishing a stable, temporary, or permanent source of income through income maintenance programs, work, or a legal settlement
- Re-establishing family relationships if families have been separated
- Reconnecting or establishing new ties with a community

These needs apply as much to community-dwelling older persons as to younger people because older persons need to re-establish relationships and satisfying activities. In addition, older persons are often concerned about the well-being of younger family members, including their children and grandchildren. Often they want to know how to help.

For this reason, as well as because they may have difficult emotional reactions themselves, mental health education and brief counseling can be very useful for older persons who were not receiving mental health services prior to the disaster and who do not need mental health treatment postdisaster.

Case managers, if they are available, can help older persons during this stage to achieve all the goals noted previously. In addition, they can be extremely helpful in assessing the need for more intensive mental health services, providing or linking older persons to information and referral services, linking them to needed services, following up to assure they get the services they need, coordinating care, and arranging affordable treatment or financial help to cover the costs of treatment. For example, after September 11, 2001, and after Hurricane Katrina, the Red Cross funded mental health benefits programs through which treatment could be provided at no cost to the patient.

For older persons who were receiving mental health services prior to the disaster, it is important their service providers provide a case management function focused on assuring the concrete needs of their clients

that were created by the disaster are adequately addressed. Treatment without attention to achieving some stability will probably be far less effective than treatment with case management supports as needed.

Older Persons in Special Housing

The key need for older persons in special housing is to regain the stability they had before the disaster. Case managers in these facilities need to focus, therefore, on the issues noted earlier. However, often their case-loads are so large that it is extremely difficult for them to adequately provide the kinds of case management services described in this chapter.

Long-Term Mental and Substance Use Disorders

After the phase of reconstruction, when life has stabilized for almost all people adversely affected by the disaster, some people, including some older persons, continue to have mental or substance use disorders related to the experience of the disaster. Some of these people had clinically significant disorders prior to the disaster that were exacerbated by the experience. Others developed disorders in the aftermath of the disaster. Some were receiving care and treatment prior to the disaster; some began treatment after the disaster. Others were not and continue to not be in treatment.

Case managers can help those who are not in treatment and who deny their need for treatment by offering valued concrete services. If properly trained, they can identify those who have clinically significant mental or substance use disorders and provide mental health education and emotional support; they may be able to persuade their patients to seek diagnosis and treatment.

For those who are in treatment, case managers can provide the full range of services typical of case management including help with concrete needs, access and linkage to needed services and benefits, service coordination, crisis intervention, and so forth.

For older persons with co-occurring mental and physical conditions, case managers can play a vital role by assuring their clients follow up on treatment regimens and lifestyle changes such as smoking cessation, diet, and exercise, which can be essential to improving and maintaining physical and mental health.

WHO PROVIDES CASE MANAGEMENT?

During disasters, FEMA, state and local emergency services, the Red Cross, and other disaster-oriented not-for-profit providers share primary responsibility for organizing disaster relief. Public health, mental health, substance abuse, and aging services systems are also involved in the provision of vital services, including case management. In addition, the private sector plays an important role during disasters through employee-assistance programs, managed behavioral health care, and elder care management.

In each system, case management is conceptualized differently, and the capability and capacity of their case managers vary.

Disaster response organizations have short-term responsibilities. Although they sometimes mount or pay for fairly sophisticated case management services that include responses to ordinary mental health needs, these services are time-limited and are not designed for people who need mental health or substance abuse treatment. They are therefore of limited value to people—older or younger—with long-term mental health needs.

In the health and mental health systems, case managers tend to have very large caseloads and serve administrative functions for home-based service providers and residential services rather than provide the kind of case management functions described in this chapter. Unfortunately, public health and mental health systems throughout the United States pay little attention to the needs of older persons. As a result, case managers, even those who are mental health professionals, are generally not trained or skilled regarding the mental health and substance use problems of older persons.

Employer-based mental health services such as employee-assistance programs and managed behavioral health organizations usually attempt to be helpful to employees and their families during a disaster. Employee-assistance programs are designed to help people to identify their needs and get access to needed services. During a disaster, they and managed behavioral health organizations (MBHOs) sometimes also offer debriefing services, mental health education, and enhanced access to outpatient mental health treatment services. These services can be useful to older persons in the workforce and to those who are being cared for by family members in the workforce. But they are not essentially designed to serve this population.

Elder care management is a service generally available only to those who can afford to pay for it. Some not-for-profit organizations provide these services on a sliding scale. Case managers for older persons are

expected to visit people in their homes and work to help them remain in their homes. They are expected to take a high degree of responsibility for their clients, help them get access to the services and benefits they need, and attempt to coordinate services. They usually have some knowledge about physical health care, but generally they are not trained or skilled in identifying or dealing with people with mental or substance use disorders.

Elder care managers generally take full responsibility for aiding older persons with disabilities. In essence, they substitute for family caregivers to the extent to which this is possible. During a disaster, elder care managers should take responsibility for providing the full range of case management services described in this chapter.

POLICY CONSIDERATIONS

The roles of case management for older persons with mental and substance abuse problems during a disaster that have been described in this chapter are, unfortunately, most often unfulfilled. Disaster plans, to the extent to which they exist at all for people with mental illness, tend to neglect older persons; plans for older persons tend to neglect mental and substance use disorders. In addition, there is a critical shortage of personnel prepared to provide case management or other services for older persons with mental or substance abuse disorders. In general, the underlying missions and visions of the service systems through which case management is provided are too limited to give priority to building a cadre of people prepared to provide case management services for older persons with mental health problems in the aftermath of a disaster.

Addressing these shortfalls requires a major reconceptualization of disaster services and of the aging, mental health, and health services systems, which currently neglect the mental health and substance use problems of older persons not only in disasters but also in their day-to-day functioning.

In addition, given the lack of literature in this area, there is a great need for research on the most effective models of case management for older persons in disasters.

NOTE

1. The greenhouse model is a nursing home model that alters the physical environment, the staffing model, and the philosophy of care to make nursing home life more

home-like. The homes have, at most, 10 older adults, each with private rooms and bathrooms and a shared communal space.

REFERENCES

- Beswick, A. D., Rees, K., Dieppe, P., Ayis, S., Goberman-Hill, R., Horwood, J., et al. (2008). Complex interventions to improve physical function and maintain independent living in elderly people: A systematic review and meta-analysis. *The Lancet*, *371*(9614), 725–736.
- Brown, L. (2007). Issues in mental health care for older adults after disasters. *Generations*, *31*(4), 21–27.
- Geriatric Mental Health Alliance of New York. (2007). *Geriatric mental health policy: A briefing book*. Retrieved January 15, 2009, from http://mhaofnyc.org/gmhany/GMHPolicyBriefingBook12_2008.pdf
- Kessler, R., Sonnega, A., Bromet, E., Hughes, M., Nelson, C. B., & Breslau, N. (1999). Epidemiological risk factors for trauma and PTSD. In R. Yehuda (Ed.), *Risk factors for posttraumatic stress disorders* (pp. 23–60). Washington, DC: American Psychiatric Press.
- Marshall, M., Gray, A., Lockwood, A., & Green, R. (1998). Case management for people with severe mental disorders. *Cochrane Database of Systematic Reviews*, *2* (Art. No. CD000050).
- Marshall, M., & Lockwood, A. (1998). Assertive community treatment for people with severe mental disorders. *Cochrane Database of Systematic Reviews*, *2* (Art. No. CD001089).
- Naleppa, M. J. (2006). Case management services. In B. Berkman (Ed.), *Handbook of social work in health and aging* (pp. 521–528). New York: Oxford University Press.
- Roberts-DeGennaro, M. (2008). Case management. In T. Mizrahi & L. E. Davis (Eds.), *Encyclopedia of social work: Vol. 1* (20th ed., pp. 341–347). Washington, DC: NASW Press.
- Rose, S. M., & Moore, V. L. (1995). Case management. In R. L. Edwards & J. G. Hopps (Eds.), *Encyclopedia of social work* (19th ed., pp. 335–340). Washington, DC: NASW Press.
- Rosen, A., & Teesson, M. (2001). Does case management work? The evidence and the abuse of evidence-based medicine. *Australian and New Zealand Journal of Psychiatry*, *35*, 731–746.
- Smith, L., & Newton, R. (2007). Systematic review of case management. *Australian and New Zealand Journal of Psychiatry*, *41*, 2–9.
- Vanderplasschen, W., Wolf, J., Rapp, R. C., & Broekaert, E. (2007). Effectiveness of different models of case management for substance-abusing populations. *Journal of Psychoactive Drugs*, *39*(1), 81–95.