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(Inside front cover)

Psychosocial Issues for Older Adults in Disasters

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“Senior citizens today are a sturdy, reliable generation. We’ve proven time and again our ability to survive everything from the Great Depression to world wars and the threat of nuclear holocaust. We’ve lived through droughts, floods, and all sorts of other natural disasters. We’ve given birth, supported our families, and stood by our loved ones through personal and financial losses. We are proud, tough, and resilient.”

“Voices of Wisdom: Seniors Cope with Disaster” Videotape
Project COPE, 1992

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FOREWORD

The development of this publication reflects a new and important partnership between the Center for Mental Health Services (CMHS) and The National Council on the Aging (NCOA), in bringing an important resource to communities to improve crisis counseling services to older adults following disaster.

Since its founding in 1950, NCOA has sounded two fundamental themes: first, we must recognize that new needs take shape as older populations continue their dramatic rise in numbers and years; second, we must recognize that the longevity revolution makes it essential that we tap the *vitality* and *strengths* of our older generations for the good of aging individuals and for our entire society.

Response to disaster raises similar themes. We must acknowledge that certain vulnerabilities exist among many elders and that these vulnerabilities are likely to intensify at times of disaster and during the often lengthy recovery process. Since 1974, CMHS, and its predecessor agency, the National Institute of Mental Health, has administered the **Crisis Counseling Assistance and Training Program**, in coordination with the Federal Emergency Management Agency, which provides supplemental funding to States for short-term crisis counseling services to victims of Presidentially declared disasters. The types of crisis counseling services provided under the program include outreach, education, community networking and consultation, public information and referral, and individual and group counseling. Tailoring these services, with specialized disaster mental health interventions and strategies, to meet the needs of special populations such as the older population is the primary focus of the Crisis Counseling Program.

This year the Crisis Counseling Assistance and Training Program marks its twenty-fifth anniversary. One of the lessons learned over the years is the resiliency of disaster victims, especially older adults. Older persons have much to offer in times of crisis. Their perspective, their life skills, and their compassion have been tempered over decades. As this guide points out, they are uniquely able to assure others, when times are difficult, that “this, too, shall pass.”

This publication is intended to provide disaster mental health and human service workers, service providers, program planners, administrators, as well as care givers, and older persons themselves with the tools and knowledge to appropriately respond to the needs of older adults in times of disaster. We also hope that this guide will provide a better understanding of the strengths and contributions of the older population and how best to use their experience and wisdom in disaster mental health response and recovery efforts.

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Participating in that call were **Ms. Ridley, Robert Benedetto, D.P.A.** of the Ventura County (CA) Department of Mental Health, **Charles G. Cook, L.S.W.** of the Minnesota Department of Mental Health, **Linda Fain** of the California Department of Mental Health, **Robert Hammaker, Ed.D.** of the Alaska Department of Mental Health, **Michael Novinski, M.P.A.** of the Illinois Department of Mental Health, **Anthony Speier, Ph.D.** of the Louisiana Department of Mental Health, **Laurent Javois** of the Virgin Islands Department of Mental Health, **Ms. McNeill** of NCOA, and **John Shorty**, then with NCOA.

Mr. Novinski also provided helpful information in later interviews, as did **Dr. Benedetto** and **Mr. Javois**. **Ms. Fain**, despite disaster situations that arose in California early in 1998, managed to provide helpful informational material.

Valuable assistance also came from agencies related directly to aging. Outstanding in this regard was **Greg Wilder**, Senior Aging Specialist for the U.S. Administration on Aging, Region VII, based in Kansas City. He had a major role in the development of the *Disaster Preparedness Manual for the Aging Network* commissioned by the U.S. Administration on Aging and the Kansas Department on Aging (the manual is briefly described in Appendix I and is referenced often in the text). Another major source of help from the aging "network" was **Bert Weber**, Disaster Coordinator for the Illinois Department on Aging. He gave many insights into the all-out response in that state to the floods of 1993.

Moya B. Thompson of the Office of the Assistant Secretary, U.S. Administration on Aging, made important suggestions about information sources.

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OVERVIEW

Older Americans, who almost by definition are survivors, may nevertheless be especially hard hit by disasters arising from natural and human caused disasters.

Their vulnerability may be caused by many factors, including:

- Physical or emotional frailty arising in the later years, particularly among the so-called “old-old,” or those well beyond age seventy-five;
- Acute late-life feelings of personal loss intensified by disaster damage of property that is often of great nostalgic or economic importance; and
- Accidents of geography that intensify disaster’s impact on concentrations of older persons. The great Midwest floods of 1993, for example, affected six of the ten states with the highest percentage of persons aged sixty-five or above, and eight with the highest percentage of eighty-five and older persons (National Council on the Aging, 1993). When an earthquake struck the Northridge and Simi Valley areas near Los Angeles, it caused extensive damage in mobile home parks that housed high percentages of older persons (Project Cope, 1992a). When Hurricane Elena threatened Pinellas County, Florida, in 1985, 1,860 nursing home patients were evacuated from nineteen nursing homes (Magnum & Kosberg, 1989). Of the seventeen persons who lost their lives when tornados struck Sedgwick and Butler Counties, Kansas, in 1991, seven were past age sixty-five. A couple, ages eighty-five and eighty-nine, died before they could get to a storm shelter (Inglish, 1991).

Another kind of vulnerability occurred during ice storms in the northeast early in 1998, when power and home heating failures intensified susceptibility to hypothermia among elders, increasing a sense of isolation and potential hopelessness (Nelson & Ridley, 1998). Intense, prolonged heat waves, on the other hand, can cause widespread hyperthermia, another condition of special consequence to older persons (Abrams, Beers, & Berkow, 1995).

Deaths, injuries, and losses are expected in disasters; so are enormous efforts to mitigate suffering, destruction, displacement, and lingering

trauma. As indicated, older persons bear a disproportionate share of such impacts, and are likely to require tactful understanding from all who would help them. This guide, therefore, is directed at:

- Health and mental health professionals, who may or may not have experience in treating or assisting elders on a regular basis or at times of extreme stress, such as disasters and their aftermaths;
- Temporary paid or volunteer emergency workers;
- Family members, who often are caregivers for elders, either at close range or long distance, and who may require help if they are to continue to provide their essential assistance to fathers, mothers, or other elder kin; and
- Professionals who work primarily in aging, either as service providers or in public agencies that receive funding through the Older Americans Act (OAA). A significant part of the information in this publication has been provided by personnel from regional, state, or area agencies on aging (AAA) that are part of an aging “network” that has developed since enactment of the OAA in 1965.

No part of this publication is directed solely at one of the groups described above. Admonitions directed to health practitioners, for example, can also inform others who want to help, including family members, in the many tasks that are needed if assistance is to be effective.

As indicated in this guide’s title, its prime thrust is to illuminate psychological or emotional difficulties that may arise within older populations during and after disasters. This manual, however, would be incomplete if it did not explore the “social” problems likely to affect emotional equilibrium.

Example: An older person who lives alone may be plunged into despair or apathy if it appears that disaster help is available only at distant emergency centers; direct outreach may be the only way to connect that person with services that not only meet essential needs, but assure that the person is not forgotten and alone.

How This Guide is Organized

The Nature of Disasters and Response to Them

Those who work with elders to combat disasters’ effects need a working knowledge of the forms that such devastating events can take, the phases that are typical, and the human responses likely to occur in each

phase. Chapter One explores these issues and concludes with an analysis of ways in which disaster mental health services differ from those in “normal” times. It draws primarily upon research and experience from Federal disaster management and mental health agency sources.

Who Are “The Elderly”?

This guide recognizes that the tens of millions of older persons grouped under the general category of “sixty-five and older” in our nation are highly diversified *individuals* each with a personal history, capacity, and outlook. Attention is given in Chapter Two, therefore to: 1) the later years of life, not as an end state, but as a phase of life span development; 2) the widely varying circumstances of our older population; 3) the array of emotional difficulties that often arise with age, with some discussion of positive interventions immediately after disasters and later; and 4) the solid contributions this “at-risk” part of our population can make for the general good during widespread emergencies.

Older Persons in Disasters

Older adults are classified in disaster mental health training literature as a special population or an “at-risk” group. Chapter Three describes attributes that make many older persons particularly vulnerable to effects of disasters. A hearing loss, for example, may cause an older person not to hear what is said in a noisy Disaster Recovery Center (DRC) or shelter. A DRC is a temporary facility established by the Federal Emergency Management Agency (FEMA) to disseminate information on disaster assistance. An ingrained unwillingness to accept “welfare” may cause an elder to reject assistance for which he/she is eligible. To overcome these and other difficulties, medical, mental health, and other disaster workers should be familiar with helping techniques described in this section.

Assistance that is available through the “aging network”—the public and private agencies that provide grassroots services—is described, as is the collaborative action often provided by temporary statewide or regional coalitions of organizations established to deal with disasters.

Family members, including caregivers, can play major roles in ways described in this section, including helping their older family members to be prepared *before* disasters occur. Families can also help by familiarizing themselves with services offered at DRCs and other relief centers to help make certain that their elders have access to these services.

Finally, “In the Aftermath” of Chapter Three shares observations of older persons who have had experience with a major disaster. Their reactions can help guide workers who are attempting to assist others. “Anniversary” events, observing survival of the first year after a disaster, can also evoke introspection and adjustment. This section closes with a discussion of “myths” about aging and disasters that persist despite evidence to the contrary.

The Nature of Disasters and Response to Them

Special challenges may overtake many older persons during disasters, but it must also be recognized that they share common experiences with others. They are affected by the overall intensity and type of catastrophe, the reaction of their community, and the phases that occur during and after the onset. Those who work to help elders recover can be more effective than they might otherwise be, if they are familiar with hard-earned insights into the often predictable impacts of disaster.

Natural disasters occur with or without warning and vary considerably in intensity and type. A major disaster is defined as any natural catastrophe (including any hurricane, tornado, storm, high water, wind driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, snowstorm or drought) or regardless of cause, any fire, flood, or explosion (Appendix C, Glossary of Terms).

The disaster may be catastrophic in scope (having an impact on large numbers of persons or entire communities), tending to unite those affected by them into common efforts not only at time of rescue or relief but during revival. Guilt feelings may arise among those who believe that they failed to take proper precautions or are being punished for violating religious mandates, or "God's Will" (CMHS, 1998 and U.S. Administration on Aging, 1994).

Disasters may be human-caused, often through unforeseen failures or abuse of technology. As Chart One on the next page indicates, emotional responses to human-caused disasters may differ markedly from those likely to arise in natural disasters. An innate tendency to attribute blame to an individual or an organization may complicate efforts to restore emotional equilibrium. In either case—natural or human—origins disasters are usually characterized by:

- widespread destruction of property
- many injuries, often with loss of life

- direct consequences to many persons and their families

In the cases of war or civil disorder, combat-related destruction may be accompanied by widespread despair, loss of financial stability, and neglect of life-sustaining systems including electric power and food supply (CMHS, 1998).

CHART ONE

Natural vs. Human-Caused Disasters

| | <i>Natural</i> | <i>Human-Caused</i> |
|-------------------------------|---------------------------------|--|
| Causes | Forces of nature | Human error, malfunctioning technology |
| Examples | Earthquakes, hurricanes, floods | Airplane crashes, major chemical leaks, nuclear reactor accidents |
| Blame | No one | Person, government, business |
| Scope | Various locations | Locations may be inaccessible to rescuers, unfamiliar to survivors, little advance warning |
| Post-disaster Distress | High | Higher, often felt by family members not involved in actual disaster |

Source: CMHS. Psychosocial Issues for Children and Families in Disasters. A Guide for the Primary Care Physician. Washington, D.C.: U.S. Department of Health and Human Services; Publication No. (SMA) 96-3077, 1996.

Disasters may also be defined in terms of magnitude that will trigger governmental response. FEMA defines disaster as: "An occurrence of severity and magnitude that normally results in deaths, injuries, and property damage and that cannot be managed through the routine procedures and resources of government. It . . . requires immediate, coordinated, and effective response by multiple government and private sector organizations to meet human needs and speed recovery." (See Appendix C: Glossary of Terms.)

It is conservatively estimated that 10 percent of disaster victims suffer adverse psychological effects (National Institute of Mental Health, 1990). For older persons, such effects may be highly varied. Those elders living in their own homes and neighborhoods may face one kind of test, such

as severe and sudden shock from a tornado with little prior notice. Those living in remote rural areas may experience prolonged stress and isolation during periods before and after flooding. Those in nursing homes or other kinds of group facilities may face what has been called “transfer trauma” (see Chapter Three), if they must be relocated.

Phases of Disaster

However much they may vary in terms of intensity and origin, disasters tend to follow certain patterns. In terms of *emotional* reactions of those affected, disaster phases are classified as follows (National Institute of Mental Health, 1983):

Warning and Threat Phase

The warning disaster survivors and communities receive before impact varies by disaster type. Earthquakes tend to strike without warning and the aftershocks intensify the shock and despair. Hurricanes can be unpredictable and change course just before reaching land. Tornadoes are often detected in the early stages, but exactly where they will touch down is unpredictable. In contrast, disaster survivors may receive ample warning of pending floods and storms. When there is sufficient warning, evacuation and preparedness activities may create anxiety for older adults with limited mobility or available transportation.

Impact Phase

Reactions to the impact of the disaster depend on warning and preparedness activities, the level of destruction, and the success of the local and state emergency response. The responses of this phase range from confusion and disbelief to action, but panic is rarely expressed.

Rescue or Heroic Phase

At the time of disaster and soon after, people who have experienced the unexpected and traumatic work together to save lives and property. They have experienced the possibility of death, intensifying their concern about the fate of others. Still, more trauma may come. Excitement and anticipation are likely to be high.

This phase, however, is also likely to be a time of shock or denial, shielding the person from intense emotions. For those who have not lost

loved ones, it may be a period of euphoria or boundless altruism. In either case, it is hardly a time for counselors to probe for more deep-rooted emotional response to trauma (CMHS, 1994).

The heroic phase should include mobilization of workers and volunteers needed for outreach to older persons, who for one reason or another may not be able to make their way to shelters.

Remedy or Honeymoon Phase

For a brief time, perhaps one week to several months, those who have experienced disaster are likely to share feelings of common purpose and mutual support engendered at least in part by public and private response to their needs. They foresee early return to "normal," even as they more fully assess the damage done to property and living patterns.

Inventory Phase

This "inventory phase" is likely to be a time when disaster survivors are more interested in discussing their thoughts about details of the event rather than exploring their feelings (CMHS,1994). It should be remembered that older persons are likely to be deeply affected by the loss of property including homes, treasured possessions, and means of mobility.

HOW NEEDS MAY CHANGE AS ATTITUDES CHANGE

"A 76-year-old woman, widowed a year before a severe storm ravaged her beach-area home, at first exhibited severe emotional reactions in dealing with agencies. This occurred, she said, 'because I don't have a man.' She was then buoyed by a mental health professional's success in reuniting her with a large local family and many good friends. Six or so visits later, however, she again became agitated by a delay in her support payments. Finally, with insightful helps from the same counselor, she resumed progress to emotional stability" (Cohen, 1990, page 16).

Disillusionment Phase

Disillusionment may set in within several months or even after a year or more, and it is likely to be especially intense among those elders who feel they have not fared well in dealing with official attempts to help

them. Troubled outlooks may be caused by snags in official disaster response, mistrust caused by perceived unevenness of relief, and a feeling that those affected by the disaster are “on their own” even before fundamental problems have been dealt with. Victims are likely to put their individual needs first as they seek to resume “everyday” life. Counselors seeking to help them may find it an appropriate time to listen carefully to their accounts of frustration and experiences (CMHS, 1994).

Reconstruction or Recovery Phase

Though support systems may have helped survivors cope with the most immediate needs and emotional responses, eventually victims are likely to recognize that they will have to take the lead in rebuilding homes, businesses, and life patterns. Many older persons may regard these tasks as too formidable or useless to be taken on. Chapter Three describes, for example, the frustration often expressed by older persons when told of complex procedures needed to qualify for Federal or state disaster relief assistance. Prolonged feelings of this kind can lead to apathy and even depression. Negative consequences during this reconstruction phase, as will be discussed later, can be countered in part by disaster “anniversary” observances at which participants can vent negative or other observations. In doing so, they often have new realizations about difficulties they have shared with others.

REWARDS OF SERVICE DURING DISASTERS

Many temporary and volunteer disaster workers describe the experience as one of the most rewarding of their lifetimes. “Giving a hand” can result in memorable satisfactions when those helped begin to act positively instead of being overwhelmed by wrenching disruptions. Professional mental health and disaster workers, of course, experience the similar gratification from what has been described as a “sense of true community” by Dr. Brian W. Flynn, when serving as Chief of Emergency Services and Disaster Relief Branch, Center for Mental Health Services. Called to Oklahoma City after the bombing of the Alfred P. Murrah Federal Building, he later wrote: “Most times, when I have the experience in best focus and perspective, I am filled with a profound sense of gratitude and privilege. I am ready to move on, feeling both the obligation and hope that comes with the gifts this experience has given me. I vow to always remember, and acknowledge, the terrible price paid, by so many, for these gifts” (Flynn, 1995, p. 166-170).

Disaster Mental Health Services Are Different

Mental health experts who have studied research data and findings from actual field experience maintain that disaster mental health services must, to be effective, differ from traditional practice patterns. An adaptation of one such set of observations (CMHS, 1994) follows:

- ***No one who sees a disaster is untouched by it.***

Strong reactions may overwhelm even those who have not had personal loss, causing a need for education about the effect of disasters on the community at large.

- ***There are two types of disaster trauma.***

Individual trauma may be defined as “a blow to the psyche that breaks through one’s defenses so suddenly and with such brutal force that one cannot react to it effectively.”

Collective trauma is “a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of community.” This kind of trauma is often less apparent to mental health clinicians. Recognizing the emotions that arise when the community around them still shows signs of devastation is important.

- ***Most people pull together and function during and after a disaster, but, in time, their effectiveness is likely to diminish.***

High levels of activity are likely in the “heroic” and “honeymoon” phases, but stress and fatigue are likely to set in later, causing short-term memory loss, confusion, and indecisiveness.

- ***Disaster stress and grief reactions are normal responses to an abnormal situation.***

Post-traumatic stress and grief reactions should be expected as responses to extraordinary situations, but are likely to be transitory.

- ***Many emotional reactions of disaster survivors stem from problems of living caused by the disaster.***

Widespread disruption of many aspects of life—locating family members, loss of shelter and food, filling out forms—will intensify other disturbed responses.

■ ***Disaster relief procedures may be confusing for the disaster survivor.***

Loss of self-esteem and feelings of anger or helplessness often result when disaster victims wend their way through Federal, state, and non-profit agencies' disaster assistance programs that are functioning under extremely unsettled circumstances. Mental health staff can help by assuring traumatized, often displaced, persons that some confusion is to be expected and by providing information on the work of specific agencies.

■ ***Most people do not see themselves as needing mental health services following disaster and will not seek out such services.***

Very effective mental health assistance can often be provided while the mental health worker is helping survivors with specific tasks that meet needs. Direct offers of mental health help are likely to be rejected by the lay persons who equate "mental health" services with being "abnormal."

■ ***Survivors may reject disaster assistance of all types.***

Placing their faith in their personal self-reliance and skills, people may reject all assistance as they seek to restore order in their own lives. Disdain of "welfare" (especially strong among older persons) may cause refusal of help designed to be available to all who need it.

■ ***Disaster mental health assistance is often more "practical" than "psychological" in nature.***

As mentioned earlier, helping survivors with problem-solving and decision making is often an effective way to achieve and sustain emotional stability. For serious reactions including severe depression or disorientation, the worker's best assistance may be to link the person with an appropriate treatment resource.

■ ***Disaster mental health services must be uniquely tailored to the communities they serve.***

Urban, suburban, and rural areas have different resources, needs, traditions, and values. Ethnic and cultural traditions must also be recognized.

- ***Mental health staff need to set aside traditional methods, avoid the use of mental health labels, and use an active outreach approach to intervene successfully in disaster.***

Mental health workers seem less threatening when they refer to their services as “assistance,” “support,” or “talking.” They must go out to community sites where survivors are attempting to cope with loss and uncertainty.

- ***Survivors respond to active interest and concern.***

They usually will be eager to talk about their experiences when approached with warmth and genuine interest.

- ***Interventions must be appropriate to the phase of the disaster.***

Mental health workers should be familiar with the phases of disaster and the differing psychological and emotional reactions likely to accompany each. Denial and shock during early disaster phases, for example, often help survivors to postpone or even alleviate more extreme emotions. Probing for details of their disaster experiences at such times is likely to be counterproductive. On the other hand, later in the aftermath of a disaster, people may be willing and even eager to talk about their reactions to extreme stress.

- ***Support systems are crucial to recovery.***

Helping families and friends reunite is one way to assure mutual support. For those with limited access to kin and acquaintances, more formal support groups can help assure them that they are not alone or abnormal in their reactions.

2

Who Are “The Elderly”?

Researchers in early studies on aging tended to focus on older persons who were institutionalized or who were being treated elsewhere for diseases associated with “old age.” A widespread impression of older persons as generally ill or frail therefore took shape. Only after several decades of such stereotyping did it become evident that “normal” or “healthy” aging should receive at least equal attention in research literature and in medical and long-term care practice.

What has emerged since then is mounting evidence not only of the prevalence of active, fulfilling years among persons sixty-five years and older, but of sustained ability to improve physical capacity, outlook, and achievement (Inglis, 1991).

It has also become commonplace for authorities on aging to challenge the assumption that persons above a given age can be regarded as a “group” with similar attributes and lifetime outcomes. In fact, the observation is made more frequently in works on aging that differences among individuals are more likely to increase, rather than decrease, as they grow older. For example, “Personalities and physical capacities become more distinct among aging individuals. It is important to recognize there are few blanket statements that can be made that will apply to individual older persons. This is as valid in disasters as it is in other situations” (Thompson Interview, 1998).

Who Is “Old”? What Is Aging?

The nation’s population of older persons is specifically served by a Federal agency called the Administration on Aging (AoA). If any governmental unit has a need to define “aging” or “older persons,” it is the AoA. The Federal legislation specifies that AoA services be provided to persons

of age sixty or above. Yet, in one AoA publication (1994) the following language is used:

"For our purposes . . . we will refer to the 'aging populations.' For us, this will mean people who are at least sixty years of age, and who generally are sixty-five years of age, or more. But beyond that distinction . . . it is difficult to generalize" (p. 4).

One reason for this difficulty is that people age in a continually changing society. In the words of a National Institute on Aging publication (1990):

People born in 1910 have grown old—biologically, psychologically, and socially—in ways that differ markedly from those born in 1940 or 1970; and the future aging patterns of those born today will predictably be still different. These differing patterns cannot be explained by evolutionary changes in the human genome, which remains much the same from cohort to cohort (Introduction, p. III).

The tendency for dissimilarity, rather than similarity, to increase as persons grow older has great significance in disaster relief situations. There is a definite need to meet the needs of older persons who require special help, as well as to make an effort to utilize the strengths and skills of the many older persons who can contribute (AoA, 1994).

Technology and improved public health measures have had substantial impact on the elderly populations, not only in terms of increase in longevity, but in the prospect of diminished disability, proportionately, among the older population. Chart Two displayed on the following page indicates now, at the turn of the century, and beyond most persons above age sixty-five will continue to reside in the community. Relatively few will be institutionalized, even as the growth of the eighty-five plus population continues a dramatic upward surge.

These findings, and decades of other research, have led most gerontologists to challenge the doctrine of inevitable aging decline. Indeed, much scholarly attention is being devoted to the factors likely to result in "successful aging," described by Rowe and Kahn (1997), a research team, as: "multidimensional, encompassing three distinct domains: avoidance of disease and disability, maintenance of high physical and cognitive functions, and sustained engagement in social and productive activities" (p. 443).

The tendency to regard aging in a more positive light than in the past is also demonstrated by the increasing use of the word "longevity" in

statements emerging from the AoA, as if to remind the nation that aging is necessary if lives are to become longer (Takumara, 1998 and Thompson, 1998).

SIXTY-FIVE PLUS IN THE UNITED STATES

- *During the 20th century the number of persons sixty-five and above has tripled. They constituted almost 14 percent (33.5 million) of the nation's population in 1995.*
- *The "oldest old"—those aged eighty-five and over—increased by 274 percent between 1960 and 1994. They numbered three million in 1994, making them 10 percent of the elderly and just over 1 percent of the total population.*
- *Elderly women outnumbered elderly men in 1994 by a ratio of three to two, twenty million to almost fourteen million.*
- *About 31 percent of all elderly lived alone in 1990, and four-fifths of these were women.*
- *The poverty rate rises with age. In 1992 it was 11 percent for sixty-five to seventy-four year olds but 16 percent for those aged seventy-five or older. Rates for elderly Blacks were 33 percent, and for Hispanics, 22 percent.*

Sources: "Sixty-Five Plus in the United States." Washington, D.C.: Bureau of the Census Statistical Brief, May 1995, and "Aging into the 21st Century," Washington, D.C.: National Aging Information Center, Administration on Aging, 1996.

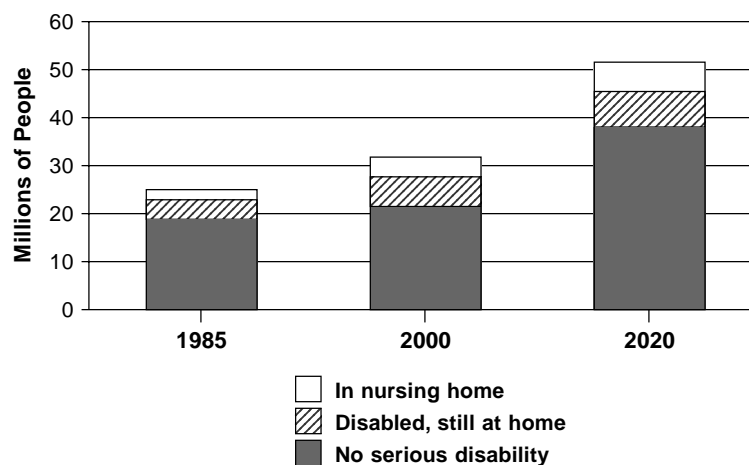
Aging as a Developmental Stage

Increasingly, the gerontological literature recognizes the importance of life experiences that begin after age sixty-five. One influential concept was advanced by E.H. Erickson's (1959) "Eight Stages of Life," which includes a late stage of maturity and self-analysis. The older adult, according to Kastenbaum's (1993) interpretation of Erickson's work "is likely to reflect on the total shape of his or her life in attempting to master the final crisis (death) and thereby achieve the final reward: wisdom" (p. 13).

Erickson himself used the term “ego integrity” to signify full unification of the personality, as opposed to despair caused by inability to reach that state. Central to achieving integrity is “an ability to introspect about the gradual evolution of life events and to appreciate the significance of each event in the formation of the adult personality” (Newman, 1987, p. 552).

CHART TWO Disability Among Older People

PROJECTIONS FOR THE POPULATION 65 AND OLDER



Source: Kenneth Manton, Duke University

This means not only overcoming negative emotions that may come with role loss (as in the transition from full-time employment to partial or complete retirement), but taking on “tasks” that may pose greater challenges “than those faced in any other stage of the life cycle” (Turner, 1986, p. 314).

These “tasks” include positive adjustments to deal with probable declines in physical strength and health, likely changes in financial status, loss of spouse or other family members and friends, new social roles including affiliation with one’s age group, and establishing satisfactory living arrangements (Turner, 1986). Not the least of these adaptations is the development of a point of view about death in terms that recognize its inevitability, but that are comforting rather than fearsome (Newman, 1987).

Formidable as the tasks may be, there are rewards that come with age, including grand parenthood and possible new eminence in endeavors that formerly might have been blocked by career demands.

The paramount goal is acceptance of one's life. Robert Butler, former Director of the National Institute on Aging (1991) has observed, "Old age, in its best sense, can mean enjoyment or something closer to the finished product—a far more mature, complex human being" (p. 67). That is, a human being who is on her or his own terms.

Sociologist Bernice Neugarten (1996) is among those gerontologists who emphasize diversity among elders. She maintains that lives fan out with time as people develop their own patterns of interest and commitments, their own sequences of life choices, their own psychological turning points, and their own patterns of relations with the few significant other people whose development impinges most directly on their own. Neugarten, in a breakthrough essay published in 1974, made the distinction between the "young-old" and the "old-old." She regarded these categories not solely in chronological terms but to make a distinction between those who are relatively healthy, affluent, and active from those who are not. Other authors have suggested that the young-old are likely to be between ages sixty-five and seventy-five or so, and that the old-old may be those aged seventy-five to eighty-five or older. Even here, in the uppermost age range, it can be dangerous to generalize about physical shortcomings. Research studies show that in individual cases thought processes (including memory) and ability to perform daily tasks can be maintained or even enhanced in this age group (Gilbert, 1998 and National Institute on Aging, 1990).

But, Disability Does Rise With Age

Increasingly, the physical well-being of older persons is expressed, not in terms of death rates or extent of certain disease states, but in terms of functional capacity. Limitations on that capacity are inconsequential for most older persons, but the fact is that disability does rise with age. The National Health Interview Survey of 1985 measured the functional capacity of elders in terms of activities of daily living (ADLs) or bathing, dressing, grooming, toileting, moving from bed to chair, being continent, and being able to feed oneself. Another means of determining functional capacity were instrumental activities of daily living (IADLs) including: shopping, using public transportation, cooking, telephoning, housekeeping, and finance management.

The survey found that 23 percent of all older persons are unable to perform at least one ADL, but about half of those eighty-five years and older need assistance to perform one or more ADLs or to carry out one of more IADLs. As many as 1.5 million older persons in the community or in institutions were unable to carry out five or more ADLs.

The 1989 National Long-Term Care Survey, a national sample of Medicare-enrolled persons sixty-five years or age and older (National Aging Information Center, 1996), found that nearly 84 percent of persons sixty-five years of age or older had no IADL or ADL limitations lasting three months or longer. Even among the persons eighty-five or older, the majority (51 percent) reported they had neither an ADL or IADL limitation, while 48.7 percent had at least one limitation and 38.1 percent had both.

Difficulties in determining the extent of disability among older populations in the future are formidable. Authors of the analysis summarized in Chart Two projected that there would be 2.8 million severely disabled elderly persons in 2040. Another analysis had as its lowest projection six million and a third projection put the number of sixty-five and over severe disability cases at perhaps 14.3 million by 2050.

Ageing and Mental Health

Emotional disturbances or conditions that, in the minds of many, are “typical” in the later years of life sometimes accompany aging. It is true that several significant challenges to modern mental health practice are related to the aging of our population. It would be as great a mistake to assume that such disorders are more prevalent than they really are as it would be to ignore them or understate them.

Mental health and health workers who are likely to work with older Americans during times of disaster should know of the differences between what is assumed and what they know about the prevalence and nature of emotional difficulties among aging persons. The American Psychiatric Association (Estes, 1995) has estimated that 15 to 25 percent of the nation’s elderly have symptoms of mental illness. The proportion in nursing home populations is approximately two thirds. It is felt that the elderly have lower prevalence rates (with the exception of dementia) than younger groups, but problems may be understated because of the widely recognized tendency of elders to resist using mental health

services and the predisposition by some practitioners and society in general to regard mental conditions as “normal” in elders (Butler, Lewis, & Slunderland, 1991).

Studies have demonstrated a strong relationship between minimizing mental health problems in late life and their direct consequences on general physical health, as illustrated by a prominent practitioner (Cohen, 1996):

In the cases of patients with cardiac arrhythmias or diabetes and who depend on medication for stable health, mental problems of forgetting (with dementia) to take their medicine or developing delusions (with schizophrenia) about their drugs, or losing motivation (with depression) to refill their prescriptions can jeopardize their health and increase the likelihood of more severe illness events (p. 7).

The difficulty mentioned earlier underutilization of mental health services by older persons has several causes. One is that seniors “tend to associate mental disorder with personal failure, spiritual deficiency, or some other stereotypic view”; another is that “older persons have been seen as noncompliant, uninteresting, and generally inappropriate by mental health professionals. . . .” (Lebowitz, 1987, p. 441).

Emotional Problems

Life crises—including the onset of widowhood, financial worries, negative impacts of retirement, fears of pain and disability, and problems caused by diminished sensory capacity—often trigger adaptive techniques, some negative, that help older persons attempt to cope with such conditions (Billig, 1993). One form of defense, denial of illness, can be a complicating factor in emergencies. On the other hand, humor can have positive value as an adaptive technique in any circumstances, but especially for combating stress (Butler, Lewis, & Sunderland, 1991).

It must be recognized, however, that the effects of intense situations are often compounded by the cumulative effect of the multiple losses likely to occur in the later years. Deaths of spouses, friends, and relatives may be the most shattering of these experiences, but declines in one’s own physical capacities and living standards are among the factors that may intensify and lengthen the consequences of such primary losses. In addition, “inevitable losses that can accompany aging may be aggravated

by cultural devaluation and neglect" (Butler, Lewis, & Sunderland, 1991, p. 89).

THE IMPACT OF WIDOWHOOD

"About 800,000 persons are widowed (in the United States) each year; most of them are old and experience varying degrees of depressive symptomatology. Most do not need formal treatment, but those who are moderately or severely dysphoric (feeling unwell or unhappy) appear to benefit from self-help groups or various psychosocial treatments. Remarkably, a third of widows/widowers meet criteria for a major depressive episode in the first month after the death, and half of these remain clinically depressed one year later. These depressions respond to standard antidepressants, although there is limited research as to when in the course of these depressions antidepressant medications should be instituted or how medications should be combined with psychosocial treatments."

Source: Friedhoff, A.J. Consensus Report, Diagnosis and Treatment of Depression in the Later Years of Life, Results from the National Institutes of Health Consensus Development Conference, 1994.

Those who work with the elderly, even in volunteer capacities, should also realize that many older adults are coping not only with immediate difficulties but with others that may not be readily apparent but are very real. (For example, emergencies may stimulate subconscious emotions related to difficulties encountered earlier in life.) Most older persons because of long experience have developed what has been called "lifelines," or "positive forces that can help people to age successfully, to cope better, and to enjoy themselves despite the deteriorative aspects of later life" (Billig, 1993). These forces include enduring relationships with others over long periods often extending into late life, experiences that remain vivid in memory and become guideposts when challenges arise, individual personality strengths that change very little with normal aging, and a capacity for hope and optimism.

Example: *A 73-year-old woman experienced what she called a "snowball of stress" in one week. She lost a filling in a tooth, noticed a leak in the roof of her house, and had to replace a water heater. The dentist then thought she needed more work than she anticipated. It took a friend's reminder that she had always been an*

optimistic person who thought she could overcome any problem. The woman acknowledged that she had "forgotten" these characteristics, and she promised to find them again to get her through several difficult weeks (Billig, 1993, p. 12).

Severe Mental Disorders

DEPRESSION

Depression in its many forms is often described as the most common of all mental disorders (Butler, 1998) of all ages. It affects approximately 15 percent of older community residents sixty-five years and older and perhaps 15 to as much as 40 percent who reside in nursing homes (American Psychiatric Association, 1987). It is a broad term that includes what Schneider (1995) described as "a constellation of physiological, effective, and cognitive manifestations" with symptoms including: "loss of interest or pleasure in usual activities; changes in appetite and weight; disturbed sleep; motor agitation or retardation; fatigue and loss of energy; feelings of worthlessness, self-reproach, or excessive guilt; suicidal thinking of attempts; and difficulty with thinking or concentration" (p. 35).

Depression should be recognized as a medical/psychiatric disorder that should be evaluated and treated; under no circumstances, should anyone's explanation be accepted that depression is "just because of old age" (Billig, 1993). However, 58 percent of older adults believe depression is a normal part of aging, which it emphatically is not (National Mental Health Association, 1996).

Many forms of treatment, including medications and monitoring of patients, are indicated for several types of depression. Therapeutic techniques that restore a sense of self-worth also offer promising ways of transcending personal and social losses (Reker, 1997). The disorder, in fact, is one of the most treatable medical problems to people who are vulnerable (Billig, 1993).

DEMENTIAS, INCLUDING ALZHEIMER'S DISEASE

According to Cohen (1986) dementia is "the serious disturbance in mental ability indicating that we have passed the boundaries of normality and that the brain is not functioning adequately" (p. 32). A more technical description by Schneider (1995) categorizes dementia as "an organic mental syndrome characterized by cognitive impairments, particularly

memory impairment, accompanied by impairments in abstract thinking, judgment or insight, language, or the ability to carry out familiar movements or properly use common objects, as well as possible changes in mood, personality, and behavior" (p. 26).

The word "organic" in the above paragraph signifies that dementia springs from physiological origins. Dementia should not be confused with "senility," a term frequently characterized in the gerontological and mental health literature as dangerously imprecise, contributing as it does to a loose, unfounded impression that advancing years inevitably bring deterioration of the mind.

There is, however, a correlation of the incidence of dementia with age. The prevalence of dementia is five percent among all persons older than sixty-five but increases to more than 30 percent in those over eighty-five. Of all dementia, the best known is Alzheimer's disease, which may account for more than two million middle-aged and older Americans, a number that could triple within the next forty years (Cohen, 1986).

Disaster workers cannot be expected to be aware of the varied forms that Alzheimer's disease may take, or the other disorders with which it may be confused. They should be aware, when the advanced Alzheimer's patient still resides in the community rather than in an institution, that family or another caregiver in all likelihood is devoting full-time attention to the patient and is a source of information and assistance.

Delirium, which is described as a sudden and temporary change in mental function or acute confusion (Williams, 1995) should not be confused with dementia. Its manifestations—clouded consciousness, difficulty in paying attention, frequent disorientation, and even delusional interludes—are likely to be rapid in onset, unlike dementia, and follow a fluctuating course, rather than the slow progressive course of dementia. Delirium is likely to be reversible, unlike Alzheimer's disease (Abrahms, Beers, & Berkow, Eds., 1995). Distinguishing delirium as the actual condition is likely to be difficult, but the distinction can be very important to make under emergency conditions. Delirium is more likely to affect attention, while dementia is more likely to affect memory. Causes of delirium can include hypoglycemia in a patient with poorly managed diabetes, side effects from mix of depressants and other drugs, and medical conditions including brain abscesses.

OTHER DISORDERS

A number of other psychiatric disorders are represented among the older population. Schizophrenia was once thought to be limited to youth, but researchers, primarily in Europe, have recognized late onset schizophrenia or paraphrenia; other older persons may have had the delusions and incoherence typical of that condition much earlier in life and have continued to display symptoms (Butler, Lewis, & Sunderland, 1991).

Severe anxiety, as opposed to temporary, situational anxiety, is thought to be related to depressive states. It is important for practitioners to recognize intense anxiety because symptoms including lack of concentration, dizziness, and disabling fears can be confused with even more severe geropsychiatric disorders (National Mental Health Association, 1996). Accurate categorization of anxiety can help counselors suggest ways to improve daily function.

THE SUICIDE FACTOR

Self-destruction among older Americans is a source of national concern. Suicide rates for the elderly, thirty-five per 100,000, are higher than any other age group, or put another way, the sixty-five plus adults representing 12 percent of the total population account for about 25 percent of reported suicides (American Psychiatric Association, 1987 and Butler, Lewis, & Sunderland, 1991). Depressive moods, very common in advanced age, undoubtedly contribute to what has been described "a passive desperate giving up" form of suicide. Disasters can intensify or cause such moods, because they cause a loss of control over one's circumstances, particularly among groups, such as the elderly, who feel they are on the lower levels of societal recognition and approval.

Older Persons in Disasters

Once again this guide must make the point that a wide range of reactions to disaster can be expected in the over sixty-five population, just as it can be expected among other age groups. Individuals are individuals no matter what their age. Experts in disaster assistance, however, classify older adults in general as a special population, likely to share similar characteristics or life experiences and likely to experience one or more widespread reactions in prolonged emergency.

These manifestations may include depression, withdrawal, apathy, agitation and anger, irritability and suspicion, disorientation, confusion, memory loss, accelerated physical decline, and an increased number of somatic or bodily complaints (National Institute of Mental Health, 1983).

Special Concerns

Many older persons are especially susceptible to the distress signals listed above because of well-documented special concerns related to aging. An AoA guide (1994) describes them in detail and is summarized here:

Sensory Deprivation

Older persons' sense of smell, touch, vision, and hearing are likely to be less acute than that of the general population causing potential difficulties in emergencies. A diminished sense of smell could make an older person less likely to identify spoiled food. A hearing loss may cause an older person not to hear what is said in the noisy environment of a DRC.

Delayed Response

Some older persons may respond slowly to calls for disaster relief for reasons including age-related slowing of cognitive and motor activity,

difficulties in comprehending radio or television broadcasts under difficult listening conditions, and impaired psycho-motor ability caused by medications. Recognizing the likelihood of delayed response can be important, as in the 1977 Kansas City flood. DRCs were kept open beyond normal limits to accommodate elders thought to be affected by the disaster. Over one-half of the elders who received services took advantage of the extended hours.

Chronic Illness and Dietary Considerations

Arthritis may prevent an elder from standing in line. Medications can cause confusion or a greater susceptibility to problems such as dehydration. Memory disorders can cause communication problems, as can neglect of special dietary considerations. Emergency food rations, for example, need to be low in sodium for the many older adults who suffer from hypertension.

Multiple Loss Effect

As described earlier, many seniors have lost their spouse, income, home, and/or physical capabilities. The compounding effect may make disaster recovery difficult. Intense attachments to specific items of property often add to their tensions.

“Welfare” Stigma and Unfamiliarity with Bureaucracy

An unwillingness to accept “welfare” may be bolstered by an unfamiliarity with government services for which elders are eligible, particularly during disasters. Older persons often have to be convinced that their taxes have helped pay for such assistance and that their acceptance of help will not keep another more needful person from receiving help. Elders are reluctant to admit to mental health problems because of a perceived stigma they attribute to mental health care. Many may fear transfer to a nursing home if their problems become known to workers.

Hyper/hypothermia Vulnerability

Extremes of heat or cold have marked effects upon older persons. This becomes critical in disasters that close down furnaces or air conditioners. About 8 percent of heatstroke deaths occur among persons fifty years of age or older; in the United States some 75,000 “excess winter deaths”

occur among the elderly, including deaths from hypothermia and deaths associated with other winter risks, such as influenza and pneumonia. Persons seventy-five years or older are five times more likely to die of hypothermia than those under that age (Abrams, Beers, & Berkow, Eds., 1995).

Transfer Trauma

Nursing homes and other residential facilities may have to move residents from one facility to another during disasters, causing distress and disorientation. Similar reactions can occur when elders must evacuate their own homes leaving behind treasured possessions. Studies report that 91 percent of nursing home residents have at least one psychiatric diagnosis and/or at least one behavioral problem. The added impact of a disaster is likely to intensify their problems.

A Minnesota occurrence illustrates the often dire consequences of transfer trauma. According to an Associated Press account by John McDonald in November 1997, fifteen of the forty-seven evacuated residents of an Ada nursing home were dead seven months after they fled rising flood waters during an April storm. The article reported: "The stress of being uprooted in the middle of the night and deposited in places far from their families has simply been too much for many of the old people weakened by age and disease, said Charlie Hicks (the nursing home director)."

Language and Cultural Barriers

Lower reading skills among elders and inadequate command of the English language can cause confusion and exasperation at relief centers or in the field. Minority elderly are especially vulnerable. Disaster agencies need bilingual and bi-cultural workers to communicate and assure responsiveness to needs. In the case of older Native Americans, it is important to remember that each tribe is unique in its culture and traditions.

Normal Behaviors Modified During Stress

Victims of disaster, whatever their age, are likely to have experienced intense emotional reactions. The maxim that no one who has seen a disaster is unaffected by it is especially true of older persons, many of

whom may take anywhere from a few days to several months merely to sort out the details of their experiences during the emergency (AoA, 1994).

Apathy or helpless stoicism may be among the likely reactions, based largely on the attitude that they will never be able to recover or replace losses ranging from property damage to death of friends or family.

An older adult patient with altered mental status may be among the most difficult for an emergency physician to diagnose critically and treat. The "spectrum of the clinical presentation" is diverse. It may be "violent to withdrawn, agitated to comatose, subtle to dramatic . . . in most circumstances a complex interplay of predisposing and precipitating factors denies the emergency care provider a simple, single, readily apparent cause" (Sanders, 1996, p. 119).

Emotional stress may induce or intensify depression, especially among those over the age of seventy or seventy-five. Symptoms may be sadness, lack of interest, pessimism, and difficulty in making decisions (AoA, 1994).

Working With Older Persons in Disaster

In general terms, professionals and disaster workers who provide assistance for distraught older persons in disasters should be guided by the following principles (National Institute of Mental Health, 1983):

- Provide strong and persistent verbal reassurance.
- Assist with recovery of physical possessions, make frequent home visits, arrange for companions.
- Give special attention to suitable residential relocation, ideally in familiar surroundings with friends or acquaintances.
- Help re-establish familial and social contacts.
- Assist in obtaining medical and financial assistance.
- Help re-establish medication regimens.
- Provide escort service.

The reference above to reestablishment of daily medication practices has special importance to older persons who may be relying on drugs to keep emotional balance, including those receiving treatment for depression.

Helpers should recognize the need for obtaining early information on pharmaceutical needs.

The same is true of persons whom they are not treating for psychological conditions, but who maintain a medication regimen for other purposes, including diabetes control. Great emotional stress can result if such regimens are disrupted or even forgotten. Twenty-five percent of prescription use in the United States is among people who are older than sixty-five, though they constitute about 12.6 percent of the population (Williams, 1995).

Additional examples of “practical” needs that arise among older persons at times of disaster appear below. They are based on consultations with experts in delivery of social and other kinds of services and literature related to aging or disaster response.

Institutionalized

Depending on the magnitude of the disaster impact, Federal, state, or local agencies may be assigned to evacuate or take other action to help patients in hospitals, nursing homes, or other residential health care facilities. It should be remembered, however, that a paramount need of older persons and their families during emergencies is to restore communication lines. This is especially true for those nursing home patients likely to succumb to the relocation “trauma” described earlier. Disaster workers can help relieve such distress by taking whatever steps are possible to reunite younger family members with their older, institutionalized relative. Experience has shown that prolonged power failure can cause not only discomfort but distress in facilities including assisted-living residences (Scherr, 1996).

Outreach or DRCs?

Outreach to elders is often the most effective mode of help. Outreach is a method for delivering crisis counseling services through face-to-face contact with older adults in their natural environments. In early stages of a disaster, it may be that the only way to help isolated individuals is to work with them in their own homes or neighborhoods.

Disaster victims register for FEMA disaster assistance through tele-registration at their convenience. The system is accessible via a toll-free telephone number that FEMA publicizes.

DRCs are temporary facilities established by FEMA, in coordination with the State, for some, but not all disasters. The number and locations of the DRCs are based on the size and geography of the disaster. A key function of the DRC is to provide information on specified programs; another is to answer specific questions about eligibility or other matters.

Among the programs and services represented at DRCs are Social Security Administration help in expediting checks delayed by the disaster, several forms of housing assistance, a desk providing linkages to programs serving the elderly, disaster relief available through the American Red Cross, the Salvation Army, and other volunteer organizations, and crisis counseling services.

Professional or temporary helpers at these centers should recognize, not only the ingrained tendency of many older persons to resist help from the "government" (see an example below), but also the often seemingly confusing or overwhelming DRC atmosphere. "There is," according to Disaster Response and Recovery: A Handbook for Mental Health Professionals (CMHS, 1994), "a high level of activity and noise," with many programs represented, each with its own work station, personnel, and procedures. The handbook therefore advises:

Mental health should be attuned to the needs of the elderly or the people with disabilities who come to the DRC. Frail elderly or people with mobility, vision, or hearing impairment may have difficulty navigating the room, hearing what is being said, or reading the fine print. In addition, they may not have the stamina to endure the long processes involved. Mental health may work with DRC managers and staff to provide special assistance in such cases, such as assigning a volunteer to an applicant with visual impairment to help in filling out forms (page 86).

Reluctance to Seek Help

The tendency of many older persons to regard acceptance of help as a defeat or a step toward total dependency is one of the most frequently observed reactions noted in studies and commentary on disaster response. In addition to the possible reasons for this attitude discussed in the preceding section, another cause may be a reluctance to be "processed" through bureaucratic channels, no matter how well-meant the channeling may be.

***Example:** Disaster relief coordinators have noticed that many older persons become puzzled when, to obtain emergency monetary relief for repairing homes or other reconstruction purposes, they must begin by filling forms and taking other steps to obtain a Small Business Administration Loan. Many older homeowners fall far short of meeting minimum income requirements for the SBA assistance. This causes denial of their application. Only then, however, can processing begin for modest payments under an Individual and Family Grant Program (75 percent Federal, 25 percent state). The complex requirements seem inappropriate to many elders, causing confusion, anger, and potential frustration to the point of rejecting any assistance, threatening emotional stability (Wilder, interview, 1998).*

Using Non-technical Language

Very few persons are likely to approach a desk marked "mental health" at a DRC or any other disaster relief site (CMHS, 1994). This is especially true of elders, whom mental health service providers have markedly underserved, partially because they tend to resist acknowledging the need for such services (Lebowitz, 1987). In disaster relief situations, referring a person to a needed service may sometimes be better instead of probing for mental health conditions and attempting to name them. It is better to refer to "human" or "social" services rather than mental health services.

Recognizing the Strengths of Older Persons

Volunteering is high among the older populations of this nation. One survey found that 20 percent of the sixty-five plus population was doing some form of volunteer work and another 20 percent were willing to become involved (Javois, 1998). Many older volunteers have valuable, extensive knowledge of community resources (Monk, 1987). The same incentives that cause such participation during ordinary times apply even more so during disasters and their aftermaths. Sixty-five percent of American Red Cross disaster volunteer workers are age fifty-five or above (Lopes, 1998). Those elders with prior mental health issues need not be excluded. The disaster literature reports many incidences of effective response to the needs of others by persons with emotional disorders. Many elders are themselves served by volunteers (meals-on-wheels, chore services, etc.) and are aware of the existence of helping networks.

They can help disaster workers restore such services, when they are disrupted. In addition, older persons are likely to have experienced major disruptions during their lifetimes. They can be a convincing voice in reassuring that “this too will pass.”

When to Refer to a Specialist

Checklists of symptoms to look for in older persons at times of extreme stress exist and can help professional or lay disaster workers to identify problems. However, providing clear cut signals on symptoms that call for close attention by a counselor or family therapist is difficult. When possible, crisis counseling staff are on hand at DRCs and elsewhere to respond immediately to questions raised by workers who think that professional help is needed (Inglis, 1991 and Weber, 1998).

Working With the “Aging Network”

Decades of experience at the community level in identifying and meeting needs of older persons have produced substantial resources such as senior centers, adult day care services that provide care for elders and respite for family caregivers, and Meals on Wheels or group meals at convenient sites. The development of such services was facilitated considerably by the 1965 enactment of the OAA, which resulted in the establishment of state and area units on aging throughout the nation. Rather than providing services directly, the state and area units provide funding for contracts to local providers who deliver the services. The loose “network” that has evolved can be of major assistance during disasters.

***Examples:** After the Northridge earthquake in California, older residents in many of the 1,500 mobile homes in the area were having symptoms of panic, disorientation, fear, sleeplessness, and anger. Thirteen senior centers became central points for phone calls, walk-ins, referrals, and triage. Outreach teams, which sought out elders who might otherwise have not received assistance, made the centers their base for visits to mobile home parks and for stress management activities (Fain, 1998 and Project Cope, 1992a). Another California earthquake struck Fresno County in 1983 and approximately 28 percent of the 72,000 older residents had some form of disability. The Coalinga Senior Center, which regularly*

offered group and home-delivered meals, increased those services dramatically. The Fresno/Madera Area Agency assigned staff to a disaster center and expanded its information and referral services to include any person needing assistance (FEMA, 1983). In Northern Illinois, outreach workers recruited through an AAA gave "face-to-face service" during the 1993 floods, including replacement of prosthetic devices and medications that had been lost during the turmoil and destruction of homes (Novinski, 1998 and Weber, 1998).

Senior centers and adult day service centers can also be of help in identifying homebound elders, getting in touch with family members including long-distance caregivers, and—if they have had programs on medication management—having some familiarity with the pharmaceutical needs of their clientele. Senior centers are especially useful for pre-disaster training. For example, in the U.S. Virgin Islands between Hurricane Hugo in 1989 and Hurricane Marilyn in 1995, centers were visited at least once a year by speakers giving information on preparations for the next wide-scale emergency (Javois, 1998). The availability of such services and knowledge can be of considerable assistance to disaster workers attempting to promote an atmosphere of calm and certainty, especially if they are provided by persons known to the elderly recipients.

Disaster Advocates

Seeing the need for assuring trained volunteer and staff helpers for older persons during times of disaster, the AoA has published a training manual for "Disaster Advocates." Modules for outreach, case assessment and management, interventions to help elders undergoing psychological reactions, and other topics important for "the full-service advocate" are offered. Actual use of the manual varies from state to state depending on several factors including frequency of disasters. It may be obtained from area or state AAAs which offer electronic means of reproducing the manual. (Additional information is provided in Appendix A: Resources.)

Eldercare Locator

A call to 1-800-667-1116 will elicit the phone number of the nearest AAA. This is often an essential step in making contact for services, outreach, and information. The location is also useful for locating providers of services.

A key goal of the AoA and its regional, state, and local agencies is to complement services and educational efforts initiated by FEMA and other Federal units that respond with services and other assistance during disasters.

Working With Coalitions

Widely varying circumstances in disasters are likely to result in widely varying participation from groups of organizations and individuals. In Illinois, for example, a major flood in 1993 triggered formation of a "Project Recovery" coalition that enlisted cooperation from the state Department of Mental Health and Developmental Disabilities, the Farm Resource Center (which coordinated crisis counseling and other services in rural flood areas), the Illinois Association of Community Mental Health Agencies, the Illinois Association of Public Health Administrators, the Alliance for the Mentally Ill/Illinois, and the National Association of Social Workers/Illinois Chapter (Weber, 1998).

The purpose was to counteract "the emotional devastation" caused by the flood. Intensive counseling was seen as a prime need. The Cooperative Extension Service of the University of Illinois at Urbana-Champaign provided informational material including a flyer, "Flood 93-Managing Stress." The College of Veterinary Medicine at the University of Illinois handled questions on flood-related landfill problems, debris disposal, contaminated wells, and water treatment plants.

Disaster response workers should be aware of the need for, and the establishment of, coalitions established to deal with specific needs that arise in differing kinds of disaster situations.

Working With Families

Families make herculean efforts to provide care and attention for elder kin. This fact is recognized in a growing literature that reports the caregiving help provided by families is invaluable and extensive (totaling perhaps 80 percent of all long-term care received by elders). Caregiver burdens (most often borne by wives, daughters, or daughters-in-law) often intensify to the point that the health of the helper deteriorates, or at least may be in danger of doing so (Brody, 1986 and Greene, 1995).

For example, in a large survey concluded in 1998, 67 percent of children who care for a parent reported depression, roughly six times the

national average. Most respondent caregivers spent more than forty hours per week in providing often intense levels of care (National Caregivers Association/Fortis Long-Term Care, 1998).

Disaster workers should recognize two points. They should be willing to tap the help that family caregivers can provide; they should also be sensitive to the pressure that caregivers are likely to be under, particularly when disasters occur.

A first step is to inform the caregiver, if separated from the older family member, where that elder is and what assistance has already been provided or may be needed. The Red Cross is especially helpful in this process. For long-distance caregivers, who arrange for services to be delivered by local providers, news about the elder is crucial. Establishing contact can also be of help to disaster workers, who may elicit valuable information from the family on the medical history and current treatment of their elderly family members.

If family caregivers show signs of stress or even burnout, they should be made aware of advocacy organizations that can identify support groups or other forms of assistance. For example, adult day services can provide respite for prolonged or brief periods. (Appendix B: Sources of Assistance and Information has additional information on sources of help for caregivers.)

Grandparents Raising Grandchildren

Approximately 1.4 million children in the United States are being raised solely by their grandparents or other older persons (Yoho, 1998). Disaster workers should be aware that the trend of full-time parenting by grandparents exists and is even increasing. They may be called upon not only to assist the older person, but to assuage concerns about the child in her or his care.

Family Initiatives

If familiar with the older person's circle of social contacts (church, physician, senior center, etc.), family members can attempt to establish whereabouts and circumstances through direct phone calls if possible. If the disaster area is still in early turmoil, await instructions from the Red Cross or other sources of help that will be announced.

Eldercare Locator

This service, already mentioned, can be invaluable. Its primary function is to provide the telephone number of the AAA closest to the person presumed in need of assistance. AAAs can provide information and referral on services available (including home-delivered meals, crisis counseling, transportation, and on other matters).

The Eldercare Locator Phone Number is 1-800-677-1116. Call between 9 a.m. and 8 p.m., Eastern Time, Monday through Friday. Have the following information ready: county and city name or zip code, brief description of the help sought.

Disaster Recovery Centers, or DRCs

As described earlier in this section, the DRC atmosphere can be overwhelming for the older person. If possible, and the older person wishes, family members can help by going to the DRC with the elderly parent or grandparent. They should also become as informed as possible about the many kinds of help available at the DRC one-stop service centers.

Relocation

Often, when older persons must be relocated because of a disaster, they become guests of adult children or even grandchildren. It becomes essential, when this occurs, for the younger family members to learn all they can about health and other services that may have already been provided or are yet to begin. Contact should be made with the AAA, or other agencies for such essential information. The Privacy Act requires that FEMA receive written consent from the applicant for disaster assistance before releasing any information to a family member. If FEMA or the AAA do not already know that the older person has moved to new quarters, they should be informed.

Strains are likely to arise as victims of intense stress move into homes of their offspring or other relatives. Tension and even physical or other forms of abuse may occur but can be resisted, if family members are alert to the possibility of such pressures and do all in their power to accommodate each other.

Preparing for Disaster

Families can also share in planning ahead for possible disaster, particularly in areas with a history of recurring emergencies such as spring floods or tornados. Stocking food and other basic needs is only part of the task. Preparedness helps alleviate anxiety. A useful checklist prepared for seniors by seniors, appears as Appendix D of this handbook.

Mental Health Advocacy

Deficiencies in provision of mental health services to older persons have long troubled practitioners and advocates in aging. Part of the problem may be a widely reported resistance by elders to using such services. A perceived double stigma—being “old” and “mentally ill”—also enters the picture (Carter, 1991 and Estes, 1995).

Encouraging signs of improvement are occurring, such as growing recognition that proper treatment can deal effectively with even severe mental problems among the older populations (Brozan, 1998 and Butler, 1991). Advocacy groups, such as the Coalition on Mental Health and Aging, are making progress on legislative and public education fronts. Family members can help by being aware of the need for action at local, state, and national levels. (See Appendix B for a partial listing of organizations that include advocacy among their functions.)

Adequate, appropriate mental health services for older persons during times of non-emergency can help assure that such services will be available during disasters. Families can be effective advocates to assure that this will be the case, not only for today’s elders, but for themselves in later years.

Time Lines for Recovery

Psychological impacts of disaster are likely to vary considerably because of wide differences in the nature and intensity of their disruptive powers. The sudden destruction caused by a tornado, for example, may not have the same effects as a flood preceded by a period of watchful waiting and the long process of determining damage and personal loss as it recedes (National Institute of Mental Health, 1979).

In addition, disaster consequences may be influenced by such factors as the economic circumstances of victims, the frequency of disasters in the area, and the effectiveness of relief measures. Studies of psychological symptoms in older adults after disaster, therefore vary considerably in their findings.

One of the most comprehensive accounts of psychological sequelae among older persons is based on interviews with more than 200 adults who experienced the 1981 flood in southwestern Kentucky and a stronger one in 1984 (Phifer & Norris, 1989). Because the interviewees were part of an older adult longitudinal study that had begun before the first flood, a baseline for the later interviews existed. Following the 1981 flood, the combined impact of personal loss increased levels of psychological distress for up to one year post-flood. Following the more severe 1984 flood, personal losses were associated with increased psychological symptoms for almost two years post-flood. Authors of the study acknowledge that their study area had a high level of economic distress and limited health care response facilities. They nevertheless feel that their findings of enduring distress are significant and they challenge other studies that found only mild or insignificant psychological reactions to older persons' disaster experiences.

Other studies about post-disaster emotional recovery periods for older persons demonstrated: older adults experienced higher level than other age groups of post-traumatic stress symptoms after an earthquake; somewhat less disaster stress was reported by older adults than middle-aged adults after Hurricane Hugo in South Carolina (Thompson, Norris, & Hanacek, 1993); and black and white elders were more likely to be psychologically recovered eight months after a tornado in Paris, Texas, than were their younger counterparts (Bolin and Klenow, 1988).

On the whole, the literature on post-disaster recovery periods among older persons is inconclusive, probably because of the wide variety of circumstances likely to arise even among disasters of the same type.

In the Aftermath

"Senior citizens today are a sturdy, reliable generation. We've proven time and again our ability to survive everything from the Great Depression to world wars and the threat of nuclear holocaust. We've lived through droughts, floods, and all sorts of other natural

disasters. We've given birth, supported our families, and stood by our loved ones through personal and financial losses. We are proud, tough, and resilient."

*"Voices of Wisdom: Seniors Cope with Disaster" Videotape
Project COPE, 1992*

Yet, when disaster strikes elders may experience sudden terror and feel overwhelmingly vulnerable. These observations, and most that follow, are described in a brochure published by Project COPE (Counseling Ordinary People in Emergencies) in San Bernadino County, California, with support from the Federal Emergency Management Agency.

The publication complements a videotape (Project COPE, 1992b) offering interviews with twenty elders who experienced the strongest earthquake in California in forty years, a 7.6 temblor that shook the Yucca Valley area of southern California in June 1992. Both the video and the publication are designed "to help senior citizens cope with the deeper personal losses that may impact their psychological and emotional health long after the actual disaster."

Among the "deeper personal losses" are belongings of great emotional importance damaged to the point of destruction or have disappeared. As shown in the video, several survivors of the earthquake appeared dazed, long after the tremors, by the loss of treasured items regarded as irreplaceable. "What we lose in a disaster can have a tremendous impact," the brochure sums up, "when coupled with previous losses" (including deaths among family and friends, possible declines in income or status, and what may seem to be a continued erosion of physical capacity).

In addition, private homes that had seemed to offer refuge may become unstable, dangerous places during an earthquake or tornado: "Walls and furniture may suddenly take on a life of their own, moving unpredictably, trapping residents, or blocking escape routes." One older homeowner, interviewed on videotape, said the experience had been so shattering to his wife that she had left him and their former home. Another woman, seemingly matter-of-fact in discussing her experiences, appeared surprised when she suddenly burst into tears. (Details on the availability of the video are in Appendix A: Resources.)

Studies of the Yucca Valley disaster and others strike common themes. A predominant message is allow time for grief and healing, but do not expect there to be deadlines for recovery. Emotional reactions to trauma

are likely to include anxiety, depression, anger, difficulties in concentrating, short-term memory loss, sleep disorders, feelings of isolation from family and familiar patterns of life, and regressive behavior.

To cope, elders are advised to speak openly about feelings of fear, anxiety, irritability, or other unexpected emotional reactions. Disaster workers are advised to call the older adult by name and to help them to find their way back to self-assurance. Counselors are urged to recommend that elders seek financial or other emergency help when needed. "Don't be embarrassed," emphasizes the brochure, "to go to agencies that offer help. . . . You have invested in these programs all of your working lives through your tax dollars. . . . When a disaster strikes, it's okay to collect on that investment."

Other guidelines to elders: take time out to relax, do not chastise yourself if total recovery does not occur in a given time frame, and if possible join in recovery efforts. Volunteer work was described by one earthquake survivor as "one of the most rewarding things in my life."

The Anniversary Observance

Older persons, and others, report uneasiness and more intense emotions as the disaster anniversary approaches. They are reminded of feelings they may have thought they had put behind them. They may wonder whether the disaster will be repeated.

An observance, or remembrance may facilitate emotional healing, at or near the first anniversary of a disaster. Such programs can be helpful to those who experience delayed reactions to disasters, including disturbing dreams, impulses to talk about incidents thought to be forgotten, and sharp unexpected reactions to everyday occurrences.

***Example:** A senior in a mobile home damaged by an earthquake heard sounds of an automobile accident months later. She immediately felt a shortness of breath and emotions akin to an anxiety attack. The street sounds somehow brought back the emotions she had felt during the earthquake (Project COPE, 1992a).*

Anniversary events "can generate mixed reactions of memory and grief, introspection and reflection, and relief and pride in having survived the first year" (National Institute of Mental Health, 1994). Some observances are relatively simple, perhaps a culmination for activities of neighborhood support groups that had met regularly since the disasters. Others

are elaborate, offering videotapes or other accounts of the disaster, participation by elected officials, and airing of memories.

Keeping Watch for Exploitation and Abuse

Extreme distress can be caused well after a disaster by schemers who seek to exploit the very real needs of victims. Home repair is a frequent area for victimization, often by unqualified con men who move on with partial or total payment (AoA, 1994). Physical abuse may arise even among family members, particularly when relocatees must take up quarters with kin for prolonged periods, such as the aftermath of a major flood (Weber, 1998). Education at disaster centers about both forms of abuse and the likelihood of an increase in abuse can help head them off.

***Example:** The Illinois Department of Aging reports that areas affected by a major flood in 1993 experienced a 38 percent increase in the number of reports of abuse, neglect, and exploitation of older persons over a similar period the prior year. All in all, summed up the department, the 241 additional reports of elder abuse and neglect “can be attributed to the flood” (Novinski, 1998).*

Identifying and Fighting Myths

Experts who have studied disasters are often troubled by what they regard as misconceptions, or even myths, about human behavior at times of extreme emergency. Panic flight from a hurricane or other impending destructive force is often anticipated in the news media. The reality is that it seldom occurs. “Ironically,” according to one analysis, “the problem is not panic, but just the opposite—trying to get the people to leave” (Dynes & Wenger, 1983, p. 12).

Similarly, there is a widespread mental picture of stunned, paralyzed victims unable to act for others or even to care for themselves. “This image,” continues the report, “is simply incorrect. The disaster literature is replete with findings indicating that those who rescue the victims are the victims” (p. 13).

The danger of such false impressions is that they can affect the provision of aid to victims. If appropriate services are to be made available, they must be based on realities, not suppositions. This cautionary advice applies with special force to the elderly.

If the community, or even the emergency workers, think of older persons as universally withdrawn, self-centered, and uninterested in their communities, or even expendable, real needs may be misunderstood or overlooked and so may the potential contributions of older individuals, not only as volunteer workers but as persons with long memories and experience that can prove invaluable.

“People may have problems and we may need to figure out ways to deal with that,” advises the critique of the myths, “but essentially the best way to plan is to treat people as resources. It is always interesting how after disasters, certain neglected categories become important in this society. People rediscover older people and find that they are competent about doing something. . . . The key is to figure out how to utilize them effectively, and you do not do that by considering them problems” (Dynes & Wegner, 1983, p. 19).

Summary

The *Voices of Wisdom* videotape (Project COPE, 1992b) offers older adults recovering from a major disaster the following advice:

- Physical reactions to a disaster are normal.
- Acknowledging our feelings helps us recover.
- Asking for what we need can help heal us.
- Focusing on our strengths and abilities will help.
- Accepting help from community programs is healthy.
- We each heal at our own pace.
- We each have different needs and different ways to cope.

It is important for older adults recovering from a disaster to talk about their feelings. Sharing their experiences with other disaster victims can help them to understand they are not alone. Also, becoming involved in the disaster recovery process and helping others to heal can be beneficial to the older adults own recovery. Older adults should be encouraged to ask for any type of help needed, such as financial, emotional, and medical assistance. Seeking assistance is a step toward recovery and independence. Older adults are a generation of survivors and with the proper support will become even stronger and more capable of facing future challenges.

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APPENDIX A

RESOURCE MATERIAL

AMERICAN RED CROSS. *DISASTER PREPAREDNESS FOR PEOPLE WITH DISABILITIES*. 1997.

This 45-page booklet is a successor to *Disaster Preparedness for the Disabled and Elderly*, created in 1994 by the Los Angeles Chapter of the ARC (and now out of print). The new version includes sections on assessing personal needs and abilities, how to enlist assistance in creating a personal disaster plan, and possible aftereffects of a disaster likely to impact persons with disabilities. Copies are available from local Red Cross chapters; also available on the World Wide Web at the following Universal Resource Locator (URL):

www.redcross.org/disaster/safety/disability.html.

Downloadable copies in WordPerfect and PDF formats are also available from this site.

AMERICAN RED CROSS. *DISASTER PREPAREDNESS FOR SENIORS BY SENIORS. WHAT WE CAN DO TO SAVE OUR LIVES*. 1995.

A group of older adults who experienced a two-week power outage caused by a massive ice storm in upper New York State wrote this guide in consultation with ARC. It includes checklists for medical needs and other supplies, a family disaster plan, and suggestions on how to shelter in place or at emergency centers. Free copies available from local Red Cross chapters.

BUTLER, ROBERT. LEWIS, MYRNA. SUNDERLAND, TREY. *AGING AND MENTAL HEALTH. POSITIVE PSYCHOSOCIAL AND BIOMEDICAL APPROACHES. FOURTH EDITION*. MERRILL, AN IMPRINT OF MACMILLAN PUBLISHING COMPANY, 1991.

Includes chapters on common emotional problems, psychiatric disorders, and organic mental disorders in later life. Part Two is devoted to evaluation, treatment, and prevention. An entire chapter is devoted to drug and other somatic therapies. Another chapter deals with ways to keep people at home.

CENTER FOR MENTAL HEALTH SERVICES. *DISASTER RESPONSE AND RECOVERY: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS, 1994.*

This publication provides “how-to” information on basic, practical issues related to planning and implementing disaster mental health services, with special emphasis on crisis counseling. Most chapters include checklists of actions to be taken before, during, and after disasters. It is written to be useful to mental health professionals who may have no previous disaster experience. A comprehensive section on “The Anniversary of the Disaster, Mental Health Issues and Interventions,” is especially informative.

Copies are available at no charge from the Center for Mental Health Services:

NATIONAL MENTAL HEALTH SERVICES KNOWLEDGE EXCHANGE NETWORK P.O. BOX 42490, WASHINGTON D.C. 20015.

Toll-Free Information Line 1-800-789-2647. CMHS Electronic Bulletin Board 1-800-790-2647. TTY 301-443-9006. FAX 301-984-8796. Internet home page: <http://www.mentalhealth.org>

CENTER FOR MENTAL HEALTH SERVICES. *DISASTER WORK AND MENTAL HEALTH: PREVENTION AND CONTROL OF STRESS AMONG WORKERS, 1995.*

Contains material useful to public, state, and private agencies engaged in disaster relief operations; regional, state, and local emergency planners; and private charitable organizations involved in disaster relief. Includes chapters on event, occupational, and organizational stressors and a training manual on help for the helpers.

Copies are available at no charge from the Center for Mental Health Services: National Mental Health Services Knowledge Exchange Network P.O. Box 42490 Washington D.C. 20015. Toll-Free Information Line 1-800-789-2647. CMHS Electronic Bulletin Board 1-800-790-2647. TTY 301-443-9006. FAX 301-984-8796. Internet home page: <http://www.mentalhealth.org>

CENTER FOR MENTAL HEALTH SERVICES. *RESPONDING TO THE NEEDS OF PEOPLE WITH SERIOUS AND PERSISTENT MENTAL ILLNESS IN TIMES OF MAJOR DISASTER, 1996.*

This technical assistance document addresses the needs of people with serious and persistent mental illness following major disasters. It uses narrative and illustration from providers, program planners,

and administrators of disaster response and recovery programs. The first essay is an "Introduction to Crisis Counseling Programs and Services to Persons with Serious and Persistent Illness." Additional information on crisis counseling services appears in the fifth essay.

Copies are available at no charge from the Center for Mental Health Services: National Mental Health Services Knowledge Exchange Network, P.O. Box 42490, Washington D.C. 20015. Toll-Free Information Line 1-800-789-2647. CMHS Electronic Bulletin Board 1-800-790-2647, TTY 301-443-9006. FAX 301-984-8796. Internet home page: <http://www.mentalhealth.org>

COPE (COUNSELING ORDINARY PEOPLE IN EMERGENCIES.) VOICES OF WISDOM: SENIORS COPE WITH DISASTER. (VIDEOTAPE) THE EARTHQUAKE RECOVERY PROJECT. SAN BERNARDINO, CA, COUNTY DEPARTMENT OF MENTAL HEALTH. 1992.

This 31-minute videotape gives suggestions on how to cope with personal trauma after a disaster. It is hosted and narrated by Ricardo Montalban and features interviews with 20 older persons who survived a severe California earthquake. It is designed to be useful to care providers, disaster counselors, and individual seniors.

Copies are available at no charge from the Center for Mental Health Services: National Mental Health Services Knowledge Exchange Network, P.O. Box 42490, Washington D.C. 20015. Toll-Free Information Line 1-800-789-2647. CMHS Electronic Bulletin Board 1-800-790-2647. TTY 301-443-9006. FAX 301-984-8796. Internet home page: <http://www.mentalhealth.org>

GATZ, MARGARET. (ED.) EMERGING ISSUES IN MENTAL HEALTH & AGING. AMERICAN PSYCHOLOGICAL ASSOCIATION. 1995.

This interdisciplinary book grew out of papers presented at the 1995 White House Mini-Conference on Emerging Issues in Mental Health and Aging. Contributors deal with such topics as promoting mental health public policy, encouraging optimal health as people age, expanding and consolidating the scientific research in late-life psychiatric disorders, and increasing access to mental health services. It contains material of interest to psychologists, psychiatrists, social workers, nurses, counselors, and others providing mental health services. Copies may be obtained from the APA Order Department, P.O. Box 2716, Hyattsville, MD 20784.

PHIFER, JAMES. NORRIS, FRAN. "PSYCHOLOGICAL SYMPTOMS IN OLDER ADULTS FOLLOWING DISASTERS: NATURE, TIMING, DURATION, AND COURSE." *JOURNALS OF GERONTOLOGY*. VOL. 44, NO. 6. PP. S207-S217, NOVEMBER 1989.

Explores the impact of two floods on a sample of elders participating in a longitudinal mental health study. Also useful because of an extensive review of the literature on the widely varying effects of disaster on older persons under differing circumstances.

U.S. ADMINISTRATION ON AGING. *AMERICA'S AGING NETWORK: COPING WITH DISASTER* (VIDEOTAPE). 1996.

Jane Wyatt poses questions and receives answers on ways in which state and AAAs can help during disasters.

This 20-minute video is meant to help during training sessions and meetings with other organizations. It is accompanied by 20-second, 30-second, and 80-second public service announcements. Available at local agencies on aging (phone numbers available by calling AoA Eldercare Locator number 1-800-677-1116).

U.S. ADMINISTRATION ON AGING/KANSAS DEPARTMENT ON AGING. *DISASTER PREPAREDNESS MANUAL FOR THE AGING NETWORK*. 1995.

Intended to help state and AAAs build upon experience gained in responding to disasters, this comprehensive manual provides much information on elder response and service needs large-scale emergencies. An entire training program for disaster advocates specifically working with older persons is included. A section on Native Americans is included. Considerable attention is given to the prevention of abuse and exploitation of older adults. The manual has been distributed to state and AAAs throughout the nation, where it has been replicated on a 3.5 inch floppy disk. The disk also includes a computerized training program for use by disaster advocates. A call to the Administration on Aging Eldercare Locator Service at 1-800-677-1116 will provide the number of the nearest AAA.

APPENDIX B

SOURCES OF ASSISTANCE AND INFORMATION

GOVERNMENT

Center for Mental Health Services (CMHS)

Provides publications and videotapes (including several described in the previous section on Resources) on human responses to disasters. Through an interagency agreement with FEMA, CMHS advises on crisis counseling and training for disaster victims and workers. CMHS, Room 17C-20, 5600 Fishers Lane, Rockville MD 20857. Telephone 301-443-4735. FAX 301-443-8040.

CMHS publications may be ordered through the National Mental Health Services Knowledge Exchange Network, P.O. Box 42490, Washington D.C. 20015. Toll-Free Information Line 1-800-789-2647. CMHS Electronic Bulletin Board 1-800-790-2647. TTY 301-443-9006. FAX 301-984-8796. Copies are also available on Internet home page: <http://www.mentalhealth.org>

Federal Emergency Management Agency (FEMA)

FEMA coordinates with other state and Federal agencies to respond to Presidentially declared disasters. It provides disaster assistance for individuals, businesses (through the Small Business Administration), and communities. Among publications that may be ordered free from FEMA are: *Hurricane Awareness-Action Guidelines for Senior Citizens* (Item # 8-0440) and *Preparedness for People with Disabilities (earthquakes)* (Pub # FEMA-75). Write to FEMA, P.O. Box 2012, Jessup, MD 20794-2012 to order publications or obtain a complete listing of publications available to the public. Copies are also available on Internet home page: <http://www.fema.gov>

National Institute on Aging (NIA)

One of the National Institutes of Health, NIA conducts and supports far-ranging biomedical and behavioral research. Its many publications include *Working With Your Older Patient: A Clinician's*

Handbook (which includes sections on depression awareness, support for caregivers, and use of a mini-mental state examination checklist) and *With the Passage of Time*, which reports on NIA's Baltimore Longitudinal Study on Aging, an excellent source of data that often explode negative stereotypes related to aging. NIA, Building 31, Center Drive, MSC 2292, Bethesda, MD 20892-2292. Telephone 301-496-1752. FAX 301- 496-1072. Website: <http://www.nih.gov/nia>

The NIA also distributes free copies of *Age Pages* containing information about health promotion and disease prevention for older adults, family members, and health professionals. One, revised in 1998, gives information on "Depression: A Serious But Treatable Illness." Free single or bulk copies may be requested by calling 1-800-222-2225.

U.S. Administration on Aging (AoA)

Together with state and AAAs throughout the nation, the AoA has worked to establish information and assistance telephone service available to older persons and family members. Approximately three million such calls are made each year. Access to an information and assistance (I&A) line may be made by obtaining the telephone number of a local AAA through the AoA Eldercare Locator Number, 1-800-677-1116.

Additional I&A advice may be obtained on the Internet from the AoA Home Page, which also offers information on AoA and its programs, resources for practitioners, statistics pertaining to aging, and ways to obtain electronic booklets on aging-related issues.

Website: <http://www.aoa.dhhs.gov>

Another service of AoA is the National Aging Information Center (NAIC), a source for much program- and policy-related material, demographic data, and information about policy and practice. Most of the center's services are free. Contact NAIC at: Administration on Aging, 330 Independence Avenue, SW, Room 4656, Washington D.C. 20201.

Telephone: 202-619-7501. FAX 202-401-7260.

E-mail: naic@ban-gate.aoa.dhhs.gov

Website: <http://www.aoa.dhhs.gov/naic>

The AoA also provides funding for the National Information and Referral Support Center at the National Association of State Units on Aging (NASUA) which is operated in partnership with the National Association of Area Agencies on Aging and the Alliance of Information

and Referral systems. Contact: NASUA, 1225 I Street NW, Suite 725, Washington D.C. 20005. Telephone 202-898-2578.

ORGANIZATIONS

Alzheimer's Disease and Related Disorders Association, Inc. (ADRDA)

A major purpose of this organization is to organize chapters as part of a national network of family support groups. ADRDA also organizes educational programs for professionals and lay persons and advises on government policy. ADRDA, 919 North Michigan Avenue, Suite 1000, Chicago, IL 60611-1676. Telephone 1-800-272-3900. FAX 312-335-1110. Website: <http://www.alz.org>

American Association for Geriatric Psychiatry (AAGP)

Founded by a psychiatrist who has emphasized geropsychiatry in his personal and other practice, this organization now has a membership of some 1,500 professionals. It has played a major role in recent White House Conferences on Mental Health. It issues a newsletter ten times a year, a quarterly journal, and a membership directory. Advocacy efforts address public policy shortcomings related to mental health care of older persons. AAGP, 1910 Woodmont Avenue, 7th Floor, Bethesda, MD 20814. Telephone 301-654-7850. FAX 301-654-4137.

American Public Health Association (AHA)

Its Gerontological Health Section focuses on community-based long-term care systems and other responses to health needs of older persons. The section offers an annual award for excellence in program innovation. AHA, 1015 Fifteenth Street NW, Washington D.C. 20005-2605. Telephone 202-789-5600. FAX 202-789-5661.

American Red Cross (ARC)

Disaster services include preparedness training, community education, mitigation, and response. Every local Red Cross chapter is charged with readiness and response responsibilities in collaboration with its disaster partners. Chapters are also asked to provide information when families call for information about members in disaster areas. Chapters are also a source of the many ARC publications,

(including two described in Appendix One, Resources). General ARC information is available at its website, <http://www.redcross.org>.

American Society on Aging (ASA)

Has a membership of professionals working in aging and is a source of information its publications including a journal, newspaper, and newsletters. One of its specialized publications is a quarterly newsletter, *Dimensions*, distributed to members of ASA's Mental Health & Aging Network. Members of the network also plan and participate in educational programs addressing mental health and aging concerns. ASA, 833 Market Street #511, San Francisco, CA 94103-1824. Telephone 415-974-9600. FAX 415-974-0300.

American Association of Retired Persons (AARP)

Has a nationwide membership of persons 50 and over and maintains advocacy, research, information programs and community services provided by a network of local chapters and volunteers. Its Widowed Persons Service Social Outreach and Support Services gives direct assistance and also has published *On Being Alone: Guide For Widowed Persons*, offering philosophical and practical suggestions for bereavement and beyond. It includes a helpful bibliography. AARP's Research and Information Center publishes a useful *Acronyms in Aging: Organizations, Agencies, Programs and Laws*. AARP, 601 E Street NW, Washington D.C. 20049. Carol Cober, AARP Senior Program Specialist in Health and Long-Term Care, is at 202-434-2263. FAX 202-434-7683.

(Note: The AARP Foundation, with support from the Center for Mental Health Services, in mid-1998 was completing work on a publication, *Building Mental Health and Aging Coalitions*. Summary Final Report: Training and Technical Assistance to Improve Access to Mental Health Services for the Elderly.)

American Psychiatric Association (APA)

This professional society of psychiatrists has a long history of concern about diagnosis, treatment, and rehabilitation of older persons (as well as persons in other age categories) with mental or emotional illness. Its Council on Aging, established in 1978, evaluates psychiatric care for older patients and offers training programs. It also maintains a psychiatrist locator (for consultation) service. APA, 1404 K Street NW, Washington D.C. 20005. Telephone 202-682-6220.

American Psychological Association (APA)

Since the White House Conference on Aging in 1981, this association has kept watch over policies and practices related to care of older persons. In 1995, APA published *Emerging Issues in Mental Health & Aging*, which drew upon papers prepared for a 1995 Mini-White House Conference on Aging and Mental Health (see Appendix One, Resources, for details). APA, 750 First Street NW, Washington D.C. 20002-4242.

Gerontological Society of America (GSA)

GSA's interdisciplinary membership includes researchers, practitioners, and educators. Its two bimonthly journals, *The Gerontologist* and *The Journals of Gerontology*, frequently report on research findings related to mental health, clinical practice, demographics, the aging process, and public policy. GSA, 1275 K Street NW, Suite 350, Washington D.C. 20005-4006. Telephone 202-842-1275. FAX 202-842-1150.

National Association of Social Workers (NASW)

NASW is often called upon to perform critically important tasks related to disaster relief. Many social workers also have roles related to aging, in such areas as senior services, home health, hospice, nursing homes, residential facilities, and life care communities. In 1998, NASW granted provisional status to the establishment of an Aging Section intended to facilitate networking, information sharing, national linkages, and advocacy. Information: NASW Sections, 750 First Street NE, Suite 700, Washington D.C. 20002-4241. Telephone 1-800-638-8799, Ext. 268. FAX 202-336-8311.

National Council of Senior Citizens

This council has a national membership of senior citizen groups that often take activist positions on public policy and other issues. Its educational efforts include publications, rallies, workshops, and a library of works on aging issues. 1331 F Street NW, Washington D.C. 20004-1171. Telephone 202-347-8800. FAX 202-624-9595.

National Council on the Aging (NCOA)

Its members are primarily practitioners in aging, advocates, educators, and public policy analysts. Of its eleven constituent units two have direct relationships with long-term care issues, The National

Adult Day Services Association (dealing with services especially helpful to family caregivers) and The National Institute on Community-Based Long-term Care. The National Institute of Senior Centers deals with programs and facilities that are often helpful during disasters or in educational efforts on preparations for disasters. The NCOA catalogue of information resources (1-800-067-2755) describes publications on matters including help for caregivers; program enrichment in adult day service centers and senior centers; and health promotion techniques. NCOA, 409 Third Street SW, Washington D.C. 20024. Telephone 202-479-1200. FAX 202-479-0735.

National Mental Health Association (NMHA)

The NMHA and its state chapters provide information, advocacy, and services. For example, an ongoing program features a National Depression Screening Day each October (In 1998, October 8) during Mental Illness Awareness Week. This program has now grown to reach more than 85,000 people at 3,000 sites. A screening site may be located by calling 1-800-573-4433 or 1-800-269-1014. Screenings are free and confidential and are likely to include an educational session on depression, a written screening test, consultation with a mental health professional, and if necessary a referral to additional help.

Sponsors of the national screening effort also include the American Psychiatric Association, the National Institute of Mental Health, the National Alliance for the Mentally Ill, McLean Hospital, the National Association of Psychiatric Health Systems, and the National Depressive and Manic-Depressive Association.

The NMHA Information Center is at 1021 Prince Street, Alexandria, VA 22314-2971. Telephone 703-838-7527.

National Voluntary Organizations Active in Disasters (NVOAD)

Member organizations include the American Red Cross, Salvation Army, Seventh Day Adventist Mennonite Disaster Service, Southern Baptist Convention Church of the Brethren, Christian Reformed World Relief Committee, Church World Service, United Methodist Committee on Relief, and at least 20 other organizations that have made disaster response a priority. If unable to determine the state VOAD coordinator, check the national office, 301-270-6782.

ADVOCACY

Alzheimer's Association

Advocacy for government funding for research and public policy to help families is among the functions of this organization (also known as The Alzheimer's Disease and Related Disorders Association. See earlier reference at start of "Organizations" section). To locate a nearby chapter, 1-800-272-3900.

The Coalition on Mental Health and Aging

Its membership includes more than forty organizations (including several of those described earlier), as well as several Federal agencies. Information exchange occurs on a regular basis on policy matters including research funding, reimbursement issues, and barriers that inhibit efficient, cost-effective interventions to prevent or treat mental disorders. The coalition also serves as a model for state and local coalitions. Its "How-to-Guide," published in 1994, has encouraged formation of such groups. c/o American Association of Retired Persons, Health and Long-Term Care, 601 E Street NW, Washington D.C. 20049. Telephone 202-434-2263. FAX 202-434-7683.

National Alliance for the Mentally Ill (NAMI)

At the Federal, state, and local levels, NAMI works to improve treatment and services for people with severe mental illness and supports increased Federal funding for research. Its membership of 170,000 persons in more than 1,100 affiliates maintain support groups and a help line (1-800 950-NAMI (6264), which provides answers to queries and referrals to local support groups and services. NAMI, 200 North Glebe Road, Suite 1015, Arlington, VA 22203-3751. Telephone 703-524-7600. FAX 703-524-0004. Website: <http://www.nami.org>

Note: Many of the organizations described earlier maintain individual advocacy efforts related to public policy or educational campaigns.

HELP FOR CAREGIVERS

Children of Aging Parents (CAPS)

This organization assists adult children with information and examples of successful techniques in dealing with illness or frailty of

older family members. Publications include *How to Find Resources in Your Area* and *Communications Skills*. CAPS, in cooperation with The Equitable Foundation, Inc., has published *Aging Parents and Common Sense. A Practical Guide for You and Your Parents* (1995). In a chapter called "Some of the Toughest Issues," this publication deals with such matters as long-distance care, recognizing elder abuse, and alcoholism in old age. (To order: \$3 for handling and shipping, The Equitable Foundation, Box C, 1290 Avenue of the Americas, New York NY 10104.) CAPS, 1609 Woodbourne Road, Suite 302A, Levittown, PA 19057-1511. Telephone 1-800-227-7294 or 215-945-6900. FAX 215-945-8720.

National Alliance for Caregiving

The National Alliance for Caregiving is a resource center that provides information on eldercare information programs and conferences, publications, and training for family and professional caregivers. 7201 Wisconsin Avenue, Suite 620, Bethesda, MD 20814. Telephone 301-718-8444.

Family Caregivers Alliance (FCA)

This California-based organization supports and assists caregivers of brain-impaired adults through education, research, services, and advocacy. Its Information Clearinghouse covers current medical, social, public policy, and caregiving issues related to brain impairments, including Alzheimer's disease. Its fact sheets and other publications deal with such topics as consumer products, assistive equipment, work, and eldercare. FCA is designated as the Statewide Resource Consultant to California's eleven nonprofit Caregiver Resource Centers, which by state statute have been established to help offspring keep an impaired family member at home. FCA, 425 Bush Street, Suite 500, San Francisco, CA 94108. Telephone 415-434-3388 or 1-800-445-8106 (in CA). FAX 415-434-3508.

APPENDIX C

GLOSSARY OF TERMS

The following is an abridged version of a Center for Mental Health Services glossary explaining terms often used in disaster mental health response. The reader may encounter these (and other) words and acronyms while reviewing literature on disaster response and recovery.

Center for Mental Health Services (CMHS)

CMHS is a center within the Substance Abuse Mental Health Services Administration (SAMHSA) and located in Rockville, Maryland. CMHS advises the Federal Emergency Management Agency (FEMA) on disaster mental health. SAMHSA is part of the Department of Health and Human Services (DHHS).

Community Mental Health Organization (CMHO)

A CMHO is the administrative agent that contracts with the state mental health authority to provide mental health services to clients in a specified service area, usually covering one or more counties. CMHOs are either state-run or private, not-for-profit agencies. Most CMHOs may be classified as one of three categories: (1) freestanding psychiatric outpatient clinics, (2) freestanding partial care organizations, or (3) multi-service mental health organizations that emphasize outpatient services but also serve persons in partial care services and/or in inpatient/ residential treatment services.

Crisis Counseling Assistance and Training Program

The Crisis Counseling Assistance and Training Program (commonly referred to as the Crisis Counseling Program) is funded by the Federal Emergency Management Agency (FEMA) through the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Public Law 93-288 as amended by Public Law 100-707). Services offered by the Crisis Counseling Program involve direct interventions, as well as crisis counseling to individuals and groups impacted by a major disaster or its aftermath. Educational activities and public information on disaster mental health issues are another component of the

Crisis Counseling Program. In addition, disaster mental health consultation and training are also provided.

The Crisis Counseling Program includes two separate funding mechanisms: Immediate Services (IS) and Regular Services (RS). States must apply for the IS within fourteen calendar days after the Presidential disaster declaration. FEMA may fund the IS for up to sixty-days after the declaration date. The RS is designed to provide up to nine months of crisis counseling services, community outreach, and consultation and education services to people affected by the disaster. Although states must submit an application for RS funds to FEMA within sixty-days of the disaster declaration, the RS funding is awarded through CMHS based on a formal review of the grant application.

Emergency Services and Disaster Relief Branch (ESDRB)

ESDRB is the branch within the Division of Program Development, Special Populations and Projects of CMHS, that provides disaster mental health technical assistance to FEMA and the State Mental Health Authority during the IS. A project officer is assigned to the state for RS and monitors the program. ESDRB is located at 5600 Fishers Lane, Room 17C-20, Parklawn Building, Rockville, Maryland 20857. The telephone number is 301-443-4735. FAX 301-443-8040.

Federal Emergency Management Agency (FEMA)

Lead Federal agency in disaster response and recovery. The Stafford Act provides the authority for the Federal government to respond to disasters and emergencies in order to provide assistance to save lives and protect public health, safety, and property. Provides funding for crisis counseling grants to state mental health authorities following Presidentially declared disasters.

Indigenous Workers

Crisis counselors who come from within the local community, cultural, or ethnic group that is targeted for crisis counseling services. They are members of, familiar to, and recognized by their own communities. They may be spouses of community leaders, natural leaders in their own right, or have a nurturing role in their communities. Examples of indigenous workers may also include retired persons, students, active community volunteers, etc. Indigenous

workers may or may not have formal training in counseling or related professions; they may be paraprofessionals or professionals.

Major Disaster

The following definition comes from Section 102 of The Robert T. Stafford Disaster Relief and Emergency Assistance Act. "Major disaster means any natural catastrophe (including any hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought) that in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under this Act to supplement the efforts and available resources of states, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby."

Outreach

Outreach is a method for delivering crisis counseling services to disaster survivors and victims. It consists primarily of face-to-face contact with survivors in their natural environments in order to provide disaster-related crisis counseling services. Outreach is the means by which crisis counseling services are made available to people.

Paraprofessional

People who work as crisis counselors and have a bachelor's degree or less in a speciality that may or may not be related to counseling are referred to as paraprofessionals. They have strong intuitive skills about people and how to relate well to others. They possess good judgment, common sense, and are good listeners. Paraprofessionals may or may not be indigenous workers. Paraprofessionals will do outreach, counseling, education, provide information and referral services, and work with individuals, families, and groups. Successful programs train the paraprofessionals regarding the human response to disaster and methods for working with people who are experiencing the psychological sequelae of disasters.

Professionals

People who have advanced degrees in psychology, social work, counseling, and related professions. Advanced degrees are at a master's level or higher. They have experience in the mental health

or counseling fields and the experience and expertise to provide clinical supervision and training to crisis counselors. Typically, a professional coordinates and supervises the local outreach team for the Crisis Counseling Program. In addition, the professional may provide crisis services directly or offer consultation and support to crisis counselors who are working with complex or difficult situations. They clinically evaluate clientele to determine whether their needs exceed the scope of the Crisis Counseling Program or they may work directly with individuals, families, and groups whose problems are unusually challenging or complex.

Professionals often need training on how crisis counseling with disaster survivors differs from traditional mental health or counseling practice. An in-depth understanding of the normal human response to disaster and techniques for helping survivors integrate these experiences in ways that help them return to pre-disaster levels of functioning are essential.

Special Populations

Special populations are targeted groups in the disaster-impacted community or area with unique needs and require specific attention by the crisis counseling program. Examples of special populations include the following: children, the elderly, ethnic and cultural groups, migrant workers, severely mentally ill/seriously emotionally disturbed (SMI/SED—for disaster-related issues only), the homeless, etc. Other special populations may be identified that are unique to the area being served by the Crisis Counseling Program.

Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act)

The Stafford Act is the legislation that enables Federal emergency response and services to be provided following a disaster. Section 416 authorizes the President to provide Crisis Counseling Assistance and Training for disaster victims following Presidentially declared disasters.

State Mental Health Authority (SMHA)

The lead state government organization for providing mental health services is referred to as the SMHA. Because this organization may be a department, division, or branch depending on the state government

system, CMHS and FEMA use the acronym SMHA to denote the lead mental health organization.

Substance Abuse Mental Health Services Administration (SAMHSA)

The Department of Health and Human Services houses SAMHSA which is divided into three centers: Center for Mental Health Services (CMHS), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT). CMHS provides the technical assistance to FEMA for the crisis counseling program.

National Voluntary Organizations Active in Disaster (NVOAD)

NVOAD is a group of voluntary organizations that have made disaster response a priority. State VOADs also exist and can direct local organizations and governments to resources within their area. If unable to determine the state VOAD coordinator, contact the national VOAD coordinator at 301-270-6782.

APPENDIX D

A DISASTER PREPARATION CHECKLIST

Disasters occur with or without warning. Preparations for dealing with them may often seem futile. But in 1998 an onslaught of disasters has prompted new emphasis on preparations intended to reduce the likelihood of damage, injury, or loss of life.

Indeed, as reported in *The Christian Science Monitor* of March 25, 1998, "The rising numbers and cost of Federally declared disaster on the rise since the early 1990s is hitting aid providers so hard that the largest of them, the Federal Emergency Management Agency, is reshaping its entire focus. FEMA's emphasis today, unlike a decade ago, is prevention, not reaction."

While FEMA reshapes policy priorities and techniques, individual families, even older persons living alone, can help in the prevention effort by making certain that they have taken sensible precautions to help them better cope with disaster, whether unexpected or predicted by timely warnings.

What follows is a highly abridged version of a checklist that may be found in an American Red Cross publication, *Disaster Preparedness for Seniors by Seniors*. (See Appendix A for details on how to obtain a copy.) A more detailed discussion of disaster preparations and supplies appears in another ARC publication, *Disaster Preparedness for People With Disabilities* (also discussed in Appendix One).

General Emergency Supplies

- Battery powered radio and flashlight with extra batteries for each
- Change of clothing, rain gear, and sturdy shoes
- Blanket or sleeping bag
- Extra set of keys
- Cash, credit cards, change for the pay phone
- Personal hygiene supplies

- Phone numbers of local and non-local relatives or friends
- Insurance agent's name and number

If you can remain in your own home, you will need:

- Water supply one gallon per day per person. Remember, plan for at least three days. Store water in sealed, unbreakable containers that you are able to handle. Identify the storage date and replace over six months.
- Non-perishable food supply, including any special foods you require. Choose foods that are easy to store and carry, nutritious and ready-to-eat; rotate regularly.
- Manual can-opener you are able to use
- Non-perishable food for any pets