Disaster Mental Health Services Following The 1995 Oklahoma City Bombing: Modifying Approaches to Address Terrorism

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ABSTRACT

How did the 1995 Oklahoma City bombing differ from prior disasters and what implications did it have for disaster mental health services and service delivery? The federal disaster mental health approach in this country developed largely out of experiences with natural disasters. The 1995 Oklahoma City bombing differed in several important ways, including the large number of human casualties, higher rates of psychopathology, and an extended period of concern due to the criminal investigation and trials, which suggested the need to consider modifications in the program. Outreach was extensive, but psychiatric morbidity of direct victims was greater than that of victims of natural disasters, emphasizing the need for attention to the triage and referral process. Other concerns that warrant consideration include practices related to record keeping and program evaluation.

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INTRODUCTION

Dwarfed now by the September 11, 2001, terrorist attacks, the Oklahoma City bombing was to that time the deadliest act of terrorism on United States' soil. It destroyed the Alfred P. Murrah Federal Building, killing 168 people and injuring hundreds more. The impact extended far beyond the immediate tragedy of those who died or sustained injuries: The incident awakened us to the reality of terrorism within our borders. Despite earlier incidents, eg, the 1993 attack on the World Trade Center, most people had dismissed or ignored the possibility of a major terrorist assault within our country. The fact that the perpetrator was an American citizen—indeed, one who considered himself a patriot—added to the horror. While the 1995 bombing was forever seared into the identity of Oklahoma City, the remainder of the country soon became complacent. The 1998 bombings of two US embassies abroad did little to shake Americans from that complacency. The massive, coordinated attacks on September 11th marked the new millennium with the recognition that the US would be forever changed. Terrorism became the nation's leading public health issue, with major implications for mental health.

The Oklahoma City bombing challenged our capacity for mental health service delivery and raised a number of important issues in the administration of disaster mental health. These issues resurfaced in the wake of the September 11th attacks and warrant careful review before another attack. The Oklahoma City experience provides a model for future efforts in other communities. With that in mind, this article reviews the federal disaster mental health approach from the perspective of the Oklahoma City experience with the aim of highlighting important lessons learned for mental health response to future terrorist events.

ORGANIZATION AND ADMINISTRATION ISSUES

An impressive mental health program was established following the 1995 Oklahoma City bombing, funded by the Federal Emergency Management Agency (FEMA), through crisis counseling grants awarded by the Center for Mental Health Services (CMHS) of the Substance Abuse Mental Health Services Administration. The program was administered by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) through Project Heartland. Fashioned on federal guidelines that had been developed and refined over decades of experience with natural disasters, it became clear that these guidelines would need modification to address the specific concerns arising out of a disaster involving weapons of mass destruction.

Establishing Authority and Responsibility

The initial and primary official responsibility for disaster and emergency management rests with local government. When local resources are inadequate state government, under the direction of the governor, assists by directing state

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resources. In these situations, the governor typically charges the state's office of emergency services with disaster management. This office in turn assigns tasks to other state agencies responsible for disaster relief and recovery. If state and local resources are insufficient for the response, federal assistance is available.[1] The relationship among levels of government recognizes the local nature of disasters and the need for involvement of people who know the community and will remain in it after rescue and recovery efforts are complete. It also guides decision-making and establishes a hierarchy of responsibility.

The nature of terrorist threat and assault raises issues with respect to this delineation of responsibility. First, boundaries may not be clear in terrorist situations. For example, imagine a biological attack with smallpox or another highly contagious agent in which disease is likely to spread across state lines and may require difficult decisions, such as when and how to vaccinate or quarantine. Second, the target of terrorism is not only the direct victims or even community in which the disaster occurs—it is the government and the nation at large. Third, terrorism raises serious national security concerns that are not appropriately left to a state or states. Lack of jurisdictional clarity in the management of the Oklahoma City bombing was minimal, but the events of September 11th underscore the need for clarity in the service of rapid and appropriate response.

Organization and Administration of Mental Health Services

Federal disaster mental health assistance is administered through the CMHS. Support is available through grants that require the state to conduct an assessment of need.[1] The existence of the federal program, and the availability of consultants experienced in disaster mental health who could project future need, were reassuring to providers in Oklahoma City that had minimal experience in this kind of work. The federal program provided an important infrastructure of knowledge, skill, initial resources, and focus from which to organize and administer mental health services, as well as the information needed to commence clinical efforts in an environment of confusion and chaos.

MENTAL HEALTH SERVICE ISSUES RAISED IN OKLAHOMA CITY

The CMHS recognized that the bombing was unique in a number of ways. The extensive loss of life and injury were unparalleled in disaster experience. Children were believed a target. Fear and suspicion permeated the environment. The criminal nature of the event would prolong the emotional trauma through a criminal investigation and trial. Developed largely out of experience with natural disasters, the federal disaster mental health approach was modified in a number of ways. Modifications included a longer period of service; specialized services to cover the criminal trial; and services to address the long-term needs of rescuers. Project Heartland remained open for over 5 years. The first 3 years were funded primarily through grants from the Crisis Counseling Program of CMHS, while the remaining years of service were supported through grants from the Office for Victims of Crime in the Department of Justice. This federal partnership was new in the aftermath of the Oklahoma City attack. Even with these modifications, tension surfaced among provider groups and agencies over several key issues. These derived from differences in philosophy and treatment approaches among professionals unaccustomed to dealing with a crisis of this magnitude.

Eligibility for Services and Service Approach

The philosophy underlying the federal program, founded largely on experience with natural disasters, assumes that everyone who experiences a disaster is somehow affected by it; that most psychosocial response represents normal reactions to very abnormal conditions; and that, while some will develop diagnosable mental disorders, traditional treatment to address their needs is outside the scope of the federal program.[1,2] Services are designated to address mental health problems caused or aggravated by the disaster and prevention of future problems. They are available to residents of the community in which the disaster occurred, to those who work in areas impacted by the disaster, and to those who were present at the disaster.[1,3] Project Heartland utilization data suggest a preponderance of services were provided to indirect community victims of the bombing. A total of 9,345 individuals received services at Project Heartland. Of those, 4,554 (49%) were themselves affected by the bombing; 1,524 (16%) identified an associate affected by the incident; 1,135 (12%) identified a friend; 1,477 (16%) identified a relative; and 655 (7%) identified multiple relationships. Of the 4,554 individuals who were themselves affected, 438 (10%) were survivors; 575 (13%) were rescue workers; 3,435 (75%) were indirectly affected; and 106 (2%) were in other categories (ODMHSAS, Integrated Client Information System, June 2002).

The federal approach emphasizes crisis intervention and support services, triage and referral, and outreach and public education for affected individuals.[1,3] With its focus on normal reactions, the federal program recognizes that although many individuals may have psychological reactions to a disaster, few actually develop diagnosable mental disorders significant enough to warrant more than crisis intervention, brief treatment, or supportive therapy.[1,2] Services are not meant to supplant those already existing in the community and are not intended for those with serious psychiatric illness.[2] Training is a key aspect of the federal program, which not only employs mental health professionals, but also relies heavily on paraprofessionals.[1]

Findings from Oklahoma City suggest that in large-scale, human-caused disasters, the need for services and traditional mental health care may be greater than anticipated according to the Crisis Counseling Program. North and colleagues[4] conducted a methodologically rigorous study of direct victims of the bombing. Six months after the incident,

approximately 45% of the sample suffered an active psychiatric disorder and one third had bombing-related posttraumatic stress disorder (PTSD). These rates were higher than in victims of other disasters using the same methods and instruments.[5-10] Therefore, while most individuals in a disaster environment are resilient, the suffering of many direct victims of this kind of massive disaster persists and has implications for service delivery. By assuming that "support, assistance, and information" are adequate to address the needs of victims,[2] the federal plan runs the risk of overlooking the problems of the neediest victims. In Oklahoma City, Project Heartland worked within a network of service providers and there were numerous alternatives for more traditional mental health care.

A little-referenced CMHS program guidance document on crisis counseling and mental health treatment acknowledges that there may be differences between what it refers to as "major" and "catastrophic" disasters.[2] This document recognizes that catastrophic disasters, which are characterized by enduring community disruption, prolonged exposure and recovery, serious secondary adversities, cumulative stress, diminished treatment capability, and threat or reality of recurrence, may lead to more serious psychological problems that require traditional mental health treatment. CMHS suggests that these catastrophic disasters may result in the need to refer more individuals to traditional mental health treatment.[2] Federal mental health officials involved in the aftermath of Oklahoma City recognized early that the need for treatment services would be greater than in more typical disasters. The crisis counseling program continued to operate under the rules, guidance, and constraints that characterized the program prior to the bombing, however. At the time, efforts to accurately estimate the magnitude of the treatment need, the scope and depth of existing personnel and funding to meet those needs, and anticipated duration of the need did not produce information consistent, comprehensive, or persuasive enough to attract additional funding by federal mental health agencies. Obtaining this type of information remains difficult. The projection of treatment needs and the evaluation of human, financial, and service system resources to meet those needs will be a major challenge as we consider future terrorist events, especially those that involve mass casualties.

Triage and Referral

The CMHS focus on normal responses has important implications for the development of triage and referral services. CMHS identifies five questions to guide decisions about referral: (1) Did the condition arise from the disaster or was it exacerbated by the disaster? (2) How well can disaster mental health staff assess the individual, and is crisis counseling the intervention of choice? (3) Is the standard informal record-keeping adequate and appropriate? (4) Is the mental health system, as opposed to other service systems (eg, primary health care or social services), appropriate for management of the individual or problem? (5) Can the disaster mental health program adequately address the individual's needs in light of the program's "time, human resource, and skill limitations"?[2]

The onset of symptoms in the Oklahoma City victims was acute, occurring on the day of the bombing for most. Psychiatric comorbidity was extensive, involving more than 60% of PTSD cases.[4] Victims with significant disaster-related mental health problems need triage to traditional treatment as soon as possible. Therefore, it is essential that those in first contact with victims know how to identify and evaluate serious or potential mental health problems, including not only PTSD, but indicators of other disorders as well.

Some professional groups in Oklahoma City had nagging concerns that significant clinical problems were not identified by Project Heartland or, if identified, were not addressed. In the only published report of service utilization data to date, Call and Pfefferbaum[11] described hours spent and clients served by Project Heartland. Few recipients (242) or hours of service (33) were logged for activities such as screening, evaluation, and referral relative to the number of recipients and hours spent in activities such as outreach (106,420 recipients; 12,442 hours), counseling and therapy (3,989 recipients; 8,930 hours), and support services (3,997 recipients; 29,561 hours). The implications of these numbers are unclear. They suggest that despite a focus on crisis intervention and support services, relatively few individuals were triaged and referred for more traditional care. It is likely, however, that the numbers do not reflect all referrals. For example, the referral category would not have been used for clients who were seen for counseling and therapy services and later referred. The utilization figures may also reflect a misunderstanding or misuse of conventional terms like "triage" and "referral," inconsistent and ill-defined categories of service, the preponderance of service to indirect victims or those needing relatively little care, or successful treatment outcome minimizing the need for referral.

With 45% of the direct victims in the study by North and colleagues[4] developing a diagnosable mental illness after the incident, one might have expected a larger volume of referrals. On the other hand, many victims received mental health services. Sixty-nine percent of those studied by North and colleagues had received some kind of mental health intervention: Forty percent reported participation in debriefings; 41% had sought professional mental health treatment; and 16% had been treated by psychiatrists. These figures point to success of the network established by Project Heartland and other traditional providers in the community. To prepare for the emotional consequences anticipated by the execution of convicted bomber Timothy McVeigh in 2001, the network was used successfully when the ODMHSAS convened mental health professional groups.

Questions about triage and referral also arose in the Oklahoma City school-based program. Seemingly disproportionate numbers of recipients served (57) and hours spent (10) in screening, evaluation, and referral compared to emergency services and crisis intervention (2,519 recipients, 1,555 hours), counseling and therapy (2,491 recipients,

4,801 hours), and support services (2,287 recipients, 17,306 hours) were logged for children's services.[12] The school-based program relied on students and trainees from local psychology, social work, and professional counseling programs—supervised by their faculty and Project Heartland program staff—to provide front-line mental health services to children. This approach had advantages: It was economical and fostered interdisciplinary experiences and training. The considerable variation in the qualifications and experience of counselors, however, raised concerns that inexperienced providers may have missed significant pathology.

Referral guided primarily by a specified number of individual sessions, as was the case in Oklahoma City, is problematic because it is arbitrary, fails to address the victim's clinical status, and disregards the important differences in training, experience, and skills between disaster mental health workers and traditional providers. In addition, using support services as treatment in individuals with significant psychopathology, commonly in a group format, may not only fail to address their needs, but may also retraumatize them by exposing them to the traumatic experiences of others and to memories of their own experience they are not ready to face, especially if they have the prominent avoidance and numbing profile that seems to characterize PTSD.[4] This is not to imply that outreach, counseling, and support services are less important than triage and referral. Instead, it underscores the need for networks of providers and increased attention to triage and referral in mental health service planning and training in disasters like the Oklahoma City bombing.

Outreach

Intent on helping the most seriously affected, traditional mental health professionals in Oklahoma City tended to discount the importance of outreach so necessary to identify victims in need of services. Clinicians in Oklahoma City struck by the fact that victims were not accessing services and by the number of canceled appointments, late arrivals, and termination of treatment by bombing cases. Whether this was avoidance of mental health care or due to other priorities associated with physical or financial needs can only be conjectured. The potential for avoidance in children can be particularly problematic, as it is compounded by a tendency for parents and other adults to underestimate their suffering.[13-15] Because many victims fail to receive treatment, the earliest encounter and, as we learned, every encounter is crucial.

Differences in disciplinary perspective and focus generated distrust among provider groups in Oklahoma City. Those skilled at offering public education and outreach services to many indirect community victims and those accustomed to treating seriously ill patients were commonly at odds. Relationships among some of these groups remain uneasy to this day.

OTHER CONCERNS

Other conflicts within the mental health community arose in the aftermath of the Oklahoma City bombing. They reflected not only the state of the field, but the sometimes disparate cultures of disaster services and traditional treatment, public health and medical models, and clinicians and researchers.

Confidentiality and Record-keeping

CMHS resists setting a national standard with respect to record-keeping, but recommends that documentation of contact include date, location, and duration of service, brief content of the session, follow-up information, and the provider's signature. CMHS views psychological testing, mental status examination, diagnosis, planning and documentation of formal treatment, and prescription and dispensation of medication as inappropriate for documentation.[2] This approach evolved out of the concern about the ethics of entering clients into a mental health system without their own explicit intent to do so (Brian W. Flynn, EdD, oral communication, June 2002). Unfortunately, the stigma associated with mental health care discourages its use. Many, if not most, of the interventions provided in the aftermath of the Oklahoma City bombing involved education, outreach, and supportive services[11,12] which do not constitute formal treatment with its accompanying documentation.

Documentation was also discouraged out of concern about confidentiality, particularly for professional rescue workers many of whom were seen at Project Heartland. The potential for records to be subpoenaed for the inevitable criminal trials of the bombing defendants also raised concern. While these concerns may have been exaggerated, the issue of victims' privacy rights was raised in another context when the Federal Bureau of Investigation and US Attorney's Office sought a list of victims.[16] On the other hand, several high-profile trial witnesses received formal mental health treatment and, to our knowledge, no records were subpoenaed.

Lack of formal record-keeping became an obvious symbol of the differences in approach between Project Heartland and the traditional mental health system, and it prevented the delivery of comprehensive services at Project Heartland. For example, psychiatrists were uncomfortable practicing on-site, but accepted referrals to their own practices and institutions. Many questioned the rationale for the no-record policy and concluded that record-keeping would create minimal problems. Medical record-keeping is the norm for most systems of care and providing services without documentation is also fraught with potential problems. This is an area needing attention in planning mental health interventions for future terrorist events.

Evaluation and the Compilation of Data

Project Heartland's position on client record-keeping was sometimes cast as a clash between clinicians and researchers. Project Heartland allowed anonymous questionnaires to be available on site for those who chose to participate in the only study of its clientele that was conducted.[17-21]

Seeing its mission as service, historically, FEMA has not allowed grant-funding to be used for evaluation and research. While virtually no evaluation of services or

treatment effectiveness was conducted in Oklahoma City, FEMA currently supports such activities. It maintains strict prohibition, based on legal interpretation as well as philosophy, against involving staff or information gathered in the intervention process for research purposes, however (Brian W. Flynn, EdD, oral communication, June 2002). Evaluation is a painstakingly difficult but important activity, and it is essential to advancing the field. While evaluation studies are likely to increase the burden on disaster mental health programs initially, these programs are in an ideal position to conduct this work and to benefit from the results.

CONCLUSION

The federal disaster mental health approach focuses on normal reactions to horrific events and provides a host of services including outreach, triage and referral, emergency services and crisis intervention, counseling and therapy, and support services.[1,3,11] Attention to the delivery of mental health services postincident should consider the degree to which we expect psychopathology and the factors that influence it in the postdisaster recovery environment. Experiences in Oklahoma City suggest that large-scale, human-caused disasters may result in greater psychiatric impairment of direct victims than do natural disasters.[4] A recent empirical review of the disaster mental health literature supports this suggestion. In an analysis of 160 samples of disaster survivors, the samples that experienced mass violence were far more likely to be severely or very severely impaired than were samples that experienced either natural or technological disasters.[22] Issues related to the type and duration of services, training, and the administration of programs must be reviewed in light of these findings. This may mean reprioritizing the focus of care and redistributing funds, greater flexibility in application of current policy, or the development of additional federal-intervention models (eg, ones that include support for treatment) and/or other funding mechanisms (eg, separate funding for treatment services). Triage and referral are essential and must occur as a fundamental part of outreach. These activities must be based on a knowledge of psychopathology and risk factors and should be emphasized in training. Renewed attention to issues, such as confidentiality and record-keeping, data collection, and formal evaluation of services is also warranted.

In a developing field like disaster mental health, where experience is expanding faster than research, and where we are faced with events for which our models were not designed, the learning curve is both steep and incomplete. We grow as much from issues that create conflict as from those for which there is consensus. Clearly, in the eyes of all involved, the mental health response to the Oklahoma City bombing included both successes and problems. Those who labored, in all venues of recovery in Oklahoma City, to find ways to adapt a longstanding model to a new situation, to solve emerging problems, and to capture their experiences through various vehicles have helped shape the response to September 11th and future events. As this country struggles to respond to the events of September 11th and the virtually certain reality of additional terrorist events, the experiences of Oklahoma City have played a significant role in shaping the course. We continue to learn from their struggles. CNS

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