COMMENTARY

Protecting Mental Health of Hospital Workers after Mass Casualty Events: A Social Work Imperative

Erika L. Sabbath, Jessica Shaw, Andrea Stidsen, and Dean Hashimoto

On October 1, 2017, a mass shooting in Las Vegas, Nevada, ended with 58 concertgoers and the gunman killed, and almost 500 people injured. In recent years, other large-scale acts of violence have caused significant morbidity and mortality: 130 dead and over 400 injured in the coordinated attacks in Paris in 2015; three dead and over 250 injured in the Boston Marathon bombings in 2013. Such events are becoming both more common and more lethal. Indeed, between the initial drafting of this commentary in mid-October 2017 after the Las Vegas attack, and its submission to *Social Work* in mid-November 2017, a mass shooting occurred at a church in Sutherland Springs, Texas, that left 26 dead (plus the gunman) and 20 injured. While this commentary was awaiting publication another mass shooting at Marjory Stoneman Douglas High School in Parkland, Florida, claimed the lives of 17 teenagers and educators and injured 17 others.

When acts such as these occur, physicians, nurses, social workers, and janitorial and food service staff see and do the unimaginable: mopping up pools of blood from the floor, trying to determine identities of gravely wounded patients, and fearing that they will encounter their own loved ones among the injured or deceased. Except for hospital staff who served in active combat, the type and scale of post-attack patient and family care are usually distressing, even to those who consider themselves unflappable. This is especially the case in smaller hospitals that rarely see trauma victims. Without proper preparation, support, and follow-up, hospital workers risk becoming secondary—and often invisible—victims of attacks, not counted in official tallies but suffering emotional wounds that affect their lives in and out of work.

Following a mass casualty, there is urgent need for the skills and services provided in hospitals by both medical social workers and employee assistance program (EAP) or occupational social workers (hereinafter referred to as EAP social workers, although we recognize that not all hospitals have on-site EAP teams). Medical social workers work with patients and families undergoing major, often life-altering trauma, and EAP social workers use similar skills to respond to mental health needs of their coworkers that may arise during the course of disaster response, providing direct support and helping facilitate supportive organizational policies and practices. However, at smaller institutions or those without a dedicated EAP social work team, medical social workers often fill both roles after mass casualty events, sometimes at the expense of their own mental health. In this commentary, we discuss roles that both EAP and medical social workers can play in supporting the mental health and well-being of hospital staff before, during, and after a mass casualty event, and provide recommendations for how these steps can be codified into hospital and citywide disaster response plans.

EVIDENCE FOR THE IMPACT OF LARGE-SCALE ATTACKS ON HOSPITAL WORKERS

Most people who directly witness a mass casualty event experience some immediate emotional disturbance, such as difficulty sleeping, fear, intrusive thoughts, or temporary increases in coping behaviors like smoking or alcohol consumption (Grieger, Fullerton, Ursano, & Reeves, 2003). Some individuals will have more persistent insomnia, agoraphobia, and other symptoms that intrude on daily life (Benedek, Fullerton, & Ursano, 2007), with a further subset developing posttraumatic stress disorder

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(PTSD) or other psychiatric illnesses (Goldfrank, Panzer, & Butler, 2003). The impact of such events, though, can extend beyond those who directly experience it. Several studies have found that working with disaster victims is associated with secondary trauma: development or increase in PTSD symptoms, resulting from repeated exposure to the traumatic experiences of others (Fullerton, Ursano, & Wang, 2004). For some, such symptoms are also paired with a shift in worldview (that is, vicarious trauma), similar to changes that happen for someone who has experienced trauma firsthand (Hammerslough, 2015; U.S. Department of Justice, Office for Victims of Crime [DOJ, OVC], 2015). Although sometimes discussed in tandem, secondary and vicarious trauma are different from burnout; the former two frequently mirror symptomology of those who directly experienced the trauma, and affect all facets of life, even after time off or switching jobs (Newell & MacNeil, 2010).

Citywide emergency response plans and hospital protocols such as the Hospital Incident Command System are effective at saving lives of the critically injured (Biddinger et al., 2013; Skivington, DeAtley, Thompson, Spurgeon, & Clark, 2014). However, these measures may be inadequate in attending to mental health needs of hospital staff. This can be true even when hospitals staff highly skilled medical social workers, as the extensive need for services by patients in the disaster aftermath may leave hospital staff overlooked and underserved. As frequency and severity of large-scale attacks in the United States and worldwide increase, so does the number of individual hospital workers exposed to others' firsthand trauma, and the potential for each of these individuals to develop symptoms of secondary or vicarious trauma. At a population level, this translates to a cumulative increase in the burden of distress and mental health concerns across the health care workforce.

COMPREHENSIVE SOLUTIONS TO SUPPORT HOSPITAL STAFF

We propose that mental health considerations for all hospital workers be a central part of disaster planning, at both municipal and hospital levels. These preparations focus on reducing secondary and vicarious trauma, so workers can care for patients while also protecting their own health and well-being. EAP social workers are positioned to serve in a key organizing role within their institutions—helping hospitals systematically anticipate, monitor, evaluate, and respond to the mental health needs of workers before, during, and after an attack (Schouten, Callahan, & Bryant, 2004). Here, we provide evidence-based recommendations for how these practices might be implemented (Quitangon & Evces, 2015; DOJ, 2015), and how such principles can be deployed to protect the mental health of medical social workers as well, especially in the absence of a strong on-site EAP.

As part of predisaster training, EAP social workers can provide resources and training to help workers establish personal disaster plans, including communication strategies with their families and contingency plans for dependent care. As part of these plans, hospitals can contribute resources such as emergency on-site child care to reduce work–family conflict and associated stressors. More generally, promoting availability and use of mental health services on an ongoing basis—from counseling to substance addiction services—will foster a higher baseline level of mental hygiene, and thus greater resilience if disaster strikes. In addition, an open and transparent organizational culture at the hospital level can foster a sense of community and connectedness that can help prevent and decrease levels of vicarious trauma (Brondolo, Wellington, Brady, Libby, & Brondolo, 2008). Numerous studies have found that organizational factors (processes, characteristics, climate) are the most important predictors of first responder well-being and stress, rising above exposure to traumatic incidents (Burke & Paton, 2006; Paton, Violanti, & Smith, 2003). A caring culture reminds medical social workers that they, too, should practice self-care and seek mutual support.

During the event, EAP social workers can work closely with hospital leaders to protect the mental health of workers who are treating or interacting with victims and families (Vineburgh, Ursano, & Fullerton, 2005). At both individual and work unit levels, such steps should promote (a) awareness, (b) care, and (c) connection. To promote awareness of secondary trauma, individuals should be taught and encouraged to practice self-awareness, and to reflect routinely on what and how they are feeling, as early identification of secondary trauma symptoms can help get individuals connected to necessary resources sooner. EAP and medical social workers can also provide managers with training on how to identify and respond to signs of secondary trauma and indications that a staffer is having difficulty coping, and when to arrange a group

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support session facilitated by the EAP or medical social worker. Resources such as the toolkit from the Office for Victims of Crime provide numerous materials for departments that may not be well trained in this area (DOJ, OVC 2015).

To promote care, individuals, unit supervisors, and organizations should prioritize setting boundaries that are supportive of worker's well-being and resiliency. Individuals should be encouraged to identify activities that they enjoy, and to set aside time for them in the days following a tragedy. Unit supervisors can help protect self-care time by ensuring that their personnel, including medical social workers, are taking breaks during shifts, are taking days off when possible, and are not shamed by their colleagues for going home when their shift is over. Furthermore, managers across the hospital (including in social work departments and EAPs) should model these behaviors themselves. At an organizational level, hospitals can reinforce these practices by guaranteeing personnel a certain number of vacation days and time off, enforcing overtime policies, and providing adequate mental health benefits.

Finally, to promote connection, individuals should be encouraged to connect with others. Unit supervisors should provide time and space for personnel to express fears, concerns, and needs without the threat of stigma or retaliation and without it affecting their performance evaluations; EAP social workers can facilitate this process (Bell, Kulkarni, & Dalton, 2003). For medical social workers, this could be a part of routine social work supervision. Unit supervisors can connect new staff with more experienced staff to serve as mentors (Gayton & Lovell, 2012). Although ad hoc group debriefings are common, hospitals should make available ongoing forums for individuals to discuss secondary and vicarious trauma, with particular effort to include environmental services staff and other contracted professionals who encounter disaster victims but may not be part of physical units.

Postdisaster, EAP social workers and hospital leadership should continue to promote awareness, care, and connection, as secondary trauma and other mental health effects may extend long past initial exposure. Thus, the previously discussed suggestions may be practiced for weeks or months after an event. If employees with ongoing mental health needs choose to transition into longer-term treatment, EAPs can identify employer and community resources, including mental health treatment and family or community support. Human resources departments can support workers' postattack recovery by accommodating requests for flexibility in work arrangements.

In hospitals without on-site EAPs, administrators need to be aware that medical social workers have high-volume and high-acuity caseloads following an attack and may simultaneously be supporting coworkers at risk of vicarious trauma. In such cases, administrators need to quickly bring in social workers from contracted EAPs to relieve medical social workers of this double burden.

Finally, citywide plans for disaster response should include guidelines for the implementation of hospital policies that protect workers' mental health in the event of a mass casualty event, so that all hospital workers receive a baseline level of support, regardless of their specific employer. We call on the National Association of Social Workers (NASW) and affiliates to partner with hospitals and cities to create, implement, and enforce such plans. We also call on social work schools to develop and implement training on responding to mass casualty events in occupational social work and medical social work courses. Ultimately, NASW, schools of social work, hospitals, and cities cannot prevent the next tragedy or large-scale violent attack, but they can all play a critical role in ensuring optimal patient care while protecting the health of their workforce. SW

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