How We Debrief: An Interpretive Description of Social Service Community Workers' Experiences

Andrea C. Krywucky, The University of Western Ontario

Supervisor: Dr. Abram Oudshoorn, The University of Western Ontario
Dr. Anita Kothari, The University of Western Ontario

A thesis submitted in partial fulfillment of the requirements for the Master of Health Information Science degree in Health Information Science
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Abstract

The aim of this research was to understand current practices of debriefing being used or not used in community social service organizations and the presumed frameworks or evidence justifying these practices in London, Ontario. The geographical area under concern has seen an increasing poverty gap, lack of affordable housing, toxic drug crisis, with mental health issues being exasperated by the pandemic. Social service agencies are overwhelmed with caseloads, creating an increase in need of care for frontline workers, as they are the first point of contact for many. This research utilized an interpretive description methodology to explore workers’ experiences and created a unique opportunity to hear practice-based knowledge from those who live the concept of concern, namely debriefing. Qualitative data were collected from staff at the 10 participating organizations, 41 participants completed online text-based surveys with 9 one-on-one interviews conducted through the Zoom platform. The results show that more than half of the sample were receiving some form of debriefing. Participants’ perceptions were further examined revealing a strong connection between two sub-themes underpinning the broader challenge of a ‘fear of disclosing’: being conceived as weak and having had traumatizing debriefing episodes in the past. Participants felt stigmatized when reaching for help, resulting in an unintentional ‘mental health stigma’ by co-workers and at an organizational level. Ultimately, we find that workers have a willingness to communicate with peers privately about their experiences but often do not feel safe enough to do so in current models of debriefing, resulting from an environment that ‘lacked psychological safety’. This study shows that most frontline workers who participated in this study, desired better organizational-led debriefing practices, rooted in evidence-based models.
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Keywords: Debriefing, vicarious trauma, secondary trauma, compassion fatigue, burnout, community social service workers, psychological safety, mental health stigma, peer-support, Personal Reflective Debriefing.
Summary for Lay Audience

Purpose of Study

This study focused on understanding current practices of debriefing being used in community and/or non-profit social service organizations and any frameworks or evidence justifying these practices. There is a lot of research looking at what contributes to psychological stress and mental health risks experienced by frontline workers, but this hasn’t led to the creation of clear standards for doing good debriefing.

Data Collection

Data were collected through online tools (i.e., short answer) from 10 organizations, 41 participants completed the questionnaire, with 12% male, 83% female and 5% preferred not to say. Participants were then given the opportunity to participate further via in-depth interviews over the Zoom platform, of which 9 participants choose to share their experiences.

Findings

The results demonstrated that over half the sample were receiving debriefing, performed in a variety of ways, from: daily debriefs to critical incidents, and were either peer or management led. The majority of debriefs were unstructured and peer-led. Through further analysis of the data, key themes were found, indicating that community social service workers felt a lack of psychological safety in the workplace. Themes were found from the perceptions and experiences of workers, showing a desire for open and supportive communication but some felt unsafe to disclose their triggered trauma responses, resulting in felt mental health stigma.
Conclusion

This study recognizes the challenges that community social service workers and organizations are faced with, resulting in creating and executing their own debriefs, without any specific evidence-based guides in place. This study stresses the importance of creating psychologically inclusive spaces for social service and community workers. Although, more research is needed to create a standard debriefing guide geared toward social service and community workers specifically.
Acknowledgements

First and foremost, I would like to offer special thanks and appreciation to my supervisor Dr. Abram Oudshoorn for giving me the opportunity to grow and learn. This thesis was created during the COVID-19 pandemic and presented unique opportunities that no one was prepared for, but we overcame together in support. Without his patience, knowledge, and confidence in my ability I would not have learned the skills to carry me through. I am grateful for all the opportunities I was awarded through this difficult journey that we call academia. It has molded me in ways that no other experiences have and changed me more than I dreamed I could be. From darkness into light.

I thank the University of Western Ontario for taking a chance on me, without hesitation. They believed I could: to Dr. Anita Kothari for always lending a kind ear and advice through those difficult challenges in my learning experience; and to Tiffany Scurr who guided me and held me up through every hurdle and obstacle, her belief in me kept me going. Finally, to Jodi Hall for her support as a committee member and her valuable support into my academic journey at the outset.

Lastly, to my friends and family who were there during those reading weeks of much needed support and needed rest.
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Chapter I: Introduction

Demand for health and social support services has increased through the Covid-19 pandemic, with increasing caseloads experienced by social service workers (Canadian Centre for Addiction and Mental Health, 2020; Gupta et al., 2021; Public Health Agency of Canada, 2020). For example, the Hunger Report (2020) involved a review of usage across Ontario’s food banks and found an increase in demand due to the pandemic stemming from unaffordable housing, food insecurity, employment loss, precarious employment, and mental health issues (Canadian Centre for Addiction and Mental Health, 2020; Gupta et al., 2021; King et al., 2020; Public Health Agency of Canada, 2020). Other support services have seen similar increasing needs among those who access their services, including increasing use or misuse of alcohol and/or substances deemed illegal, resulting in addiction issues (Canadian Centre for Addiction and Mental Health, 2020; Dubey et al., 2020), increasing intimate partner violence (Statistics Canada, 2020), and strains on homelessness support services (Ndumbe-Eyoh et al., 2021; Schwan et al., 2020; Public Health Ontario, 2021). These concerns for vulnerable populations are echoed in this study’s location of London, Ontario, and reflect ongoing challenges of: the scarcity of affordable housing, the lack of a safe drug supply, and increasing mental health issues (Canadian Centre for Addiction and Mental Health, 2020; Public Health Ontario, 2020). Ultimately, this is a difficult time for those who work in frontline support services (Statistics Canada, 2021).

Social service agencies and their workers are responsible both for programs and services within funded community, municipal, provincial, and federal requirements, as well as individual outcomes aligned with the mission of their organization (Canadian
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Alliance to End Homelessness, 2021; London Homelessness Coalition, 2021; Mayor’s Advisory Panel on Poverty, 2016; Ontario Budget, 2021; Smith et al., 2017). Through these services, social service workers are exposed to many difficult issues faced by individuals they support, including personal/social problems, addictions, mental health challenges, food insecurities, homelessness, violence, physical/sexual abuse, poverty, social injustices, and legal and criminal litigations. These complex challenges are difficult for persons accessing supports to manage on their own and they therefore frequently rely on the care, counselling, and community/social supports that community agencies provide (Canadian Alliance to End Homelessness, 2021; King et al., 2020; London Homelessness Coalition, 2021; Mayor’s Advisory Panel on Poverty, 2016). Regardless of the precise role, social workers, social service workers, community service workers, and peer support workers are all called upon to share in the traumas of those living on the margins of Canadian communities. The risks associated with working in social service sectors can range from vicarious trauma, re-traumatization, compassion fatigue, secondary trauma, stress disorders, burnout, and possible career exit (Cocker & Joss, 2016; Cohen & Collens, 2012; Finklestein et al., 2015; Jenkins & Baird, 2002; Waegemaker Schiff & Lane, 2019).

In 2018, the Canadian occupational projection system (COPS) explored the human resources need for social and community services over the next ten years, showing an insufficient amount of workers to fulfill the needs of Canadians seeking support (Government of Canada, 2018). This gap may be exacerbated, if high turnover rates continue as a result of unforeseen strain on service delivery in social service community work (Scanlan & Still, 2019). A key element to sustaining workers is how organizations address the daily stressors of the work or particular crises, such as potentially traumatic
incidents (Cooper et al., 2001; Hallinan et al., 2019). However, both the literature and the practices around dealing with challenging experiences is highly variable. This study seeks to expand our understanding of debriefing in the context of the challenges faced by social service workers working with increasingly marginalized populations.

Debriefing is broadly defined by the Oxford English Dictionary (n.d.) as, “To obtain information from a person after the completion of a mission or journey.” A mission or journey has a long or arduous connotation attached; it has a beginning and an end. Usually, a person(s) is briefed prior to a mission or journey, in preparation of what is to come, and upon completion of said task is debriefed to ensure transparency, to relay information, and/or to recover from stressful events (Oxford English Dictionary, n.d). Debriefing can be a formal process (structured) to facilitate a discussion within an organization involving trained personnel, which is planned and follows an organized framework, or an informal process (unstructured) following an unexpected event that requires debriefing (Aspire Training & Consulting, 2015; CISP, 2018; NZNO, 2019; Canadian Patient Safety Network, 2019). Other definitions of debriefing use clinical learning perspectives and tend to be more in-depth and are defined or adapted to suit a variety of work environments (Coggins et al., 2020; Moore et al., 2018; Nadir et al., 2017; NZNO, 2019; Patient Safety Network, 2019). While approaches may vary, goals of debriefing appear relatively consistent with the practice aimed at creating safer working environments for carers, service users, and organizations (NZNO, 2019; Patient Safety Network, 2019; CISP, 2018).
Purpose of Study

The purpose of this study is to understand current practices of debriefing being used in community and/or non-profit social service agencies and the presumed frameworks or evidence underpinning these practices. Debriefing has been primarily used to mitigate effects of trauma exposures that may result in trauma-related stress disorders or injuries by individuals working in healthcare, rescue services, policing, humanitarian aid, and nursing but may also be used in other occupational roles (Aspire Training & Consulting, 2015; Blacklock, 2012; Healy & Tyrell, 2013; NZNO, 2019). Understanding the breadth and rationale of current practices is the first step in a broader goal to ultimately develop more evidence-based standards of practice for community and/or non-profit social service agencies, to aid in the reduction of burnout and career exiting, to create an increase in evidence to sustain and support social service workers in work and improve their overall wellbeing (Aronsson et al., 2017; Cocker & Joss, 2016; Cohen & Collens, 2012; Gunasingam et al., 2014; Maslach & Leiter, 2017; Moore et al., 2018; Schmidt & Haglund, 2017; Waegemahers Schiff & Lane, 2019).

Statement of Problem

Effective debriefing practices used as a care practice in high-risk occupational settings have been found to be inconsistent throughout the literature, with conflicting findings, ranging from high efficacy, to concerns regarding possible re-traumatization or ineffectiveness (Aronsson et al., 2017; Coggins et al., 2020; Pender & Anderton, 2016; Gunasingam et al., 2014; Maslach & Leiter, 2017; Moore et al., 2018; Rose et al., 2002; Schmidt & Haglund, 2017). Debriefs are used as a form of communication, to inform, educate, or prevent psychological distress and are used in various contexts, more
specifically, in high-risk work environments, either individually or in groups (e.g., firefighting, paramedics, policing, military, emergency medicine or healthcare settings) (Aspire Training & Consulting, 2015; Blacklock, 2012; Healy & Tyrell, 2013; NZNO, 2019). The comprehensive review of differing modalities of debriefing and related evidence is complicated to a degree by the vast array of terms both used to present the harms workers experience and the processes used to address these harms.

**Researcher Positionality**

This research may aid community organizations of various sizes who struggle with addressing complex needs of oppressed and marginalized groups and the fallout this has on staff. I came to this work as both an ‘insider’ and an ‘outsider’ and was working in the front-line sector at the outset of this study but also now taking on the role of student researcher (Lu & Hodge, 2019).

I had volunteered with a grassroots non-profit organization for over six years; we operated as a collective who advocated and supported our most vulnerable at-risk community members, while providing a safe space for women and gender non-conforming individuals. Our mandate was to help those who provided sexual services, to do so with dignity and safety, primarily to “meet individuals where they are at”. We relied on our community funders and each other for support but didn’t anticipate the full impacts this pandemic would have on the organization or our community members.

When the pandemic began, we attempted to accommodate the increasing needs of individuals who were deprived of access to equitable resources by extending our hours of operation and populations served. This was with little resources for our volunteers to be supported or prepared for the approaching crisis. We supported others affected by; deep
poverty, inequitable access to mental/physical life sustaining supports, and resources. One can only bear to see so much pain, despair, and struggle, to take the burden, to hold space until it takes a psychological toll— as was my experience. I experienced burnout and had to step back and allow myself to rest.

It has taken months to rebuild, through education, resources, and support to learn how to better cope. It was through acquiring new work, that I learned the benefits of structured workplace supports that promote emotional wellbeing for support workers (e.g., huddles, team debriefing formal and informal, open-door policies, on-call leadership, and access to counsellors). The research interest is situated within these contextual factors, that shaped and contributed to the identity of the researcher’s perspective, through their experience of the existing variations in workplace supports.

This research has been inspired by working frontline prior and during the pandemic as an opportunity to help community-based nonprofit organizations and others who work in human social services or community work— that debriefing may help address psychological risks in the context of caregiving and be part of a healing process. I acknowledge the subjective nature of the interpretative research process within the boundaries of the chosen methodology, interpretive description. I came to the work with varying relationships with the workers and the organizations who might be participants. For each interview I disclosed my position as both a former front-line worker and a student researcher. Participants may have varyingly seen me as a peer or as a person with distinct academic power. I acknowledged my juxtaposition as both insider and outsider and practiced reflexivity on a concurrent basis to understand how my own experiences and roles influenced data collection and analysis (Bukamal, 2022).
Research Questions

The following questions guide this work:

1. What current practices in debriefing are currently being implemented by health and social service organizations?

2. What are the perspectives of frontline social service workers on debriefing supports being offered or not offered?

Study Significance

Existing research has examined the many factors that contribute to psychological stress and mental health risks experienced by frontline healthcare workers, social service workers, and emergency services workers—focused on trauma exposure, prevention, interventions, and organizational responses (Aronsson et al., 2017; Gunasingam et al., 2014; Hallinan et al., 2019; Maslach & Leiter, 2017; Moore et al., 2018; Ruotsalainen et al., 2015; Schmidt & Haglund, 2017). Social service workers care for vulnerable populations (e.g., homelessness; addictions; street-based sex work; poverty; violence/abuse) and are subjected to varying levels of trauma comparable to frontline healthcare, first response and emergency services (Hallinan et al., 2021; Kim et al., 2022). Vulnerable populations rely on care, advocacy, and services that social services workers offer and due to the high demand for services, workers often carry sizeable caseloads and face heavy expectations from employers. In the work, those on the frontlines face risks associated with stress disorders, injuries, burnout, and possible career exit which are considered health and safety issues by occupational standards (Canadian Centre for Addiction and Mental Health, 2020; Public Health Agency of Canada, 2020; Canadian Centre for Occupational Health and Safety, 2018). Quality debriefing is recommended for
these service workers to aid in mitigating and managing the unintended effects of working with and for these populations (Richins et al., 2020), to aid in sustainability and in quality practice, which will benefit employers, employees, and service recipients.

While burnout is a real challenge (Korman et al., 2022), to date there is no evidence-based standards of practice tailored specifically for community social service workers to effectively mitigate and/or manage trauma exposures through debriefing (Cocker & Joss, 2016; Reynolds, 2019; Thomas & Li, 2020; Waegemaker Schiff & Lane, 2019). Current findings in the literature suggest a lack of sufficient research representing community and/or non-profit social service sectors, which may be resulting in a limited body of knowledge around evidence-based practices (Cocker & Joss, 2016; Waegemaker Schiff & Lane, 2019). This is unfortunate as much research has been conducted discussing the increased risks associated with social service work, specifically symptoms of vicarious trauma, secondary trauma, compassion fatigue, and burnout (Cocker & Joss, 2016; Finklestein et al., 2015; Reynolds, 2019; Thomas & Li, 2020; Waegemaker Schiff & Lane, 2019). For example, one study conducted in 2019 found rates of burnout and staff turnover within mental health organizations (e.g., social workers, mental health professionals, nurses, child and youth workers, and child welfare workers) were high, with statistical measures fluctuating between 21% and 67% (Waegemakers Schiff and Lane, 2019).

With no common evidence base, there is little consensus across social service sectors for using viable and sustainable solutions aimed at preventing and/or managing experienced effects of trauma-exposure for workers (Cocker & Joss, 2016; Cohen & Collens, 2013; Waegemakers Schiff & Lane, 2019). Community social service workers may also encounter moral and ethical dilemmas through patient/client interactions, creating
internalized conflicts by which workers may feel helpless or may be restricted by organizational protocols (Reynolds, 2014 & 2019). Another increased risk that may be contributing to workers experiencing vicarious trauma is past traumas from lived experiences, frequently occurring in social services where these lived experiences may be prioritized in hiring (Cocker & Joss, 2016; Cohen & Collens, 2012; Finklestein et al., 2015; Jenkins & Baird, 2002; Waegemakers Schiff & Lane, 2019). Due to the innate factors of shared experiences seen in social service working environments, or the similarities of related past traumas, workers may be at an increased risk for encountering vicarious trauma (Finklestein et al., 2015; Waegemakers Schiff & Lane, 2019). Community social service workers require organizational changes in how they are supported to face the inherent risks associated with human service work, including interventions mitigating these harms that may aid in the reduction of work-related mental stress injuries, burnout, and staff turnover (Cocker & Joss, 2016; Cohen & Collens, 2013; Herrera-Sanchez et al., 2017; Hallinan et al., 2019). Debriefing is one specific practice that has been presented and implemented in very different ways (Anderson et al., 2020; Devilly et al., 2006; Harrison & Wu, 2017; Healy & Tyrell, 2013; Everly et al, 2005; Pender & Anderton, 2016).
Chapter II: Theoretical Overview of the Literature

Literature Review Strategy

Guided by the research questions, a non-systematic review of literature was conducted using both structured and unstructured approaches to ensure breadth of the review. The aim was to present a comprehensive synthesis, identifying key areas of interest, historical perspectives, achievements, debates, and research gaps (Green et al., 2006).

The search utilized a preliminary unstructured phase, and a subsequent structured approach, involved searches of; Google, Google Scholar, and a library database using simple terms like debriefing and social service work. The structured approach followed the development of key terms from the unstructured approach. This involved phrase and truncation searches of electronic databases: Psychnet ProQuest, Science Direct, PUBMED, Scopus, PsychINFO (OVID). This was followed by secondary referencing from primary sources, matching against the unstructured search results, and additional grey literature primarily obtained through Google searches. Terms of reference used, were: “debrief”, “critical incident debrief”, “psychological debrief”, “occupational support”, “Intervention debrief”, “case conference”, “compassion fatigue”, “burnout”, “vulnerable population”, “homeless”, “community agency”, “social service work”. See Table 1 for the complete structured search strategy.

The literature were then scanned for relevant terms of reference, checking works cited and tracking most recent publications, then reviewed and interpreted, taking note of reoccurring themes and topics. As part of the reflexive process using my ‘insider’ ‘outsider’ research position, I immersed myself in the literature, seeing beyond my own lived experiences, viewing the deeper contextual meanings was my first step in the process
(Bukamal, 2022; Pautasso, 2022; Thorne et al., 2016). The notable gap in existing literature is lack of clear evidence-based model or framework for structured debriefing practices for social service and community workers.
Table 1

Search Strategy

<table>
<thead>
<tr>
<th>Domain</th>
<th>Target</th>
<th>Search Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>Community social service workers or community-based service workers or non-for-profit organizations</td>
<td>“care giver” or carer or “community agency” or “support work” or “frontline work” or “community service work” or “social service work” or “vulnerable populations” or homelessness</td>
</tr>
<tr>
<td>Intervention</td>
<td>Post-exposure interventions or informal debrief or formal debrief</td>
<td>debrief or “occupational support” or “collective care” or “peer support case conference” or “supervisor support” or “critical incident stress debrief” or “critical incident stress management” or “critical incident debrief” or “psychological debrief” or “employee care” or “group debrief” or “intervention debrief”</td>
</tr>
<tr>
<td>Condition</td>
<td>Post-traumatic occupational stress injuries</td>
<td>burnout or “post-traumatic stress disorder” or “stress related” or “compassion fatigue” or “vicarious trauma” or “lived experience” or “mental health” or “mental illness” or “mental wellbeing” or wellbeing or “health risk” or “health hazards”</td>
</tr>
</tbody>
</table>

Summary of Literature

Discussions of debriefing to reduce the effects of trauma exposure have noted controversy, with research showing conflicting results; to debrief or not to debrief has been a recurring theme throughout the literature (Blacklock, 2012; Devilly et al., 2006; Miller, 2004; Rose et al., 2002; Tamrakar et al., 2019; Timms, 2019). In order to have a clear
understanding of debriefing, there is benefit in unpacking its original intent and establish a historical perspective. Beginning in 1974, Dr. Jeffrey T. Mitchell developed critical incident stress debriefing rooted in crisis intervention theories, the first article of which appeared in the Journal of Emergency Medical Service in 1983 (Everly et al., 2005). Since then, newer models have surfaced, expanding into other health and service organizations to be used and adapted for use with direct trauma survivors, such as National Organization of Victim Response Debriefing, American Red Cross Debriefing and Psychological debriefing (Miller, 2004). A large portion of literature used debriefing models incorrectly, with good intentions but poor execution—several group sessions did not have the required training, a mental health professional present, were used for the wrong population or occurred without follow-up. Critical Incident Stress Debriefs (CISD) are meant for use with healthcare, emergency, or disaster relief personnel, aimed at minimizing the effects that can cause post-secondary trauma following a traumatic event (Blacklock, 2012; Healy & Tyrell, 2013; Miller, 2004; Mitchell, 2005). As well as following a specific set of guidelines, the seven phases involve a systematic process that includes a mental health professional with Critical Incident Stress Management (CISM) trained peer supports using these following phases: introductory, fact, thought, reaction, symptom, teaching, and re-entry phase (Blacklock, 2012; CISP, 2018; CPSI, 2019; Mitchell, 1983 & 2005). A closer review of the research on CISDs shows that the supportive evidence remains contested.

In particular, a concern raised through the literature is the lack of high-quality research evidence to support debriefing approaches, including randomized control trials (RCT) (Devilly et al., 2006; Tuckey & Scott, 2014; Tamrakar et al., 2019). To date there are only two group RCTs that have been conducted with emergency personnel, both
showing positive results (Adler et al., 2008; Tuckey & Scott, 2014). The Adler et al. (2008) RCT used the appropriate target group (e.g., Peacekeepers), included the required seven-stage method of debriefing (CISD; e.g., Mitchell & Everly, 1996), and demonstrated lower reports of post-traumatic stress compared to a Stress Management Class and higher perceived organizational support—along with findings that this approach did not cause any undue distress/harm related to CISD. Tuckey and Scott (2014) showed improved quality of life of participants and lowered substance use/misuse, but no significant effects on post-traumatic stress. The debate of CISDs has been repeatedly raise in the literature and effectiveness was challenged by the Cochrane Review on Psychological Debriefing (Rose et al., 2002) concluding psychological debriefing (PD) to be ineffective and was updated in 2010 showing no change to conclusions. Cochrane reviews are considered the gold standard of reviews and follow a clear set of rules and guidelines, stated in the Cochrane Handbook (Devilly et al., 2006; Tamrakar et al., 2019). A critical assessment was conducted of the Cochrane Review on Psychological Debriefing and found 14 out 15 studies included in the Cochrane Review were conducted on civilian victims of trauma, not what CISD/PD was intended for, and included in the review were numerous studies that had methodological issues (Tamrakar at al., 2019). The review failed to meet rigour criteria set out in the Cochrane Handbook, as well as it presented potentially biased results as a large portion of the studies included in the review were conducted by the reviewers — it has yet to be updated (Rose et al., 2002, 2010; Tamrakar et al., 2019).
### Table 2

**Comparison of Formal Debriefing Models**

<table>
<thead>
<tr>
<th>Model</th>
<th>Author</th>
<th>Population</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma Risk Management (TRiM)</td>
<td>Jones et al., 2003</td>
<td>Military personnel</td>
<td>Prevent psychological distress. Peer group risk assessment. Builds on CISD.</td>
</tr>
<tr>
<td>Psychological Debriefing (PD)</td>
<td>Dyregove, 1997</td>
<td>Interdisciplinary groups/teams</td>
<td>Planned structured group process to prevent critical incident stress, improve recovery by promoting cognitive processes of event occurrence.</td>
</tr>
<tr>
<td>American Red Cross Debriefing (ARCD)</td>
<td>Armstrong et al., 1998; American Red Cross, n.d.</td>
<td>Emergency rescue personnel and persons effected by crisis from disasters.</td>
<td>Disaster mental health relief, respond to people’s psychosocial needs affected by disaster, preparedness, response, and recovery from experienced crisis.</td>
</tr>
<tr>
<td>Personal Reflective Debriefing (PRD)</td>
<td>Schmidt &amp; Haglund, 2017</td>
<td>Interdisciplinary healthcare workers</td>
<td>Proactive structured debrief adding personal self-reflection to deepen and reinforce social support from team members.</td>
</tr>
</tbody>
</table>

Literature from the past decade on various debriefing practices, referring to table 2 for the complete list comparing models currently used— which primarily focuses on reducing or mitigating the effects associated with secondary trauma that can contribute to
mental health disorders and productivity losses—with an estimated cost to the Canadian workforce of between $17 and $51 billion annually (Agency for Healthcare Research and Quality, 2019; Anderson et al., 2020; Harrison & Wu, 2017; Miller, 2004). Debriefing has been used formally or informally to inform, educate, or reduce the effect of trauma exposures and may or may not follow certain requirements, protocols, and guidelines in which the organizations intend (Aspire Training & Consulting, 2015; Blacklock, 2012; Healy & Tyrell, 2013; NZNO, 2019).

Common terms associated with debriefing may include ‘critical incident stress debriefing’ (CISD) or ‘psychological stress debriefing’, which reside under the ‘critical incident stress management’ (CISM) umbrella and the techniques are encouraged following a traumatic event (Anderson et al., 2020; Devilly et al., 2006; Harrison & Wu, 2017; Healy & Tyrell, 2013; Mitchell, 2005; Pender & Anderton, 2016). Although other forms of debriefing have been found and used in various ways in work related settings, not all are related to traumatic or critical event mitigation (e.g., huddles, case conferences, meetings and round table discussions), which are used to mitigate the effects of stress-related disorders by monitoring stress and wellbeing of colleagues, to identify and use performance standards using self-assessment strategies, increase team cohesion, and improve client-centred care (Aspire Training & Consulting, 2015; Azizoddin et al., 2020; Grey et al., 2021; Moore et al., 2020; NZNO, 2019).

Organizational approaches can vary in workplace settings, and it is important to consider what is intended by using methods of debriefing, how the debriefing is conducted, when it should be conducted, and why it is conducted (Coggins et al., 2020). These elements should be considered prior to implementing or executing debriefing practices.
There is broad agreement across multiple disciplines that debriefing is a helpful endeavour (Critical Incident Stress Program, 2018; Coggins et al., 2020; Devilly et al., 2006; NZNO, 2019; Pender & Anderton, 2016), however, studies have highlighted gaps in the science of debriefing. For example, there is a systematic review of crisis-focused debriefing in which studies were highlighted that consistently found no statistically significant improvement experienced by participants pre-and post-intervention with one reporting higher perceived event-stress related scores than participants who were not debriefed (Anderson et al., 2020). This literature unpacks the nuances and variations of approaches and the evidence or lack of evidence related to these.

Throughout the literature, concerns around risks of working in caring professions have been repeatedly raised as the work can result in compassion fatigue, reduced job satisfaction, and ultimately burnout including career exit (Aronsson et al., 2017; Gunasingam et al., 2014; Maslach & Leiter, 2017; Moore et al., 2018; Schmidt & Haglund, 2017). Indicators that have been associated with burnout include: anxiety, sleep disturbances, self-medicating, substance use or misuse, and issues with social and professional relationships (Aronsson et al., 2017; Schmidt & Haglund, 2021). Persons working in caring professions are at a higher risk of developing stress disorders that may transgress into their personal and/or professional lives; as a result, these persons are at higher risk of using unhealthy coping mechanisms (e.g., substance use or misuse) (Gunasingam et al., 2015; Tuckey & Scott, 2014). Literature focused on debriefing as burnout prevention is common. For example, an RCT including junior doctors’ highlights impacts of debriefing aimed at reducing the effects of burnout. The study used various themes associated with burnout to guide debriefing sessions including various coping
strategies, work-life balance, levels of support at work, and personal opinions from *junior doctors* (Gunasingam et al., 2015). The trial found that formal debriefing was well received by 60% of participants, and researchers ultimately concluded that female interns were at a higher risk of developing burnout compared to their male counterparts (Gunasingam et al., 2015). Unfortunately, research from a similar study of *drug service workers* presented contradictory results and concluded that males are at an increased risk of developing burnout and poor coping mechanism that may be due to socially constructed beliefs with expressing emotional vulnerability (Volker et al., 2009). Gender differences exist between those identifying as male and female, but further investigation is required to explore these differences. Alcohol use during informal debriefing sessions amongst interns was seen as an appropriate way to address burnout by both control groups, supporting previous concerns discussing how healthy or unhealthy coping mechanisms may be that are being taken up by workers (Gunasingam et al., 2015). Using substances as a form of coping is problematic because it can create unintended consequences unforeseen by the individual, such as having these mechanisms evolving into a substance use disorder (Tuckey & Scott, 2014).

Healthcare, social service, and emergency services workers experience or suffer from occupational work-related stress, at times resulting from high caseloads, shift work, and high expectations or lack of support, which can lead to an increase in burnout rates (Aronsson et al., 2017; Ruotsalainen et al., 2015). Mitigating effects of occupational stress using peer support staff can be enacted through real-time learning of events (e.g., huddles, ad hoc meeting, debriefing sessions) that increase team cohesion of staff members (Moore et al., 2020). Occupational stress has been found to be high among health and social service
workers (Toor, 2019; Waegemakers Schiff & Lane, 2019). This might be addressed through supportive work environments; a study of non-profit workers examining the perceived value of co-workers’ relationships in reducing occupational stress through peer support found a positive correlation between peer support and reducing occupational stress (McClure & Moore, 2021). Organizations that promoted peer support had better outcomes in terms of stress relief (Aspire Training & Consulting, 2015; CISP, 2018; McClure & Moore, 2021; Moore et al., 2020; Remtulla et al., 2021). Anderson et al. (2020) conducted a systematic review of peer-support and crisis-focused psychological debriefing interventions, designed to mitigate stress disorders, encompassing various service providers. Unfortunately, the authors concluded that half of the studies reviewed had limited generalizability of results as varying psychological interventions were used and compared between varying demographic populations (e.g., patients with experienced trauma to fire and rescue services). The study noted inconsistent approaches across populations and interventions resulting in inconsistent evidence for the effectiveness of peer support as a viable tool to mitigate the effects of occupational stress or trauma exposure. The authors suggested that current research evidence regarding peer-reviewed literature of effective organizational programs, interventions, services, and education aimed at reducing stress exposure is minimal and requires expanding (Anderson et al., 2020). Workplaces that encourage staff to lean on one another for support can help to reduce mental health stigma and promote psychological safety, by providing peer support during times of crisis; it can provide spaces for expressing emotional vulnerability, reduce occupational stress and highlight the importance of healthy coping while reinforcing quality improvement measures (Remtulla et al., 2021; Moore et al., 2020).
Not all debriefing is related to critical incidents. For example, a real-time, non-critical incident debriefing approach was explored in clinical settings as an educational tool to provide feedback and create guidelines for future practice (Nadir et al., 2017). Real-time debriefing may promote constructive criticism and self-reflection to improve worker performance (Nadir et al., 2017). This was highlighted through a survey of over 300 physicians, investigating the perceptions or understanding of real-time debriefing practices and found barriers and facilitators that contribute to the implementation process (Nadir et al., 2017). The most likely situations to be debriefed were: emotionally upset colleagues, critical events, miscommunication, and poor teamwork. Formatting of group debriefings was unfortunately inconsistent, attributed in part to the fact that participants lacked appropriate training to conduct debriefing and 85% discussed time constraints to perform debriefing (Nadir et al., 2017). Benefits of debriefing in this study included learning and colleague feedback, open opportunities to confront miscommunication, and promoting team performance.

Proactive debriefing interventions aimed at mitigating the effects of trauma exposure can increase resiliency and reduce compassion fatigue over time, when used consistently, not only as a post-traumatic event method but as a method of proactive maintenance (Azizoddin et al., 2020; CISP, 2018; NZNO, 2019; Schmidt & Haglund, 2017). Resiliency can be defined as an increased ability to cope during or following traumatic events; in the past resiliency was seen as a character trait but now is viewed as a dynamic process that can be strengthened through multiple interventions (Schmidt & Haglund, 2017). Studies exploring proactive debriefing practices as a method to increase resiliency and maintain consistency of care across interdisciplinary teams can be seen throughout the literature.
HOW WE DEBRIEF: AN INTERPRETIVE DESCRIPTION OF SOCIAL SERVICE COMMUNITY WORKERS’ EXPERIENCES

(Azizoddin et al., 2020; Nadir et al., 2017; Rowan et al., 2021; Schmidt & Haglund, 2017). One study conducted at a level-one trauma centre and hospital used nightly debriefing consisting of connecting interdisciplinary personnel (e.g., physicians, medical residents, nurses, physician assistants, emergency service assistants, pharmacists, case managers, technicians, and emergency radiologists) over a web-based platform, as part of a larger quality improvement measure to increase clinician resiliency and wellbeing (Azizoddin et al., 2020). The study used six domains to inform quality improvement measures: clinical context, provider experience, staffing and scheduling, protocol feedback, teamwork/collaboration, and wellness/resilience (Azizoddin et al., 2020). Group leaders were trained in debriefing practices and partook in weekly check-ins with a debriefing consultant, using simulated sessions to practices skills acquired through the program (Azizoddin et al., 2020). Engagement in the program by interdisciplinary teams was high during the project and results were positive, providing feedback for creating meaningful changes to clinical processes while increasing clinician and patient safety (Azizoddin et al., 2020). However, an increase in clinician resiliency was not conclusively found, but there were positive trends in work culture, by increasing access of psychological supports through nightly debriefs, while enhancing an individual’s feelings of psychological safety (Azizoddin et al., 2020; Remtulla et al., 2021). Psychological safety can be understood as the concept where individuals feel empowered to ask questions, discuss concerns, admit errors, and express emotional vulnerability, without fear or negative implications of interwork vulnerability from colleagues (CPSI, 2019; Remtulla et al., 2021).

Key facilitators that increase an organization’s resiliency are described as: an organization’s ability to predict issues that may arise, help staff with issues to cope and
provide ways to aid individuals in recovery to prevent them in the future (CPSI, 2019; Remtulla et al., 2021; Schmidt & Haglund, 2017). Debriefing strategies require psychological safety for transparent communication across care teams, while informing leadership roles of issues that may arise throughout daily events, which can create a workplace setting that is built on trust, communication, and empathy (CPSI, 2019; Gray et al., 2021). A narrative study exploring one nurse’s experience presented an intervention used to mitigate compassion fatigue, termed Personal Reflective Debriefing (PRD) (Schmidt & Haglund, 2017). PRD is an individually focused method, structured to support personal reflection through learning and developing abilities to cope and heal based on increasing resiliency and proactive coping (Schmidt & Haglund, 2017). The study concluded that creating an environment that encourages psychological safety is paramount in fostering a positive organizational structure of work. PRD contributed to increased morale, decreased turnover, and improved patient care interactions. That said, caution should be taken when conducting the debriefing process to not re-traumatize or cause undue stress supported by debriefing as a process that requires full consent of participants and not being mandatory (Coggins et al., 2020; Pender & Anderton, 2016; Schmidt & Haglund, 2017).

A variety of research reviews have been conducted related to trauma experiences of emergency response, military, and humanitarian personnel (Anderson et al., 2020; Devilly et al., 2006; Elder et al., 2020; Richins et al., 2020; Rose et al., 2002). These reviews have examined trauma exposure and impacts on mental health, social, and organizational outcomes to assess benefits and suggest recommendations for their delivery in workplace environments (Anderson et al., 2020; Devilly et al., 2006; Elder et al., 2020; Richins et al., 2020; Rose et al., 2002).
An important distinction is that trauma is an individualized experience and perspectives can vary depending on each person’s personal past circumstances; trauma is subjective yet may require support of an objective view in order to process. The Richins (2020) review covered three distinctly different but similar types of organizations in which staff encounter traumatic events/circumstances (e.g., death, grief, injury, or poverty). The study concluded that most staff were receiving psychological debriefing interventions that varied between CISD, trauma risk management (TRiM), non-specific debriefing, and psychological first aid (Richins et al., 2020). Studies varied in outcome measures, and notable variations in study quality were exposed. However, a consistent result were rescue service workers consuming a statistically significantly lower quantity of alcohol and reporting higher quality of life (Richins et al., 2020). Overall, it was found that CISD and TRiM were more effective in facilitating recovery following traumatic events than the other debriefing models (Richins et al., 2020).

CISD/CISM debriefing is standard practice in clinical, policing, and rescue settings/services. While one-on-one debriefing has been indicated as an approach within social work, as often described it might actually fall outside the definition of debriefing and be rather a counselling session. In social service or community-based services debriefing is not as common as within emergency services, although a training manual, Facilitate Workplace Debriefing and Support Processes: Learner Guide, used for education of best-practices for mitigating psychological stress/distress in community services is available (Aspire Training & Consulting, 2015). This guide includes practical tools for debriefing as led by organizational management or administration. While some
evidence and tools exist, the practice of debriefing in community and social services is still highly variable, and at times not in place at all.
Chapter III: Methodology

This study follows an interpretive descriptive approach with qualitative data. Interpretive description is intersubjective in that, the researcher and participants are perceived as co-constructing knowledge grounded in human experiences of a particular phenomenon. In this case, that phenomenon is debriefing. Interpretive description seeks to ask broad questions about a social phenomenon and is an inductive approach to research that is best suited for applied disciplines (e.g., social sciences, social work, and nursing) (Burdine et al., 2020; Hunt, 2009; Thorne et al, 1997 & 2004; Tramonti et al., 2020).

In this thesis, social service work in communities is the disciplinary domain. Interpretive description is particularly suited to solving practice challenges by basing approaches in the lived experiences of service providers or service recipients (Burdine et al., 2020; Hunt, 2009; Thorne et al, 1997 & 2004; Tramonti et al., 2020). Qualitative health research in practicing professions requires a grounding in human experience, listening to the wisdom of practitioners to help researchers immerse in the realities of daily work, and help separate between what may be professed at an organizational level and what is experienced on a frontline individual level. This study exists at the juncture between health and social services, focused on social service providers who might define themselves as community social service workers, community-based workers, or human service worker, and are all situated within non-profit work environments.

Interpretive description was developed by nursing scholars Thorne, Reimer Kirkham, and MacDonald-Emes (1997) and offers a pragmatic methodological approach to aid in clinical reasoning, embracing the value of subjective experiences of frontline providers and using these to address pertinent clinical challenges. Interpretive description roots
knowledge in values and expectations, embracing tacit knowledge and producing new evidence for best-practices in community and health research (Thorne et al., 1997, 2004).

[Diagram: Venn diagram showing the intersection of Social service workers values & expectations, Tacit Knowledge, and Formal evidence]

**Figure 1.**

Adapted Model of social service work from Sally Thorne’s (2016) clinical science model used in interpretive description.

**Research Design**

Congruent with interpretive description, this study design was built around creating opportunities to hear practice-based knowledge from those who live (or miss out on) the concept of concern: debriefing. Participants had an opportunity to share their experiences further, if they so choose, by participating in semi-structured virtual interviews. This provided insight of current practices used or not used in the workplace. Data derived from the semi-structured virtual interviews provided further possibility for the researcher to explore variations and comparisons across organizations. The researcher provided participants with an electronic version of the letter of information, outlining the purpose and objectives of the study, consent was presented via the online tool in plain language and again for the online interviews through email correspondence. The online questionnaire
were conducted at participant’s convenience (Hunt, 2009; Thorne, 2008) allowing for engagement throughout the COVID-19 pandemic, with the understanding of time constraints occurring in this context (Ashcroft et al., 2022; Schmid & Bradley, 2022).

For those who chose an additional one-on-one virtual interview, these were used to further gather information of their individualized experiences with debriefing practices, occupational supports, and/or leadership support around trauma exposures, as well as perspectives regarding what logic or frameworks might be underpinning the form of debrief. Interviews were conducted over an internet platform (e.g., Zoom) for ease and to address accessibility issues that may arise during the COVID-19 pandemic. Interviews were audio recorded using the Zoom platform with back-up voice recording in case of loss of data. The interviews were transcribed using Microsoft Word built-in transcription software, then re-checked by listening to each interview to compare and check for errors, than adjusted found errors by hand.

**Settings**

Social service agencies are at the frontline of public health initiatives, working with and for persons who experience social welfare disparities, social injustices, homelessness, poverty, violence, addiction issues, and mental health issues with, at times, limited support for their own mental health (Canadian Centre for Addiction and Mental Health, 2020; Dubey et al., 2020; Gupta et al., 2021; King et al., 2020; Public Health Agency of Canada, 2020).

The community of study was located in Southwestern Ontario, situated on the traditional lands of the Attawandaran peoples alongside Algonquin and Haudenosaunee people. There are three First nations Communities with longstanding ties to this geographic
region: Chippewa of the Thames First Nation (Anishinaabe), Oneida Nation of the Thames (Haudenosaunee) and, Munsee-Delaware Nation (Leni-Lunaape). The population of this region is diverse, spanning socio-economic levels. However, there is a substantial poverty rate in the region, measured in 2015 as 11.6% of citizens living below the Low Income Cut Off (LICO) threshold, compared to 9.8% of all people living in Ontario (Poverty Trends in London, 2020). Notably, these statistics were pre-COVID-19 pandemic and there is concern that poverty has grown as preliminary pandemic income benefits have mostly been withdrawn. While a lack of income is one of the most common factors used to define poverty, it is a multidimensional problem and varies in social, natural, economic, and political contexts with far-reaching effects, placing people at increased risk of experiencing hunger, malnutrition, poor health, homelessness, inadequate housing, social discrimination, and social exclusion. The region of study has seen a 38% rise in cases of opiate overdoses deaths compared to pre-COVID-19, representing the increasing need for substance use health, harm reduction, a safer supply of drugs, and better access to mental health supports (Public Health Ontario, 2020). The population of persons experiencing homelessness is difficult to enumerate but the use of an emergency shelter occupancy rate in 2019 of 111% shows that existing services are stretched in their ability to meet community needs. Of households assisted by the local food bank, 27% were first time visitors in 2019 (Poverty Trends in London, 2020). The poverty gap is increasing, the lack of affordable housing, the toxic drug crisis, mental health issues have been exasperated by the pandemic and social service agencies are overwhelmed with caseloads of persons who require complex care.
Participant Recruitment, Sample and Sampling Procedures

Congruent with interpretive description and the goal to understand breadth of debriefing experiences, sampling focused on maximizing the number of different organizations and therefore organizational practices covered. Sub-sectors of interest were: frontline community social service work who serviced at-risk populations, homelessness sectors, addiction services, not-for-profit agencies, street out-reach services and emergency shelter organizations.

The research began with sharing the project information with leaders in applicable organizations known to the researcher in London, Ontario and its surrounding area. Distributing the request for participation through these broad networks increased the likelihood of participation across as many organizations as possible. In all cases, a recruitment poster (Appendix F) was offered in addition to study details, should organizations chose to participate, by sharing the project with staff. A letter of information and invitation to participate was sent to administrators of each organization through email correspondence (Appendix A), with the intent that they forward research materials (Appendix B) to all staff within the organization. This study used a random snowball sampling approach to recruit participants with participants invited to forward on the materials to colleagues, and therefore connected with potential participants from various levels of employment, education, pay structures, and responsibilities. Ultimately, participants consisted of social workers, social service workers, community service workers and peer support workers, working with marginalized and oppressed individuals. This included forty-one community social service workers (5 male, 34 female, 0 non-
Inclusion/Exclusion Criteria

Inclusion criteria were people who are social workers, social service workers, community service workers, and peer support workers, who are in contact with marginalized and oppressed individuals through social services, community social services, and non-profit organizations. It is noted that workers in this demographic often lack access to adequate wages and benefits, workplace supports, post-trauma related workplace injury supports, and adequate training opportunities necessary to build resilience to the impacts of this work, particularly in comparison to healthcare workers and first responders (i.e., police, firefighters, and paramedics) (Rossiter et al., 2020). Participants had to work within the community of study and be proficient in written and spoken English.

Exclusion criteria were being healthcare workers, first responders, or any other profession outside the inclusion list. That said, it is noted that some community workers may actually have healthcare or emergency service backgrounds or credentials or may be in a volunteer position.

Methods

Aligning with interpretive descriptions flexible approach to data collection and analysis, we consider the experiential knowledge, background, and perspective of the researcher is a relevant form of data, worthy of inquiry and analysis (Thorne et al., 2016). Data collection used a multi-level approach, beginning with a qualitative online tool (Appendix C), composed of a demographics portion and descriptive questions; with some multiple choice, and were completed by frontline workers within a single, mid-sized
community in Canada. Subsequent semi-structured interviews (Appendix E) helped round out perspectives of the varying ways in which organizations use or do not use debriefing methods. In addition, approaching individual agencies provided a wide range of information from the broader social service sector, such as coalitions, networks, and a task force. Reflexive journaling and notes were derived from concurrent data collection and discussions with peers, and supervisors allowed the researchers perspective into the work without over-shadowing the perspectives of participants. Discussions with peers and supervisors provided space for furthered the analysis, by challenging the researchers positioning, through questioning and reasoning. The iterative processes is a continuous comparative analysis, involving prolonged engagement with all forms of data, including researcher positionality, illuminating a “…tentative truth claim…” (Thorne, et al., 2004, p. 4).

Data Analysis

The preliminary approach was to read through all the data collected (i.e., online tool, transcripts), to reflect using a multi-lens, while questioning and reasoning, then sorting and organizing data into smaller more manageable forms. Coding and organizing text (see Appendix H), in this case using a somewhat abductive approach by first coding around key content areas of; experiences shared with clients, commonalities, intriguing words and key words of interest (Hunt, 2009; Thorne et al., 1997, 2004, 2016; Burdine et al., 2020). Presenting key features of contexts in an organized manner allowed the research to begin developing commonalities and recognized differences.

Final steps of analysis was categorizing and proposing/refining themes, we then utilized multiple frameworks to organize and identify categories. Drawing from thematic
analysis (Braun & Clarke, 2006), and constant comparative analysis using a reflective process (Grove, 1988). Reflexive journals and notes examining personal/professional assumptions of the researchers’ ontological views were also used to guide the analytical process, identifying patterns to relationships and categories to themes creating a “…sense making structure…” (Thorne et al., 2004, p. 4). Analysis was further deepened by categorizing current debriefing practices, (see Table 3; Appendix G) from participant perspectives, presenting the breadth of approaches used in organizations.

From here, final steps of analysis was categorizing and proposing, while refining themes. Reflection on the spoken and unspoken theoretical assumptions and frameworks, that were or might have been guiding providers’ choices in selection of various types of debriefing practices were noted and coded. The researcher worked closely with her thesis committee members and an informed peer in processing and conceptualizing the research findings based on coding and categorizing. Developing themes were aided in creating a visual representation of the debriefing experience with continued refining of the visual to create developed representation of proposed themes. Finalized main themes were constructed, shaped, and reshaped through an iterative process of discussion back and forth with the committee, returning to the data and key quotes (Thorne et al., 2004). Proposed themes were then titled; fear of disclosing, stigmatization of needing help, lack of psychological safety, missing the emotional essence of the worker, mental health stigma, leaning on each other for support, and open communication with supportive listening. (see 1.2 of the thematic map) (Hunt, 2009).
Rigour

This research used multiple diverse and interpretive practices to aid in establishing credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985) contributing to the trustworthiness of research project. Credibility was established through prolonged engagement within the culture of community and social service work through the researcher’s history of working within the community of interest adding to the development of trust and rapport. Transferability and confirmability were maintained through a written record of each stage of the analysis showing the development of codes, categories, then the many versions of themes through their development process, including associated quotes providing for thick description. Transferability and confirmability added to the process of dependability by the researcher creating a traceable and logical process that can be audited. Seeking a deeper understanding of the researcher’s theoretical perspective through their personal values and/or experiences regarding the topic of concern, the researcher used methods derived from multiple sources of data, adding depth to by providing a deep description to ensure data saturation was achieved (Thorne et al., 2004; Fusch et al., 2018).

One means of bringing to forefront the intersubjectivity of qualitative research is to use reflective journaling for the researcher to explore their own perspectives, values, and beliefs (Fusch et al., 2018). Reflexive journaling was helpful in this context wherein the researcher had both lived the issue of study and was familiar with the community in which the study was conducted. This included insider knowledge of some of the debriefing approaches in place at some of the participating organizations. While this included a bias towards frustration with the perceived inadequacy of current debriefing approaches, it also
aided in accessing organizations to conduct the research and allowed use of common language within interviews help participants see they were understood.

**Ethical Considerations**

Because of the size of community of study, there are many organizations that provide a singular service or support a singular population. Therefore, maintaining anonymity in this context was key particularly in presenting demographics or in considering any data to de-identify in interview transcripts. Informed consent highlighted rights around confidentiality and anonymity (Sanjari et al., 2014; Thorne, 2016) but also included that anonymity can never be absolutely guaranteed as a reader might recognize a particular anecdote. The proposed research was reviewed and approved by the Western University Non-Medical Research Ethics Board (NMREB).
Chapter IV: Findings

Context and Time

To situate this work, it was entirely conducted during the Covid-19 pandemic, services were on-going but with tremendous stress and precarity. The effects of the pandemic were far reaching, with many businesses and services forced into lockdowns, pushing more of those seeking services to limited health and social services for support (Ontario Nonprofit Network, 2020). Services across Ontario saw increased needs from service users contributing to the strain on services who were still in operation (Ontario Nonprofit Network, 2020; Schmid & Bradley, 2022). Frontline workers had to adapt to the changing context as it unfolded, in the moment. Workers were positioned as ‘heroes’ without considering inadequate resourcing and health risks, i.e., working within spaces of greater risk (Schmid & Bradley, 2021).

Population and Sample

From the ten participating organizations, 41 respondents completed the online questionnaires (Sample 1), with 12% male, 83% female and 5% prefer not to say; although there were minimal male participants in comparative to their counterpart, this is representative of the workforce within helping professions (World Health Organization, 2019). Participants were given the opportunity to participate in virtual interviews to expand on the topic of concern. Nine participants concluded interviews with eight female and one male. Participants had many different work titles, but the majority of participants had incomes ranging from $35,000-$49,999, with age being primarily between 25-35 years old, and less than three years working experience.
The participants represented 10 organizations, accounting for a wide range in programming and service users. Participant experiences were mixed across this variety of organizations, however there were some consistent aspects of experiences and recommendations which are adapted herein into themes and subthemes.

**Themes and Sub Themes**

1) Fear of disclosing; sub themes, rooted in poor debriefing, showing weakness; 2) Stigmatization of needing help; 3) Lack of psychological safety; 4) Missing the emotional essence of the worker; 5) Mental health stigma; 6) Leaning on each other for support; 7) Open communication with supportive listening.

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**Figure 1.2 Thematic Diagram**

A thematic map analysis of qualitative and quantitative data from frontline community and social service workers illustrating the relationship between themes.
Theme 1: Fear of Disclosing

Key challenges faced by frontline workers were *fear of disclosing*, we proposed two sub-themes within this theme; *rooted in poor debriefing* and *showing weakness*. First, the experience of some participants with poor debriefing practices, resulted in hesitancy to disclose to their peers and leadership for fear of punitive measures. Secondly, how an overall fear of disclosing involves a concern of being stigmatized by their peers and leadership, related to their ability to confidently do the work, within a culture that promotes resiliency and looks down on psychological needs as weakness. It is important to take note of this distinction within the theme *fear of disclosing*, as they both have the same consequence, relating to stigma but the processes of how these occur are different.

Disclosure has been defined as the act of revealing private or sensitive information, conveyed between individuals (Zamir et al., 2022) in this context disclosure happened in the recounting of shared experiences between workers or in groups through debriefs or peer-to-peer networks. Disclosure can be controversial in human service work, as workers are more than likely to have lived experiences, sharing in similarity or proximity as the clients they serve (see Figure 1.3). This can be presented as an advantage in certain circumstances, empowering them in their work but also places them at increased risks for re-traumatization, vicarious trauma and stigma if disclosed. In figure 1.3, key words of interest were found and compiled into the word cloud representing these shared experiences between workers and clients.
Stigma as defined by Goffman (1963) refers to the social attribute that is discrediting for an individual or group and can negatively impact self-concept and identity formation (p. 3). Perceived stigma is disruptive to one’s self-esteem, ability to cope, and effects interpersonal relationships. Self-stigma is the result of prejudices that individuals often hold of themselves and can be higher in individuals who may be managing mental illness, in recovery or have lived experiences (Haustuti & Timming, 2021). Disclosing in relation to debriefing at work can be viewed as a form of help-seeking, “…the higher the self-stigma, the more likely the individual is willing to disclose to remedy self-
stigma…” (Haustuti & Timming, 2021, p. 3312). Enabling disclosure opportunities may enable access to support and improve wellbeing for workers.

The nature of human service work can be personal for service providers and their clients, with variances in risks and level of trauma exposure. Some shared experiences are reflected in viewed traumatic encounters of human distress, “…a gentleman was hitting people with a skateboard…we’re going to step in, between another person and the skateboard…it was a severely violent situation…” (P2). Following the incident, staff were not debriefed or given sufficient time to decompress or reflect. Providing spaces that allow for reflection and healing, or as some participants said, “…more heal days…having proper supports after difficult shifts…ability to take breathers when needed” (P35; P32; P28; P18) allows for assumptions that workers were requesting room for decompression and healing. Another worker had encountered a deceased person with blood on them, in the housing facility where they worked, and they too were not debriefed; a co-worker’s observations of their change in behaviour stated, “…he was the first to respond and wasn’t the same…he eventually left the organization…” (P3).

Sub-theme 1: Fear to Disclose Rooted in ‘Poor Debriefing’

The majority of participants (66%) who opted into the study stated they were receiving some form of debriefing. The data presented a diversity of responses and variances in effectiveness, there was no singular form of debriefing requested by participants. Many participants expressed a desire for increased supportive roles by supervisors, leadership and managers following critical events. In conjunction with opposing views, some suggest having leadership perform or led debriefs may prevent authenticity in responses for fear of punitive measures or stigma.
Participants shared some of their experiences in leadership led debriefs, “…it’s a lot of you getting in trouble…fear of reprimand…being sent home…threatened to be written up…” (P002; P001; P18). Concerns of punitive measures in leadership lead debriefs were raised, expressing their reluctance in disclosing, “…putting staff down instead of providing education” (P19). Debriefing practices should take an educational stance, allowing for support and deconstruction of events, creating a space that promote relatively safe disclosures (Anderson, 2021; Mitchell, 1997; CPSI, 2019). Many reported they “…stopped reaching out to management…”, leading the researcher to conclude that punitive measures were causal factors in workers reluctance of help-seeking behaviours.

Poorly conducted debriefs were a common occurrence, and multiple workers felt their experiences were being discounted and ignored, “…consistently being talked over…did not truly listen…rushed…not allowing all voices to be heard” (P29; P36; P26; P13). Participants struggled with the processes in their organizations debriefing sessions. Adding to hesitancy in group debriefs, some members experienced felt stigma from others who dominated discussions who devalued their perspectives. The probability of disclosure in debriefs were diminished, negatively effecting perceived organizational support.

Sub-theme 2: Fear to Disclose ‘Showing Weakness’

Participants recounted their experiences of not feeling safe enough to share the effects on their mental health and the real consequences if shared, “…being told what I am feeling comes from a place of insecurity and I need to fix that to work here…I need to fix that…” (P35; P4). Comments like these show the consequences of disclosing, deepening self-stigma shame and guilt, instead of reducing discriminatory practices during
disclosures (Hastuti & Timming, 2021). Organizations are responsible for the wellbeing of their workers, supporting the learning process, ultimately enhance staff abilities.

Although, organizations place an increased importance on resiliency of workers, in their ability to ‘handle it’ or withstand the emotional toll, “…you should be more resilient be able to handle it…” (P7) this has a downside of placing fault and the onus onto workers, “…I don’t want a manager telling me that I just need to be more mindful…” (P1). While resiliency is helpful, it does not address concerns raised but continues to frame thinking that’s follows a neoliberalist agenda, placing workers as the central cause for their felt secondary trauma, rendering full responsibility presumably helpful on one’s ability to self-regulate (Newcomb, 2022).

Interview participants reveal their conflicted positioning in human service work,

“…In the professional world when you state you're struggling, you are looked at different. People will want to, baby you, they'll protect you more or they still think that you're just not fit for the job…” (Participant 001).

“I think if you show any sort of trauma response, it's kind of like OK, she can't actually handle it…you should be more resilient, be able to handle it because you're in that position of power or authority. I think, I think that's, uh, assumed by leadership, yeah, is that you're supposed to be more resilient” (Participant 007).

Several workers felt showing weakness or vulnerability caused them harm, they were misunderstood, and unsupported, feeling fearful to disclose theirs struggles experienced through work. Alternatively, workers would benefit from discouraging beliefs of ‘us versus them’ where workers are positioned as powerful in relation to client’s powerlessness (Zamir et al., 2022). This assumes that workers have coping abilities and support that clients do not, which may be true but does not negate those who continue to struggle may require increased supports.
Theme 2: Stigmatization of Needing Help

Concerns and awareness of underlying issues were raised by participants, showing some organizations were deficient in providing support and strategies when needed or in the moment. Participants explain some of these experiences, “…I sent the incident report through, no one followed up to make sure your OK…just you and these clients, and there’s just no follow up…sometimes leadership is not providing the amount of care” (P2; P7). Challenges with neglected follow ups were common, showing workers minimal care in their daily experiences can lead to normalizing behaviours of secondary trauma and furthering isolation, in effect preventing, and reinforcing reluctance to disclose (Newcomb, 2022). Attempts were made to reach out for support with some participants being ignored or invalidated, “…having management know who I am instead of ignoring me…I didn’t feel heard or respected more so judged….” (P16; P28), deepening insecurities of self-worth and self-esteem, leaving workers feeling uncared for, or unappreciated.

Social service and community workers are vulnerable to work related stress disorders (Kinman & Grant, 2017); emotional demands inherent to the work require some level of resiliency to endure trauma lived and relived. Participants noted that by raising awareness of how levels of resiliency vary individually, care should be taken in individualized ways. Interactions in work depicted an increasing risk of experiencing stigma, not only from co-workers but leadership as well, “being deemed unwell, overly sensitive or uh, overreacting…you feel nobody seen you…you’re just a number nobody cares…”(P1). This particular participant has worked frontline with the most vulnerable populations for over 10 years, they have lived experience in the community they support. They continue to feel that workers are being neglected as they explained in their struggles to be seen, to be met
where they are at, in that moment of need, “…oftentimes we're forced to carry heavy **** alone…” (P1).

Participants who shared their experiences of ‘feeling too much’, disengaged from participating in debriefs or were reluctant to share. This fear of disclosing, showing weakness and stigmatizing of needing help, are rooted in a key organizational issue: lack of psychological safety.

**Theme 3: Lack of Psychological Safety**

While not experienced by all participants, we have taken collective comments about the inability to share mental health needs as a theme titled ‘lack of psychological safety’ within organizations. Psychological safety in the workplace is define as, “the belief that the work environment is safe for interpersonal risk taking” (Edmondson, 2018, p.8). Concepts may include, “feeling safe to show and employ one’s self without fear of negative consequence to self-image, status or career” (Ito et al., 2021, p. 467). It is known to improve interprofessional relationships revolving around safety and disclosure, while encouraging learning from error, collaboration, engagement of quality improvement and client care (Edmondson, 2018; Ito et al., 2021). Psychological safety also seeks to improve teamwork, and workplace culture and does not seek punitive measures where team members are blamed or shamed (Edmondson, 2021).

Many community social service workers who participated in this study felt a ‘fear in disclosing’ their emotional needs and experiences in the workplace, fearing; punitive measures, judgement, stigma, shame or seen as incompetent or weak. Through careful analysis of the data, participants were experiencing a lack of safety in disclosing psychological needs, showing workplace cultures in organizations were deficient in
creating safe spaces that promote psychologically safe work environments. Although, it may be unintentional, it is problematic and can have a great impact on organizational performance (Edmondson, 2018).

The unintended mental health stigma in the helping professions is occurring in organizations; participants discussed their own struggles with their paradoxical position in work. The nature of community social service work is to help those in need and without regular opportunities for debriefs, community social service workers experiences are “…bottled-up and put on the back burner…” (P3).

**Theme 4: Missing the Emotional Essence of the Worker**

Safety to discuss work related experiences free of stigma, judgement and fear of punishment have been repeatedly expressed throughout the data, but healthy workplaces are fostered and maintained through team cohesion with supportive models of care. Many participants found missed opportunities for connection, they desired safe spaces that were honest and supportive, one interview participant (P2) shares an interaction with a counsellor on shift,

“…she put me in her office, and said we need you, need you to just sit here for a couple of minutes and take a breather. Do you want to talk about it? And asked, what do I need?”.

This interaction was simple and met them where they were at, in the moment, leadership provided compassion and a safe space. Acknowledging emotional responses may create strong feelings of belonging, acceptance and allows room for sharing. Others expressed needing help to process events, believing in their collective strengths and not just the singular process of one-on-one communication.
“Debriefs are emotionally most, mostly emotional, so it's mostly because, because we are people who are going through this with our community who are seeing things that we don't see on an everyday basis. It's really important to talk about how we're feeling and how we're feeling as group and how we can move forward and take care of each other” (Participant 007).

Theme 5: Mental Health Stigma

In interpreting the root issues around barriers to explore worker’s own mental health needs, we have proposed an underlying stigma. Workers were experiencing felt stigma, manifesting through social interactions in the workplace by discounting, ignoring, or applying negative judgements of their feelings. Organizations have a responsibility to maintain safety in work, for clients and employees. They lacked in creating spaces that promoted psychological safety, while those who had options to engage in debriefs were shamed or guilted for not being resilient enough. Many participants were left feeling unheard or feared punitive action. Ultimately, this at times resulted in reducing help-seeking and increasing internalized feelings of self-stigma, preventing them from disclosing their true needs. “…I think mental illness stigma, though in the workplace might be a little bit more stigmatized. Uhm, I think if you are currently going through something, then it’s a little bit more of a less honest discussion.” (P3). Although many had good experiences in the pragmatic ways organizations mitigated harms at work, the majority who participated in this study were not afforded the same care, bringing us to conclude how they were solving stressors on their own.

Theme 6: Leaning on Each Other for Support
Although the frequent frustration among workers with debriefs was evident, the agency of workers was also demonstrated. Workers established their own circles of trust and developed ways of being with one another, to console, listen and be understood through peer-to-peer support. Peer-support is defined as, “…a supportive relationship between people who have a lived experience in common…it is improving the mental health of their peers by helping them towards recovery, empowerment, and hope” (CPSI, 2019, p. 13).

Participants shared how they used informal peer debriefing to cope with psychological distress, “…at the end of each shift we try to debrief to make sure that we're all caught up on the same page of how everybody is feeling, making sure that nobody is leaving this space in a traumatized or triggered state” (P7). While this may present as an example of an effective solution, through group engagement of problem-solving, it poses risks that without the use of evidenced informed practiced based knowledge and skills, it may cause unintentional harm and latent effects of vicarious trauma (Clark et al., 2019). While participants may find leaning on each other for support effective, an over reliance on peers may increase risks of exposure to secondary trauma and is insufficient as the only means of support. Allowing spaces that support ones self-determination in choice would create and better protect worker safety.

Others expressed ways they leaned on one another in times of needed release, using peer-support as a source of feedback, that could directly relate to their shared experiences;

“…I usually go to someone I trust. We go for a walk. We kind of just like scream together like cry together. Just get the emotions out and then talk about what I need moving forward and how they can support me and what next steps need to be done and if we should do it together again…” (Participant 006).

“…we're like, Oh my goodness, what did we just witness, like, that was, you know, we were able to really talk about it and I started opening up because, I was so
emotionally dysregulated from that whole experience from the incident and my co-worker said the same thing, like he also felt the same way. We just both, kind of, start sharing the same similarities…it was good to having an existing relationship…” (Participant 003).

“…we're in a group chat with all the case management. So, all case managers in the same group chat and we can just bounce ideas, if we have a difficult situation and have someone help us out…it's a very healthy work environment compared to what I've came from” (Participant 002).

Several participants spoke about the benefits of informal debriefs between peers and seemed more likely to reach for support from one another, rather than in groups. They felt safe in disclosing their emotions and experienced traumas. Some participants also stated that, “I don’t want dump on them, they don’t have the best set up” (P2), describing a sense of shared burden of responsibility in caring for other co-worker’s mental state. Showing worry and concern by further added to the emotional toll and increasing risks of “taking it home” (P1) meaning bringing stress from the workplace into one’s home environment. It is challenging for workers to be positioned as both carer and caring for co-workers, noting it was harder to support others when they are struggling or feel depleted.

Theme 7: Open Communication with Supportive Listening

Although several participants shared satisfaction with current debriefing practices, many others felt unsupported by their organization in terms of policies and practices. Participants noted to their desire to communicate openly in debriefs, indicating a willingness to discuss their own emotional experiences and the benefits of ‘open communication with supportive listening’. Participants felt that the inclusion of being mindful and open with intentional support during debriefings would alleviate stressors associated with themes found in this study; ‘fear in disclosing’ and ‘stigmatization of needing help’. While promoting psychological safety would reduce mental health stigma
in debriefs and organizations. Participants shared their desire to communicate openly with supportive listening;

“I think it would be helpful to process the emotions that we hold onto in our hearts, minds, and bodies…debriefs would also facilitate opportunity to grow together as a staff and create a collective strength - which is needed to do this work and do it well. I think a debrief process would help staff connect the dots of their emotions as well as help them understand what triggers they may have - and what they may need in terms of support from their staff team and organization. Additionally - and most significantly, an intentional debriefing process would benefit clients, as staff would not be carrying past trauma or emotions in the same way that they would without an intentional debrief. As a result, clients would be better supported and connected to the staff” (anonymous).

“The work is very hard, being able to process emotional tensions…is key for a healthy work environment”.

“…it is good for us to confront the intense emotions we feel and feel support from the team…”.

“It would help newer staff feel less alone in what they're experiencing”.

“It helps reduce secondary trauma when debriefing after every session…this field of work can be emotionally draining, and debriefing is a process to help reduce the impact of witnessing trauma”.

“It helps to process situations, manage stress, improve workplace resilience, build team strength and improve team communication”.

Tallying the online responses showed that the majority of participants were practicing team debriefs regularly with 35% not receiving any debriefs. Debriefings were represented in various forms such as huddles, co-visions, and team meetings, and participants were able to express themselves freely with support from their peers and leadership (Table 3). While participants experienced intermittent styles and practices of debriefing, variations in delivery did not always produce positive results. Debriefing practices were not concurrently streamlined across organizations and best practices could
not be concluded from this study. Participants shared their ideas of the benefits and hopes to achieve through proper debriefs.

Table 3

*Current debriefing styles conducted*

<table>
<thead>
<tr>
<th>Current Debriefing Styles</th>
<th>Frequency Conducted</th>
<th>Who Facilitates These</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular</td>
<td>• On a need only basis&lt;br&gt;• No clearly defined&lt;br&gt;protocols&lt;br&gt;• Varies in frequency</td>
<td>• All staff</td>
</tr>
<tr>
<td>Critical Incident</td>
<td>• Only critical incidents&lt;br&gt;• No clearly defined&lt;br&gt;protocols/guidelines</td>
<td>• Varies; all staff, leadership, program supervisor, manager, no designated person, Chaplain, shift coordinator.</td>
</tr>
<tr>
<td>Huddles</td>
<td>• Daily</td>
<td>• All staff</td>
</tr>
<tr>
<td>Co-Visions</td>
<td>• Monthly</td>
<td>• Co-conducted</td>
</tr>
<tr>
<td>Team Meetings</td>
<td>• Weekly/Daily</td>
<td>• All staff</td>
</tr>
<tr>
<td>Department Meetings</td>
<td>• Weekly</td>
<td>• Leadership, supervisors, managers</td>
</tr>
<tr>
<td>Supervisions</td>
<td>• Monthly</td>
<td>• Supervisors</td>
</tr>
</tbody>
</table>
Participants were asked: *Whether you currently have debriefing or not, would you want regular debriefing at your workplace? If yes, Why do you think this would be helpful?*

“…it opens up communication, and it lets that person who's gone through that crisis know that they are cared and valued, and that their experience is real, and they're heard, and they're not alone…” (Participant 001).

“…I think it usually depends on the relationship that you have with the person that you're debriefing with, and I think it depends on if you feel after the conversations been had, that you've actually been heard and the things that you said were acknowledged in a way that you know you're able to move on with it and some you know, like I think that takes maybe a certain level of skill and the person that you're working with….” (Participant 004).

“…because without that debrief I feel that not even just mentally to be like hey someone else feels the same way I do about this situation or uh, or they don't, you know, doesn't really matter, but also it gives you the opportunity to hear different perspectives on what happened and in which case you can grow as a person, because if you don't kind of look back and you're like, yeah, you know what that was kind of messed up, wasn't it? You know, like you don't really think about it, unless you talk about it” (Participant 005).

“…if you don't have the opportunity to debrief, you know chat about it and kind of chat about how you're feeling. You're more likely to kind of bottle that up and then hold resentment against the people you serve.” (Participant 005).

“It is hard in the moment to know when a debrief would help in some situations. Also, when you are struggling it can be hard to reach out. Routine debriefs would make it easier to engage and bring to light issues we may not be aware we are experiencing” (P37).
Chapter V: Discussion

Significance of Study

As an experienced frontline worker, I entered this work assuming that the majority of community social service workers were not receiving debriefs on a regular basis and those in place would likely be structured around improving client relations and outcomes. However, the data suggested that 66% of the sample were receiving some form of debriefing, but often with poor execution and lacking in structure. Debriefs caused unintended distress, in some cases participants felt re-traumatized leading to future avoidance of disclosing mental health concerns. Many participants felt it was unsafe to disclose their personal or lived experiences at work of any triggering encounters during debriefs, increasing internalized self-stigma and fear of punitive consequences if disclosed.

It is important to consider potential risks of secondary trauma when conducting debriefs; structuring debriefs that provide and foster an environment that is free from judgement and promote compassion, and empathy with open communication may result in better outcomes for workers mental wellbeing. This study demonstrates a strong connection between a fear of disclosing one’s own needs with a lack of psychological safety in the workplace. The results indicated that there were two perceptions creating a ‘fear of disclosing’, one relating to being conceived as weak and the other relating to having had traumatizing debriefs in the past or debriefs that resulted in punitive actions. Either way, these experiences were limiting disclosures.

Community social service workers are the first point of contact for individuals in crisis and are leaders in promotion, prevention, and treatment of mental health issues, and presumably, workers should be offered the equivalent care as their clients in supporting
their own wellbeing. There was an irony noted in participants describing the missions of their organizations as promoting health and wellbeing of those they served, and then noting barriers to their own health and wellbeing in the workplace. Organizations value individuals with lived experience with many hired in precarious work positions; precarity in work is defined as, “…job insecurity, low wages and lack social benefits…” (Greer et al., 2020, p. 1). The invaluable experiential knowledge these workers have, aids in reaching and serving their communities by improving trust and understanding through their own lived experiences. Workers who are often positioned in precarious positions in roles as: peer support, part-time or relief status often face barriers in accessing equitable resources such as, extended health benefits, face job and financial instability, and housing insecurity due to the precarity of their work (Greer et al., 2020; Gillard et al., 2022; Mamdani et al., 2021; Olding et al., 2021). Organizations overreliance on precarious labor is the direct result of government funding cuts and neoliberal agendas impacting the non-profit sector (Greer et al., 2020; Mamdani et al., 2021), creating a deepening of structural violence perpetuating the power imbalances experienced by precarious workers. The challenges that participants faced in this study were access to mental health supports, with many relying on one another as peer support workers as a solution. This is problematic on many levels, assuming that without proper training risks of re-traumatization increase, further burdening peers who are not equipped with the tools or education to provide counsel.

While debriefing was found to be a frequently occurring practice, it was primarily critical incident focused with the goal of improving workplace processes. By not focusing on the emotional wellbeing of staff, these debriefs were at times conducted poorly, increased risks of secondary trauma or including staff members not relevant to the
discussion, decreasing the sense of safety in the debrief. The inconsistent and intermittent styles of debriefing practiced may stem from the nature of the work. An ever-changing landscape of needs expressed by clients on a day-to-day basis, coupled with variances of structural supports across organizations, and the unfolding COVID-19 pandemic, may be contributing to instability of the workplace environment and decreased prioritization on staff wellbeing. The increasing demand of support is primarily devoted to client-centered care, resulting in time constraints to perform proper debriefing practices during the course of a workday. These results build on previous research (Waegemakers et al., 2019) concerning community social service workers’ mental health, vicarious trauma and re-traumatization associated with this field, showing that workers have a willingness to communicate their emotional or triggering experiences but did not feel safe enough to do so in their current workplace cultures.
Chapter VI: Conclusion

Implications and Recommendations

The traumatic events or experiences viewed, heard, or lived by community social service workers create risk for long lasting effects that transcend from work to home (Pincus et al., 2022). Increased risks to workers mental wellbeing bear similarity to better acknowledge burdens of healthcare, first response teams and emergency workers (e.g., deep poverty, mental health crises, violence viewed and experienced) (Hallinan et al., 2021; Kim et al., 2022). While there are increasing guidelines regarding debriefing practices for emergency service personnel (Mahaffey et al., 2021), these have not been paralleled by similar focused creation of debriefing practices in social services. Therefore, it is worth considering existing modalities from other sectors that prioritize the emotional wellbeing of the workers, such as Personal Reflective Debriefing (PRD) for interdisciplinary healthcare workers. PRD is a Proactive Structured Debrief adding personal self-reflection to deepen and reinforce social support from team members (Schmidt & Haglund, 2017).

The PDR model is promising in terms of prioritizing a focus on worker wellbeing over workplace processes. In the absence of high-quality, organization-led debriefing practices, workers in community and social service settings are instead practicing unstructured peer-led debriefs that include their lived experiences, feelings, traumas, and triggers. Although risks associated with re-traumatization in debriefs have been raised in the current literature and in this study, it should be also carefully weighed with when debriefing is appropriate, to reduce risks associated with vicarious trauma and re-traumatization as experienced by community social service workers viewed in this study. Another recommendation is promoting education and training for peer supporting roles in
organizations through skills and development of evidence informed practices (Mental Health Commission of Canada, 2016), while others have adopted a specific program with successful outcomes for mental health workers increasing the wellbeing of workers with lived experience (Gilliard et al., 2022). While this cannot be generalized across the sector based on the scale of this study, it demonstrates that debriefing is frequently taking the shape of utility for workplace practices over staff emotional wellbeing. While working with peers on an informal basis demonstrates the resiliency of frontline workers, this also represents an insufficient approach by organizations that are ultimately responsible for their staff. Peer debriefing as a fall-back carries high risks of poor practices or vicarious trauma.

Limitations and Challenges

Limitations to this study included engaging broad participation in the survey. This study was conducted during the height of the COVID-19 pandemic, creating challenges in gaining entry and participation from agencies and their workers. COVID-19 caused an increase of need in many communities who experienced: employment loss, housing issues and/or loss, illness, increased rates of addiction, COVID-19 deaths, and high rates of overdose deaths, to name a few outcomes. Community social service agency client lists grew, putting workers at an increased risk of trauma related exposures, while leaving them helpless, resulting in decreasing supports from COVID-19 provincially mandated closures. A higher rate of participation may have provided further nuance to the study data. The sample of participants in this study was predominantly white women, lacking representations of gender, culture, and racial diversity to parallel to the population in which the research was conducted. The quantitative question in the survey, “years of employment”, amounted to: Less than one year = 22%; 1-3 years = 49%; 3-5 years = 10%;
5-10 years = 7%; 10 years or more = 12%. The structuring of this question is ambiguous and does not show a full representation of participant’s overall work experience, there was ambiguity in whether participants were indicating overall work experience or just experience at their current organization. This can result in misinterpretation of workers experience in community social service work as a whole, and an increase in work experience may equate to higher rates of resiliency or experience with working in a caring position could situate the worker to manage trauma exposures more effectively with perhaps increased ability of coping mechanisms.

**Concluding Remarks and Future Research**

Community work requires community workers, yet the COVID-19 pandemic has seen an unprecedented exit from health and social service workforces. Organizations have an opportunity to create a context of resilience as opposed to a context of burnout. The current variability in debriefing styles across organizations was quite visible in the data and included improperly executed debriefs without a set structure and without prioritizing worker wellbeing, causing participants to be negatively affected. Taking up evidence-based approaches of debriefing with clear and consistent policies regarding when and how debriefing occurs should not just promote staff wellbeing or organizational processes but also subsequently promote positive client outcomes. Instead, mental health injuries (Waegemakers et al., 2019) are leading to high rates of burnout resulting in early career exists and high turnover rates. This study was conducted to understand community social service workers’ perspectives of debriefing; we suggest future research is needed in developing best-practice guidelines, targeting community social services workers who are working in community settings, to gain a deeper understanding of how the culture of work
may foster environments that promote psychological safety. In order to better support organizations and their workers, future research is required to develop frameworks and supports, to influence a cultural change within organizations to reduce the harms experienced. It is well known that many who seek to work in the helping professions have their own complex experiences of trauma (Voronka & Grant, 2022). In this context, workplace incidents can serve as triggers that may require active follow-up. At the same time, these traumas may be root motivators for helping professionals. Having an awareness of the emotional toll of the work and the emotional complexity that helpers bring to their careers accentuates the need for psychologically safe working environments.
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Appendices

Appendix A: Email to Executive Directors of Community Social Service Organizations

Good morning/afternoon, [executive directors/chair/leader name here]

My name is Andrea Krywucky, I am a Master’s student in the Faculty of Health Information Sciences at the University of Western Ontario, conducting a research study under the supervision of Dr. Abe Oudshoorn. We are aiming to understand the use of debriefing practices as an organizational support from the perspective of frontline community/social service workers.

I am contacting you regarding the dissemination of a research opportunity to your staff who may fit the following criteria: social workers, social service worker, community service workers, case managers, or peer support workers who are in contact with marginalized/vulnerable individuals who access social services, community social service, and non-profit organizations. The survey consists of multiple choice and short answer and may take approximately 20-30mins to complete. Following completion of the survey, participants will also be given an opportunity to participate in a 1hr virtual interview. Individuals who have chosen to participate in the interview portion of the study will receive an honorarium of $20 for their participation and appreciation of their time.

If you are amenable, I have attached a document of the project information page that can be forwarded directly to your staff. If you would like further information, I’m happy to connect with you to discuss this project in detail.

I have personally worked in community social service settings for 8 years and have seen the toll this work can on have our community workers in terms of vicarious trauma. I am interested in how we are already or could further optimize debriefing practices to maintain and enhance our community workforce to continue to deal with challenging human experiences.

If you have any questions, please feel free to contact me.

All the best,
Andrea Krywucky
Master of Health Information Sciences Candidate
Faculty of Health Information Sciences
University of Western Ontario
Appendix B: Letter of Information and Survey

Letter of Information and Consent- Key Informant Interview

Project Title: How We Debrief: An Interpretive Description of Social Service Community Workers’ Experiences

Principal Investigator (PI): Abe Oudshoorn, FIMS & Nursing Building, Room 2304, University of Western Ontario, London, Ontario, Canada, N6A 5B7

Student Researcher: Andrea Krywucky

Dear Potential Participant:
We are inviting you to participate in a research study conducted by Abe Oudshoorn (Principal Investigator [PI]). This project aims to explore at least 10 individual experiences exploring debriefing practices of community social service agencies in London and surrounding area in Ontario. In this study we are recruiting participants aged 18 years or older who reside in London and surrounding area in Ontario and identify as being situated within one or more of the following groups that work with vulnerable and at-risk populations in community service, non-profit, and/or social service work: 1) lived experience in the research setting, 2) social service worker, 3) social worker, 4) community service worker, and 5) peer support workers.

What is the purpose of the study?
The purpose of this study is to understand your experiences working in environments that serve vulnerable and at-risk populations. Individuals working in community social services are exposed to incidents that may invoke feelings of psychological distress, secondary trauma, vicarious trauma, may be triggering for persons with lived experience, and may decrease staff members ability to cope with repeated exposure, with an increased possibility of burnout. Every organization deals with these ongoing stressors or critical incidents in different ways. The aim of this project is to understand social service workers perspectives of formal/informal debriefing practices, their frameworks, and organizational protocols for minimizing the effect of traumatic events for frontline staff.

Through this project, we will address the following question(s):
What current practices in debriefing are currently being implemented by community service, non-profit and/or social service organizations? What are the perspectives of front-line social service workers on debriefing supports being offered (or not offered)?
What will I do?
First, if you consent to participate in the interview portion of the study, the participant [if they choose to participate] will contact the student research (Andrea Krywucky) by email which is also provided at the end of the Qualtrics survey. The participant will then be contacted through email correspondence to schedule a virtual interview, that will be conducted over the Zoom platform. The interview will take approximately 60 minutes to complete and will be recorded on Zoom and audio-recorded with the voice record function on iPhone, (note: only the audio file will be saved for recordings and will be immediately downloaded to Western OneDrive, the files will then be deleted off the laptop and iPhone) unless you (the participant) indicated otherwise. Audio recording of interviews are mandatory, to ensure accuracy of data.

Secondly, [if participant chooses to participate in the interview portion], the interviewer will ask you to complete the private online (virtual interview) and demographic questionnaire (Via Qualtrics software). This will ask participants to share their role title (if applicable), age, city/community where you currently reside, educational background, ethnic/cultural identity, gender identity, whether they consider themselves part of the Lesbian, Gay, Bisexual, Transgender, Queer or Two Spirited (LGBTQ2S) community, or whether they identify with one of the four groups of experts (i.e., social worker, social service worker, community service worker and, peer support worker). This information is collected to ensure that there is diverse and inclusive study representation. Participants can refuse to answer any of the demographic questions. Your full name will be requested only on the consent form. All information will be kept confidential and stored securely in Qualtrics and Dedoose. Your full name will only be kept on the secure Master list, and not used elsewhere. The demographic data will be aggregated and presented as group participant data. Lastly, the interviewer will ask the predetermined list of interview questions.

What are the risks and benefits of the study?
There are no anticipated risks anticipated for study participants, however some participants may find discussing experiences of vicarious trauma emotionally upsetting. A list of provincial supports is available and will be provided to you as a hard copy or to view/download from Qualtrics during the online consent process. Participants are permitted to leave the interview and/or withdraw from the study at any time.

While we do our best to protect your information there is no guarantee that we will be able to do so. Security statements for all software that will be used throughout the study are included below for your information:

Qualtrics: [https://mysurveys.uwo.ca/general_information1/qualtrics_security.pdf](https://mysurveys.uwo.ca/general_information1/qualtrics_security.pdf)
Server: US and Canada

Zoom: [https://explore.zoom.us/docs/en-us/privacy.html](https://explore.zoom.us/docs/en-us/privacy.html)
Server: US and Canada
This research explores the experiences of social service community workers who may or may not have had experience with debriefing practices to mitigate the effects of trauma exposures, vicarious trauma, compassion fatigue, stress disorders and burnout. Understanding the breadth and rationale of current practices is the first step in a broader goal to ultimately develop more evidence-based standards of practice for community and/or non-profit social service agencies, to aid in the reduction of burnout and career exiting, to create an increase in evidence to sustain and support social service workers in work and improve their overall well-being.

**Can I withdraw from the study?**
Yes, you may withdraw from the study at any time without negative consequences. If you wish to withdraw, you may end the interview early and/or request that your data not be included in the study. The research team will have access to a master list, which is a record that includes the participant’s name, interview time/date, and assigned pseudonym. This will enable the research team to remove your data prior to publication or dissemination of the findings.

**Compensation**
Participants with lived experience working as; social worker, social service worker, community service worker and peer support worker will be compensated $20.00 CAD for their participation. Participants with lived experience working as; social worker, social service worker, community service worker and peer support workers are provided an honorarium to acknowledge their unique lived experience(s) and contribution to the study in the interview portion of this project.

**Is the study voluntary and confidential?**
Participation in this study is completely voluntary. As previously mentioned, participants can withdraw from the study at any time without explanation. Even if you consent to participate you have the right to not answer individual questions or to withdraw from the study by ceasing or exiting the interview at any time. If you choose not to participate or to leave the study at any time it will have no effect on you. You do not waive any legal right by consenting to this study.
You must indicate informed consent prior to participating in an interview. During a virtual interview, participants will complete a secure, online informed consent form (via Qualtrics software). Each participant will be sent a unique identifier link, that can only be accessed by members of the research team.

Following the interviews, Transcript Heroes will transcribe the audio-recorded data. Aside from this transcription service, only the research team (student researcher, Andrea Krywucky; PI, Dr. Abe Oudshoorn) will have access to your information. Transcribed data will be analyzed in a secure platform: Dedoose. The data will be anonymized by the PI using pseudonyms and stored in an encrypted, password-protected drive. Identifiable
information, including your name, age, and interview date and location, will be removed. This information will be included in a master list, accessible to only the PI and Co-PI. Research data will be stored for 7 years post-publication, and subsequently deleted. The research team endeavors to maintain participant privacy and confidentiality; however, the law requires us to report certain information. Any disclosure of abuse, suicidal ideation, or homicidal ideation will be promptly reported to the appropriate service (e.g., law enforcement, Children’s Aid Society [CAS], etc.).

**Results of the Study**
Results from the study will be shared with leadership of the organizations that have chosen to participate, through a dissemination of the final research results in written form. If you would like a copy of the study results, please contact the Principal Investigator, Dr. Abe Oudshoorn at the phone number or e-mail included below and/or the research student, Andrea Krywucky at the email provided.

**For More Information:**
The Western University Non-Medical Research Ethics Board may require access to the study records to monitor the conduct of this research. Please contact the Office of Human Research ethics if you have questions or concerns about your rights as a participant and/or the conduct of this study.

Please contact the Principal Investigator Dr. Abe Oudshoorn with any questions pertaining to the study, including the purpose and participant requirements.

Sincerely,
Dr. Abe Oudshoorn
Assistant Professor at Western University, Arthur Labatt Family School of Nursing
This letter is yours to keep for future reference

Consent Form

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction. I agree that unidentifiable, direct quotes may be used in sharing the research:  ☐ Yes  ☐ No

If you do not agree to the use of direct quotes, your data will still be utilized in the analysis, but no direct quotes used in sharing the results of the study.

I consent to the use of audio-recording during the interview:  ☐ Yes  ☐ No

Participant’s Name (please print):
_______________________________________________

Participant’s Signature:  _______________________________________________

Date:  _____________________________

Person Obtaining Informed Consent (please print):  _____________________________

Person Obtaining Informed Consent’s Signature:  _____________________________

My signature indicates that I have explained the study requirements and considerations to the above participant, answering any questions or concerns.

Date:  _____________________________
Appendix C

How We Debrief — Qualtrics Quantitative and Qualitative Questionnaire

Does your team have a debriefing process?

Is it regular or only critical incident related?

How often does this occur?

Who facilitates this?

Do you discuss patient/client related incidents only or also staff issues?

Are staff safe to bring their lived experiences into this debrief environment?

Do you have other team building processes apart from debriefing?

If yes, please explain?

Whether you currently have debriefing or not, would you want regular debriefing at your workplace?

If no, why not?

How would this be structured? What would it cover?

Aside from debriefing, what other practices would reduce your risk of burnout at work?

Have you ever experienced a debriefing process that was poorly done? If yes, what made it frustrating, retraumatizing, or sub-par?

You are invited to participate in an interview to talk further on the issue of debriefing. If you would like to receive more information about an interview, please contact Andrea Krywucky

Thank you for taking the time to complete this survey. Your time and responses are appreciated.
Welcome to the research study!

We are interested in understanding current debriefing practice being used in community and/or non-profit social service agencies. You will be asked to answer some questions about what current practices are being used to mitigate effects of trauma exposures that may result in trauma-related stress disorders or injuries by individuals working in community and/or non-profit social service agencies. Your responses will be kept completely confidential.

The study should take you around 20-40 minutes to complete. Your participation in this research is voluntary. You have the right to withdraw at any point during the study. The Principal Investigator Dr. Abe Oudshoorn or the student researcher Andrea Krywucky if you have any questions or concerns.

By clicking the I consent button below, you acknowledge: Your participation in the study is voluntary. You are 18 years of age. You are aware that you may choose to terminate your participation at any time for any reason.

I consent

I do not consent
Qualtrics Survey

1. Does your team have a debriefing process?

If yes:

   a. Is it regular or only critical incident related?

   b. How often does this occur?

   c. Who facilitates this?

   d. Do you discuss patient/client related incidents only or also staff issues?

   e. Are staff safe to bring their lived experiences into this debrief environment?

2. Do you have other team building processes apart from debriefing?

3. Whether you currently have debriefing or not, would you want regular debriefing at your workplace?

4. How would this be structured? What would it cover?

5. As opposed to debriefing, what are top things that would reduce your risk of burnout at work?

6. Have you ever experienced a debriefing process that was poorly done? If yes, what made it frustrating, retraumatizing, or sub-par?

You are invited to participate in an interview to talk further on the issue of debriefing. If you would like to receive more information about an interview, please click this link:
Appendix D

Demographic Questionnaire

Instruction Welcome to the demographics portion. Thank you for your participation in this qualitative research project: How We Debrief. Please complete the following demographics questionnaire.

Thank you for your participation, participation in this research is voluntary. You have the right to withdraw at any point during the study. The Principal Investigator Dr. Abe Oudshoorn or the student researcher Andrea Krywucky if you have any questions or concerns.
Gender: What is your gender?

- Male
- Female
- Non binary/ Third gender
- Prefer not to say

Age: What is your age?

- Under 18
- 18 - 24
- 25 - 34
- 35 - 44
- 45 - 54
- 55 - 64
- 65 - 74
- 75 - 84
- 85 or older

Ethnicity: What is your ethnic or cultural origin(s)?

For example: Canadian, Indigenous, Chinese, East Indian, English, Italian, Filipino, Scottish, Irish, Portuguese, German, Polish, Dutch, French, Jamaican, Pakistani, Iranian, Sri Lankan, Korean, Ukrainian, Lebanese, Somali, Columbian, Jewish, etc.

Race: Which race category best describes you?

- East Asian (Korean, Chinese, Japanese, Taiwanese decent)
- Latino (Latin American, Hispanic)
Middle Eastern (Arab, Persian, West Asian decent (e.g., Afghan, Egyptian, Iranian, etc.)

South Asian (East Indian, Sri Lankan, Pakistani, Indo Caribbean etc.)

Southeast Asian (Filipino, Cambodian, Vietnamese, Thai, other southeast Asian decent)

White (European decent)

Indigenous (Inuit, Metis, First Nations, Cree, Anishinaabe, Ojibwe)

Option/category not listed

Prefer not to answer

How many years have you worked at your place of employment?

1 year or less

1 - 3 years

3 - 5 years

5 - 10 years

10 years or more

Employment Title: What is your position at your place of employment? Select all that apply.

Peer support

Case manager

Social service worker

Social worker

Medical staff
○ Harm reduction

○ Other ______________________________________________

Education: What is the highest degree or level of school you have completed?

○ Less than a high school diploma

○ High school degree or equivalent (e.g., GED)

○ Some college, no degree

○ Associate degree (e.g., AA, AS)

○ Bachelor's degree (e.g., BA, BS)

○ Master's degree (e.g., MA, MS, MEd)

○ Doctorate or professional degree (e.g., MD, DDS, PhD)

Employment: What is your current employment status?

☐ Employed full time (40 or more hours per week)

☐ Employed part time (up to 39 hours per week)

☐ Relief status

☐ Unemployed not currently looking for work

☐ Student

☐ Retired

☐ Self-employed

☐ Unable to work

☐ Volunteer
Education: What is the highest degree or level of school you have completed?

- Less than a high school diploma
- High school degree or equivalent (e.g., GED)
- Some college, no degree
- Associate degree (e.g., AA, AS)
- Bachelor's degree (e.g., BA, BS)
- Master's degree (e.g., MA, MS, MEd)
- Doctorate or professional degree (e.g., MD, DDS, PhD)

Income: What is your employment income range?

- Less than 20,000$
- 20,000 - 34,000$
- 35,000 - 49,999$
- 50,000 - 74,999$
- 75,000 - 99,999$
- Over 100,000$
- Prefer not to answer
Appendix E

Interview Guide

The purpose of this study is to understand your experiences working in environments that serve vulnerable and at-risk populations. Individuals working in community social services are exposed to incidents that may invoke feelings of psychological distress, secondary trauma, vicarious trauma, may be triggering for persons with lived experience, and may decrease staff members ability to cope with repeated exposure, with an increased possibility of burnout. Every organization deals with these ongoing stressors or critical incidents in different ways. The aim of this project is to understand social service workers perspectives of formal/informal debriefing practices, their frameworks, and organizational protocols for minimizing the effect of traumatic events for frontline staff.

1. We come to this project with the presumption that some of the people supported through health and social services have complex needs. Can you start by telling me a bit about the supports you provide for people in your work?
   ➢ What are some of the hardest experiences your clients share with you?
   ➢ What are some of the most difficult experiences you have with clients?
   ➢ Can you give an example of a particularly stressful experience and the debriefing that did or did not occur afterwards (can be current or past employment)?

2. When you think about psychological debriefing practices, what do you picture these to be?

3. Does your organization use debriefing practices?
   ➢ Are debriefings conducted formally or informally?
   ➢ Can you tell what this looks like?

4. What do you think of debriefing practices in general?
   ➢ Helpful? Not helpful?
   ➢ If helpful, when are they used, what do you hope to accomplish?

5. Have you had experiences with debriefing that follow a particular protocol or process?
➢ What was this protocol?

➢ If no explicit protocol, what do you think are the beliefs that underpin how organizations do (or don’t do) debriefing?

6. What would you consider to be ideal debriefing practices?

➢ When are they conducted?

➢ Where are they conducted?

➢ How are they conducted?

➢ Who is included (e.g.: staff members, leadership, social worker, mediator, peer support)?

➢ How long do they take?

➢ How are power relations managed in debriefing? (ex. based on gender, role in the organization, seniority, etc.)

7. Do you think your organization and staff can benefit from consistent use of debriefing practices? Why? Or why not?

➢ Does debriefing relate directly to experiences of burnout?

➢ Do you think mental health stigma existing in organizations?
Appendix F

PARTICIPANTS NEEDED FOR RESEARCH IN SOCIAL SERVICES COMMUNITY/NON-PROFIT AGENCIES

We are looking for volunteers to take part in a study of experiences and/or knowledge of debriefing practices that may or may not be occurring in social service work and who meet the following criteria:
1) Identify as; Social service workers, social workers, community service workers, peer support workers.

If you are interested and agree to participate you would be asked to do a qualitative survey 20-40 minutes

To learn more about the study or participate, please contact Andrea Krywucky
Ethical Approval

Date: 24 March 2022
To Dr. Abe Oudshoorn
Project ID: 1/9629
Study Title: How We Debrief: An Interpretive Description of Social Service Community Workers’ Experiences
Short Title: How We Debrief
Application Type: NMRB Initial Application
Review Type: Delegated
Full Board Reporting Date: May 6 2022
Date: Approval Issued: 24/Mar/2022 14:56
REB Approval Expiry Date: 24/Mar/2023

Dear Dr. Abe Oudshoorn

The Western University Non-Medical Research Ethics Board (NMRB) has reviewed and approved the WREIM application form for the above mentioned study, as of the date noted above. NMRB approved for this study remains valid until the expiry date noted above, conditional to timely submission and acceptance of NMRB Continuing Ethics Review.

This research study is to be conducted by the investigator noted above. All other required institutional approvals and mandated training must also be obtained prior to the conduct of the study.

Documents Approved:

<table>
<thead>
<tr>
<th>Document Name</th>
<th>Document Type</th>
<th>Document Date</th>
<th>Document Version</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview Schedule Appendix D</td>
<td>Interview Guide</td>
<td>16/Jan/2022</td>
<td></td>
</tr>
<tr>
<td>Email for Recruitment Virtual Interview - G</td>
<td>Recruitment Materials</td>
<td>67/Feb/2022</td>
<td>1</td>
</tr>
<tr>
<td>Interview Letter of Information and Consent - Appendix F</td>
<td>Written Consent/Assent</td>
<td>67/Feb/2022</td>
<td>1</td>
</tr>
<tr>
<td>How We Debrief Virtual Interview Demographics</td>
<td>Online Survey</td>
<td>68/Feb/2022</td>
<td>1</td>
</tr>
<tr>
<td>How We Debrief (J)</td>
<td>Online Survey</td>
<td>68/Feb/2022</td>
<td>2</td>
</tr>
<tr>
<td>Email for Recruitment Graphics Survey - Appendix E</td>
<td>Recruitment Materials</td>
<td>73/Feb/2022</td>
<td>2</td>
</tr>
<tr>
<td>Survey Letter of Information - Appendix C</td>
<td>Implied Consent/Assent</td>
<td>67/Feb/2022</td>
<td>1</td>
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</table>

No deviations from, or changes to the protocol should be initiated without prior written approval from the NMRB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

The Western University NMRB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Fetal/Tal Health Information Protection Act (PHFA, 2004), and the applicable laws and regulations of Ontario. Members of the NMRB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMRB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 000000841.

Please do not hesitate to contact us if you have any questions.

Sincerely,
Kelly Patterson, Research Ethics Officer on behalf of Dr. Randall Graham, NMRB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).
## Appendix G

### Qualitative & Quantitative Survey Questions: How We Debrief

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your team have a debriefing process?</td>
<td>Yes = 66% No = 34%</td>
</tr>
<tr>
<td>How Often Do Debriefs Occur?</td>
<td>As needed = 4 responses&lt;br&gt;At the end of shift = 5 Responses&lt;br&gt;Daily = 2 Responses&lt;br&gt;Weekly = 4 Responses&lt;br&gt;Bi-Weekly = 3 Responses&lt;br&gt;Monthly = 3 Responses&lt;br&gt;Quarterly = 1 Response&lt;br&gt;It varies = 3 Responses&lt;br&gt;Critical Incident Only = 8 Responses</td>
</tr>
<tr>
<td>Who facilitates these debriefs?</td>
<td>Manager/Supervisor/Leadership = 16 Responses&lt;br&gt;Staff = 13 Responses&lt;br&gt;On Call Support = 2 Responses&lt;br&gt;Critical Incident training staff = 1 Response&lt;br&gt;No designated person = 1 Response</td>
</tr>
<tr>
<td>Do you discuss patient/client related incidents only or also staff issues?</td>
<td>Both, client related, and staff related issues = 17 Responses&lt;br&gt;Client focused only = 12 Responses</td>
</tr>
<tr>
<td>Are staff safe to bring their lived experience into this briefing environment?</td>
<td>Yes = 23 Responses&lt;br&gt;No = 2 Responses&lt;br&gt;They are invited to but it’s not safe = 1 Response</td>
</tr>
</tbody>
</table>
| Do you have any other team building processes apart from debriefing? If yes, please explain? | Yes = 56%<br>No = 42%<br>“Co-visions: one-on-one, scheduled meetings with a peer. Prompts are given around a specific topic or staff are free to use the time to discuss issues or talk about whatever makes sense to them in that time frame”<br>“Once a week all staff meeting + Co-vision (talks among peers)”<br>“we do creative check-ins, morning check-in that include imagination, sometimes mindfulness activities, co-visions require long walks and thinking outside of the box (being outside of the building), team meetings often take place on the grass by the church (we call it the staff theatre), and we have some simple games. We also have de-clutter parties which involve bringing
munchies to share while we all clean and declutter and blast some music... and once in a while we go out for lunch together, or for a walk together”

“team meetings, shift changes, team building days, co-visions, group walks and social activities”

“team meetings every week, team huddle everyday x2”

“Team building days every few months”

“weekly check-ins with team and leadership, and bi-weekly supervision with manager”

“We have regular team meetings, and opportunity to go over "gripes and successes” are offered. If debriefs are needed, typically they are done in the moment with a co-worker.”

“As relief staff, I am usually covering for full-time staff whilst these take place, so I am not as familiar with their process/events”

“Morning Huddles, Monthly Staff Meeting, Yearly team building session, workshops offered for us to attend.”

“Staff meetings with organized bonding activities”

“We start each day with a check in to review the previous day, call each other in, and any client or staff related incidents”

“There is annual agency professional development days and workshops that can be attend upon request”

“Morning huddles, team meetings, group sessions with a social worker”

“We have a morning huddles, it is an opportunity for workers to sit down and go over support plans and speak about any issues/ concerns that they were hoping to address”

“we do huddle’s every morning before we open to discuss events from previous days, any changes and
### HOW WE DEBRIEF: AN INTERPRETIVE DESCRIPTION OF SOCIAL SERVICE COMMUNITY WORKERS’ EXPERIENCES

| Whether you currently have debriefing or not, would you want regular debriefing at your workplace? If no, why not? | Yes = 95%  
No = 5%  
“I feel like we touch base daily, we are too busy to debrief everyday”  
“I don’t know” |
| --- | --- |

<table>
<thead>
<tr>
<th>Desired Debriefing Practices and Reasoning</th>
<th>“I work in addictions and mental health, and it can be a lot - the vicarious trauma doesn't stay at work. I take it home with me and think about it quite a bit - I wish I was able to debrief with my coworkers to mitigate</th>
</tr>
</thead>
</table>
burn-out and inadvertent trauma being place upon myself”.

“Having extra time off when there are aggressive interactions with tenants”

“It is important to debrief to avoid burn out. However - staff don't often engage when debriefing is offered”

“It is hard in the moment to know when a debrief would help in some situations. Also, when you are struggling it can be hard to reach out. Routine debriefs would make it easier to engage and bring to light issues we may not be aware we are experiencing”

“The work is very hard, being able to process emotional tensions about tenants and with other staff, and about the program, is key for a healthy work environment”

“I think it would be helpful to process the emotions that we hold onto in our hearts, minds, and bodies. I think it would be beneficial to discuss possible solutions (depending on if the situation that occurred may have a solution if it were to happen again). Debriefs would also facilitate opportunity to grow together as a staff and create a collective strength - which is needed to do this work and do it well. I think a debrief process would help staff connect the dots of their emotions as well as help them understand what triggers they may have - and what they may need in terms of support from their staff team and organization. Additionally - and most significantly, an intentional debriefing process would benefit clients, as staff would not be carrying past trauma or emotions in the same way that they would without an intentional debrief. As a result, clients would be better supported and connected to the staff”

“it is good for us to confront the intense emotions we feel and feel support from the team”

“It would help newer staff feel less alone in what they're experiencing”
| “It helps reduce secondary-trauma when debriefing after every session (regardless, if, an "incident" occurred). I work in crisis and often see low - high risk suicidal ideation, situational stressors, and various traumas. This field of work can be emotionally draining, and debriefing is a process to help reduce the impact of witnessing trauma” |
| “I think debriefing is a helpful practice in order to best understand our reactions and responses to potentially triggering/traumatic experiences or situations which offer a good learning opportunity” |
| “always good to ensure everyone is doing OK” |
| “We encounter a lot of conflict, crisis and do intervention at the street level” |
| “Debriefing is helpful because it forces you to make time to connect your team on where they’re at. Touch base on the interactions throughout the shift” |
| “it helps to process situations, manage stress, improve workplace resilience, build team strength and improve team communication” |
| “It is good for staff moral and connection. Good for the mental health of employees to be able to discuss traumatic incidences or current/past issues that arise” |
| “So, everyone is on the same page” |
| “The job we do is always based in crisis, emotional support and the like. Having a structured, organized debrief would be beneficial in avoiding burnout and compassion fatigue” |
| “It helps me leave work at work, and not take it home with me. It allows me to wind down after a day of emotionally difficult work” |
| “So that whoever was involved in the incident or daily work has an opportunity to reflect, discuss challenges, and action solution-based strategies going forward” |
| “Allows us to cope with work-related issues at work instead of taking it home” |
“staff checks in from management, more debrief time”
“it helps the staff grow and learn”

“Having the support, being able to talk about it and discuss what was done well or what needs to be improved. Having people on the same the page of what is going on”

“we need each other period! Some people have a hard time talking or releasing information that can be harmful to the body. It also helps increase team cohesiveness which impacts both one’s personal and professional life”

“Gives you a space to release the feelings associated. Coming together as a team for support or different perspectives”

“Each person provides insight into the situation and how to best proceed with it. I think if I have to write an incident report, a debrief session should be a part of the timeline process”

“As staff working on their own my work can be very isolating”

“I do a lot of debriefs with teammates, but no official process. Helps the mental health of staff”

“To discuss stressful situations”

“To discuss the "highs" and "lows' of the work we do. To unpack critical events”

“Incidents occur on a daily occurrence, and at least one overdose a week”

“Everyone seems to want different things when it comes to debriefing and so it seems like we don’t have a more formalized routine process because no one is clear what type of activity should be done. So it there was something regularly scheduled we would at least have something for staff to rely on and reduce pressure on managers to do this when they aren’t qualified”
<table>
<thead>
<tr>
<th>How would this be structured? What would be covered?</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I’m not sure how it would be structure. However, I’d like it to cover overdose and client death debriefs, staff mental health promotion and healthy coping strategies”</td>
</tr>
<tr>
<td>“After having a difficult incident w/ a tenant taking 2 hours after to brief by ourselves”</td>
</tr>
<tr>
<td>“One on One or in groups. It would cover topics like coping strategies. Naming feelings. Etc”</td>
</tr>
<tr>
<td>“Best healthy cultures I’ve worked with have 1. personalized daily check-ins/check-outs (5-15mins), 2. weekly staff meetings for progress follow up, accountability and processing (1.5-2hrs), monthly strategic (for assessing project planning and implementing new interventions), quarterly reviews (to review goals/failures стратегических планов, достижений и пробелов). More nuanced there are also other intentional containers, such as: 1. peer co-visioning/co-supervision meetings (spaces for staff to support each other outside of dynamics with team leads), 2. matured clinical direct supervision which includes basic personal support, professional coaching, admin, accountability (weekly mtgs with supervisor), 3. Access to ongoing clinical counselling supervision, which is being able to access a third party hired for the organization where staff can go and process personal/professional issues/trauma/burn-out, without direct repercussions with their superiors”</td>
</tr>
<tr>
<td>“Debrief with either a) staff involved in debriefed situation and supervisor or b) staff involved in debriefed situation and someone familiar with organization and work but not supervisor (remove power dynamic). A brief check in would occur after the incident followed by a longer discussion 3-7 days”</td>
</tr>
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after the incident occurred. It would cover staff reflections on the situation as well as staff emotions - as well as potential solutions moving forward. It would also cover what the staff needed from their team or organization for support”

“having a informal conversation in a place that is trusting and non-judgemental”

“I prefer unstructured debriefing. I like how my coworkers and I created an environment where we check in with each other. You never see a client without one or two people popping by your office to ask, "how did it go?" I would cover basic information about the session, what I did as a social worker, and any feelings that came up. I would also ask about where I could do better for next time (if I feel unsure) or other resources within the community”

“Self-care routines, keeping up with my physical needs (like sleep since I work night shifts), and personal supports to reach out to”

“On a regular day, debriefing should be casual, and offered in the moment, giving anyone an opportunity to discuss critical incidents. Structured debriefing should be made available on a scheduled basis to offer employees the opportunity to come together as a team and work through critical incidents”

“having a informal conversation in a place that is trusting and non-judgemental”

“I don’t know how it would be structured but it would cover what we see in a day/week/month”

“Debrief at the end of each shift, be able to reach out following the shift, and be able to access counselling if necessary”.

“Debrief with us is structured loosely, we form a circle around a table or standing and we either bring up a big event, discuss our feelings on said event separately or we go around and ask about the interactions of each
individual to know how they are feeling with everything that occurred in the shift”

“Things that went well, followed by things that could improve and suggestions, then any other input from the team”

“As incidences arise, directly after the incidence as well as scheduled debriefs to go over any issues”

“Severe incidents that could be qualified as traumatic”

“It can be organic or structured. I would like to see something that discusses wins and challenges”

“It would be structured as a conversation, where co-workers can discuss anything relevant to the day’s events - client related, agency related, things that are working well, and things we need to reconsider”

“What happened, what went wrong, what went right, how are we feeling”

“everyone has the chance to speak, free to give and receive feedback but also discuss emotions about situations at work, seeing what each individual need’s”

“should be daily”

“what could have we done better? what did we do well? is anyone holding on to anything, or been impacted by the situation? do you need a break if so, or to talk more in depth in what has impacted you?”

“Simply 20 minutes to just chat with a manager after a stressful shift or situation would be great”

“That's left to the experts :) many different ways”

“Weekly general meetings, biweekly or monthly standing meetings with manager and then as needed. To discuss any problems or after an incident”

“Small groups of 4; what actually happened; how did it feel/what is the impact?; what do we need to do right now?”
How we debrief: An interpretive description of social service community workers' experiences

| Regular staff meetings that focus on case management |
| Somewhat structured, somewhat left open ended so we can journey together. How are you feeling after witnessing that? What went well? What could we do better the next time? |
| Once a month meetup sharing of "highs" / "lows", critical events, open sharing |
| It should be that when an incident occurs a manager talks to each employee involved separately to discuss what they were feeling, how they think the situation was handled, and if they have any questions that arose |
| Not sure |
| Weekly or bi-weekly with coworkers. Current struggles, networking, team building and to check on with each other |
| Check ins, support, a supportive team |

Aside from debriefing, what other practices would reduce your risk of burnout at work?

| decreased caseloads, staff morale boosting events, increased sick time and personal time, clear communication outlining job description and not expecting staff to take on more or things outside of her job description |
| To be able to redirect tenants to available community resources |
| Prioritizing work/life balance |
| Better structure around break times, clearly defined boundaries that all staff adhere to equally |
| 1. Relational approach to the work (prioritizing quality of connection at all levels for the organization,
rather than the grinder, 2. meaningful conscious "ritualization’s" to process tragedies and collective trauma in community, 3. Focusing in the spiritual and personal development of frontline workers and leaders (to grow models outside of the paternalistic/learned helplessness the sector continues to feed into unconsciously...), 4. To re-shift the focus on resources, funding and initiatives to strengths based approaches (as opposed to needs base lenses and clinical institutional approaches and measures)... in other words, instead of clumping homeless people struggling with addictions and mental health into one building, to start instead to seeing social services as community organizers and facilitators towards integration, mix refugees, indigenous aunties, low income families or young families, student activists, artists, seniors, retired folk, and community oriented folk into buildings where people with mental health and/or addiction could be fully welcomed to have a real sense of family”

“This intentional lunch breaks and more benefits for counseling”

“This more heal days per year”

“This Self-care, days off after a critical incident with a client”

“This Adequate paid care time and vacation, financial support for counselling, team building exercises and establishing an adequate self-care routine outside of work”

“This Rotate duties amongst staff on a regular basis, take time away after each six months of work, provide regular education opportunities, do teambuilding and conflict resolution refreshers”

“This Having proper supports after difficult shifts i.e., counseling available, following day touch bases on difficult events proper support on shift; adequate staffing, and more than one larger responsible role on shift”
“tap out strategies to trade with other staff when you notice you're unable to provide the best care for a patient/client”

“Self-care time, use of vacation days, paid sick time”
“more condensed hours rather than hours spread out for significant time”

“Built in paid time off for contract workers. Better mental health supports on site for front line workers”

“Regular supervision with the leadership team and a safe environment to discuss with coworkers any difficulties I am facing at work in a less structured way”

“A non-toxic team”

“specific time off for mental health, shorter hours, more variety through the workday”

“more breaks at work, people that do not smoke, never get a break”

“work life balance, ability to take breathers when needed and options for training”

“Having management present during the shifts I work, having management actually know who I am instead of ignoring me or asking if I’m new despite being here for a couple years, having staff appreciation during shifts other than 8-4PM. I work after 4 or on weekends and never see anyone or aren't here for celebrations and continuously miss out”

“I could go on for ever: every person is unique- using creative ways to keep in touch with the senses (music, touch, poetry, sight and images, tastes sharing in cooking and food, fun: using laughter, & humor (stand-up comedy, videos), the use of pictures and stories to enlighten and strengthen the human condition, creative, spiritual, intellectual, and physical group activities that allow a person to socialize, gain confidence and connectivity. Being authentic to self and others if necessary, teaching). the amazing impacts
through therapeutic touch of pets and animals: horses, dogs, etc... Checking on people more frequently - people are not always honest with themselves or others for many different reasons, Encouraging healthy food & nutrition, water and nature walks or breaks - mandating self-care dates, of course decrease caseload expectancy”

“Team building activities”

“I cannot leave work premise during hours, so a nice environment (especially outdoors) would be helpful. I find myself sitting in my car alone just to have some quiet time because there is no specific spot to do so”

“No having to cover off other positions and having requesting time off approved”

“Having more than $500/yr for therapy (only if you don't choose other things from what's available). A therapist we could have access to. Actually being given breaks. Not having to deal with staffing shortages. Having consistency with policy and procedures. Health and Safety being taken seriously”

“Staff events, acknowledging life events such as birthdays, work anniversaries”

“appreciation by managers and workplace of work done, praise, check-ins, Increasing self-care, full staff team”

“Due to staff shortages, it is hard to find some time to separate yourself from the environment”

“Higher pay and more flexibility in schedule”

“Team leads and managers working frontline shifts. Access to better mental health support. Professional development courses”

“Better leadership”

“Staff events, trainings”
Have you ever experienced a debriefing process that was poorly done? If yes, what made it frustrating, retraumatizing, or sub-par?

<table>
<thead>
<tr>
<th>Response</th>
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<tbody>
<tr>
<td>“Not that I can think of”.</td>
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<tr>
<td>“Debrief without knowing all details and then I have to guess or ask”</td>
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<td>“It felt like a wound was opened and there was no support/after care when leaving the group”</td>
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<td>“I can't think of anything right now”</td>
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<td>“Team leaders being over stressed and pretty burned out themselves... losing sight of the real interpersonal issues, and worrying more about their liabilities, and red tape... it was rather a sad experience”</td>
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<td>“Yes - the individual facilitating the debrief had their own agenda and did not truly listen to what I was saying”</td>
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<td>“being told what I am feeling comes from a place of insecurity and I need to fix that to work here”</td>
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<td>“It wasn't that the debriefing process was poorly done, it was that there were multiple debriefings with different people, and having to retell it multiple times was frustrating”</td>
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<td>“I work night shifts and my debriefing with my supervisor feels sub-par. My supervisor works day shifts, so she never sees me within my social work roles. My coworkers see me in action, and I can debrief with on the spot since we have similar hours”</td>
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<td>“yes, not keeping it safe, putting staff down instead of providing education. Staff talking over each other”</td>
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<td>“Yes. When people aren't given the opportunity to openly discuss their response to a situation in a judgement free environment, debriefs can do more harm than good. Providing a safe space to discuss critical incidents without fear of reprimand is a necessary component of debriefing”</td>
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<tr>
<td>“no”</td>
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“Yes. A volunteer with past trauma was trying to debrief and they were consistently being talked over by another volunteer who was trying to over identify with the situation”

“Yes, I have experienced debriefing where I was made to feel unheard, my experiences were downsized and not understood, I didn’t feel heard or respected but more so judged and like I was being dramatic. I have also been in debriefing wherein an interaction was harmful on shift and when it was brought up the other party exited instead of discussing. I, as the person leading the debrief often do not debrief myself because my team doesn’t turn it back; i think this is something we can involve in our debrief procedure”

“No”

“If a staff member is unable to remain openminded- take or give feedback. Rushed debriefs, staff members trying to dominate debrief or have a "hero" complex”

“Yes, was not confidential and was taken outside of facility”

“Yes, the manager started off asking what I thought I did wrong and how it could have been done better. It was very putative”

“No, I have not”

“no”

“yes, when things are just a quick "are you good?" and then continue operating. I feel that everyone should be given the opportunity to have a safe space to say "I'm not okay" rather than feeling pressured to not talk and move on”

“I have never had a debriefing session. Staff is too busy to do this or are not present when I am working so it does not occur”

“yes”

“No”
“Not allowing all voices to be heard can be frustrating in a debriefing process. There should be an opportunity for everyone”

“No”

“When it simply is not done or not cared about”
“I have never had a debriefing situation”

“I have only done one debriefing session in my time here when I believe there should have been at least once a month. I did set up monthly debriefing sessions, but that manager resigned before I could even implement it”

“Every debriefing process I have been a part of has been done poorly. I think because social service agencies can’t afford regular debriefing services and try to do it on their own without the right qualifications”

“Yes. My feelings were minimized and there was no follow up or offer for resources”

“Not being able to openly discuss the incident”

“Getting everyone to tell their version, basically everyone in the debriefing event was retraumatized listening to everyone recount the event”
Appendix H

Thematic Analysis

| Experiences Shared w/clients & Day to Day Work Expectations | - Domestic Violence  
- Unwanted Pregnancies  
- Suicide Ideation  
- Historical Trauma  
- Sexual Trauma/Assaults  
- Death and Dying  
- Unemployment  
- Incarceration  
- De-escalation  
- Food Insecurities  
- Life Skills  
- Housing Support  
- Harm Reduction: support/education/materials  
- Viewing and Experiencing: Violence/severe/physically harming  
- Drug use  
- Overdoses  
- Counselling  
- Crisis’s  
- Sex work & Bad Date Reporting  
- Dispensing Medication  
- Mental Health Crisis’s  
- High Volumes of Clients  
- Substance Withdrawals  
- Eating Disorders  
- Providing Community  
- HIV/AIDS  
- Health Issues (i.e., illness, infection, abscesses)  
- Psychosis (i.e., drug induced, mental health break) |
| Commonalities | - No formal Debriefing process/procedure  
- Informal debriefs  
- Would like someone to call/reach out to  
- Stigma  
- Wants a Debrief after a traumatic Incident  
- With 24 hours of incident  
- Other supports to be available  
- Lack of education of debriefing methods  
- Stopped reaching out  
- Hesitant to reach out  
- Manager as soul support following incidents |
- Chaplain as support (not culturally inclusive)
- No-follow up
- No Counsellor on shift
- Monthly supervisions
- Understaffed
- Free counselling
- Small groups for debriefing sessions preferred
- Individualistic support

**Intriguing Words**
- Dump, Vomit, Unload (e.g., words used to express talking it out)
- Chaos
- Human Shield
- Not forcing (e.g., when someone has not processed or ready to talk)
- Put up with abuse
- No one appreciates them
- First point of contact
- Wears different hats
- Emotional environment
- Get stronger
- Lack of safety
- Feeling fearful
- Tougher skin
- Back burner
- Overwhelmed
- Bottle-up feelings
- Resentment
- Humour
- Situations sink in as time passes
- Trust/lack of trust
- Withstand
- Dignity
- Hope
- Cope
- Isolating
- Tap out strategies
- A non-Toxic team
- Normal breaks

**Key Words**
- Informal debriefs
- Peer-to-peer support
- Open communication
- Supportive Listening
### Themes

<table>
<thead>
<tr>
<th>Emergent Themes</th>
<th>Quotes</th>
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<tbody>
<tr>
<td>Lack of Psychological Safety</td>
<td>“...In the professional world when you state you're struggling, you are looked at different. People will want to, baby you, they'll protect you more or they still think that you're just not fit for the job...” (Participant 001).</td>
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<tr>
<td>Spectrums of resiliency</td>
<td>“...Just you and all these clients, and there's just no follow up...” (Participant 002).</td>
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<td>Lived experience as an impediment</td>
<td>“...it's always a encourage that you can go to your manager, you can chat with the chaplain, but it's never right in this like, follow up on, like I worked there this past weekend, and I revived a young kid on the men's floor, and I sent the incident report through the all the on-call managers, my supervisor, and the Director and no one followed up to make sure that you're OK...” (Participant 002).</td>
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<td>Lived experience as the driving force in work</td>
<td>“I've watched the burnout happen it's, people leave because they don't feel appreciated. They're not taken care of properly” (Participant 002).</td>
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<tr>
<td>Fear of disclosing</td>
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<td>Mental Health stigma in organizations</td>
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<td>Emotionally &amp; physically taxing work</td>
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<tr>
<td>Missing the emotional piece in debriefs</td>
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“…I know that one of my previous or coworkers that has now left. He witnessed some like a really close client, he was really close with, he found them like, you know dead with blood on his forehead and they never really knew. Why, he passed. Which was really sad, and you could just tell, like there was no debriefing and then even like months after you could tell like 'cause he was the first one to respond like he was, Isn't the same.” (Participant 003).

“…I don't get anything from the debriefs in the zoom I'm there to support people and to be and to be present most of the times I don't feel psychologically safe. I don't speak like I'll be honest most of the times when I do, it's with a leadership because I don't know, I, I, just do that just feels right for me that's I feel like that's what I should be doing. Yeah, and I feel that they're more qualified to be supporting me in the way that I need to be supported” (Participant 004).

“so sometimes leadership is not providing the amount of care that they need to. They just kind of assume that if you're in a higher role, it's your responsibility to care for that shift in that state” (Participant 007).

“You should be more resilient, be able to handle it because you're in that position of power or authority. I think, I think that's, uh, assumed by leadership, yeah, is that you're supposed to be more resilient” (Participant 007).

“I think if you show any sort of trauma response, it's kind of like OK, she can't actually handle it (Participant 007).

“It is hard in the moment to know when a debrief would help in some situations. Also, when you are struggling it can be hard to reach out. Routine debriefs would make it easier to engage and bring to light issues we may not be aware we are experiencing” (Survey)

“they are invited to, but it’s not always safe” (Survey)

“It is important to debrief to avoid burn out. However - staff don't often engage when debriefing is offered” (Survey)

“Having management present during the shifts I work, having management actually know who I am instead of ignoring me or asking if I'm new despite being here for a couple years,
having staff appreciation during shifts other than 8-4PM. I work after 4 or on weekends and never see anyone or aren't here for celebrations and continuously miss out” (Survey)

“Regular supervision with the leadership team and a safe environment to discuss with coworkers any difficulties I am facing at work in a less structured way” (Survey).

“A non toxic team” (Survey).

“…Checking on people more frequently- people are not always honest with themselves or others for many different reasons, Encouraging healthy food & nutrition, water and nature walks or breaks- mandating self-care dates” (Survey).

” I cannot leave work premise during hours, so a nice environment (especially outdoors) would be helpful. I find myself sitting in my car alone just to have some quiet time because there is no specific spot to do so” (Survey).

“IT felt like a wound was opened and there was no support/after care when leaving the group” (Survey).

“being told what I am feeling comes from a place of insecurity and I need to fix that to work here” (Survey).

“When people aren't given the opportunity to openly discuss their response to a situation in a judgement free environment, debriefs can do more harm than good. Providing a safe space to discuss critical incidents without fear of reprimand is a necessary component of debriefing” (Survey).

“A volunteer with past trauma was trying to debrief and they were consistently being talked over by another volunteer who was trying to over identify with the situation” (Survey).

“I have experienced debriefing where I was made to feel unheard, my experiences were downsized and not understood, I didn't feel heard or respected but more so judged and like I was being dramatic. I have also been in debriefing wherein an interaction was harmful on shift and when it was brought up the other party exited instead of discussing. I, as the person leading the debrief often do not debrief myself because my team doesn't turn it back; i think this is something we can involve in our debrief procedure” (Survey).
“If a staff member is unable to remain openminded—take or give feedback. Rushed debriefs, staff members trying to dominate debrief or have a "hero" complex” (Survey).

“…was not confidential and was taken outside of facility” (Survey).

“not keeping it safe, putting staff down instead of providing education. Staff talking over each other” (Survey).

“when things are just a quick "are you good?" and then continue operating. I feel that everyone should be given the opportunity to have a safe space to say "I'm not okay" rather than feeling pressured to not talk and move on” (Survey).

“My feelings were minimized and there was no follow up or offer for resources” (Survey).

“Not being able to openly discuss the incident” (Survey).

“Getting everyone to tell their version, basically everyone in the debriefing event was retraumatized listening to everyone recount the event” (Survey).

“…Due to the stigma of being a helper and being you know, the job description being like, yeah, it's you know you're going to see some **** and you should be able to deal with it…I think that many people internalize that and then. Keep what they're struggling with inside…” (Participant 001).

“…I don't want a manager telling me that I just need to be more mindful…” (Participant 001).

“…I think mental illness stigma, though in the workplace might be a little bit more stigmatized. Uhm, I think if you are currently going through something, then it's a little bit more of less or less honest discussions.” (Participant 003).

“…Access to ongoing clinical counselling supervision, which is being able to access a third party hired for the organization where staff can go and process personal/professional issues/trauma/burn-out, without direct repercussions with their superiors…” (Survey).
“…Debrief with either a) staff involved in debriefed situation and supervisor or b) staff involved in debriefed situation and someone familiar with organization and work but not supervisor (remove power dynamic)” (Survey).

“…having a informal conversation in a place that is trusting and non-judgemental…” (Survey).

“Relational approach to the work (prioritizing quality of connection at all levels for the organization, rather than the grinder. Meaningful conscious "ritualization’s" to process tragedies and collective trauma in community. Focusing in the spiritual and personal development of frontline workers and leaders (to grow models outside of the paternalistic/learned helplessness the sector continues to feed into unconsciously…to re-shift the focus on resources, funding and initiatives to strengths-based approaches (as opposed to needs base lenses and clinical institutional approaches and measures)” (Survey).

“more heal days per year” (Survey).

“Team leaders being over stressed and pretty burned out themselves... losing sight of the real interpersonal issues, and worrying more about their liabilities, and red tape...it was rather a sad experience” (Survey).

“It wasn't that the debriefing process was poorly done, it was that there were multiple debriefings with different people, and having to retell it multiple times was frustrating” (Survey).

“…It could be a rather large power dynamic with that right having your room (referring to having a team lead during debriefing) yeah, and that could make somebody feel not able to discuss their true feelings for fear of judgment…” (Participant 001).

“…oftentimes we're forced to carry heavy **** alone because that's just the profession that we're in and that mentality has damaged people incredibly, myself included and so yes, you feel left less apt to be reaching out when you're turned away…” (Participant 001).

“…the prospect of like being deemed as an unwell or overly sensitive or uh, overreacting or uhm. Sometimes people will
be like, well, do you want the shift off and you're like no I don't, if I go home right now all I'm gonna do is sit and stew about that. If going home isn't going to help me. I need to be busy I need to stay, stay here, and stay focused, Because if I go home that's going to harm me. I'm going to be hurt. Please don't send me home…” (Participant 001).

“Never. It is only clarifying the social work role and the work you did with the client. If a co-worker shares a lived experience, it is within the context of just chatting/getting to know each other NOT debriefing” (Survey)

**Sub-Theme: Fear of disclosing and the stigmatization of needing help**

“…When you have strong people who have carried so much, UM, feel that they can't debrief and get rid of things because they, are protecting their livelihood at that point…” (Participant 001).

“…I should just be able to manage that. That maybe I am overreacting and then no, you feel nobody seen you, you're invisible. You're just a number nobody cares and that leads directly to burnout, because then you become insensitive and you start protecting your feelings and your, in your yourself and you clam up and then you become, you know salty or cynical and then you don't trust your peers or your team…” (Participant 001).

“I stopped reaching out to management a few years back.” (Participant 002). ***Could be linked to poor debriefing

“…There were two people that went down so, there needed to be more than one staff out there, so whoever was using they used the same thing and they both dropped so we hear the radio call. Myself and my co-worker went out in the middle of the night, but it was on like Bathurst St. So, like we're technically supposed to stay on Salvation Army property. So, it was, like, I'm still, you can see the building, like my radio is still working, and I had to do like CPR compressions for it was like a 9 minute event, and it was a young Kid like he was 16/17 like really young. When it came to, like, he punched me, like very common with overdose, he's very violent. He's now in withdrawal and instead of like having my manager check in on me, I was threatened to be written up because I went off property…kind of made me be more hesitant to
reach out to management... (Participant 002). ***Poor Debriefing

“...Staff are only making like 16 bucks an hour and they go in there and they put up the abuse. It's, it's, not fair what, they have to put up with in an 8-hour shift for the amount of money they're taking home at the end of the day and no one really appreciates them. There's not a lot of staff appreciation. It's a lot of you get in trouble a lot…” (Participant 002).

***Poor debriefing

“...I would definitely do that without any question, because that's being accountable to the work that I'm doing and the woman that I'm trying to support. But I mean, I haven't really. I did actually, I did kind of and, but I did it in a very different way. Uh, just recently, actually because it was just getting to be too much. I just started talking about it in a way because I was just so overwhelmed... So, it just kind of came out so.” (Participant 004).

“...I think when, when, something has happened it should be a common practice and I think that if somebody is not, you know, discussing it after something has happened” (Participant 004).

“...I feel that if you don't have the opportunity to, you know come chat about it and kind of chat, chat about how you're feeling and, and, everything like that. Uhm, that you're more likely to kind of bottle that up and then hold resentment against the people you serve.” (Participant 005).

“...There's more people unwilling to disclose like their own experiences than people who are willing to disclose their own experiences. So that kind of can lead to an environment that feels like. It would be more difficult to open up about it 'cause no one else was talking about it” (Participant 006).

Sub-Theme: We Lean on Each Other Instead (Peer-to-Peer Support)

“...I want a peer who has had that experience to be like holy **** that was really heavy…” (Participant 001).

“...a team lead is not appropriate for that position. Uhm, because they're not there like the team…” (Participant 001).

“...I would say it's a lot of like more so with my peers, so I don't if I'll talk to my coworkers about it, but then I also don't want to dump all that on them so it's they don't have the best setup…” (Participant 002).
“You know it's, it's, a lot, but, but, yeah, just kind of having a co-worker who's going to be that person…” (Participant 002).

“…we have our work, cell phones and we're in a group chat with all the case management. So, all case managers in the same group chat and we can just bounce ideas option if we have a difficult situation and have someone help us out that I, I, find it very. It's a very healthy work environment compared to what I've came from.” (Participant 002).

“…A manager check in and also like appreciating what you're going through. But then also having with the peer side of it of they're going through the same problem, could be going through the same, kind of things that you are...” (Participant 002).

“…during the day you have a peer support worker who has lived recovery and you have two counselors and at night-time it's also two counselors…the shelter you're working sort of by yourself…and you rely on people in different departments…your other person to back you up.” (Participant 003).

“…I know sometimes like we'll both time take the initiative to ask one another, but in terms of management I mean. Like everywhere is having staffing crisis. So, like that's there's a lot, of you know, all other priorities, uhm…” (Participant 003).

“…We're like, Oh my goodness, what did we just witness, like, that was, you know, we were able to really talk about it and I said, I think, I started opening up 'cause, I was so emotionally dysregulated from that whole experience from the incident and co-worker said same thing, like he also felt the same way. It's just like. Just both, kind of, saying, let's start sharing the same similarities in that regard…it was good to having an existing relationship…” (Participant 003).

“…I think mental health in terms of mental health and how our mental health are doing? I find that when I work, you think, yeah? Even after being seen, we'll kind of talk about it with your coworkers who feel like we'll check in with one another more informal. Well, like sometimes you’re very vulnerable and like it's, it's actually very nice and, and, you know, inspiring to hear that.” (Participant 003).
“...anyone involved in whatever just happened should be included, and in situations where it's maybe just you based on how you're feeling, it could just be between you and another co-worker just chatting about (Participant 005).

“Who wants to lead the debrief today could be beneficial to keep the flow going…but I would say that the person that's moderating should kind of be someone that is involved” (Participant 005).

“Yeah, informal I usually go to someone I trust. We go for a walk. We kind of just like scream together like cry together. Just get the emotions out and then talk about what like I need moving forward and how they can support me and what next steps need to be done and if we should do it together again…as long as we get to the we do the portion where we can kind of just get like my emotions out of my body and then it makes me feel a lot better so I can actually move forward and be productive with this situation” (Participant 006).

“I would say informally and so at the end of each shift we try to debrief to make sure that. We're all caught up in the same page of how everybody feeling making sure that nobody is leaving, leaving this space and a traumatized state, or in a triggered state” (Participant 007).

“Regular debrief is led by staff, Critical debrief lead by leadership. If leadership is unavailable the team will hold a debrief amongst themselves” (Survey)

“we do creative check-ins, morning check-in that include imagination, sometimes mindfulness activities, co-visions require long walks and thinking outside of the box (being outside of the building), team meetings often take place on the grass by the church (we call it the staff theatre), and we have some simple games. We also have de-clutter parties which involve bringing munchies to share while we all clean and declutter and blast some music... and once in a while we go out for lunch together, or for a walk together” (Survey)

“coffee chat meeting times via zoom, debrief can be a time to share an abundance of feelings and facts of frustration , sharing fun thoughts, songs and pictures to break up quiet, challenging or emotional day, sharing pet days, creating text
threads of encouragement, literal physical presence if needed, sharing back yards or homes for lunch, pee, or debrief times throughout the day, self-care activities' before meetings, check in during and after meetings, sending out emails requesting ideas for team building skills, utilizing the energy of plants in both a group, participant and in office environment” (Survey)

“To allow staff to come together and speak about situations that occur, I would want to ensure it was done safely and is not retraumatizing others” (Survey).

“…peer co-visioning/co-supervision meetings (spaces for staff to support each other outside of dynamics with team leads) …” (Survey).

“I work night shifts and my debriefing with my supervisor feels sub-par. My supervisor works day shifts, so she never sees me within my social work roles. My coworkers see me in action, and I can debrief with on the spot since we have similar hours” (Survey).

“When it simply is not done or not cared about” (Survey).

A Desire for Open Communication with Supportive Listening (Solution)

“…it opens up communication, and it lets that person who's gone through that crisis know that they are cared and valued, and that their experience is real, and they're heard, and they're not alone…” (Participant 001).

“…I think it usually depends on the relationship that you have with the person that you're debriefing with, and I think it depends on if you feel after the conversations been had, that you’ve actually been heard and the things that you. Said, uh, we were acknowledged in a way that you know you're able to move on with it and some you know, like I think that takes maybe a certain level of skill and the person that you're working with I don't know.” (Participant 004).

“…because without that debrief I feel that not even just mentally to be like hey someone else feels the same way I do about this situation or uhm, or they don't, you know, doesn't really matter, but also it gives you the opportunity to hear different perspectives on what happened and in which case you can grow as a person, because if you don't kind of look
back and you're like, yeah, you know what like that was kind of messed up, wasn't it? You know, like you don't really think. About it, unless you talk about it” (Participant 005).

“…Like you need to be able to talk about it to kind of release that you know that was kind of crappy, what that person just said to me and rather than, than there being like wow like that really hurt my feelings instead. Now you're able to like kind of chat with a co-worker or during a debrief. But you know, it's a lot easier to be like you know what that was actually a pretty good one, you know and you're, you're, laughing with your coworkers. You've turned it into a funny situation. Versus you sit there being like Ouch, you know like so, I find that helps.” (Participant 005).

“Debriefs are emotionally most, mostly emotional, so it's mostly because, because we are people who are going through this with our community who are seeing things that we don't see on an everyday basis. It's really important to talk about how we're feeling and how we're feeling as group and how we can move forward and take care of each other” (Participant 007).

“it is initiated by patient/client related incidences, but staff are able to clear the air among other staff about how the incidence was handled” (Survey)

“I work in addictions and mental health, and it can be a lot - the vicarious trauma doesn't stay at work. I take it home with me and think about it quite a bit - I wish I was able to debrief with my coworkers to mitigate burn-out and inadvertent trauma being place upon myself” (Survey)

“it helps to process situations, manage stress, improve workplace resilience, build team strength and improve team communication” (Survey).

“It is good for staff moral and connection. Good for the mental health of employees to be able to discuss traumatic incidences or current/past issues that arise” (Survey).

“It helps me leave work at work, and not take it home with me. It allows me to wind down after a day of emotionally difficult work” (Survey).
“Gives you a space to release the feelings associated. Coming together as a team for support or different perspectives” (Survey).

“I’d like it to cover overdose and client death debriefs, staff mental health promotion and healthy coping strategies” (Survey)

“Allows us to cope with work-related issues at work instead of taking it home” (Survey).

“the individual facilitating the debrief had their own agenda and did not truly listen to what I was saying” (Survey)

“people talking over others, taking things personally and not looking at the situation in hand” (Survey).

“Not allowing all voices to be heard can be frustrating in a debriefing process. There should be an opportunity for everyone” (Survey).

<table>
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<tr>
<th>Sub-Theme: Missing the emotional Essence of the worker</th>
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<tr>
<td>“…a phone call is best for me, and I can either just verbally state how I'm feeling and what that went and how that went and how I'm feeling and then a touch base.” (Participant 001).</td>
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<tr>
<td>“…I think just like, like, yeah like just supportive listening. It's like I think the biggest thing for me but that's all I'm really after a situation about just someone to listen and to talk… I don't have to bring it home. Like my partner always has to hear about it and I always feel so bad coming home and telling him about this stuff because it's heavy” (Participant 002).</td>
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<tr>
<td>“…counselor on shift and she just put me in her office, and she said we need you need to just, sitting here for a couple minutes to like, take a breather. Do you want to talk About it? And…what do I need? I found that to be the most beneficial… (Participant 002).</td>
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| “…an hour booked in with them and if I need 5 minutes so, if, I need the full hour. That's fine too. Just chatting and seeing how things are going. If there's any situations that have been
difficult. We want to talk about. Yeah, kind of like just what we need, that it's very much like, staff focused I find, which is the nice…” (Participant 002).

“A factual document, it stating, like you know the names of the people, the time and all that sort of what where, but then because it's also such an emotional environment too, I think there needs to be a balance between that the you know. Actual objective versus subjective…” (Participant 003).

“One of the challenges is finding the time. Everyone is so busy. Like I said, everyone is understaffed, and has too many things to do, so it would obviously be on the back burner, but in an ideal world it would be nice to have consistent debriefing sessions.” (Participant 003).

“…Things just seem to be getting very impersonal. It's not personal anymore, it's almost, and it's very different because I need that. I need that when I'm talking to someone. Me, I need it to feel kind of personal and, and, I know it's not personal because it's counseling. I understand that, but it gives the warm regard. It gives the compassion it gives you know the pieces that I think that some of us are, are, lacking. I guess in, in, and the and I don't know getting the support. I think that we may need, especially when we're working with such high acuity people, right?” (Participant 004).

“…everyone has the chance to speak, free to give and receive feedback but also discuss emotions about situations at work, seeing what each individual need’s…” (Survey).

“…Like occasionally, if it was known to be a bad call that you had a supervisor might call you and be like, OK, just making sure you're good, but there was no real like hey, how you’re feeling after that call or anything. It was just kind of like Oh yeah. Like someone just died, but on to the next call, you know. Very hush hush” (Participant 005).

“The work is very hard, being able to process emotional tensions about tenants and with other staff, and about the program, is key for a healthy work environment” (Survey)

“I think it would be helpful to process the emotions that we hold onto in our hearts, minds, and bodies. I think it would be beneficial to discuss possible solutions (depending on if the
situation that occurred may have a solution if it were to happen again). Debriefs would also facilitate opportunity to grow together as a staff and create a collective strength - which is needed to do this work and do it well. I think a debrief process would help staff connect the dots of their emotions as well as help them understand what triggers they may have - and what they may need in terms of support from their staff team and organization. Additionally - and most significantly, an intentional debriefing process would benefit clients, as staff would not be carrying past trauma or emotions in the same way that they would without an intentional debrief. As a result, clients would be better supported and connected to the staff” (Survey).

“It is good for us to confront the intense emotions we feel and feel support from the team” (Survey).

“It would help newer staff feel less alone in what they’re experiencing” (Survey).

“As staff working on their own my work can be very isolating” (Survey).

“One on One or in groups. It would cover topics like coping strategies. Naming feelings. Etc” (Survey).

“A brief check in would occur after the incident followed by a longer discussion 3-7 days after the incident occurred. It would cover staff reflections on the situation as well as staff emotions - as well as potential solutions moving forward. It would also cover what the staff needed from their team or organization for support” (Survey).

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<td>Lack of Psychological Safety (Problem)</td>
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<td>Unintended Mental Health stigma in organizations</td>
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<td>We lean on each other instead (Peer-to-Peer Support)</td>
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<td>A Desire for Open Communication with Supportive Listening (Solution)</td>
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Curriculum Vitae

Name: Andrea Krywucky

EDUCATION

University of Western Ontario
London, ON
Masters of Health Information Sciences

King’s University College at Western University
London, ON
Honors Bachelor of Arts Specialization in Sociology

King’s University College at Western University
London, ON
Bachelor of Arts in Sociology

EMPLOYMENT EXPERIENCE

Regional HIV/AIDS Connection
London, ON
Harm Reduction Worker

SafeSpace London
London, ON
Coordinator

TEACHING EXPERIENCE

Western University
London, ON
Teaching Assistant – Media, Information, and Technologies (MIT1025)

Western University
London, ON
Teaching Assistant – Deviance (SOC2259)

RESEARCH EXPERIENCE

Grant Writing — SSHRC-CRSH Insight
London, ON
Research Fellow – University of Western Ontario

London Middlesex Mental Health & Addiction Strategic Direction Office
London, ON
Research Assessment of Deliverables
Western University  
London, ON  
Research Assistant – Arthur Labatt Family School of Nursing

Centre of Hope: Withdrawal Management  
London, ON  
Student Researcher: Addictions & Theory Research

PROFESSIONAL DEVELOPMENT, CERTIFICATES AND LICENCES

- Learn To Lead workshop  
  o Managing conflict collaboratively  
  o Strength-based-leadership I & II  
  o Presenting with Impact  
  o Listening to people
- First Aid & CPR Training
- Basic Life Support Training
- Building Resiliency workshop: Proactive response to enhance workplace wellness and organizational health
- Sensitivity Training  
  2020
- WHIMIS
- Human Ethics Research Training
- Harm Reduction Strategies
- Canadian Alliance for Sex Work Law Reform  
  o Reinforcing Our Capacity to do Public Education and Media Workshop  
  o Alliance Core Messaging: Addressing the Challenges of Messaging Realities  
  o Doing Public Speaking and the Media: Principle’s in My Toolbox  
  o Canadian Alliance for Sex Work Law Reform Core Messaging
- Naloxone Administration Training  
  2018
- Safe Management Group Inc. De-escalation Training