Debriefing and Collaborative Safety:
Creating the “AHA” Moment in Healing Environments for Safety and Connection

Stacy Reh
PPS/PPS 2.0 Project Director

Barbara Wilson, LCSW, MSW
Senior Consultant and Training Specialist UBHC
Coach PPS
Rigorous Debriefing

- Tertiary Prevention Strategy
- Restorative
- Reparative
- Patterns and Customized Responses
Role of a Debriefing Process

Brings Executive Leadership on board

Real Time Data on what occurred from Staff and Youth perspective

Manage events better to avoid a “next time”

What did we learn? What do we change?
UIR = Story

Youth…… restrained….. medical attention….hospitalized…..location….. agencies involved…….persons involved….. check for high, moderate….. assault…..injury…. severity…..perpetrator…victim…..witness…..

Detail plan for action and or review, including; treatment plan review or changes, therapeutic interventions, clinical interventions, program, facility, or staff changes related to incident, etc; Include your efforts with the youth related to the incident even if you are not affiliated with the location of the incident;
Rigorous Debriefing as a Process

Quantitative
Problem Driven
Who
A stepwise process

Qualitative (story in a trauma lens
Solution Focused
Why and How
~ using brain based science and trauma informed approaches
A stepwise process
Rigorous Debriefing as a Core Strategy

Debriefing and Healing

The use of Apology

Attention Seeking.....Connection Seeking

Power/Authority/Coercion.....Relationship

Engaging Families as Partners in Care
How Debriefing was used in Coaching

- As a place to begin
- Incident review for deepening trauma lens ~ language matters
- Regulation plan development
- Policy change / modification
- Informal practices
- Data development for tracking and review
Focusing on the wrong thing
Rigorous Debriefing

- Focus is on process
- People involved become part of solution
- Gets to the story of what happened
- Speaks with empathy and compassion about a situation that occurred
Bringing all 6 Core Strategies into Debriefing

1) Leadership toward Organizational Change
2) Use of Data to Inform Practice
3) Workforce Development
4) Use of Seclusion/Restraint Prevention Tools
5) Full Inclusion of Youth and their Families
6) Rigorous Debriefing
Curious not Furious
Where language follows movement

body work
<table>
<thead>
<tr>
<th>Regulation Planning</th>
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<tbody>
<tr>
<td>Facial /Body</td>
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<tr>
<td>Gestures</td>
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<tr>
<td>Movement</td>
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<tr>
<td>Language</td>
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Story (repair and restore)
to see things differently
The Pay Off

$ $  
Workman’s Comp

Call Outs

Retention

Value and Voice
Developing a Framework for Learning

1) Event

2) Response

3) What we know

4) What We Need to Know

5) Where to Place Focus

6) Take Away
Stress Responses

- **Executive State**
  - Prefrontal Lobes
  - What can I learn from this?

- **Emotional State**
  - Limbic System
  - Am I loved?

- **Survival State**
  - Brain Stem
  - Am I safe?
Iceberging to develop Trauma Lens
Story

Micah is a 15 yo Hispanic male with a history of hospitalizations. He resides with his paternal grandmother and 2 siblings. Micah’s father died and his mother is estranged from the family. Micah has been in 3 Out of Home placements. His plan is to return home; however, his behaviors have escalated. The incident that brings us to this debriefing is as follows:
Sunday at 11:00 am Micah goes to local corner store with his money, and other youth from program, and staff. He is told to make a selection in the store of whatever he wants.

Micah makes the selection, and when he returns to the program is told he can’t have it by the supervisor on site. Micah becomes highly aggressive. He punches the wall, screams at other youth, assaults staff, and is restrained. After the restraint, Micah spends the day in his room.
In the record

History of being parentified
Triggered by disrespect
Triggered by “No”
Struggles to trust
History in the home of mental health
History of explosive behaviors
Please don’t touch me
Goes from 0 to 100
What have staff noticed:

- Pacing
- Tension in face, nostrils, neck
- Elevated volume in voice
- Less words
- Go to Phrase
- Up and Down movement
- Walks in circles
Collaborative Safety
A Systems Approach to Change
7 Transitions to a Safety Culture - Just Culture

1. Blame to Accountability

2. Applying quick fixes to understanding underlying systemic features

3. Fallible Humans in Perfect Systems to Fallible Humans in Imperfect Systems

4. First Stories to Second Stories

5. Employees are a Problem to Control to Employees are a Solution to Harness

6. Accountability up to Responsibility Down

7. Simple to Systemic Accident Models

Scientific Underpinnings
How Collaborative Safety and Promising Path to Success complement and support each other and our system?

• Both approaches acknowledge the need of leadership throughout the process in order to have organizational change.
• Both use data to inform practice, to recognize trends and to identify considerations for needed improvements, one at the youth/local level and one at the systems level.
• Both recognize the importance of youth and family voice in the incident review process.
• Both are based on a belief of no blame/no shame.
Just Like Debriefing, We Move From First Stories to Second Stories

To dive beneath surface level descriptions of events and understand the true sources of challenges and successes.
Both share common desired outcomes

- Increased trust in the provision of care
- Improved staff morale
- Enhanced system improvement
- Improvements in employee retention
- Increased accountability
- Increased public trust
- Creation and sustainability of healing environments and systems
Collaborative Safety looks at specific incidents for the purpose of doing a deeper dive to see if systemic factors (policies, practices, procedures, etc) have an impact on the local decision-making process.

Debriefing often happens at the local level with a focus of being curious and taking a closer look at factors that may have lead an incident involving a youth, a staff member and/or a program.
Aahahaha !... Questions/Comments