REDUCE Behavioral monitoring

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PARADIGM FOR EXPLORING COERCIVE PRACTICES

Paradigm A: Behavioral precaution is used to protect the patient. We cannot have the patient upset the milieu, hurt themselves or others and have to follow the rules. Without such monitoring, they will victimize others, hurt others, and we will get into trouble. This speaks of our **duty to protect them**.

Paradigm B: The person who is being monitored finds it as a **coercive practice**, thwarts their freedom, loss of privacy, reminds them of their previous traumatic experiences and this sets the stage for reenactment of previous responses be it dissociation, self harm, violence and often leads to further regression.

Paradigm C: We function as an **interdependent community** consisting of persons served, their loved ones, staff members (and their loved ones) who work here and all others who are involved. Without this interdependence we don't exist. Any **change occurs at this relational level**.   By helping those served, we learn and grow as well. It is critical that we have a deeper understanding of this relationship before we can make any changes. Any **behavioral monitoring is a coercive approach** and is in the continuum of restraints and seclusion on one end of the spectrum and collaborative approach on the other end. **All coercive approach has the ability to re-traumatize the entire community including all the persons served, the staff, family and others who are involved.**

PUBLIC HEALTH APPROACH

Primary prevention-

Leadership toward Organizational Change: Accountability, involvement and articulating a vision, values and philosophy that expects reduction of all coercive practices; Foster a climate of support for microsystems, simple rules, encourage innovation and clarify prohibition; Developing and implementing a unit based performance improvement action   plan; Leadership Witnessing- Oversight of every continuous behavioral monitoring event lasting **over 3 days** by senior management

Use of Data to Inform Practice: Reducing the use of coercive practices requires the collection and use of data by facilities at the individual unit level; OSH -data to each unit; display in a QI data wall; display data on behavioral monitoring, seclusion, restraints, staff injury, involuntary medications used, clinical hold; interpret data in a non-punitive manner.

Workforce Development : Educational and training needs in working with trauma. Multidisciplinary team training to understand and treat the impact of trauma.; Create treatment environment whose policy, procedures, and practices are based on the knowledge and principles of recovery and the characteristics of trauma and attachment theory informed systems of care; Training on trauma/attachment informed care as part of the orientation and   repeated annually; The staff is **at risk of getting traumatized or re-traumatized** and **burnout** at all levels. Staff wellness program to address this issue is vital.

Secondary prevention-

 Knowing triggers and using trauma- informed strategies, creative and innovative early intervention to de-escalate conflict is an important step. Steps to eliminate the conditions that lead to behavioral monitoring.; **Shared Narrative**- Routine trauma histories should be part of the assessment and ongoing annual assessment. Our EMR can have **trauma screening, screening for adverse childhood experience (ACE), list of triggers of traumatic reenactment in all patients and can alert and display in the first screen when we open their medical record**. Align with the healthier part of person served; **Role of Peer support** in event oversight, monitoring, debriefing interviews, peer support services; **Religious and spiritual needs to help heal the '*wounded inner child*';** In addition to treatment directed at symptom management of PTSD, address and repair the relational aspect of the trauma- Minimize fragmentation of team; Generous family Visitor policy; Phased therapy to address trauma; Every unit **activities to focus on reducing emotional and behavioral dysregulation**. Availability of comfort room,   community practicing emotional regulation, distress tolerance and other mindfulness based stress reduction and relaxation activities and incorporated into the daily routine. Practice Alternative **Dispute Resolution Techniques** and other conflict resolution techniques if conflicts arise.

Tertiary prevention-

Early release, active debriefing of staff and person served in order to minimize risk of harm; Immediate post debriefing with staff followed by a Root Cause Analysis should be standard practice. This should be conducted in a '*no blame non -judgmental manner*' and the staff should feel safe when participating in such an activity; create an individualized "*de-escalation*" plan. The lessons learned should direct staff training and changes in the practice.

Selected References

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