When Ordinary Interventions Don’t Work

Serial Self-Injury Profiling and Behavior Management Intervention

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Florida Department of Corrections
Background and Overview

1. Introduction and the Nature of the Problem
2. Developing the Serial Self-Injury Profiling System
3. Functional Assessment: ABC’s
4. Building a Behavior Management Plan: Do’s and Don’ts
5. Challenges to Success
6. Summary Points
Introduction and the Nature of the Problem
A Changing System of Care

In 1955, over half a million patients in psychiatric hospital settings; in 2004 down to about 40,000.

Increase in Mentally Ill Offenders: At the End of 2000, Nearly One Million Individuals with Mental Illnesses were in the Criminal Justice System

Over 600,000 mentally ill on community supervision

Over 300,000 people with mental illnesses incarcerated in our jails and prisons

FDC Mirrors National Trend in Mentally Ill Population

Percentage of Inmates Receiving Ongoing Mental Health Treatment in FDC

Bureau of Research & Data Analysis, Florida Department of Corrections, Date prepared: August 1, 2007
Increase in the Percentage of Inmates with Severe and Persistent Mental Illness (SPMI) within the Mentally Ill Population

(Psychotic Disorders, Bipolar Disorders, Major Depression)

Bureau of Research & Data Analysis, Florida Department of Corrections, Date prepared: January 11, 2007
Mentally III Inmates Have More Problems with Behavioral Control

Mentally ill inmates in general population are almost twice as likely to be placed in Confinement as non-mentally ill inmates.

Mental Health Grade: S-1 = No Mental Illness S-2 & S-3 = Mental Illness

Bureau of Research & Data Analysis, Florida Department of Corrections, Data as of: June 30, 2007
So What We are Beginning to See is an Increase in Parasuicidal Behavior

- Parasuicide is not the problem for the inmate, but the inmate’s attempted “solution” to a problem

- So, we need to learn:
  - What the problem is that the inmate is trying to solve
  - What the function of the behavior is
  - What alternative behaviors the inmate can use to solve or work around the problem
  - What interventions are needed to structure behavioral change
As a Result, We May Fall into the “Mad or Bad” Dichotomy of Maladaptive Behavior

<table>
<thead>
<tr>
<th>“Bad”/“Slick”</th>
<th>“Mad”/“Sick”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manipulative</td>
<td>Due to mental illness</td>
</tr>
<tr>
<td>Behavioral</td>
<td>Severely depressed</td>
</tr>
<tr>
<td>Malingering</td>
<td>Dissociative</td>
</tr>
<tr>
<td>Attention seeking</td>
<td>Truly suicidal</td>
</tr>
</tbody>
</table>

- From a risk assessment perspective, labeling according to a taxonomy of intent misses the point
- From a diagnostic perspective, very different types of behaviors get lumped together under “bad”
- From a clinical perspective, such labeling can result in dismissive attitudes and actions
This Creates a Problem Because Intent and Lethality are not Perfectly Correlated

<table>
<thead>
<tr>
<th></th>
<th>No Suicidal Intent</th>
<th>Suicidal Intent Present</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N = 49</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inmate-perpetrated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>parasuicidal incidents</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Low Lethality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cutting fatal in 1 out</td>
<td>65%</td>
<td>12%</td>
</tr>
<tr>
<td>of 275 attempts (0.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• McKee (1998)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>High Lethality</strong></td>
<td>2%</td>
<td>20%</td>
</tr>
<tr>
<td>Hanging fatal in 52</td>
<td></td>
<td></td>
</tr>
<tr>
<td>out of 602 attempts (8.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• McKee (1998)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Not reported (&quot;except as other&quot;)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hanging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Overdosing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cutting with stitches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cutting w/o stitches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Head banging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cutting w/o stitches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cutting with stitches</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Developing the Serial Self-Injury Profiling System
Serial Self-Injury Profiling System

The Bureau of Mental Health is creating a Profiling System designed to track inmates with a history of serial self-injurious behaviors. When complete, this Profiling System will:

- Identify inmates with a history of engaging in repeated incidents of self-injurious behaviors.
- Identify common personality traits and patterns of behavior associated with individuals involved in serial self-injurious behaviors.
- Identify risk factors associated with serial self-injurious behaviors.
- Construct individual profiles to assist in:
  - assessment and accurate diagnoses,
  - determination of appropriate levels of care, and
  - effective treatment planning.
- Conduct trend analyses of factors related to these behaviors including but not limited to such things as location, seasonal issues, demographics, housing assignments, precipitating events, etc.
- Assist in reducing costs associated with medical care for serial self-injurious behaviors.
Two Informational Sources to Build the Profiling System

Corrections Data Center (CDC)

- Demographic information (age, race, gender, sentence, etc.),
- Disciplinary record,
- Housing assignment history (CSU, general population, confinement, etc.),
- Mental health diagnostic history, and
- History of outside hospitalization costs related to self-injurious behaviors,
- Other available information.

02/12/09 Welcome to the Corrections Data Center (CDC)

Available Data Centers:

CDC - CORRECTIONS DATA CENTER | FLAIR - Financial Services
SRC - Shared Resource Center (DMS)  |
KDC - Kirkman Data Center (DHSMV)  |
DNR - Natural Resources Data Center |
HRS - HRS Technology Center       |
NWR - North West Regional Data Center |

>> FOR OFFICIAL USE ONLY <<
Enter DATA CENTER ID (or command)   LU:
===>             IP: 170.219.14.119 02198
Mental Health Case Reviews

- Mental health/social history,
- Medication Regimen,
- Current Risk Assessment,
- Description of incident,
- Precipitating Circumstances,
- Instrument of self injury, and
- Mental status at time of incident including inmate statements about incident
- Diagnostic Information
A Walkthrough the Profiling System

Office of Health Services
Bureau of Mental Health

Serial Self-Injurious Profiling System

Add/Edit Inmate Records
View Reports
Exit Program
# Diagnostic History within Department

<table>
<thead>
<tr>
<th>Name</th>
<th>DC#</th>
<th>XXXXXX</th>
<th>Date</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doe, John</td>
<td>XXXXX</td>
<td></td>
<td>6/1/2000</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5/21/2001</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7/20/2001</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2/29/2008</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4/22/2008</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7/20/2001</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4/22/2008</td>
<td>32</td>
</tr>
</tbody>
</table>

### AXIS I-A
- **6/1/2000**: Depressive Disorder NOS
- **5/21/2001**: Major Depressive Disorder Recurrent Severe with psychotic features
- **7/20/2001**: Schizoaffective Disorder
- **2/29/2008**: Bipolar Disorder NOS

### AXIS I-B
- **6/1/2000**: Borderline Personality Disorder
- **5/21/2001**: Borderline Personality Disorder
- **7/20/2001**: Alcohol Dependence
- **4/22/2008**: Impulse-Control Disorder NOS
- **4/22/2008**: Borderline Personality Disorder

### AXIS II
- **5/21/2001**: No Diagnosis
- **7/20/2001**: Borderline Personality Disorder
- **4/22/2008**: Borderline Personality Disorder

### AXIS III
- **5/21/2001**: No Diagnosis
- **2/29/2008**: No Diagnosis
Serial Self-Injury Profile

Mental Illness
Violence
Prison Adjustment
Hospitalizations

Exit
## Baseline Information

<table>
<thead>
<tr>
<th>Reason for Hospitalization</th>
<th>Burn</th>
<th>Asphyxia</th>
<th>Foreign Body</th>
<th>Laceration</th>
<th>Poison Overdose</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Hospitalizations</td>
<td>X</td>
<td>X</td>
<td>Xxx</td>
<td>Xxx</td>
<td>Xxx</td>
<td>Xxx</td>
<td>xxxx</td>
</tr>
<tr>
<td>Total cost</td>
<td>Xxxxxxxx</td>
<td>Xxxxxxxx</td>
<td>Xxxxxxxx</td>
<td>Xxxxxxxx</td>
<td>Xxxxxxxx</td>
<td>Xxxxxxxx</td>
<td>Xxxxxxx</td>
</tr>
<tr>
<td>Average cost per visit</td>
<td>Xxxxxxxx</td>
<td>Xxxxxxxx</td>
<td>Xxxxxxxx</td>
<td>Xxxxxxxx</td>
<td>Xxxxxxxx</td>
<td>Xxxxxxxx</td>
<td>Xxxxxxx</td>
</tr>
<tr>
<td>Percent of visits</td>
<td>Xxxx%</td>
<td>Xxxx%</td>
<td>Xxxx%</td>
<td>Xxxx%</td>
<td>Xxxx%</td>
<td>Xxxx%</td>
<td>Xxxxx%</td>
</tr>
<tr>
<td>Percent of cost</td>
<td>Xxxx%</td>
<td>Xxxx%</td>
<td>Xxxx%</td>
<td>Xxxx%</td>
<td>Xxxx%</td>
<td>Xxxx%</td>
<td>Xxxxx%</td>
</tr>
</tbody>
</table>
Behavior Management in Corrections
What is It?

- A systematic, planned, principled, proactive approach to problem behaviors, with multiple components:
  - Risk assessment
  - Functional assessment
  - Interventions to build and reinforce desired behaviors, and provide safety for problem behaviors
  - Systematic measurement, monitoring, and supervision of the plan
  - Multi-disciplinary collaboration
Behavior Management
Operant and Pavlovian Theories

Based on learning principles:

- Behaviors that are rewarded are more likely to be repeated
- Behaviors that are not rewarded are less likely to be repeated
- Consequences of behaviors can be modified to change how likely and how rewarding the behaviors are
- Triggering situations can be modified to stimulate desired behaviors and reduce problem behaviors
Scope of Behavior Management

When to Use It?

- Planned behavioral interventions not developed unless behaviors are problematic – typically:
  - Dangerous to self or others
  - Or interfere substantially with treatment

- “Nuisance” behaviors typically do not need a behavior management plan

- Behavior management plans best utilized when ordinary interventions haven’t worked
Operating Assumptions of Effective Behavior Management

- It is easier to change behaviors than it is to change people

- Interventions focus on behaviors and the contexts in which they occur
  - Not on “people” or “character traits”
  - And not on “intent” or “motivation”

- Assessing the function of the behaviors is key
Diagnosis (nature of mental illness) → Function of problem behaviors → Antecedents or triggers

Severity and Risks of Behaviors
- To self
- To others

Behavioral Management Plan

Accidental and deliberate

1. Interventions and step-wise plan to increase freedoms, privileges and rewards as behavior improves (measurable)
2. Interventions to ameliorate skill deficits, increase repertoire of replacement behaviors, increase consequential thinking
3. Explicit plan to implement safety measures when problem behaviors return

Problem behaviors
Consequences or what inmate gets out of behaviors; what perpetuates behaviors
Example: Describing the Problem of Aggression/Violence

“Violence is the language of the unheard.”

Violence Talks:

- Helps me control and dominate others
- Gives me a voice
- Gets me recognition and status
- Relieves my tension
- Gives me revenge for all the violence done to me
- Makes me feel better
- “It’s what I do!”
Types of Aggression in Corrections

- Violence to self:
  - Cutting/scratching/inserting
  - Overdosing
  - Swallowing
  - Burning
  - Ligatures
  - Head banging
  - Smearing feces into wounds, orifices

- Violence to others:
  - Enucleation
  - Hitting, kicking, scratching
  - Shanks, weapons
  - Spewing body fluids
  - Verbal abuse
  - Genital mutilation
  - Choking

- Verbal abuse
- Genital mutilation
- Violence to others
- Violence to self
- Choking
- Shanks, weapons
- Spewing body fluids
Types of Aggression in Corrections

Both types of aggression can occur in the same inmate

Using self as hostage or punching bag

Using others as hostage or punching bag

Severe Personality Disorders

• Psychopathic
• Antisocial
• Borderline
• Narcissistic
• Histrionic
### Two Types of Aggression

<table>
<thead>
<tr>
<th>Instrumental</th>
<th>Affective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increases self-esteem</td>
<td>Decreases self-esteem</td>
</tr>
<tr>
<td>Causes pride</td>
<td>Causes shame</td>
</tr>
<tr>
<td>Strategic (driven by consequences)</td>
<td>Reactive (driven by antecedents)</td>
</tr>
<tr>
<td>Life-long pattern</td>
<td>Ebbs with age</td>
</tr>
<tr>
<td>Psychopathic</td>
<td>Borderline</td>
</tr>
<tr>
<td>Interventions need to focus on</td>
<td>Interventions need to focus on antecedents</td>
</tr>
<tr>
<td>consequences</td>
<td></td>
</tr>
</tbody>
</table>
Common Motivations

- Control others
- Exact revenge
  - Can involve fantasized injury of another person
- Maintain/bolster self-image or reputation
  - The “badder” the better
  - Copycat self-injury/media attention
    - Self-amputation of external ear \( \} \) three cases in same correctional facility
- Obtain trips to outside hospital
- Obtain opioids, anesthesia
Common Motivations

- Feign being a patient (Munchausen Syndrome/Factitious Disorder)
- Get a “rush” (endorphin-induced euphoria)
- Distract self from feeling emotional pain
- Stop feeling numb or empty
- Communicate emotional pain
- Obtain connection, nurturance from others
  - Attention is proxy for longed-for attachment
The Manipulative/Instrumental Cycle

Injury to self-importance (getting “dissed”)

Projects shame on to other person, blames other person

Purges self-image of shame

“Cleansed” self is glorious and triumphant

Contemptuous and deceitful “getting over” with self-injury

Sources: Bursten, B. (1972, 1973/2001) [see references]
The Reactive/Affective Cycle

Damaged self and damaged relationship lead to more distress

Communicates distress; gives target for venting; may be attempt to reconnect

Injury to connection (abandonment betrayal)

Shame and rage; blames other person but also may blame self

Inability/unwillingness to contain emotions leads to impulsive, explosive self-injury
The ABC’s of Functional Assessment
Functional Assessment

**Definition:**

A systematic assessment of problem behaviors and the events in the environment that predict and maintain the problem behaviors.

Must be completed before the behavior management plan is developed.
<table>
<thead>
<tr>
<th>Setting Events (&quot;Distal&quot; Antecedents)</th>
<th>Predictors (Immediate Antecedents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Isolation from family and community</td>
<td>• “Dear John/Jane” letter, death of relative</td>
</tr>
</tbody>
</table>

**Problem Behaviors**
- Cutting inner arm five times with razor

**Maintaining Consequences**
- Distraction
- Self-soothing/endorphin release
Functional Assessment Does Not:

- Lead to a psychiatric diagnosis
- Focus on identifying psychopathology inside the individual
- Trigger implementation of a “canned” or prepackaged set of interventions
- Constitute a behavior management plan
Functional Assessment **Does:**

- Form the foundation of behavior management plans
- Place problem behaviors in context
- Identify events in the environment that can be changed to reduce problem behaviors
  - Antecedents and consequences
- Require collaborative participation and communication with all parties
Five Components of Functional Assessment

1. **Clear and precise definition of problem ("target") behaviors**
   - Includes sequences of behaviors
   - Includes classes of problem behaviors that occur together

2. **Identification of events, times, and situations that predict problem behaviors**
   - "Distal" and "proximal" predictors
Five Components of Functional Assessment

3. Identification of consequences that maintain the problem behaviors
   - The function of the problem behaviors

4. Development of summary statements or hypotheses that describe steps 1-3

5. Ongoing clinical and observational data to test summary statements

## Basic Definitions

<table>
<thead>
<tr>
<th>Antecedents:</th>
<th>Behaviors:</th>
<th>Consequences:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Events in environment that precede and predict behaviors</td>
<td>Concrete activity or responses emitted by the individual</td>
<td>Events in environment that strengthen and maintain behaviors</td>
</tr>
<tr>
<td>- Preconditions</td>
<td>- Targets of interventions</td>
<td>- Reinforcers</td>
</tr>
<tr>
<td>- Triggers</td>
<td>- Objective</td>
<td>- What the individual gets out of the behaviors</td>
</tr>
<tr>
<td>- Setting events</td>
<td>- Observable</td>
<td></td>
</tr>
<tr>
<td>- May be “distal” or “proximal,” general or specific</td>
<td>- Measurable</td>
<td></td>
</tr>
</tbody>
</table>
Building a Behavior Management Plan

Do’s and Don’ts
Do’s

- Conduct a functional assessment
- Collaborate carefully with security, medical, legal, and administration
- Specify hierarchy of measurable, objective treatment targets
- Utilize incentives and positive reinforcement
- Collaborate with inmate

Don’ts

- Build cookie-cutter or “wing it” plans
- Act unilaterally
- Use punishment or deprivation as “tools”
- Include emergency interventions in plan
- Discard traditional interventions
- Get caught up in labels
Do: Collaborate with Security, Medical, Legal, and Administration

- Behavioral management plans developed unilaterally will fail out of the gate
  - Worse than not doing anything
- Consistency is essential
  - Procedures, reinforcements, safety interventions, tone, and interactions
- Self-injurious inmates often seek the weakest link
Do: Develop Measurable Objectives

- “Inmate Jones will demonstrate a 50% reduction in frequency of self-injurious behavior over the next three months/by [date].”

- “Inmate Watson will participate in all scheduled sessions, without interrupting others, calling others names, shouting, or being assaultive, on a continuous basis for a minimum of three months.”
Do: Utilize Incentives and Positive Reinforcement

- Reinforce positive behaviors with positive consequences
- Most frequently overlooked intervention in managing self-injurious inmates
- Establish a plan for dispensing incentives in response to specified periods of problem-free behaviors
Do: Develop Collaborative Alliance with Inmate

- Difficult to establish and challenging to maintain, but essential for behavioral change

- Three root elements of a working alliance:
  1. Collaborating on joint tasks
  2. Working on shared goals
  3. Developing a positive affective bond
Don’t: Include Deprivation or Fear Induction in Plan

- **Deprivation**
  - Prolonging seclusion, restraints, and/or removal of clothing and normally available property, peers, activities, and freedom of movement longer than needed for safety

- **Fear induction**
  - Threatening inmate with adverse consequences (restraints, disciplinary diet, water restrictions) in effort to motivate behavior change
Don’t: Discard Traditional Interventions

- Multi-modal approaches are superior to “tagging and bagging” inmate as “behavioral”
- Routine mental status examinations
- Psychotropic medications
- Group and individual therapy
- Meaningful daytime programming
Challenges to Success
Challenges to Success

- Staff splitting and failure to obtain buy-in
- Negative countertransference
- Lack of fidelity to behavior management plan
- Inadvertent reinforcement of problem behaviors
- Limited ability to reinforce positive behaviors
- “Extinction bursts” and escalation
- Vicarious traumatization
Goals of Behavior Management

- Increase inmate’s autonomy and functioning
- Increase inmate’s quality of life
- Decrease problem behaviors

Not:

- Control over inmate
- Punishment of problem behaviors
- “Tricking” inmate into acting better
- Minimizing mental health services
What is Required to Make it Work?

- Functional assessment
  - Focus on what predicts and maintains behavior, not on motivation or intent
- Risk assessment
- Collaboration with all parties (including inmate)
- A realistic, relatively simple plan
- Multi-modal interventions
- Ongoing monitoring and measurement
- Care/support for staff
ALWAYS REMEMBER!

- Not a silver bullet: no magic cure for chronically parasuicidal inmates
- Not a stand-alone intervention: inmates need much more than a behavior plan
- Not a quick-fix: sometimes years before reliable progress is seen
- Inmates often get worse before they get better
- Some will suffer self-inflicted death
- Documentation is critical!