

BRACE™ Applied to the Prevention and Management of Self-Injurious Behavior
(SIB) in a Jail or Prison Segregation Unit
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I. PRESENTING PROBLEM:

The Segregation Unit is for the temporary housing of inmates for disciplinary time, pending investigations, pending classification actions, “cooling off,” pending evaluation, pending transfer, or threat to self or others. Consequently, the Segregation Unit temporarily houses the most noncompliant, disruptive, manipulative, dependent, unstable, and violent inmates. Violence includes both violence to others (ranging from verbal threats to predatory assault) and violence to self (ranging from verbal statements to suicide).

Violence to self, often called self-injurious behavior (SIB), is generally viewed by staff and other inmates as irrational and impulsive, and thus beyond voluntary control, rather than learned and maintained by current consequences, which would make such behavior subject to the basic principles of learning and related management and treatment. Those inmates evaluated by mental health staff as suicidal are referred to a residential mental health unit for treatment of suicidal behavior and intent. However, those inmates evaluated by mental health staff as voluntarily inflicting self-injury for reasons other than suicide are not referred to a residential mental health unit. Additionally, any inmate who is transferred to a residential mental health unit due to self-injury or suicidal gestures, and who is evaluated by the receiving mental health staff as not having suicidal intent, that inmate will not be admitted to residential mental health, but will generally return to the referring unit as soon as possible. Thus, non-suicidal SIB must be managed and treated at the local level.

The fact that an inmate is not psychotic and that his behavior is goal oriented and under voluntary control does not mean that the self-injurious behavior is not high risk and dangerous. All self-injurious behavior must be managed as high risk and dangerous, regardless of the inmate’s motives or where the inmate is housed.

Inmates who are willing to inflict self-injury in order to motivate others to meet their needs frustrate the good intentions and usual efforts of Custody, Case Management, Medical, and Mental Health staff:

- Custody staff are trained to manage crisis within a shift to shift frame of reference, and to de-escalate violence through segregation, protective structure, negotiation, and counseling - transferring problem inmates which require a higher level of custody or treatment than is available at the facility.
- Case Management staff are trained to provide advice, counseling, and program placement based on inmate needs and adjustment - transferring inmates according to classification and program needs.
- Nursing staff are trained to treat physical problems in a compassionate manner while gathering information related to the status of the patient and the cause of the

symptoms being treated - transferring patients to medical facilities according to medical necessity.

- Mental Health staff are trained to provide therapy to individuals who are motivated to resolve cognitive and behavioral problems and improve adaptive functioning - transferring inmates who are psychotic or suicidal to residential mental health units.

However, inmates who intentionally engage in SIB to motivate staff to meet their needs get progressively worse instead of better when staff respond in their usual manner to meet those needs. It is the after-the-fact consequences of the SIB and the nature of staff responses to the SIB that strengthens or weakens the SIB. Prisons are generally equipped to deal effectively with both predators and victims, but not when the predator and the victim are the same person.

After-The-Fact crisis intervention must be combined with Before-The-Fact crisis prevention in order to 1) manage and treat Manipulative Self-injurious Behavior (M-SIB), 2) minimize the adverse impact such behavior has on staff and other inmates, and 3) decrease the costs in terms of physical and psychological injury, energy, time, money, and other resources. Note that the adverse effects of all types of SIB spread to the families and friends of both staff and inmates. Additionally, to the degree that such behavior is successful during incarceration, it will be continued when the inmate returns to the community.

II. TARGET BEHAVIOR:

Definition: For current purposes, **Manipulative Self-Injurious Behavior (M-SIB)** is defined as threatened or actual physical self-injury which is 1) learned behavior, 2) intended to establish a specific effect other than suicide, and 3) is not a result of psychosis.

Examples: M-SIB includes but is not limited to reporting (orally, in writing, or by gesture) intent to self-injure or actually cutting self; swallowing inedible objects (e.g., razor blades, batteries, fingernail clippers, paper clips) or consuming harmful solutions (e.g., shampoo, cleaning agent, soap); creating physical symptoms for medical treatments (scratching self to produce rash, picking sores or otherwise creating wounds or bruises, pulling out stitches, rubbing feces in wound); creating conditions to suggest or allow for hanging (e.g. making a noose, tying clothing or sheets to bars or wall fixtures; placing belt or sheet around neck); and, hitting head or other body part on wall, floor, or other hard or sharp objects.

The above definition of M-SIB is designed to facilitate both management and treatment decisions:

- ☑ maximizes the individual's safety while keeping the focus on personal responsibility.

☑ makes the individual accountable for words spoken as well as actions taken, which establishes clear behavioral limits before-the-fact of M-SIB and gives words more power and meaning.

☑ establishes intervention as early as possible in the pathological sequence, keeping secondary gains to a minimum. It is noted that some individuals seek such early intervention (negative reinforcement by removal from current circumstances and placement in segregation), but early intervention 1) keeps actual self-injury to a minimum, 2) keeps the inmate from gradually increasing pain tolerance and willingness to risk 3) keeps the inmates from gradually learning to increase the M-SIB in terms of intensity, frequency or duration to eventually accomplish segregation, and 4) gives the inmate and staff an opportunity to develop alternative problem-solving strategies. The inmate's motives, strategies, and alternatives will become increasingly apparent.

☑ "loss of impulse control" is treated as a selective and systematic failure to exercise patience (self-control or self-restraint) rather than a neurological deficit. Similarly, "poor impulse control" is managed and treated as a learned habit of using such violence as a problem solving device rather than allowing the M-SIB to become an inmate controlled consequence of misconduct.

☑ encourages systematic problem-solving by staff and exposes an inmate's active opposition to essential services or required activities of daily living as a continuing pattern of criminal conduct.

☑ keeps the focus on the inmate's personal responsibility for building adaptive alternatives to current M-SIB, rather than allowing the inmate to present himself or herself as a helpless victim of impulses.

☑ manages and treats M-SIB which is used as a means of protest, countercontrol, or expression of anger as any other form of aggression or active opposition to essential structure or security - i.e., as a matter of conduct and character, regardless of mental or emotional status.

☑ even M-SIB which functions to relieve boredom or realistic situational anxiety is considered to be subject to the basic principles of learning and voluntary control.

☑ emphasizes that even a person who is psychotic may also display M-SIB which is learned and is not directly related to the psychosis.

☑ emphasizes that each individual, within the limits of their ability and control, is ultimately responsible for what they learn and teach, including their own risk and opportunity management.

III. GOAL AND OBJECTIVE STATEMENTS:

Goal Statement: Within the limits of existing resources, policy, and essential safety and security considerations, establish a comprehensive program to effectively manage and treat Self-Injurious Behavior in a prison or jail disciplinary or segregation unit.

Objective Statements:

Objective # 1: As measured by the special protective precautions taken by Custody Staff, decrease the frequency and duration of SIB incidents by 25% of baseline within 6 months of the date of implementation; by 50% of baseline within one year of the date of implementation; by 75% of baseline within 18 months of the date of implementation; and by 90% of baseline within two years of the date of implementation.

Objective # 2: As measured by the level of medical treatments provided by Medical Staff, decrease the severity of SIB by 25% of baseline within 6 months of the date of implementation; by 50% of baseline within one year of the date of implementation; by 75% of baseline within 18 months of the date of implementation; and by 90% of baseline within two years of the date of implementation.

Objective # 3: As measured by the frequency of transportation for emergency medical treatments, decrease the costs of SIB in terms of transportation, employee overtime, and medical expense by 25% of baseline within 6 months of the date of implementation; by 50% of baseline within one year of the date of implementation; by 75% of baseline within 18 months of the date of implementation; and by 90% of baseline within two years of the date of implementation.

IV. FUNCTIONAL ANALYSIS AND RATIONALE:

Self-Injurious Behavior (SIB) comes in many forms and serves many functions. Each case must be considered on an individual basis within the context of the person's learning history (which includes their beliefs and values as well as behavior) and their current situation (which includes both their physical and cognitive status and their entire behavioral environment or life situation).

All SIB is rational from the point of view of the person engaging in it - behavior which serves no function ceases to occur due to costs as measured in terms of energy, time or resources. In fact, understanding the relationship of costs to benefits is the key to most behavior problem solving. But what is considered to be a cost and what is considered to be a benefit is an individual matter based on past experience and current circumstance (including learned expectations).

The fact that a person is willing to engage in SIB does not make that person psychotic. People voluntarily engage in various types of behavior which produce pain/discomfort, being more than willing to suffer immediate pain/discomfort for the prospect of long term gains, and more than willing to risk long term pain/discomfort for

the prospect of immediate gains. Whether for fame, fortune, or a sense of well-being and control, people willingly expose themselves to all types of pain/discomfort, from the extreme sacrifice and discipline of professional athletes and dancers to people who attend horror shows, from thrill seekers to the deprivations of monastic life, from mountain climbers to cave explorers, from tattoos and body piercing to high heel shoes, from excesses to deficits of eating, from law enforcement to criminal conduct, people willingly expose themselves to high risks and inflict themselves with all sorts of physical and psychological pain/discomfort. However, such behavior is completely rational and understandable in terms of human nature and the basic principles of learning - in this sense, SIB also is “lawful” ... it too must follow the basic principles of learning ... it too is learned and shaped according to current conditions and consequences.

Non-psychotic inmates engage in SIB to motivate others in a particular manner and the SIB is voluntary and goal oriented – i.e., it is Manipulative (M-SIB). That is, the SIB is a means to an end — the SIB clearly functions to establish an outcome or have a specific effect - being a way to either 1) get, keep, prolong, or increase some type of pleasure/comfort (called positive reinforcement), or 2) to avoid, escape, delay or decrease some type of pain/discomfort (called negative reinforcement). Either of these two types of consequences (positive reinforcement or negative reinforcement) will strengthen the SIB, making it more likely to occur again in the future.

Examples of M-SIB functioning to establish positive reinforcement (often called “approach behavior” since the underlying motivation is to gain or keep something): To obtain favors or privileges of any kind (newspaper, special visits, extra phone calls, having message delivered), to gain interaction with favored staff (e.g., female nurse or therapist), simple attention or social interaction, medications to “get high,” access to information (information is a commodity in prison), to gain status or build a “reputation,” to create a feeling of power and control, as an expression of anger or contempt, to watch staff efforts to control something beyond their power to control, to “get even” with a particular staff (e.g., force them to do paperwork or work overtime), to provide entertainment for other inmates, to gain information about particular staff (e.g., are they naive and a good target for exploitation), to measure and evaluate staff motives or concerns based on their responses, to gain access to particular areas of the prison or the community, to build a lawsuit, to build a relationship with staff, to create conditions to reinforce particular staff (i.e., by “letting” the staff help them), to elicit community or family sympathy and support, to provoke displays of staff fear or anger, or to transfer to another facility (to be with a friend, closer to home, etc.).

Examples of M-SIB functioning to establish negative reinforcement (often called “avoidance behavior” since the underlying motivation is to escape or avoid something): Segregation as protection from other inmates, to escape or avoid performance demands (work, study, personal responsibilities, compliance with rules or authority), debt avoidance, relief from boredom, to escape or avoid current consequences (e.g., pending investigation, pending transfer), to escape or avoid the physical or psychological effects of drug withdrawal, to gain medications to sleep (i.e., to avoid being awake a normal amount of time), to escape or avoid thoughts or feelings about past

or current conduct (shame or guilt), to escape or avoid thoughts or feelings about the future (anxiety or fear), to escape or avoid complex or difficult circumstances (reactive rather than proactive decision-making, destructive rather than constructive problem-solving), to transfer to get away from an enemy or to avoid increasing exposure as deceptive, dishonest and emotionally manipulative and exploitive.

It should be noted that M-SIB may include what a person does (swallow inedible, cut self, bang head) or what a person does not do (refuse essential services and treatments such as seizure medications or food).

M-SIB is effective only if there is someone who is naive and cares about the individual's well-being or someone is charged with their care. Such patterns are generally learned in the developmental home environment but are also highly prone to being reinforced in foster homes, group homes, and all types of institutions, including jails and prisons. The appropriate and indicated treatment program in all cases is training the primary care providers in the basic principles of learning and reaching a "meeting of the minds" with respect to management and treatment decisions, particularly related to the consequences for the M-SIB.

If SIB is successful in motivating staff in the manner the inmate desires, over time and circumstance, the SIB will be used in more situations, serving more functions (to acquire desirable consequences or to avoid undesirable consequences), and thus become more potent, increasing in frequency, intensity, and duration, becoming increasingly costly and more difficult to manage and treat.

V. METHODS:

- Staff training in the basic principles of learning, focusing on the development and function of SIB, the various types of SIB, the need for early intervention, and how to minimize both positive and negative reinforcement of all types of SIB.
- Clarification of all departmental and staff roles related to routine care, management, and treatment of SIB.
- Establish clear lines of authority and responsibility for rapid and consistent implementation of consequences.
- Establish a clear profile of the inmate's conditions of confinement, conduct, changes in status, contacts, and actions taken by staff - to allow for effective management and treatment decisions across shifts and service areas.
- Establish general interpersonal guidelines for staff to manage and treat inmates who display SIB.

- Establish three month baseline measures of SIB based on available custody and treatment records, and maintain ongoing records to evaluate the effectiveness of current prevention and intervention procedures.
- **Within the limits of policy and procedure:**
 - ✓ **FIRST**, stop or minimize all identified and controllable sources of positive reinforcement of SIB, and
 - ✓ Stop or minimize all identified and controllable sources of negative reinforcement of SIB.
 - ✓ **THEN**, provide approved and appropriate reinforcement for relatively adaptive alternatives to SIB.
 - ✓ Then, if necessary and approved, establish increasing costs for M-SIB. Note that eliminating sources of positive and negative reinforcement is in effect a punishment procedure, which should be a sufficient increase in costs. That is, given effective implementation and time for the changes to take effect, eliminating reinforcement will eliminate the motivation for the M-SIB.

V. PROCEDURES:

A. Basic Staff Training Program Focusing on Self-Injurious Behavior

1. Reinforcers are unique for each individual.
2. People work (behave) for relative (net) gain: to increase pleasure/comfort and/or to decrease pain/discomfort.
3. The same behavior may serve different functions and have multiple consequences.
4. The function and potency of reinforcers change across time and circumstance.
5. Reinforcement of any given behavior is punishment of alternatives and vice versa.
6. Short term gains have long term costs and vice versa.
7. Relatively low energy, high effect behavior is predisposed to selection.
8. Behavior is lawful and the principles of learning operate independent of our awareness of them.

9. Imagined behavior has real consequences.
10. The principles of learning are amoral but values and beliefs are learned.
11. One's behavior is another's consequence.
12. What a person does not do is as important as what a person does.

B. General Interpersonal Guidelines

1. Observe, Behave & Communicate for Problem Solving:

- a. Learn to listen and listen to learn (with your eyes as well as your ears). What is the inmate's status on lock-up? What are his eating & sleeping patterns? Any physical limitations (vision, hearing, ambulation) or special precautions (allergies, assault risk)? Can s/he read/write/tell time? How does he spend his time? What does he talk about? How does he relate to staff/inmates?
- b. Be prepared to answer and do provide accurate documentation.
- c. Learn how your behavior functions as a consequence for both other staff and inmates.

2. Honesty is still the Best Policy:

- a. Honesty provides for consistency and predictability across time and circumstance.
- b. Accurate information and clear expectations decrease anxiety and anger.
- c. Give words meaning and power by keeping yours and remembering his or hers.

3. Control Your Own Self First:

- a. Actively manage your emotions - particularly displays of anger or fear. Be professional.
- b. Manage your own social and dependency needs – e.g., to be important, to “solve” the problem; to help or console or nurture; to heal or rescue; to feel needed or liked or to be “special.” Relate according to your job responsibilities.

c. Manage your own power and control needs – i.e., to force submission or compliance; to exercise authority or to feel superior; or to express your contempt, anger or disgust. Be consistently fair as well as firm.

4. Insist on Personal Responsibility:

a. Do not offer any statement or question which suggests the inmate is not responsible for or able to control his or her own behavior or emotions.

b. Do not agree with, accept or offer any statement which places blame for the inmate's SIB or related emotions on someone else, some past event or "the system."

c. Avoid assumptions about SIB - most SIB is learned and is subject to the basic principles of learning. SIB has both form and function - it serves a purpose ... don't you serve it by letting it control your emotions or behavior in a manner inconsistent with your job duties - follow standard procedures.

5. Do Not "Negotiate" or Barter & Trade for SIB:

a. Protect the inmate as indicated and according to policy but do not give SIB any more power, influence, or control than is essential for safety and security.

b. Stop all unnecessary positive reinforcement of SIB - e.g., no promises, no favors, no special privileges, no gains; no staff begging, pleading or scolding.

c. Stop all unnecessary negative reinforcement of SIB - e.g., no excuses, no missed consequences, no reason for "starting over," no avoidance of responsibilities.

6. Do Not "Counsel," Focus on, or Otherwise Discuss SIB With or in Front of an Inmate (unless you are the primary case manager or therapeutic decision-maker):

a. Provide essential services and treatments in a matter-of-fact, professional manner without undue comment or questions about SIB.

b. "Pay Your Attention" to relatively adaptive behavior rather than to SIB - before SIB occurs.

c. When in doubt, focus on the present and "Describe the Situation" – i.e., current events, but not SIB. Provide accurate information; structure time; and simplify complexity.

7. Teach Progressively More Responsible Behavior:

a. Provide clear behavioral limits for staff and inmates based on both rights and responsibilities, including professional boundaries - i.e., by defining ADAPTIVE as independently exercising rights AND meeting corresponding responsibilities, and defining MALADAPTIVE as violating rights OR not meeting responsibilities.

b. Establish clear expectations and provide consistent, timely, and relevant follow through - with consequences being as natural and instructional as possible - and consistent with policy and procedure.

c. Stop or minimize both positive and negative reinforcement of maladaptive behavior, but also relieve all forms of unnecessary pain/discomfort and actively create opportunities for the development of adaptive alternatives to SIB – i.e., opportunities for self improvement and personal development.

Just my opinions, of course.

Russell L Smith