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ScienceDirect

Cognitive and Behavioral Practice 23 (2016) 485-501

Cognitive and Behavioral Practice

www.elsevier.com/locate/cabp

Cognitive Behavioral Suicide Prevention for Male Prisoners: Case Examples

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Suicide is a serious public health problem but a problem that is preventable. This complex and challenging problem is particularly prevalent among prisoners, who are associated with a five-fold increase in risk compared to the general community. Being in prison can lead people to experience fear, distrust, lack of control, isolation, and shame, which is often experienced as overwhelming and intolerable, with some choosing suicide as a way to escape. Few effective psychological interventions exist to prevent suicide, although cognitive behavior therapies appear to offer some promise. Offering cognitive behavior suicide prevention (CBSP) therapy to high-risk prisoners may help to reduce the likelihood of self-inflicted deaths. In this paper we present three cases drawn from a randomized controlled trial designed to investigate the feasibility of CBSP for male prisoners. Implications of the current findings for future research and clinical practice are considered.

The prevention of suicidal behavior is a high priority for health care providers (Department of Health, 2012; Department of Health & Human Services, 2012) and yet it continues to be a complex and challenging problem. In the UK, more than 6,000 people take their own lives each year, reflecting an annual rate of suicide of 11 per 100,000—a rate that has remained largely unchanged for over 30 years (Office for National Statistics, 2013). In addition to completed suicides, a consideration of the prevalence of suicidal ideation is important. Approximately 1 in 6 people will experience suicidal ideation at some point in their lives, which will drive 1 in 20 into making an attempt (Bebbington et al., 2010). This equates to a person dying from suicide every 2 hours and an attempt being made every 6 minutes. Of course, not all individuals who engage in suicidal ideation or behavior will eventually take their own lives, but all aspects located along the suicidal continuum are accompanied by significant, distressing, disruptive, and undesirable psychological states worthy of therapeutic intervention (Tarrier et al., 2013).

The large body of epidemiological research into completed suicides has enabled the identification of key characteristics associated with an exaggerated risk. Typically, a high-risk profile would be of a young male who is less "integrated" within his community, so more likely to be single or divorced with no children and unemployed. He has an almost 90% likelihood of experiencing a diagnosable mental disorder, most likely depression, substance use, personality disorder and/or psychosis (Arsenault-Lapierre, Kim, & Turecki, 2004).

The high-risk profile can be seen to describe a substantial majority of the prisoner population, which have been shown to have a different demographic than the general population. Typically, male prisoners represent approximately 95% of the inmate population, with most establishments restricted to male-only prisoners. The age of prisoners upon reception tends to be between 18 to 35 years (Andersen, Sestoft, Lillebæk, Gabrielsen, & Kramp, 1996; Bland, Newman, Thompson, & Dyck, 1998; Teplin, 1990), with those aged below 18 years detained in Young Offender Institutions. The backgrounds of prisoners contain an exaggerated likelihood of childhood neglect, low levels of educational achievement, perhaps explaining the below-average levels of intellectual and cognitive functioning reported for adult prisoners (Birmingham, Mason, & Grubin, 1996; Davidson, Humphreys, Johnstone, & Owens, 1995). Almost half of prisoners say they have no academic qualifications, compared to 15% of the general population (Ministry of Justice [MoJ], 2012a).

Prisoners are a socially excluded population (Social Exclusion Unit, 2007), with unemployment, poor housing, financial difficulties, and loss of access to family and close support significantly more common than in the general population (Birmingham et al., 1996; Brooke, Taylor, Gunn,

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Keywords: suicide prevention; cognitive behavior therapy; prisoner

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& Maden, 1996; National Offender Management Service, 2007; Teplin, Abram & Mcclelland, 1996). The "prisoner experience" has been shown to be severely detrimental to the individual's mental health and well-being (Birmingham, 2003). The social and health inequalities that are brought with the person as they enter custody, referred to as "imported vulnerability," highlights the complexity of needs and challenges facing offender health and social care services responsible for meeting prisoners' needs.

The rate of mental health problems in prisons is notoriously high. Up to 90% of prisoners have a diagnosable psychiatric disorder (Department of Health, 2005; Royal College of Nursing, 2009) with 70% having two or more comorbid diagnoses (Department of Health, 2008). Prisoner groups typically have complex and long-standing mental health problems, such as psychosis, personality disorder, anxiety, and depression, often comorbid with substance and/or alcohol misuse (HM Inspectorate of Prisons, 2007). For instance, half of female and a quarter of male prisoners reported clinical levels of anxiety and depression, compared to 16% of the general population, and 25% of female and 15% of male prisoners reported symptoms of psychosis, compared to a rate of 4% in the community (MoJ, 2013a; Wiles et al., 2006).

Suicide behavior is far more common within prisons compared to the community. Annual suicide rates of over 60 per 100,000 prisoners are 5 to 8 times that reported for the general population (Fazel, Grann, Kling, & Hawton, 2011; MoJ, 2012b), leading some to describe suicide as the leading cause of preventable death in prisons (Baillargeon et al., 2009). In addition to those suicide risk factors shared with the general population, prisoner populations experience additional risks due to the prison context. Overcrowding (Leese, Thomas, & Snow, 2006); extended periods of isolation (Bonner, 2006); interpersonal violence among other prisoners; and subsequent traumatic stress responses (Blaauw, Arensman, Kraaij, Winkel, & Bout, 2002) have all been shown to heighten the risk of suicide behavior. Coping with a prison environment that engenders fear, distrust, and a lack of control can leave prisoners feeling overwhelmed and hopeless, leading some of them to choose suicide as a way to escape (Birmingham, 2003; Fazel et al., 2011). As such, prisoners have continued to be identified as a key high-risk group in the updated suicide prevention strategy for England and Wales (Department of Health, 2002, 2012).

In the UK, prisoners have the right to expect a health care service equivalent to that received by the general public (Home Office, 1990, 1991), with NHS mental health in-reach teams (MHIRTs) responsible for the delivery of mental health care for prisoners (HM Prison Service and NHS Executive, 1999). The demands placed upon many MHIRTS have exceeded their ability to supply good-quality health care, especially to those at risk of suicidal behavior (Bradley, 2009; Brooker, Ricketts, Lemme, Dent-Brown, & Hibbert, 2005; HM Inspectorate of Prisons, 2007). Prisons in England and Wales currently operate the Assessment, Care in Custody and Teamwork (ACCT) system, which aims to provide individualized care and support for prisoners at risk of suicide or self-harming behaviors (HM Prison Service, 2005). The ACCT system offers both crisis interventions as well as multidisciplinary care to those with longer-term problems. ACCT can be aligned to the Care Programme Approach used within UK mental health services, with a focus beyond the surveillance and monitoring of prisoners to also include an individualized and interactive process to positively manage the risks presented by the prisoner. An ACCT is said to be "opened" for a prisoner when a risk becomes known to staff, and remains open while the risk persists, during which time fortnightly reviews are undertaken by prison staff (both health care staff and the prisoner contribute towards these reviews). When the level of risk is considered to be safely reduced, the ACCT is "closed." Previous evaluations have reported this approach to supporting suicidal prisoners to be sufficiently sensitive in that the help provided is being delivered to high-risk individuals; however, considerable unmet need remains among the prisoner population, with substantial proportions of suicidal prisoners failing to be identified as at-risk (Humber, Hayes, Senior, Fahy, & Shaw, 2011; Senior et al, 2007).

Empirical evidence for treatments shown to be effective in the prevention of suicide behavior is limited, although psychological treatments, particularly cognitive behavioral therapies, have attracted considerable interest, with preliminary findings indicating significant promise of a preventative effect. In a review and meta-analysis of 25 studies of cognitive behavioral interventions for suicide behavior, a highly significant overall effect was reported (Tarrier, Taylor, & Gooding, 2008). The review highlighted that group CBT interventions were ineffective whereas individual sessions alone or when coupled with group sessions were highly effective. Importantly, CBT was only found to be effective when the therapy directly focused on the *prevention of suicidal behavior*, whereas suicide prevention viewed as a secondary gain within the treatment of another mental health problem (e.g., CBT for depression or psychosis) was ineffective. Since the review, this evidence base has continued to become more established. In a trial of 10 sessions of cognitive therapy following a recent suicide attempt, relative to participants receiving usual care, CBT recipients were 50% less likely to reengage in suicide behavior in the subsequent 18 months and achieved significant improvements on measures of depression and hopelessness and the rate of recovery for problem-solving skills (Brown et al., 2005; Ghahramanlou-Holloway, Bhar, Brown, Olsen, & Beck, 2012). Similarly, in a sample of 90 patients presenting to a local medical center following suicidal behavior, those randomized to receiving 12 sessions

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