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Cognitive behaviour therapy for adolescent offenders with mental health problems in custody

Paul Mitchell [a,*], Kirsty Smedley [a], Cassandra Kenning [b], Amy McKee [b], Debbie Woods [b], Charlotte E. Rennie [b], Rachel V. Bell [a], Mitra Aryamanesh [b], Mairead Dolan [b]

[a] Greater Manchester West Mental Health NHS Foundation Trust, Research Office, Gardener Unit, Bury New Road, Prestwich, Manchester, M25 3BL, United Kingdom
[b] University of Manchester, Oxford Road, Manchester, M13 9PL, United Kingdom

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A B S T R A C T

Many studies have identified high levels of mental health problems among adolescents in custody and there is increasing evidence that mental health problems in this population are associated with further offending and mental health problems into adulthood. Despite recent improvements in mental health provision within custodial settings there is little evidence of structured interventions being offered or of their effectiveness being evaluated. A cognitively based intervention was developed and offered to adolescents with a variety of mental health problems in different secure settings, and the outcomes compared with a control group. Although this small-scale study did not identify significant differences in outcomes for the two groups, both recruitment and retention in therapy were good, and potential candidates were not excluded on the basis of learning difficulties or co-morbidity. The study demonstrated the viability of a delivering cognitively based intervention for common mental health problems within secure settings.

Introduction

Studies in the United Kingdom (Office for National Statistics, 2005) and internationally (Angold et al., 2002; Sawyer, Arney, Baghurst, & et al., 2001) suggest that between 10% and 20% of adolescents in the general population experience mental health problems. However, studies with adolescent offenders, both in the UK (Kroll et al., 2002) and internationally (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Vreugdenhil, Doreleijers, Vermeiren, Wouters, & van den Brink, 2004; Vermeiren, Jespers, & T.E, Moffitt, 2006) have found much higher prevalence rates. In particular, adolescents in custody have high rates of disorders such as depression and anxiety (Abram, Teplin, McClelland, & Dulcan, 2003; Lader, Singleton, & Meltzer, 2000; Teplin et al., 2002).

This population has high rates of conduct disorder (Bailey, Thornton, & Weaver, 1994; Pliszka, Greenhill, Crismon, & et al., 2000), substance misuse problems (Goldson, 2000; Kroll et al., 2002; Pliszka et al., 2000; Vermeiren, Schwab-Stone, Deboutte, Leckman, & Ruchkin, 2003) and learning difficulties (Hall, 2000). They also have many unmet health (Dolan, Holloway, Bailey, & Smith, 1999; Rutter & Giller, 1984) and education needs (Anderson, Vostanis, & Spencer, 2004; Chitsabesan & Bailey, 2006). Most importantly, they have multiple needs across all these domains (Abram et al., 2003; Vermeiren, Jespers, & T. Moffitt, 2006; Vreugdenhil, Vermeiren, Wouters, Doreleijers, & van den Brink, 2004).

In recent years the high prevalence rates of mental health problems among adolescents in custody have been highlighted as an area of concern (Bailey, 2003) and despite improvements in prison health care their needs often remain unmet (Audit

* Corresponding author. Tel.: +44 161 772 3419; fax: +44 161 772 3443.
E-mail address: paul.mitchell@gmw.nhs.uk (P. Mitchell).

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Commission, 2004; Bailey, Vermeiren, & Mitchell, 2007; Nicol et al., 2000). The prognosis for this group is poor; mental health problems during adolescence are a risk factor for future offending (Rutter, Giller, & Hagell, 1998), further mental health problems into adulthood (Maughan & Kim-Cohen, 2005), and the development of antisocial personality disorder (Bailey, Pederson, Losel, & Vermieren, 2007; Harrington & Bailey, 2004).

Cognitive Behaviour Therapy (CBT) is a highly structured intervention with a well-established evidence base. CBT based interventions have been developed specifically for young people with a variety of problems including depression (Reinecke & Shirk, 2005) and offending behaviour (McGuire, 2003). These interventions either target specific mental health problems such as depression and are accessed on a voluntary basis through Child and Adolescent Mental Health Services (CAMHS), or they target behaviours such as offending and are generally delivered as part of a court imposed sentence and are therefore compulsory.

The structured approach of CBT clinical trials, while helpful in generating a significant evidence base, often have a narrow therapeutic focus and have been criticised for using samples that are not clinically representative, thus raising questions about the more general implementation of the interventions (Reinecke & Shirk, 2005). The trials often have exclusion criteria such as learning disability (Curry, Wells, Lochman, Craighead, & Nagy, 2003) or exclude otherwise eligible participants on the basis of co-morbidity, despite this being common in the diagnoses of young people (Vermeiren, Jespers, & T.E, Moffitt, 2006). Co-morbidity has been noted as a predictor of premature termination of treatment in trials as well as influencing the effectiveness of treatment (Kazdin & Holland, 1997) and therefore is thought to complicate the treatment process (Reinecke & Shirk, 2005). However, the high prevalence rates of co-morbidity and learning disability among this population means that their use as exclusion criteria would seriously undermine the subsequent practical usefulness of any clinical trial.

Engaging and retaining young people in therapy is also acknowledged to be a common problem (Kazdin & Holland, 1997). Interventions typically rely on the participants' willingness to undertake homework tasks and assume competence in carrying these out and reporting back at subsequent sessions. Literacy skills and some capacity for reflection are also assumed. These problems are even greater when working with young people with aggressive and antisocial behaviour (Kaminer, Tarter, Bukstein, & Kabene, 1992; McGuire & Priestley, 1995) and pose particular challenges working with young people in secure environments.

Young people can have difficulties building a relationship with a therapist due to issues of trust (Reinecke & Shirk, 2005) and some studies have suggested that treatment outcomes in a number of interventions can be predicted by relationship variables (Shirk & Karver, 2003). Therefore the working relationship between therapists and young people, and their families, is of utmost importance both in terms of retaining them in the therapy and treatment outcome (Garcia & Weisz, 2002; Kazdin & Holland, 1997). CBT programmes for young people have also been criticised for excessively emphasising behavioural rather than cognitive interventions (Stallard, 2002).

Thus there are a number of difficulties in using CBT to address the mental health problems of adolescent offenders in custody. However the news is not all bad; some studies have reported CBT interventions for co-morbid disorders to be feasible with good levels of retention and attendance at therapy sessions (Curry et al., 2003). The authors acknowledged this success was due to pro-active therapist engagement with the young people and a high level of non-clinical activity and case management such as liaison with parents and professionals. Another recent study (Rohde, Clarke, Mace, and et al., 2004) found that CBT could reduce symptoms and improve social functioning for adolescent offenders with co-morbid depression, and again retention in therapy was good. There is growing evidence that CBT can be an effective intervention for people with learning disability providing sufficient attention is paid to communication style and materials (Brown & Marshall, 2006; Stenfert Kroese, Dagnan, & Loumidis, 1997).

Apart from innovations in cognitively based interventions, other therapeutic models have been developed which explicitly address both engagement and motivational challenges. These include Dialectical Behaviour Therapy (DBT) (Katz, Cox, Gunasekara, & Miller, 2004), Motivational Interviewing (Greenwald, 2000), and Narrative Therapy (Jenkins, 1998). Such innovations are particularly important when developing interventions for hard to reach groups such as adolescent offenders.

There have been few studies evaluating the effectiveness of interventions for mental health problems among adolescent offenders; a recent systematic review (Townsend et al., 2010) identified only ten robust studies, including the community-based study by Rohde, Clarke, et al. (2004) cited above. The review found that the best evidenced studies were for group-based CBT interventions but that more high quality RCTs were needed to extend the evidence base.

Custody based studies on adolescents are even more limited in scope. Rohde, Jorgensen, Seeley, et al. (2004) found that a cognitively based coping skills course for depressed adolescents enhanced the coping of adolescents in custody. There is also evidence that relaxation based interventions may be beneficial for managing the stress of young people in custody (Nakaya et al., 2004). However, both of these studies recruited from the general population of detained adolescents rather than those with mental health problems.

Therefore after reviewing currently available manualised CBT interventions and taking the above factors into account the clinicians attached to the research team developed a new intervention specifically for use in the trial (described below). The aim of the study was to assess the viability of delivering a cognitively based intervention to adolescents with mental health problems in secure care, and evaluate the effectiveness of the new intervention

Method

Trial design

A multi-site RCT design was used to test the effectiveness of the intervention and also assess the viability of offering an intervention to this population. Five trial sites were used; four Secure Children's Homes (SCH) and a Young Offender