

# **ASSESSMENT OF MENTAL HEALTH ISSUES WITH YOUNG OFFENDERS.**

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*Paper presented at the  
Juvenile Justice: From Lessons of the Past to a Road for the Future Conference  
convened by the Australian Institute of Criminology  
in conjunction with the NSW Department of Juvenile Justice  
and held in Sydney, 1-2 December 2003*

Recent surveys in Australia suggest that 1 in 6 children and young people will be at risk of developing a significant mental health problem prior to the age of 18 years. Surveys of young offenders suggest that as many as 60% of incarcerated young offenders are at risk of significant mental health problems. However, the assessment of the contribution of mental health issues to the young person's offence remains a difficult task. How the identification of mental health problems may affect judicial decision-making is also a key issue in forensic psychology. Two approaches exist to identify the importance of mental health concerns as contributors to a young offender's behaviour. The first is through the application of research findings (in reports and through training) and the second through specialist reports. Section 32 and Section 33 reports, within the NSW system act as filters, attempting to identify the relevance of mental illnesses and mental conditions. However, these Sections are not always well understood by psychologists. Problems in the assessment, conceptualisation of a mental illness and a mental condition and the use of these reports are presented in a case series.

The population of young people relative to all people in Australia is declining, having dropped by 2% in the decade before 1996. However the rate is expected to be stable for the next 10 years with juveniles making up 10.8% of the Australian population (Muckerjee et al., 1997). Comparing various studies of problems in our young people Davis et al (2000) suggest that approximately 14.3% of these will experience crippling emotional disorders. (Young adults – those aged between 18 and 24 years had the highest incidence of mental health disorders –27%).

The Mental Health of Children and Young People survey (Raphael, 2000) collected data on identifying the extent of the problem based on a survey of 4,500 young people across Australia and their parents. It excludes surveys of young homeless people, people in detention and people in hospital care, and thus represents a minimum estimate of problems.

Key findings from the National Mental Health Survey (Raphael, 2000) are that between 14% to 18% of our young children have some kind of mental health problems. Comparing this to overseas studies we find that studies in New Zealand, Puerto Rico, Pennsylvania, Canada and New York report, for similar age groups using similar methodologies ranges from 18% to 22%.

### **Juvenile Delinquency.**

A useful working definition of delinquency, and one used for this paper is that delinquency represents persistent law breaking in a minor. In NSW Weatherburn, (1996) demonstrates an increased rate of serious offending by young people in a climate in which general youth offending is not rising at the same rate, as well as increased rates of drug related offending amongst juveniles. Research reported in South Australia (Putniðð, 2002) and Queensland (Lynch, Buckman & Krenske, 2003) identify that recidivist rates in the long term for incarcerated juveniles approach 100%. Recidivist data for non-incarcerated young offenders suggests desistence rates of approximately 70% (Cain, 1996 cited in Lynch et al., 2003; Hogg, 1999). Analysis of data provided by the Australian Institute of Criminology (Muckerjee et al., 1997) show increasing rates of juvenile violent crime with current rates of arrest for serious assault similar for both adults and juveniles.

### **Mental Illness and Juvenile Delinquents.**

Compared to the general population, what can we expect to be the prevalence of mental health problems in juvenile delinquents? There are a number of caveats to the answer to this questions. More is known about incarcerated and detained youth than youth who may offend, but remain within the community. This group is the group with the least likely recidivist rates. Since this later group forms

the bulk of the juvenile delinquency population, our answers to the questions of prevalence are necessarily skewed towards the more serious offender and the questions we can ask about what influences “create” the more serious offender reflect mental health (Grisso, 1999) as well as psychosocial issues. Secondly, there is by no means a uniform means of collecting data on detained youth, and hence it is not easy to generalise from the studies available.

Grisso (1999) reports on three studies from the United States that suggest that however defined, juvenile delinquents have a prevalence rate of mental health concerns around the 40% to 50% mark, with girls reporting higher rates of disturbance than boys. He provides some rough indicators on specific diagnoses. That is, compared to the general population of adolescents juvenile delinquents are 4 times more likely to be diagnosed with conduct disorder, 10 times more likely to be diagnosed with a substance abuse disorder, 3 times more likely to have an affective disorder but have anxiety disorders at the same rate as the general population of adolescents.

In our study of 90% of all incarcerated young offenders in Queensland in 1995, (Lennings & Pritchard (1998) we found that approximately 66% of respondents indicated significant pathology on a screening test derived from the SCL-90R. This finding was consistent with the then visiting psychiatrist anecdotal comment that 60% of the young offenders he saw had some kind of mental health problem.

Recently, the NSW Department of Juvenile Justice has conducted a significant research program into those young people held in custody (see papers by D. Kenny and C. Vecchiato, this volume). Using the Adolescent Psychopathology Scale, the data reveals a significant relationships between psychopathology, especially comorbidity, and criminal behaviour.

Grisso’s (1999) paper is useful in that reviews mental illness in terms of 6 broad classifications of mental health problems. These are

- *Conduct Disorder* (generally a synonym for chronic delinquency and, Grisso suggests, may not represent a true mental illness at all). However, since Conduct Disorder may be related to failures of parenting, child abuse, and especially supervisory neglect, the presence of this disorder may reflect contextual elements necessary in the explanation of offending behaviour. In addition, Frick, Barry & Bodin, 2000) have identified early onset conduct disorder as predictive of later psychopathy and may suggest that anti-social personality disorder may have its origins in a mix of biological and environmental influences that can be identified early in the development of a child. (See Moffitt, 1993 for a similar discussion).
- *Attention Deficit and Hyperactivity Disorder*. In particular he identifies the attendant impulsivity and educational failure associated with this diagnosis as important in relating the condition to delinquent behaviours. The notion is that a biological vulnerability (such as ADHD) intersects with environmental vicissitudes and it this diathesis that sensitises the child or adolescent to maladaptive behaviour (see Blackburn, 1993; Frick et al., 2000 for further discussion). Since the large number of young people diagnosed with ADHD also have low cognitive function, the diathesis is a particularly pernicious one.
- *Affective Disorders*. Grisso identifies the role of depression as a precursor to rage as a means of linking this condition to delinquency. Whilst the concept of “masked depression” has largely gone out of fashion, there is now a large body of evidence to reveal the wide-spread nature of depression in young people, and the role depression plays as a precursor to substance abuse disorders (Ruchkin et al., 2003). Depression is a concomitant of poor attachment, social skills deficits, and a sense of antagonism. How depression, as a clinical entity, may or may not be related to specific

offences is at times not the point. The issue is that depression can exist as a form of coping attrition and the presence of depression can be seen as a facilitating factor for maladaptive behaviour, specific offences are a part of this generalised maladaptive responding.

- *Trauma/Anxiety*. Young people are subject to trauma both through discreet acts (such as assaults and accidents) but also as a function of poor parenting practices and child abuse. There is a rich research tradition identifying the role child abuse plays in later delinquency (see Farrington, 1994; Wiig, Widom, & Tuell, 2003). Post traumatic stress has been found to be common among adjudicated juvenile delinquents (Ruchkin et al., 2002). Grisso suggests that trauma and anxiety can be particularly implicated in delinquency through the hypervigilance and threat-assessment preference associated with these conditions.
- *Psychotic Disorders*. Although very rare in practice, it is the prodromal conditions and related conditions such as borderline and schizoid disorders that create significant disturbances in the ability of young people to relate to others that sensitise such young people to offending (Grisso, 1999) Whilst there continues to be debate about whether psychoses do, or do not, increase the risk of violent crime, it appears that the co-occurrence of psychosis and substance abuse is a particular toxic reaction and does markedly increase risk of engaging in violent crime for the sufferer (Monohan, 1995).
- *Developmental Disability and neurological dysfunction*. Such disabilities create problems in executive function, and adaptive function (Blackburn, 1993). Within expert assessments the context in which behaviour occurs may reflect the failure of adaptive functioning within a situation that results in an offence.

### **Implications of Development for Mental Disorder in Young Offenders.**

Understanding the impacts of mental illness issues needs to recognise the developmental context. For instance, if the developmental context creates a specific vulnerability in its own right, then the impacts of even moderate mental illness may be magnified. Depending on the issue being examined, developmental trends suggest that a period of confusion exists when adolescents may, or may not, develop skills akin to those of adults in understanding and accounting for their own behaviour (Steinberg & Cauffman, 1999). This period of confusion generally occurs between the age of 13 and 17. During this period developmental trends are such that by the age of 17 we can confidently expect that a juvenile should be able to understand, and have the appropriate cognitive and emotional development to account for his or her behaviour and be responsible for it. Before 13 years of age, they suggest we can be confident they do not have such abilities. That is, prior to the age of 13 juveniles demonstrate reasoning, emotional and social competencies more like children than like adults. Factors, which impact on the ability of adolescents to explain their own behaviour, include:

- the extent to which we can impute *meta-cognitive abilities*. By metacognitive abilities is meant the capacity of a young person to have awareness of their thinking processes,
- the extent to which adolescents of this age may be affected by emotional and psychological pressures about which they lack insight, (that is, the hormone problem (re: are adolescent victims of their hormones),
- the tension between the developmental tasks of establishing identity and autonomy from the family in the context of continued dependency on the family and other social institutions .

- Differences in maturation rates between adolescents that can produce significant developmental pressures. For example the early development of breast in young girls, or the failure to grow in young men may produce crises in self-esteem, and a sense of difference.

Mental illness is a less clearly defined term for adolescents (Grisso, 1999). There are at least two problems in discussing the concept of mental illness with young people. The first of these is the difficulty of extending the categorical approach currently taken in conceptualising and defining mental health into a developmentally sensitive population. For instance, Grisso points out that adolescence is a time of change, in which symptoms may appear and mutate, and in which the course of a problem is dynamic and may not achieve the stability usually assumed with adult manifestations of disorder (see Cicchetti & Rogosh, 2002). Secondly, there has been trenchant critique, even within adult populations, of the assumptions underlying mental illness and in particular the categorical system.

Kruger and Piasecki (2002) quote findings of a large epidemiological survey in the United States that revealed that 79% of all respondents with at least one life time diagnosis of a mental illness reported an additional but different diagnosis as well. Further, 59% of the sample reported comorbidity rates for 3 or more disorders within the last 12 months. They argue for a dimensional approach, based on the observation that even in adult populations diagnoses are not stable, that comorbidity is the norm, not the exception, and that studies utilising path analytic and confirmatory factor analytic approaches to diagnosis has revealed that the super-ordinate dimensions of Internalising and Externalising disorders extend into adulthood and can be used to explain and group the statistical patterns or likelihood of comorbid diagnosis.

### **The Assessment Issue.**

The point of this talk has been to outline the context that the psychologist faces in preparing assessments on young offenders charged with offences heard in the Magistrates courts. At one end, the rehabilitative ideal suggests that psychological factors should be taken into account when considering the young person before the court. On the other hand, the court has multiple demands on it, protection of the community, ensuring community standards about “just desserts” are met, and providing an example to others also have to be considered. Expert Witnesses can assist the court at times, and, if the data are correct, often times, in determining the extent to which mitigation, leniency, or even challenges to *mens rea* can be made. In some ways the Section 32 assessment is akin to a fitness assessment, and can have somewhat similar implications – the defendant may not have to plead, but there is a prevailing view that since Children’s Court generally deal with lesser offences, the tests for mental illness and mental condition are less than for higher courts and more serious charges.

Section 33 and Section 32 allow a magistrate to determine whether a defendant should be viewed as suffering from a mental illness, disorder or condition. Section 33 is rarely used, and in many cases is viewed as too hard to utilise. Since all the dispositions available to a magistrate in Section 33 are also available in Section 32, most times a person is asked to conduct an assessment based on Section 32 if in the local or Children’s Court.

Section 32, states, that “(i)f at the commencement or any time during the course of proceedings it appears to the Magistrate:

*that the defendant is developmentally disabled, is suffering from a mental illness or from a mental condition for which treatment is available in a hospital, but is not a mentally ill person within the meaning of Chapter 3 of the Mental Health Act 1990 (Part 9), and*

*that, on an outline of the facts alleged ... it would be more appropriate to deal with the defendant in accordance with the provisions of this Part than otherwise in accordance with the law”.*

If established, Section 32 (and Section 33) allows the magistrate to “*take the action set out in subsection (2) or (3)*”

- 2) *(a) adjourn the hearing*  
*(b) grant bail or*  
*(c) make any other order the Magistrate deems appropriate*
- 3) *may dismiss the charge and discharge the defendant*  
*(a) into the care of a responsible person*  
*(b) attend on a person or place specified for assessment and/or treatment*  
*(c) unconditionally”*

The task for the expert is to determine what a mental condition is. On the basis of convention a mental condition appears to be Substance abuse disorders, a “Severe” Axis 2 (personality disorders), most commonly Anti-Social Personality Disorder and Borderline disorder, and in some cases a person may show a range of comorbid symptoms without any clear diagnosis (Such diffuse symptomatology may attract diagnoses such as Personality Disorder Not Otherwise Defined, or personality disintegration as a result of complex or chronic Posttraumatic stress disorder and the like).

### **The Case Review.**

Following is an analysis of series of 110 cases of mine, referred for psychological assessment pending sentencing in Court. The sample has been collected over the last 6 years of my part time forensic practice. It is a convenience sample, in that the only selection criteria used for these cases is that a solicitor felt there was some need for a psychological assessment. Of the 110 cases 13 were girls (12%), 97 boys. The mean age for the sample is 16 years and 4 months, (sd. 1.6 years) and Figure 1 reveals the age distribution. A number of the cases are 18, however all of these committed their offence as juveniles. Two cases do not appear in this analysis who committed crimes as juveniles, were aged over 18 and were seen by me for Serious Offender Review board assessments. The data includes approximately 5 cases referred for parole reviews and a further 5 cases referred for appeals that logically could not have lead to arguments relating to Section 32 or Mental Health assessments (but could have in their trial). The head charge for each young offender is shown in Figure 2.

Figure 1.  
Age of Sample of Young Offenders N=110

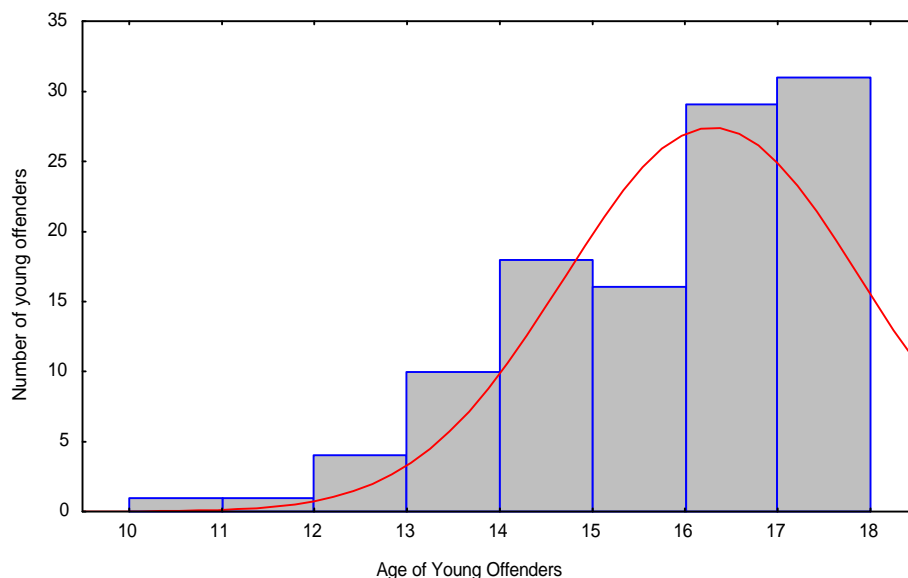
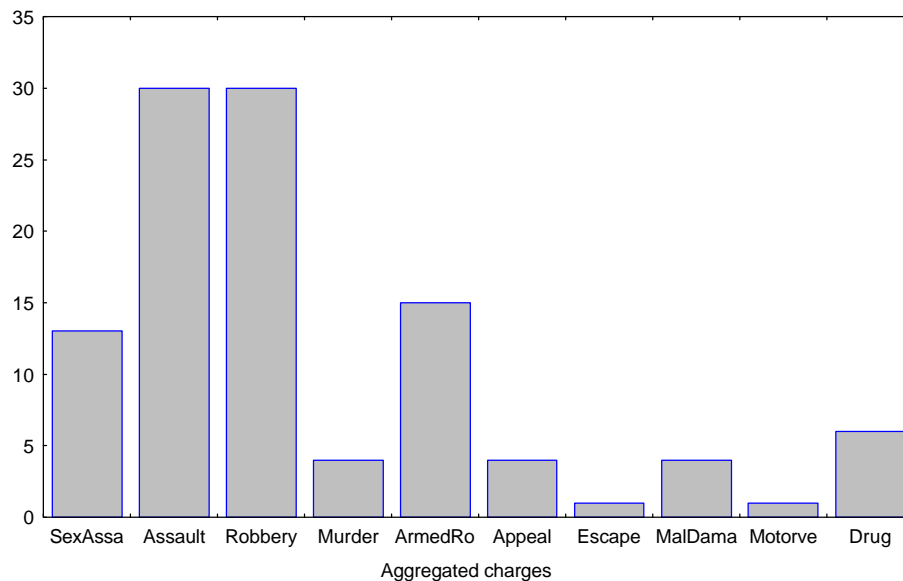


Figure 2  
Head Sentence for Sample of Young Offenders N=110



In order to facilitate my argument, I constructed 8 dummy variables. The rankings on these variables are shown in Table 1. The variables are:

*Intelligence:* 3 levels, level 1 is an IQ above the borderline mentally retarded range but defined here as a FSIQ greater than bottom 5% of the population; the second level is defined as borderline, an IQ falling between the bottom 2% and bottom 5% and mentally retarded, an IQ falling lower than the bottom 2% of the population.

*Externalising disorders:* combining ODD and CD: for a “severe” or first level diagnosis, the disorder had to be frank and either severe or have an early onset, and be supportive by collateral diagnoses; for a mild diagnosis, the disorder had to have an adolescent onset and/or be inferred from behaviour without prior diagnoses;

*Attention Deficit and Hyperactivity Disorder:* (including 2 young people with diagnosis of Aspergers), as with Externalising disorders for a “severe” or first level diagnosis, the disorder had to be frank and be supportive by collateral diagnoses; for a mild diagnosis, the disorder had to be inferred from behaviour without prior specialist diagnosis diagnoses;

*Depression* for a “severe” or first level diagnosis, the disorder had to clearly have a severe quality and been present for a considerable period of time , a mild diagnosis meant the depression was reactive, or there was some doubt about the diagnosis;

*Anxiety/trauma* disorders (including Posttraumatic Stress Disorder and severe adjustment disorders (e.g. severe grief following the death of a parent or sibling) for a “severe” or first level diagnosis, the disorder had to clearly have a severe quality and been present for a considerable period of time, a mild diagnosis meant the anxiety was reactive, or there was some doubt about the diagnosis;

*Psychosis.* For a “severe” or first level diagnosis, the disorder had to clearly have a severe quality and been present for a considerable period of time and have collateral diagnosis (including treatment with anti-psychotics). A mild diagnosis meant the diagnosis was in doubt, only prodromal features were observed, the person had incomplete presentations, or the psychosis was drug related.

*History of head injury,* included a number of neurological conditions including hydrocephalus (1 subject), epilepsy (confirmed with EEG diagnosis), and history of significant head injuries occasioning long periods of unconsciousness with demonstrated neurocognitive impairments. A mild category was created for those with probable epilepsy or a history of some convulsions but not regular and without medication, or those with a history of minor head injury involving loss of consciousness for brief (less than a few hours);

*Substance abuse,* was divided into 4 categories. The most severe category was demonstrated dependence including observation of a primary drug of use (usually either heroin or alcohol); demonstrated tolerance and withdrawal; the moderate range included those with a history of heavy poly-substance abuse; mild referred to a group with substance abuse issues but generally opportunistic rather than dependent use and with little consumption of “heavy” illicit drugs. No substance use included a group that used alcohol or marijuana on a recreational basis;

*Child abuse.* Also divided into 4 levels. The most severe level indicates a profound history of early onset and multiple abuse types; moderate referred to a long history of abuse but with intermittent periods of care without abuse or to a history of neglect without supporting evidence for sexual and/or physical abuse; mild referred to a lesser history of abuse, usually contained within a few years and often associated with transient partners of the mother. The no abuse category did not include abuse free, but may include a person who experienced some very time limited experiences or bullying at school.

*Mental Health Assessment.* A final category simply identified whether the assessment required me to undertake either a Section 32 assessment, a Part 9 mental health assessment or a fitness assessment. . Of the 97 reports available for analysis only 18 involved requests for mental health assessments (MHAs), 2 Section 32 assessments were not requested of me, but volunteered as part of my formulation. There were no Section 33. Of the 16 requests 4 were for Part 9 mental health assessments for District Court, and there were 2 fitness assessments (including 1 Doli Incapax and one had a Part 9 inference drawn from it by the Judge).

Table 1.  
Distribution of Severity Assessments on clinical Variables N = 96

Clinical Variable	None	Mild	(Moderate)	Severe
I.Q	72	9		15
Externalising Disorders	32	35		29
History of ADHD	71	10		15
Depression	46	33		17
Anxiety & Trauma	36	35		25
Psychosis	84	10		2
Head Injury	64	27		5
Substance Abuse	28	23	24	21
Child Abuse	31	17	24	24



Table 2.

Data for Mental Health Assessment.

	Sex	Offence	Age	IQ	CD/ODD	ADD	Dep	Anx/ Trauma	Psych	Sub Abuse	Neuro	Child Abuse	Request Type
RMC	1	appeal	14	4	1	1	1	1	2	1	1	2	Part 9
BT	2	Sex Ass	11	1	1	1	1	1	1	1	1	1	Part 9
DN	1	Rob	18	1	2	1	1	2	2	3	1	1	Part 9
RS	1	Sex Ass	18	4	1	1	2	2	1	2	4	4	Sect 32*
RR	1	Assault	16	1	2	4	4	2	2	2	2	3	Sect 32*
DA	2	Murder	18	1	1	1	4	4	2	3	1	4	Sect 32#
GA	1	Assault	17	1	1	1	2	4	2	1	2	4	Sect 32#
NP	1	Arm rob	16	1	1	1	4	4	1	2	2	3	Sect 32
OA	1	Assault	17	4	2	1	1	1	1	1	1	1	Sect 32
PS	1	Assault	17	2	1	2	4	4	1	1	1	3	Sect 32
RL	1	Assault	14	1	1	1	4	4	1	1	1	2	Sect 32
SC	1	steal	15	4	2	4	1	2	1	1	2	4	Sect 32
MK	2	Ass Rob		4	2	1	1	2	1	3	1	4	Sect 32
OA	1	Rob	16	1	4	4	1	2	1	1	2	2	Sect 32
ZM	2	Rob	15	4	4	1	2	4	1	2	1	4	Sect 32
PC	1	Sex Ass	16	4	1	1	1	1	1	1	4	2	Fitness
DR	1	Sex Ass	17	4	2	1	2	1	1	2	1	1	Fitness^
SW	2	murder	15	1	1	1	2	4	2	1	1	1	Fitness+

Notes to table: Sect 32\* = Section 32 assessment not requested but volunteered as part of my formulation; Sect 32# means Sect 32 assessment requested but not supported; Fitness ^ indicates including Doli Incapax assessment and Fitness+ refers to the case where the Judge undertook to extract from the formulation a fitness argument

Table 2 provides the raw data for this group of 18. Generally, the analysis reveals a surprisingly low level of request for mental health assessments and especially section 32 assessments. It seemed to me the main question I could ask of my data was there anything distinguishing the group who received mental health assessments? To answer this I first re-coded my data to a binary form – comparing the severe level against the mild and no-symptom level for IQ, Externalising, Internalising, ADD, Psychosis, and Head Injury groups, and splitting Child Abuse and Drug Abuse down the middle. A total “vulnerability score” was then calculated (mean = 11.48 , s.d.= 1.68, range 9 – 15) and I took the upper quartile of this group as my mental illness group. I then compared the young offenders for whom mental health assessments were either requested or volunteered by me with the rest of the young offenders by their membership within the upper quartile. This is shown in Figure 3.

Mental Health Assessment Request		
	Yes	No
Upper Quartile	7	20
Lower ¾'s	12	57

Note: there are in fact 27 cases in the upper quartile because of rounding effects.

Figure 3.  
Mental Health Assessments Requested by Quartile distribution.

Chi square Analysis revealed no significant difference ( $p=.34$ ). That is, less than half of the requested assessments are found in the most disturbed group of young offenders. As a second check I compared the mean “vulnerability” score for those that had a mental health assessment against the mean vulnerability score for the rest of the young offenders. Again there was no significant difference (Mental Health Assessment mean= 12.10, no mental health mean= 11.48,  $F(1,94) = 3.23$ ,  $p=.075$ ).

That is, whatever drives the request for mental health assessment does not appear to be simply a function of their overall fragility in terms of mental health. Indeed, looking at the data, and you will have to take my word on this, one of the most salient variables to come out was the solicitor making the referral. One solicitor in particular was responsible for half of the Section 32 requests.

What distinguished the mental health assessments? It seems to me that one or other of the categories might be more important in leading to a specific request for, or identification of a mental health problem.

The Mental Health Assessment group is slightly younger than the over-all sample (age = 15.88) and as a proportion has more females in it 28% (5 of 18). Table 3 reports on the various presentations of problems for the MHA group. The table can be compared to the general pattern of symptoms. For the purpose of exploratory analysis only a Logistic Regression was undertaken with the entire sample, all measures treated as dichotomy scores other than age. Measures used were age, IQ, history of ADD, CD, Head Injury, Depression, Anxiety, Child Abuse, and Substance Abuse. Psychosis was not entered as there were no serious cases. The equation was significant (Chi Square = 30.73, d.f. 9,  $p<.001$ ). The odds ratios are shown in Table 3. Of interest Internalising disorders and cognitive problems appear to be the most influential in predicting whether a request for a mental health assessment is made. Variables not influential at all are history of substance abuse and, supporting Grisso’s contention that Externalising Disorders are not seen as a mental illness, history of conduct disorder or ODD. Psychosis had no cases. Of interest is that none of the requested assessments were for young offenders with a known history of psychosis, reflective of the very low frequency of that disorder in my sample. (Presumably, psychotic Young Offenders are referred to psychiatrists).

Table 3  
Distribution Of Conditions For MHA Group and Odds Ratios (Predicting MHA).

Condition	Severe	Mild	None	Odds Ratio
Gender				1.10
Age				1.00
ADD/ Aspergers	3	1	14	1.82
Conduct disorder	2	6	10	0.19
IQ	8	1	9	2.30
Head Injury	2	5	11	2.55
Depression	5	5	8	3.68
Anxiety/ Trauma	7	6	5	4.48
Psychosis	0	6	12	0
Drug (1)	9	9		0.10
Child Abuse	9	9		1.31

(1) categories collapsed into severe and mild

## **Conclusion.**

In short, it seems that there is no compelling logic as to who gets a mental health assessment. The analysis conducted here reveals that very few young offenders were pathology free. Although no reliability checks for diagnosis were made (in most cases all those receiving a severe ranking received it because of documented history of having the specific problem), the mental health problems of the young offenders was inescapable. More than half had serious substance abuse problems, and more than half reported moderate to severe histories of child abuse. Those that do receive a mental health assessment are characterised by internalising disorders and by cognitive deficits. Despite clinical assessment identifying high levels of psychopathology, the mere “fact” of psychopathology is often either disregarded or irrelevant to the dispositional process. Whether it should or not is a matter for both policy debate, and the collaborative process that can exist between lawyer and mental health expert.

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