

A Study of the Multiple and Complex Needs of Australian Young Adult Offenders

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Youth offending is an important issue; it has significant social, psychological, interpersonal, and financial impacts on the society. International research has shown that young offenders generally have multiple and complex needs across a wide range of domains; however, research examining the depth and breadth of difficulties faced by young offenders in Australia is lacking. Arguably, such information is critical to help guide the development of valid preventative and treatment initiatives. This article describes a study examining the prevalence of mental illness, low intelligence, psychopathy, risk for reoffending, and criminogenic needs in 75 youth and young adult offenders in Victoria, Australia. Results suggest that the prevalence of mental illness and low intelligence is high in this population. Most (86%) of the sample had likely *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* Axis I disorders (including mood, anxiety, substance use, eating, and psychotic disorders); 15% had a Full Scale Intellectual Quotient (FSIQ) below 70; and an additional 25.7% had an FSIQ in the borderline range. The majority (80%) of the sample was considered to be at a high or very high risk of reoffending. The high prevalence of mental health issues found in this population highlights the need for comprehensive and multifaceted assessment, and for psychosocial treatment and management to be comprehensive, addressing clinical, criminogenic, and social domains.

Key words: criminogenic need; low intelligence; mental illness; young offenders.

What is already known on this topic

- 1 Young offenders generally have multiple and complex needs across a wide range of domains (e.g., mental health, intelligence, social, familial).
- 2 Offending by young people has significant social, psychological, interpersonal, and financial effects.

What this paper adds

- 1 Data on the depth and breadth of difficulties faced by young offenders in an Australian context.
- 2 This data may help guide the development of valid preventative and treatment initiatives.

In Australia, juvenile offending has increased annually since 2004, with rates of assault increasing by 48% between 1996 and 1997, and between 2006 and 2007 (Australian Institute of Criminology, 2009). Further, during this period, the rate of juvenile offending more generally has typically been twice that of adults (Australian Institute of Criminology, 2009). Although rates of juvenile offending in Victoria decreased overall in the period 2009/2010 and 2010/2011, rates of assault and homicide increased (Victoria Police, 2011). Internationally, there has been significant research interest in young offenders and their offences, given the social, psychological, interpersonal, and financial effects (Welsh et al., 2008). In summary, this research has shown that young offenders generally have multiple and complex needs across numerous domains, including those of physical and mental health, education, and community (Carswell, Maughan, Davis, Davenport, & Goddard, 2004;

Chitsabesan & Bailey, 2006; Department of Human Services, 2001; Fergusson, Lynskey, & Horwood, 1996; Herrington, Harvey, Hunter, & Hough, 2007; Katsiyannis, Ryan, Zhang, & Spann, 2008; Kroll et al., 2002; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002).

The accumulated research on risk of reoffending suggests that there are eight major, well-validated risk factors (the "big eight") in both adults and adolescents (Andrews, Bonta, & Wormith, 2004). These include the "big four": history of antisocial behaviour, antisocial cognition, antisocial associates and antisocial personality pattern, as well as problems in the domains of family and marital relationships, education and employment, recreation, and substance abuse (Andrews et al., 2004). In addition to these static (unchanging or historical) and dynamic (changing) risk factors for offending, young offenders have also been found to have a higher prevalence of mental illness (Carswell et al., 2004; Chitsabesan & Bailey, 2006; Department of Human Services, 2001; Fergusson et al., 1996; Katsiyannis et al., 2008; Kroll et al., 2002; Teplin et al., 2002) and intellectual disability (Herrington et al., 2007; Kroll et al., 2002) than young people in the general population. However, research into the extent of these problems in Australian young offenders remains lacking. Against this background, this article describes a study examining the prevalence of mental illness, intellectual disability,

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psychopathy, risk for reoffending, and criminogenic need in youth and young adult offenders in Victoria, Australia. Before describing the study in detail, the relevant literature examining these issues in young offenders will be reviewed.

Criminogenic Need

Criminogenic needs are those dynamic factors that are causally related to criminal behaviour (e.g., substance misuse, antisocial attitudes, antisocial peers). These consist of risk factors (those that contribute to an increased likelihood of criminal involvement) and protective factors (those that contribute to decreasing the likelihood of criminal involvement). The elucidation of criminogenic need assists in programme development by identifying the factors that should be targeted in treatment (individual or group) in order to prevent future offending (Andrews et al., 2004).

Of the well-known risk factors for offending, affiliation with delinquent others is a particularly important risk factor for criminal behaviour in young people (Borum, Bartel, & Forth, 2000; Hoge & Andrews, 2003). In adolescents, being associated with a delinquent peer group predicts both school-related problems and antisocial behaviour (Dishion & Loeber, 1985; Patterson & Dishion, 1985; Perrone & White, 2000), while parental criminality has long been linked to violent behaviour in children (Farrington, 1989). Siblings also exert a great influence on other children in the family. For example, adolescents in London with delinquent siblings were more than twice as likely to engage in violence compared with those without delinquent siblings (Maguin et al., 1995).

The use of drugs and alcohol are also factors that contribute to antisocial behaviour in youth. A national sample of over 12,000 adolescents in the USA found that rates of violence were higher among adolescents who used substances, including alcohol (Dukarm, Byrd, Auinger, & Weitzman, 1996). This link was further demonstrated by a 20-year longitudinal study, which found that drug use in early adolescence was associated with delinquency in later adolescence and adulthood (Brook, Whiteman, Finch, & Cohen, 1996).

School and/or work engagement is also relevant when assessing risk in young people (Borum et al., 2000; Hoge & Andrews, 2003). Interest in school and/or work is generally considered to be an important protective factor, while an absence of commitment to school and/or work is considered an added risk factor. Similarly, the way in which individuals spend their spare time influences their propensity for offending. Engaging in prosocial behaviours, such as organised sports or clubs, acts as a buffer against the risk for delinquency (Hoge, Andrews, & Leschied, 1996), while a deficit of such social connections has been found to be a strong predictor of delinquent behaviour (Simourd, Hoge, Andrews, & Leschied, 1994). Engagement in such activities may be influenced by a final factor contributing to risk for offending: the presence of pro-criminal attitudes. This relates to what an individual thinks about their own and others' violations of the law, the consequences of violating these laws, as well as their thoughts and beliefs about the importance of these laws (Andrews et al., 2004). To the authors' knowledge, there are no published studies examining criminogenic need in Australian young offenders.

Psychopathy

Psychopathy is a disorder characterised by a constellation of affective, interpersonal, and behavioural traits (Hare, 1996) that has long been associated with increased risk of offending in young and adult offenders (Douglas, Vincent, & Edens, 2006). The development of the Psychopathy Checklist-Revised (PCL:R; Hare, 1991) has helped provide an operational definition for the construct of psychopathy. While Skeem and Cooke (2010) have described an alternative conceptualisation of psychopathy, outlining the dangers in merging the construct of psychopathy with the PCL:R, it remains the "gold standard" (Vitacco, Neumann, & Jackson, 2005, p. 466) for the assessment of psychopathy. Psychopaths, as defined by the PCL:R, are egocentric, impulsive, irresponsible, lie pathologically, and persistently violate social norms and expectations (Hare, 1996). Despite these traits, these individuals are often superficially very charming. Psychopaths use this charm, along with manipulation, intimidation, and violence, against other people to get what they want without guilt or regret. These traits are believed to emerge in adolescence (Forth, Kosson, & Hare, 2003).

Mental Health in Young Offenders

Research has consistently found high rates of mental illness in young offenders, in secure care and in the community (Carswell et al., 2004; Chitsabesan & Bailey, 2006; Chitsabesan et al., 2006; Teplin et al., 2002). Young people with a mental illness account for a disproportionate number of those convicted of crimes (e.g., Elonheimo et al., 2007), and mental illness is prevalent among young offenders. For example, an American study of 1,829 detained youth found that two thirds of males and approximately three quarters of females met diagnostic criteria for at least one *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R)* Axis I disorder (Teplin et al., 2002), with substance-related (50.7% males, 46.8% females), anxiety (21.3% males, 30.8% females), and affective disorders (18.7% males, 27.6% females) being the most commonly reported. Similarly, high rates of mental illness have been identified in young offenders in the UK (e.g., Carswell et al., 2004; Chitsabesan et al., 2006; Kroll et al., 2002). These results suggest that mental illness is an important factor to consider when assessing and treating young people who offend. Few Australian studies have examined mental illness in young offenders. Bickel and Campbell (2002) found that 46% of young people in custody in Tasmania met criteria for mood disorders on the Adolescent Psychopathology Scale, 36% for posttraumatic stress disorder, and 32% for other anxiety disorders. Similarly, high rates of mental illness were found in studies using varying methodologies with young people in custody and on remand in South Australia and New South Wales (Richards, 1996; Sawyer, Guidolin, Schulz, McGinnes, Baghurst et al., 2010; Sawyer, Guidolin, Schulz, McGinnes, Zubrick et al., 2010).

Intellectual Functioning

Numerous studies have found intelligence to be negatively correlated with a number of social behaviour problems, including criminal activity (Lynam, Moffitt, & Stouthamer-Loeber, 1993);

as intelligence (intelligence quotient or IQ) increases, rates of offending decrease (Jensen, 1998). A New Zealand birth cohort study found that IQ, as measured at age 8–9, was negatively correlated with rates of arrest and conviction at age 25 (Fergusson, Horwood, & Ridder, 2005). A number of UK studies further demonstrated the extent of this problem, with between 11% (Herrington et al., 2007) and 27% (Kroll et al., 2002) of the young offenders assessed as having an IQ below 70 (extremely low). Additionally, between 39% (Herrington et al., 2007) and 44% (Kroll et al., 2002) of the young people in these samples had an IQ below 80 (borderline). Lynam et al. (1993) have argued that low IQ results in delinquency and not vice versa, as the relationship between low IQ and delinquency was not modified by academic performance, race, social class, impulsivity, or motivation (Lynam et al., 1993). The authors are not aware of any published study that has examined rates of low intelligence in young offenders in Australia.

The Current Study

The present study sought to estimate the prevalence of mental illness and low intelligence, and the level of psychopathy and criminogenic risk/needs in a sample of young Australian offenders living in the community. While published data on the prevalence of mental illness in young offenders in Australia are available, at the time of writing the authors were aware of no published study examining the prevalence of low intelligence and criminogenic need in Australian young offenders, nor of published studies that examine the range of these problems within one sample. It forms part of a study examining the impact of various risk and protective factors on recidivism in young offenders. Against the background, it was hypothesised that there would be higher rates of mental illness in this sample (compared with widely available normative data from the Australian Bureau of Statistics, 2007), and that there would be a higher proportion of individuals with low (<80) Full Scale Intellectual Quotient (FSIQ) (compared with normative data from the Australian version of the Wechsler Abbreviated Scale of Intelligence [WASI]; Wechsler, 1999). Finally, because the participants were recruited from a support service for medium- to high-risk young people, it was expected that the majority of the sample would be rated as at least a moderate risk to reoffend.

Method

Participants

Participants were 75 (64 males, 11 females) young people (range = 16–30; $M = 22.53$ years; standard deviation (SD) = 4.015) recruited from Brosnan Youth Services (BYS), a branch of Jesuit Social Services, in Melbourne, Australia. BYS provides support across four sites for young people aged 13 and above exiting the youth justice and adult justice systems who are considered by the justice system to be at a medium- to high-risk of reoffending, and have multiple and complex needs (i.e., accommodation issues, limited social supports, health problems). Services provided do not include a religious component. Participants were recruited and interviewed over a 17-month

Table 1 Demographic Characteristics of Participants

Variable	Males		Females	
	<i>n</i>	%	<i>n</i>	%
Cultural identification				
Non-Indigenous				
Australian/New Zealander	40	62.5	8	72.7
Indigenous/Torres Strait Islander	5	7.8	0	0.0
Pacific Islander	5	7.8	3	27.3
Asian	3	4.7	0	0.0
African/Caribbean	4	6.3	0	0.0
European	2	3.1	0	0.0
Middle Eastern	1	1.6	0	0.0
Mixed race	4	6.3	0	0.0
Current disposition				
No current disposition	23	35.9	6	54.5
Good behaviour bond	6	9.4	0	0.0
Community-based order	30	46.9	5	45.5
Supervised bail	3	4.7	0	0.0
Suspended sentence	2	3.1	0	0.0
History of past charges				
Yes	60	93.8	9	81.8
No	4	6.3	2	18.2
Official assault charge				
Yes	42	65.6	4	36.4
No	22	34.4	7	63.6

period (February 2010–July 2011). The rate of turnover through the service was low, as many referred young people refused to engage with the service, whereas those who did typically remained engaged for long periods of time. Participant characteristics are presented in Table 1.

Materials

The WASI

The WASI (Wechsler, 1999) is a short-form of the Wechsler Adult Intelligence Scale—Third Edition (WAIS-III; Wechsler, 1997); it provides a reliable and valid estimate of verbal, performance, and general intellectual functioning in clinical, psycho-educational, and research settings (Wechsler, 1999). According to the Wechsler (1997), an FSIQ above 80 is considered to be within the normal range, a FSIQ between 70 and 79 is indicative of borderline intellectual functioning, and 50–69 indicates extremely low intellectual functioning (Wechsler, 1999). Average reliability coefficients for the WAIS-III (Wechsler, 1997) and the Wechsler Intelligence Scale for Children-Third Edition (Wechsler, 1991) are strong, ranging from .96 (6- to 16-year-olds) to .98 (adult groups; Homack & Reynolds, 2007). The WASI has been referred to as an “excellent device” (p. 57) for cognitive screening (Stano, 2004), and it has been used in a number of studies measuring intellectual functioning in adult and youth offenders (e.g., Colwell et al., 2005; MacKenzie, James, McEwan, Mullen, & Ogloff, 2010; Sondenaa, Rasmussen, Palmstierna, & Nottestad, 2008).

The Structured Clinical Interview for DSM-IV-Screen (SCID-Screen) computer program

The SCID-Screen (First, Gibbon, Williams, & Spitzer, 1999) is a computer-administered screening version of the Structured Clinical Interview for *DSM-IV* (First, Spitzer, Gibbon, & Williams, 1996). The SCID-Screen explores Axis I diagnoses through 76 branched questions (follow-up questions are skipped if a patient reports not having certain symptoms) written at a Grade 7 level, providing a diagnostic screen (listing “likely,” “probable,” and “unlikely” diagnoses based on the number of symptoms endorsed) for Axis I disorders. The computer-administered SCID-Screen has been used in studies of adolescents (Hazel, 2007), substance users (Ohlin, Hesse, Fridell, & Tatting, 2011), inpatients (Ndeti et al., 2009), and individuals with social anxiety disorders (Dalrymple & Zimmerman, 2008).

The Level of Service Inventory/Case Management Inventory (LS/CMI)

The LS/CMI (Andrews et al., 2004) is a measure of criminogenic needs and risk for general criminal reoffending that is valid for individuals aged 16 and over. The LS/CMI is a revised version of the Level of Service Inventory—Revised, with which it is highly correlated (Andrews et al., 2004). According to Andrews et al. (2004), this high correlation “strongly suggests that 20 years of validity research on the former version of the LSI is reasonably applicable to the LS/CMI” (p. 117). Nevertheless, validation studies were undertaken with the LS/CMI and have found that the total score was correlated between .41 and .44 with general recidivism, and between .26 and .29 with violent recidivism in male offenders (Andrews & Bonta, 2003; Andrews, Bonta, & Wormith, 2006; Girard & Wormith, 2004). Results have also been promising with female offenders (Rettinger & Andrews, 2010).

The Psychopathy Checklist-Screening Version (PCL:SV)

The PCL:SV (Hart, Cox, & Hare, 1995) is a 12-item, 3-point (0–2) scale based on the PCL:R (Hare, 1991). The PCL:SV is scored in a similar manner to the PCL:R, and yields two factor scores, which equate with the factors derived from the PCL:R and a total score (range 0–24). Internal consistency was acceptable for a clinical scale (0.84), with high item homogeneity, and confirmatory factor analysis found the two factor model to be a good fit (Hart et al., 1995). Overall, the PCL:SV has revealed adequate psychometric properties when used as a screen for the possible presence of psychopathy (Hart et al., 1995). The PCL:SV is an appropriate instrument for assessing psychopathy in adolescents (e.g., Andershed, Kohler, Louden, & Hinrichs, 2008; Fougere, Potter, & Boutilier, 2009; Langevin & Hare, 2001; Toupin, Basque, Cote, & Deshaies, 2008). Total scores below 13 on the PCL:SV are considered indicative of a non-psychopathic personality, total scores between 13 and 17 “maybe psychopathic,” and PCL:SV scores of 18 or above “likely psychopathic.”

Procedure

Individuals were considered eligible to participate if they were aged over 16 years, able to speak English without an interpreter, and deemed capable by both their case manager and the first

author (AF), who conducted the interviews, to give informed consent. Posters advertising the research and inviting people to contact the researchers were placed at each of the four BYS sites. Additionally, researchers regularly met with case managers in each service to raise awareness of the project, and to invite the case managers to provide plain language explanatory sheets to their clients. Finally, researchers maintained a regular presence at the research sites (2–3 full days per week), and introduced the research to young people who attended at the centres.

Consent was obtained to interview the participants and access their BYS files, from which relevant information regarding their biopsychosocial history, criminal history, and personality were recorded. Files contained no official police criminal history reports, but referrals from court were available and these more often than not detailed past criminal convictions. All files contained information on the individuals’ current legal status and charges/convictions. Each participant was administered the PCL:SV (Hart et al., 1995) semi-structured interview guide, the WASI (Wechsler, 1999), the SCID-Screen (First et al., 1999), and the Resilience Scale-14 (Wagnild & Young, 1993; results of this assessment will be reported in a subsequent article). Data from the interview and file were used to score the PCL:SV (Hart et al., 1995) and LS/CMI (Andrews et al., 2004). Where content differed between the file and interview, greater weight was given to information most suggestive of psychopathology, as per the PCL:SV scoring instructions (Hart et al., 1995). Interviews took between 60 and 120 min, and breaks were permitted between tasks. On two occasions, the testing was completed on a second visit. Participants were offered a \$AUD 30 gift voucher upon completion (or partial completion) of the interview as recognition of their time, effort, and expert opinions.

Ethical approval to conduct this study was obtained from the Monash University Human Research Ethics Committee and the Victoria Police Human Research Ethics Committee. Additionally, permission to conduct the research was obtained from the Board of Jesuit Social Services.

Statistical Analysis

Data were analysed with IBM SPSS Statistics 19 (2010; IBM, Mountain View, CA, USA). Frequency calculations were undertaken to ascertain the prevalence of mental illness, low intelligence (FSIQ below 70 and below 80), psychopathy, and criminogenic risk/need. Data were examined for normality, skewness, and kurtosis. IQ data for FSIQ, Performance IQ (PIQ), and Verbal IQ (VIQ) were normally distributed. The same was true for PCL:SV total score, LS/CMI total score, and the LS/CMI family/marital, companions, alcohol/drug problem, and anti-social personality subscales. PCL:SV Factor 1 scores and LS/CMI criminal history subscale scores had significant levels of both skewness and kurtosis. The remaining subscales (PCL:SV Factor 2, and LS/CMI education/employment, leisure/recreation, and procriminal attitudes subscales) had significant levels of skewness but not kurtosis. For the purpose of the analyses in this article, data transformations were not conducted as the authors sought to include the full breadth of complexity of the participants. Because of the small number of females, gender comparisons were not made; however, results will be described both for the sample as a whole and by gender.

Results

Intellectual Disability

FSIQ scores ranged from 52 to 118, with a mean of 83.38 ($SD = 14.576$); 14.9% of the sample ($n = 11$) were found to have an FSIQ below 70 (extremely low range); 25.7% ($n = 19$) had an FSIQ between 70 and 79 (borderline range); 29.7% ($n = 22$) had an FSIQ between 80 and 89; the FSIQ of 25.7% ($n = 19$) fell between 90 and 109, and 4.1% ($n = 3$) had an FSIQ score between 110 and 199. VIQ scores ranged from 55 to 114, with a mean of 80.54 ($SD = 13.909$), while PIQ scores ranged from 56 to 128, with a mean of 89.64 ($SD = 17.215$). VIQ and PIQ scores were significantly different $t(73) = -5.047$, $p < .001$.

When results were examined by gender, it was found that the majority of the females (6, 54.5%) had an FSIQ in the low average range. One (9.1%) had an FSIQ in the extremely low range and one had an FSIQ in the borderline range, two (18.2%) had an FSIQ in the average range, and one (9.1%) had an FSIQ in the high average range. In contrast, the largest proportion of male participants (18; 28.1%) had an FSIQ in the borderline category, with 10 (15.6%) in the extremely low range, 16 (25%) in the low average category, 17 (26.6%) in the average category, and 2 (3.1%) in the high average category.

Mental Illness

Two participants did not complete the SCID-Screen assessment. In total, 65.8% ($n = 48$) of this reduced sample ($n = 73$) were identified as having at least one "likely" Axis I disorder (substance use disorders not included). When substance use disorder diagnoses were included in the analysis, 86.3% were identified as having a "likely" Axis I diagnosis. These included mood disorders ($n = 14$), anxiety disorders ($n = 37$), posttraumatic stress disorder ($n = 25$), substance use disorders ($n = 51$), psychotic disorders ($n = 3$), and eating disorders ($n = 3$). The total number of "likely" diagnoses in each individual ranged from zero to eight, with 71.2% ($n = 52$) of participants presenting with comorbid Axis I disorders.

With substance use disorders included, all 11 (100%) of the female participants were screened as having a "likely" Axis I disorder compared with 52 (83.9%) of the males. With substance use disorders excluded, 10 (90.9%) of the females were screened as having a "likely" diagnosis compared with 38

(59.4%) of the males. The total number of "likely" diagnoses in each individual between genders was similar, with males ranging between zero and eight, and females ranging from one to seven. The mode for both genders was three.

Psychopathy

PCL:SV total scores ranged from 0 to 19, with a mean of 10.59 ($SD = 3.901$). Fifty-six (74.7%) individuals were categorised as non-psychopathic, fifteen (20%) as maybe psychopathic, and four (5.3%) as likely psychopathic. All 11 of the female participants were categorised as non-psychopathic.

Criminogenic Risk/Need

Most (97.4%; $n = 73$) of the sample was rated as medium risk or higher on the LS/CMI. One person (1.3%) was rated as very low risk, another was rated a low risk. The highest proportion of the sample was rated as high risk (49.3%), followed by very high risk (30.7%) and medium risk (17.3%). Table 2 contains the proportion of the sample rated as very low to very high risk on each subscale. When participants were examined by gender, it was found that one (9.1%) of the females was rated as very low risk, three (27.3%) as medium risk, five (45.5%) as high, and two (18.2%) as very high risk. In comparison, no males were rated very low risk, one (1.6%) as low risk, 10 (15.6%) as medium risk, 32 (50%) as high risk, and 21 (32.8%) as very high risk.

Discussion

The aim of the present study was to identify the prevalence of mental illness, intellectual disability, psychopathy, and criminogenic risk/need in a community sample of young adult offenders in Victoria. Results demonstrated that extremely low intelligence (FSIQ < 70) and borderline intellectual functioning (FSIQ = 70–79) were high, and in comparison with normative data presented in published manuals, substantially higher than the general population. According to Wechsler (e.g., Wechsler, 1999), the IQ of 2% of the general population is below 70, and only 8% of the general population would be expected to have an FSIQ below 80 (compared with 14.9% and 25.7% of this sample). The importance of this finding is its relevance to service provision. Low IQ is an important consideration in

Table 2 Percentage (Number) of Participants in Risk Category by LS/CMI Subscale and Total Score

Subscale	Very low	Low	Medium	High	Very high
Criminal history	10.7 (8)	10.7 (8)	18.7 (14)	44.0 (33)	16.0 (12)
Education/employment	2.7 (2)	5.3 (4)	13.3 (10)	26.7 (20)	52 (39)
Family/marital	10.7 (8)	36.0 (27)	30.7 (23)	17.3 (13)	5.3 (4)
Leisure/recreation	12.0 (9)	0.0 (0)	13.3 (10)	74.7 (56)	0.0 (0)
Companions	2.7 (2)	12.0 (9)	33.0 (33)	16.0 (12)	25.3 (19)
Alcohol/drug problem	2.7 (2)	33.3 (25)	40.0 (30)	20.0 (15)	4.0 (3)
Procriminal attitudes	57.3 (43)	18.7 (14)	17.3 (13)	4.0 (3)	2.7 (2)
Antisocial pattern	0.0 (0)	10.7 (8)	18.7 (14)	44.0 (33)	26.7 (20)
Total score	1.3 (1)	1.3 (1)	17.3 (13)	49.3 (37)	30.7 (23)

LS/CMI, Level of Service Inventory/Case Management Inventory.

rehabilitation; young people with low IQ may have difficulty comprehending and learning from routinely delivered standardised treatment programs, which would have been developed for mainstream offenders with average intellectual abilities. Most noteworthy was that only 4 of the 11 participants with a recorded FSIQ below 70 were engaged with the specialised intellectual disability service within BYS.

Although this is a small sample, and low IQ is not the sole requirement for registration with disability services (and the WASI is a brief screen for intellectual disability), this finding highlights a significant issue with potentially poor identification and limited servicing of young offenders with intellectual deficits. Individuals working within the justice system need to be more aware of the prevalence of intellectual disability within the offending population, and be informed of the pathways available to provide these young people with the support they are eligible to receive. Tools such as the WASI and the Kaufman Brief Intelligence Test, Second Edition (Kaufman & Kaufman, 1990) provide brief, well-validated screens for intellectual deficits and are suitable for use with offenders and young people. Further, specialised treatment programs designed for offenders with low intelligence are commonly available within the justice system and in the community (e.g., Disability Forensic Assessment and Treatment Service in Victoria, Australia). However, problems exist for those individuals with low IQ who do not meet formal diagnostic thresholds (e.g., the young people in the borderline IQ category). These individuals may have difficulty accessing, and may not necessarily be offered, the specialised programs and assistance that may benefit their rehabilitation. Additionally, this study demonstrated that these young people have significant shortfalls in language production and comprehension, which indicates they would be unlikely to benefit from traditional treatment programs that rely substantially on verbal skills.

Similarly, the young people in this research were found to have much higher rates of mental illness compared with the general population. While it is estimated that 20% of the general Australian population is suffering from a mental illness at any time (Australian Bureau of Statistics, 2007), over 86% of the young people who took part in this research likely suffered from at least one current mental illness. These results are similar to the results of international research discussed earlier (Carswell et al., 2004; Chitsabesan & Bailey, 2006; Chitsabesan et al., 2006; Teplin et al., 2002). Mental illness has the potential to impact upon individuals' ability to serve their sentence, their response to standardised treatment programs, and their ability to abstain from criminal activity following completion of their sentence. Individuals suffering high prevalence disorders often fail to receive services within public mental health services and within the criminal justice sector; nevertheless, these disorders are often comorbid with other more serious mental illnesses, substance use, and offending behaviour. These disorders also impact on offenders' response to offence-specific treatment; as such, they require assessment and treatment prior to the individual engaging in offence-specific work.

The young people in this community sample demonstrated relatively low levels of psychopathy when compared with other forensic, non-psychiatric samples (Hart et al., 1995). Rates of likely psychopathic personalities in this population are esti-

mated to be between 17.9% and 37.5% (Hart et al., 1995); this is much higher than the 5.3% found in this sample. One reason for this finding might be due to the voluntary nature of engagement with the service where recruitment for this study occurred; highly psychopathic young people may be unwilling to engage with a support service in the community. Therefore, this may be an under-representation of the true level of psychopathic personality in the Victorian young offender population. Future research might assess psychopathy in mandated clients to gain a better estimation of prevalence in youth and young adult offenders in Australia.

It is perhaps unsurprising that high levels of criminogenic risk/need were found within this group of offenders since the service was directed to moderate- to high-risk offenders. In general, these young people presented with extensive criminal histories; financial, relational, and housing instability; few prosocial extracurricular activities; and major barriers in the areas of education and employment. The domains of education/employment and alcohol/drug problems were particularly problematic for these young people. This speaks to the need for these domains in particular to be targeted in treatment. Intervention and management within the education/employment domain may involve supporting the young person in educational programs (either in custody or in the community), and assisting the young person to obtain and maintain suitable employment. Research has suggested that vocational education and community employment programs are also successful in reducing recidivism in adult offenders (Bouffard, Mackenzie, & Hickman, 2000), and may therefore be beneficial to young offenders as well. Regarding drug and alcohol use problems, these results highlight the importance of accurate screening and assessment. Effective treatment programs targeting substance use, including education around harm minimisation, are required.

Limitations

An important limitation of the assessment of mental health problems in this study arises from the use of the SCID-Screen. Endorsing a single item noting the presence of recurring, persistent, and distressing thoughts would identify an individual for the "likely" presence of obsessive-compulsive disorder (OCD). A total of 28 participants (37.3%) were identified as having this "likely" diagnosis, increasing the proportion of the population as a whole with "any" Axis 1 diagnosis. While this is almost certainly an overestimation of the prevalence of OCD within the population, it should be noted that only one participant presented with a diagnosis of OCD alone, and only three presented with OCD and just one other diagnosis. As such, this issue is unlikely to have greatly affected the overall prevalence of mental illness within the sample.

Another limitation of this study was that the sample size was modest, which precluded more detailed consideration of the interplay between multiple risks and needs. Participants were also drawn from metropolitan Melbourne, they voluntarily attended a support service, and the proportion of young offenders who identified themselves as Indigenous was also small. The prevalence rates identified here may, therefore, be dissimilar to other settings, such as rural and remote settings, where there are more female offenders, within institutions, and with Indigenous

young offenders. Nevertheless, the similarity of these findings with research conducted in countries such as the UK (Chitsabesan et al., 2006; Kroll et al., 2002) and the USA (Carswell et al., 2004) confirms that youth and young adult offenders are a particularly vulnerable, complex, and high-needs group.

Conclusion

This research has provided important data in the Australian context on the depth and breadth of problems faced by young offenders. Treatment providers and those engaged in the management of young offenders must ensure that these important mental health issues are properly identified, that services meeting all of these needs are available, and that young offenders with mental health issues are properly treated.

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