Emotional Intelligence Mental Health And Juvenile Delinquency

Dr. Jennifer Margaret Hayes,
School of Psychology, University College Dublin and Health Service Executive - South.

Dr. Gary O' Reilly,
School of Psychology, University College Dublin.

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Research Team

This research was conducted by Dr. Jennifer Margaret Hayes and Dr. Gary O' Reilly.

Dr. Hayes is a Senior Psychologist with the Health Service Executive - South. She has a dual qualification in clinical psychology and in counselling psychology. Her main research and practice interests include the assessment and treatment of mental health difficulties amongst young people who engage in serious criminal conduct, breaking patterns of offending and enhancing the emotional competency of young people with mental health and offending difficulties. In December 2006 Dr. Hayes was the recipient of the Therese Brady Award as recognition of the importance of her research in this area.

Dr. Gary O' Reilly is a Senior Lecturer and the Deputy Director of the Doctoral Programme in Clinical Psychology at University College Dublin. He is also a Principal Clinical Psychologist at the Children's University Hospital, Temple Street, Dublin. His current research and practice interests include the development of effective interventions for young people who engage in criminal behaviour, the development of Cognitive Behavioural Interventions for children and adolescents, and human intelligence. He has co-edited a number of books including The Handbook of Clinical Intervention with Young People who Sexually Abuse (2004) and The Handbook of Intellectual Disability and Clinical Psychology Practice (2007) both published by Brunner-Routledge.

Dr. Hayes and Dr. O' Reilly share a commitment to the identification and promotion of effective and child centred assessment and intervention strategies that meet the psychological needs of this complex client group. They are committed to the provision of therapies that lead to a significant reduction in the frequency and severity of criminal conduct and significant mental health gains.

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suspect
case

Executive Summary

RESEARCH AIM

The aim of this research was to describe young people detained by the Irish State for engagement in serious criminal conduct across a number of psychological domains. These domains included, levels of criminality, psychological morbidity, cognitive functioning, trait emotional intelligence and ability emotional intelligence. This research also aimed to briefly identify family and school related factors associated with young people who have offending problems. To achieve this, their functioning was compared to that of young people referred to a psychiatry service and to that of young people from the general community who did not have offending or mental health difficulties.

KEY FINDINGS

Young people detained by the Irish State present with complex and debilitating psychological difficulties across a number of different domains.

CRIMINALITY

Levels of criminality amongst young people in detention in Ireland are very serious. Results showed that a total of three hundred and thirty five crimes led to the detainment of the thirty young people included in this research. About one in three boys in detention in Ireland are sentenced, at least partially, on the basis of at least one interpersonally violent crime. Other types of crimes included acquisitive crimes, property crimes, driving offences, failure to comply with Gardai / Court and other offences. Approximately two thirds of young people in detention will have been incarcerated in a different detention school at a different point in time. These findings suggest that levels of criminality amongst young people incarcerated in Ireland are very serious and are likely to pose significant monetary and psychological costs to victims, to the legal system and to society as a whole.

PERSONAL AND FAMILY CHARACTERISTICS

Young people in detention in Ireland come from criminalised families. The vast majority of detainees have at least one family member who has a criminal conviction (97%) and a family member who has served time in jail (90%). Young people who are in detention have a history of behavioural problems that manifested themselves in school. Truancy, school suspension and expulsion are characteristics associated with young people residing in detention schools.

PSYCHOLOGICAL MORBIDITY

Staff working in Irish detention schools should expect that approximately eight out of ten boys in their care will meet diagnostic criteria for at least one psychological disorder and that, for most of these boys, their mental health difficulties will be compounded by co-morbidity. On average, boys with mental health problems can be expected to experience

mately one-third of detainees will meet diagnostic criteria for a mood or anxiety disorder, two-thirds will experience an externalising / disruptive psychological disorder and that approximately two-thirds will meet diagnostic criteria for a substance related disorder.

The level of drug use among detainees is a matter of grave concern. Results suggest frequent use of a wide range of substances, which are first taken in childhood. On average, cannabis use begins at nine years of age for those with a dependency disorder and at ten years of age for those with a use disorder. The average age at which cocaine is first used by detainees with these abovementioned disorders are 13 and 14 years respectively. Results suggest that, despite their incarceration, these boys have continued access to alcohol and drugs, probably accessed through home leave, which maintains their dependency and use difficulties.

Staff in Irish detention centres can expect that at any given time approximately one in every five boys in their care will be experiencing suicidal ideation and that a similar proportion will have attempted to take their lives on at least one occasion in the past.

COGNITIVE FUNCTIONING

Over one fifth of detainees have full scale IQ scores in the intellectual disability range and detainees as a group can be expected to have lower cognitive abilities than have adolescents referred to a psychiatry service and adolescents without offending or mental health difficulties.

TRAIT AND ABILITY EMOTIONAL INTELLIGENCE

Irish detainees, when compared with adolescents who are without mental health and offending problems, were not found to have different levels of adaptability or total trait emotional intelligence. However, young people detained by the Irish State experience significantly lower levels of ability emotional intelligence than those of young people who do not have offending or mental health difficulties. Detainees possess a reduced ability to perceive emotions accurately, to use emotional information to facilitate thinking and a reduced ability to regulate emotions. Detainees experience similar deficits in emotional competence, to those of young people referred to a psychiatry service for mental health treatment.

RECOMMENDATIONS

There are a number of important policy development, service development and research implications stemming from the results of this research.

POLICY DEVELOPMENT

There is a need for policy development to ensure that the psychological needs of young people in detention are met during their period of incarceration. Policies should clearly specify the role that detention has in meeting the psychological needs of incarcerated youth. These policies should centre on the ethos that detention provides circumstances in which considerable opportunities for psychological treatment and rehabilitation could and should be exploited. Policies are also needed to set high standards that guide the types of assessment and treatment procedures implemented to address psychological need. Policy should highlight a commitment to evidence-based assessment and treatment approaches.

Policy development is also warranted to ensure that detention is viewed as an opportunity to assertively target factors that have contributed to a young person's criminality and to deconstruct factors that increase the likelihood of a young person re-offending following release. To achieve this effectively, policies which highlight the importance of evidence-based assessment and intervention methods for the assessment and treatment of criminality are required.

Policy development that highlights the important role of on-going empirical research is warranted. This will ensure that our understanding of the needs of young people in detention continues to improve. This in turn will lead to an improvement in service delivery and improve our ability to meet the psychological needs of young people who are incarcerated.

IMPLICATIONS FOR SERVICE DEVELOPMENT ASSESSMENT AND INTERVENTION TEAMS

The research findings detailed in this report show that young people in detention have serious levels of criminality, complex and debilitating psychological difficulties and deficits in IQ and in EI. To address these issues adequately requires the development of multi-disciplinary assessment and intervention teams. These teams should be lead by a senior clinician who is competent in the assessment, diagnosis and treatment of mental health problems amongst incarcerated young people. Teams should include input from clinical psychology, psychiatry, social work, family therapy, addiction counselling, probation and clinical nurse specialist.

IMPLICATIONS FOR ASSESSMENT

SCREENING

All detainees should be screened for the presence of psychological disorders and intellectual disabilities on entry to detention.

COMPREHENSIVE MULTI-DISCIPLINARY ASSESSMENT

Any youth identified as at risk of experiencing a mental health difficulty should receive a comprehensive, multi-disciplinary team assessment. This should follow best practice guidelines, result in a diagnosis and highlight key predisposing, precipitating, maintaining and protective factors associated with each youth's mental health difficulties. A formulation of each child's difficulties should lead to the development of evidence-based intervention programs.

Every youth identified through the screening process as at risk of experiencing an intellectual disability should receive a full diagnostic assessment which includes an evaluation of their

cognitive abilities and adaptive functioning. All youths, regardless of their mental health status require a comprehensive, evidence-based, multi-disciplinary assessment to identify factors associated with their offending behaviour. The identification of precipitating, predisposing, maintaining and protective factors should lead to a formulation of their criminal problems and lead to the development of an intervention program that aims to break patterns of offending behaviour.

RISK ASSESSMENTS

The findings highlighted in this report point to the need for specific psychological risk assessments on entry to a detention school. The aim of these assessments should be to estimate the level of risk of self-harm and / or the level of risk that the youth poses to harming others. Assessments are also required to determine risk associated with sudden discontinuation of illicit substances on entry to detention. This will ensure that substance withdrawal is both controlled and safe. Risk assessments should clearly specify the extent of risk and factors that can be targeted to reduce that risk. This information should then be used to guide interventions with a view to effectively reducing risk levels.

ASSESSMENT OF PSYCHOLOGICAL NEEDS PRIOR TO DISCHARGE

Each youth should be assessed prior to their discharge. This should aim to identify what steps are needed to ensure a seamless transition from structured life in detention to oftentimes a very unstructured and chaotic life post-release. Such assessments should also inform the identification of and referral to appropriate treatment services in the community and ensure continuity of care. Pre-release assessments should also aim to identify suitable educational or occupational placements within the context of each youths cognitive ability and personal strengths. The identification of risk factors that are likely to lead to exasperation of psychological difficulties and / or to reengagement in patterns of offending behaviour should also be identified. This information should lead to the development of appropriate interventions which serve to support each young person following their release.

REASSESSMENT

Regular reassessment is required throughout each youth's period of detainment, especially in times of increased stress. This will ensure that appropriate changes to each child's intervention program are made in accordance with fluctuations and changes in their mental health needs.

IMPLICATIONS FOR TREATMENT

PSYCHOLOGICAL DISORDERS

The results of multi-disciplinary team assessments should inform the development of multi-disciplinary intervention programs. Evidence-based therapies that have been scientifically shown to reduce criminality and to reduce psychological difficulties are the interventions that should be delivered to young people. There is a large body of scientific evidence which supports the effectiveness of specific therapeutic approaches for specific psychological disorders. This empirical literature should be used to ensure that effective therapeutic interventions are delivered to young people in detention schools. Therapeutic approaches should be individually tailored to each youth's level of emotional and cognitive competence.

INTELLECTUAL DISABILITIES

The development of specially designed educational and intervention programs is required to meet the needs of young people with intellectual disabilities who reside in detention schools. Additional supports from special educators and psychologists are also required in conjunction with supports to safeguard the rights of young people with an intellectual disability.

SKILLS BASED INTERVENTION PROGRAMS

A number of evidence-based interventions should be automatically delivered to all youths in detention. Evidence-based interventions that improve anger management skills, relaxation skills and cognitive thinking skills should be delivered. Skills based programs to increase emotional competence should also be developed and delivered to every young person in detention.

STAFF TRAINING / PSYCHOEDUCATION

Staff training and psychoeducation should be delivered to help staff recognise symptoms of psychological disorders and to understand the interplay between psychological difficulties and a youth's behaviour. Training to support staff in implementing strategies that will assist youths to manage their problems is warranted. Staff training on how best to manage difficult and stressful situations that arise as a result of a young person's emotional and behavioural problems is also needed. In addition, psychoeducation on intellectual disabilities and the management of problems associated with cognitive deficits is warranted.

IMPLICATIONS FOR EARLY IDENTIFICATION / PREVENTION

Early identification of youth who are at risk of becoming involved and entrenched in patterns of offending behaviour is important. All youths who come to the attention of Gardaí as first time offenders should be referred to community care psychology services for psychological assessment and intervention. Pupils who engage in truancy and display repeated behavioural difficulties in school should be referred by school principals to community care psychology services for assessment and intervention.

IMPLICATIONS FOR SERVICE MONITORING AND EVALUATION OF SERVICE PROVISION

Systems that evaluate the effectiveness of assessment and intervention procedures and that lead to audits of the mental health services provided to young people in detention are required. This will ensure that the psychological needs of children are being met effectively and that services are cost-effective.

IMPLICATIONS FOR RESEARCH

YOUNG PEOPLE ON THE CUSP OF CRIMINALITY

In the interest of early intervention and prevention, empirical research is required to identify the psychological needs of young people who are on the cusp of involving themselves in criminality. Research is needed to describe the function of such behaviour, to identify the factors that are likely to precipitate and maintain criminal behaviour and to analyse of the psychological needs of such youths and their families. This will inform the development and delivery of community based interventions that are effective in reducing offending problems in the community.

FAMILY CHARACTERISTICS

A comprehensive empirical research project that describes the family characteristics of young people who are in detention is needed. Identifying important family characteristics that are associated with a youths offending and mental health problems will guide and inform the assessment and treatment of young people with offending problems within the context of their families.

EMOTIONAL COMPETENCY

The development of skills based EI skills programs are needed. This research should include an evaluation of the efficacy of such program in increasing the emotional competency of young people who are incarcerated.

Acknowledgements

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• Mary Keating and Elizabeth Harte.

CHAPTER ONE

Methodology

SUMMARY

This chapter describes the methodology used in the current research. A description of the participants constituting the main index group and the two comparison groups is provided. The instruments used for the data collection, the procedure availed of to gather the data, data management and statistical analyses are described also.

PARTICIPANTS

Eighty people took part in this research. Thirty participants were adolescent males residing in juvenile detention schools in Ireland (Ferryhouse, n=4; Oberstown, n=4, Trinity House, n=14, Finglas Child and Adolescent Centre, n=8). These boys constituted the Offender Group. The rate of participation across detention centres ranged from 33% to 87%.

Twenty participants were teenage boys who were awaiting an initial appointment or in the early stages of assessment with an adolescent psychiatry service in the Health Services Executive - South (Mental Health Group). The remaining 30 participants were regular teenage boys in the general community who did not have offending or mental health problems (Control Group). There was no significant difference in the ages of participants across the three groups.

THE OFFENDER GROUP

On average young people in the offender group were 14.9 years of age. All boys had been sentenced to serve time in detention as a result of criminal convictions. A total of 335 charges led to the period of detention being served by participants at the time of data collection. On average each respondents had 11 charges each, however, the number of offences per participant ranged from one to sixty. At the time of data collection participants had been detained, on average, for 314.5 days. A total of 76.7% of boys included in this research reported being detained on at least one other occasion.

THE MENTAL HEALTH GROUP

Twenty consecutive referrals of teenage boys to a psychiatry service in the Health Services Executive – South (HSE-S) constituted the Mental Health Group. Eleven youths were awaiting an initial appointment and nine were in the early stages of assessment. Participants were on average 14.6 years of age. Fifteen boys were referred to the psychiatry service by general practitioners (75%), two by social workers (10%) and the remainder by other professionals (15%). The reasons for referral were anxiety problems (20%, n = 4), behavioural / conduct problems (20%, n = 4), adjustment difficulties (15%, n = 3), emotional problems (15%, n = 3) attention and / or hyperactivity problems (10%, n = 2), mood problems (10%, n = 2) and other problems (10%, n = 2).

THE CONTROL GROUP

Thirty boys from the general community formed The Control Group. These boys were recruited from a secondary school in Co. Cork and were on average 15.3 years of age. Individuals experiencing emotional or behavioural difficulties were identified through the administration of the Youth Self-Report and their data was excluded from further analyses. Likewise the data pertaining to any boy who reported in the demographic questionnaire that they had ever been arrested or had been to court on foot of a criminal charge was excluded from further analyses. Data from five participants was excluded in total. This process enabled a clearer understanding of the relationship between emotional intelligence, mental health problems and criminality amongst the three groups of participants.

INSTRUMENTS

The following instruments were used for data collection:

1. The Diagnostic Interview Schedule for Children (DISC-IV; National Institute for Mental Health, 2000).
2. Emotional Quotient Inventory: Youth Version, Short (EQ-I: YV: BarOn & Parker, 2000).
3. The Mayer Salovey Caruso Emotional Intelligence Test: Youth Version (MSCEIT: YV: Mayer, Salovey & Caruso, May 2, 2006).
4. Wechsler Abbreviated Scale of Intelligence (WASI; Wechsler, 1999).
5. Youth Self Report (YSR; Achenbach & Rescorla, 2001)
6. Demographic Questionnaire.

THE DIAGNOSTIC INTERVIEW SCHEDULE FOR CHILDREN VERSION-VI (DISC-IV; NIMH, 2000)

The DISC-IV is a structured diagnostic interview that was used to diagnose psychiatric disorders in the Mental Health and Offender Groups. The DISC-IV is administered with a computer and is designed to assess the presence of 32 specified psychiatric disorders that occur in children and adolescents aged between nine and 17 years. It is based on the Diagnostic and Statistical manual – Version IV (DSM-IV; APA, 2000) and on the International Classification of Diseases (ICD-10; WHO, 1992) classification systems.

The complete DISC-IV contains approximately 3000 items. Three hundred and fifty eight of these are "stem" questions and, as such, are asked of every respondent. Stem questions outline the essential features of a psychological diagnosis in very broad terms. A positive endorsement of a stem question leads to a contingent question. There are 1,300 contingent questions in the DISC-IV. These determine whether an endorsed stem symptom meets the frequency, duration and intensity criteria required for an ICD-10 or DSM-IV diagnosis to be made. There are 732 questions relating to the age of onset, impairment and treatment of symptoms. These are asked when stem and contingent questions result in a clinically significant result.

The DISC is the most extensively tested and widely used child and adolescent diagnostic interview for young people (Wasserman et al., 2004). It has been used in large scale, Irish regional epidemiology studies (Martin and Carr, 2006), in treatment-outcome studies (Hinshaw et al., 1997), and in determining the therapeutic services required to meet psychiatric need in residential care facilities (Friman, 1999; McDonald, 1998). It has also been used in research that determined levels of psychiatric difficulty in young offenders detained in the United States (Garland et al., 2001; Wasserman et al., 2002). The DISC-IV is the screening tool recommended for use by the Centre of the Promotion for Mental Health in Juvenile Justice for all newly detained juveniles in the United States (Wasserman et al., 2003).

THE MAYER SALOVEY CARUSO EMOTIONAL INTELLIGENCE TEST: YOUTH VERSION (RESEARCH VERSION) (MSCEIY: YV); MAYER, SALOVEY AND CARUSO, MAY 2, 2006)

The MSCEIT: YV (research version) was utilised in the current research to determine the levels of ability emotional intelligence amongst participants in all three groups. The MSCEIT: YV is currently being developed by Mayer, Salovey and Caruso as a measure of emotional intelligence in children and adolescents aged between 10-17 years. The MSCEIT:YV is based on the theory of emotional intelligence described by Mayer and Salovey (1997) and the test is similar to the adult measure for ability emotional intelligence (MSCEIT).

Similar to the MSCEIT, the youth version of this measure is a paper and pencil test. It contains 184 items, completion of which yields a total emotional intelligence score. This score is comprised of two area scores, namely, experiential emotional intelligence score and strategic emotional intelligence score. The experiential emotional intelligence score consists of two branch scores; perceiving emotions score and facilitating thought score. The strategic emotional intelligence score is also comprised of two branch scores, understanding emotions score and managing emotions score.

No fully developed, ability-based measures of emotional intelligence for children and adolescents exist to date and the MSCEIT:YV was sourced for the present study prior to its commercial publication. The successful pre-publication acquisition and inclusion of the MSCEIT:YV (May 2, 2006) in this research provided an opportunity to avail of a cutting edge tool in this field of study.

Validity and reliability studies relating to the MSCEIT:YV are currently under development and are not yet available. The MSCEIT, however, has good internal consistency (Mayer, Salovey & Caruso, 2003) and excellent split-half reliability (Mayer, Salovey & Caruso, 2003).

THE BARON EMOTIONAL QUOTIENT INVENTORY (EQ-I: YV, BARON AND PARKER, 2000).

The EQ-i:YV was chosen for use in the current research as a measure of trait emotional intelligence for participants in the three groups. The EQ-I: YV is based on the theory of trait emotional

intelligence described by BarOn (1997) and represents the gold standard assessment tool for research on trait emotional intelligence.

It assesses self-reported levels of Trait Emotional Intelligence in children and adolescents ranging from 7-18 years of age. The short version of this self-report instrument consists of 24 items presented in a four-point Likert-style response format. Participants are asked to read each item and rate how accurately it describes them. The response options are "very seldom true of me", "seldom true of me", "often true of me" and "very often true of me". The scale consists of four subscales, namely, "Interpersonal Scale", "Intrapersonal Scale", "Adaptability Scale" and "Stress Management Scale". These subtests are combined together to form a Total Emotional Intelligence score. Higher scores on subtests reflect higher emotional intelligence. Administration time is approximately 10 minutes. The EQ-I: YV has good to excellent reliability and good validity (BarOn and Parker 2000).

WECHSLER ABBREVIATED SCALE OF INTELLIGENCE (WASI; WECHSLER, 1999)

The Wechsler Abbreviated Scale of Intelligence (WASI; Wechsler, 1999) was included in the present study to measure cognitive ability amongst participants in all three groups. The WASI is an abbreviated intelligence test for people aged between six and 89 years of age. It parallels the Wechsler Intelligence Scale for Children (third edition) (WISC-III; Wechsler, 1999) and the Wechsler Adult Intelligence Scale (WAIS-III; Wechsler, 1997) and yields Verbal (VIQ), Performance (PIQ) and Full Scales IQ (FSIQ) scores. Vocabulary and similarities subtests make up the verbal scales and block design and matrix reasoning comprise the performance scale. The WASI has excellent validity and reliability (Wechsler, 1999).

THE YOUTH SELF REPORT (YSR; ACHENBACH & RESCORLA, 2001)

The YSR was utilised in the current research to identify and screen out unsuitable participants (those with a mental health difficulty) in the Control Group. The YSR is a self-report likert style questionnaire that detects emotional and behavioural problems in children aged between 11 and 18 years. The YSR contains 112 items. Respondents are asked to rate how accurately each item describes them on a three point scale ranging from 'not true' to 'sometimes true' to 'often true'. The instrument yields three subscales; comprising of a 'total problems scale', an 'internalising scale', and an 'externalising scale'. There are nine syndrome / DSM-Oriented Scales including the 'anxious / depressed scale', the 'withdrawn / depressed scale', the 'somatic complaints scale', 'social problems scale', the 'thought problems scale', the 'attention problems scale', the 'rule-breaking behaviour scale', the 'aggressive behaviour scale' and the 'other problems scale'. Three Competency Scales also from part of the YSR and include the 'activities scale', the 'social scale' and the 'academic scale'. This instrument has excellent reliability and validity (Achenbach & Rescorla, 2001).

DEMOGRAPHIC QUESTIONNAIRE

A demographic questionnaire was administered to all participants to elicit information about each child's personal characteristics and those of each child's family.

INDEX OF CRIMINALITY

An index of each boy's offending difficulties in The Offender Group was obtained by recording the offences leading to each boy's current detention period. This was obtained by reviewing each child's official court charge sheets.

PROCEDURE

Ethical approval was sought and granted from the HSE-S. Permission to conduct the research was sought and granted from the Directors and Boards of Management at each of the participating detention schools and from the school in Co. Cork where participants forming the Control Group were recruited. Informed consent was obtained from all participants and from their parents.

Each young person in The Offender and Mental Health Groups met with the researcher between 4-10 times for approximately 45-minute periods during which the DISC-IV, WASI, MSCEIT:YV, EQi:YV and the demographic questionnaire were administered. Because literacy difficulties are extremely prominent in a young offender population, the researcher read out each item on each instrument to every participant in the Offender and Mental Health groups and she recorded responses for them. Feedback sheets outlining each boy's results were compiled. Feedback sheets and verbal feedback relating to boys in The Offender Group were given to each boy's key worker and / or senior management. Feedback sheets and verbal feedback pertaining to boys in The Mental Health Group were given to staff working in the participating psychiatry service. Verbal feedback was offered to boys in both groups about their own individual results.

The WASI, MSCEIT:YV, EQi:YV and YSR were administered to all participants in The Control Group. All boys were offered written and verbal feedback on their own individual results. The parents of boys identified as experiencing clinically significant difficulties were contacted and offered verbal and written feedback.

DATA MANAGEMENT

All data were entered, verified and analysed using Statistical Procedures for Social Sciences (SPSS) Version 11. Raw data were recoded and totals computed as per questionnaire instructions. Internal reliability (Cronbach's Alpha) was calculated for each measure. Descriptive statistics were calculated for levels of criminality. Chi-square analyses were used to compare The Offender and Mental Health Groups on a number of variables thought to describe personal and family characteristics of young people with offending difficulties.

T-tests and chi-squared analyses were availed of to compare rates of psychological difficulty between The Offender Group and The Mental Health Group.

A series of multivariate analyses of variance (MANOVA) were conducted to explore whether significant differences existed between The Offender, Mental Health and Control Group on traditional intelligence, trait emotional intelligence and ability emotional intelligence. There were minor fluctuations in the number of individuals included in each analysis due to missing data. The sample size included in each analysis is, therefore, specified for each analysis. Results from these analyses are reported in detail in the Chapters Two to Six.

CHAPTER TWO

Levels of Criminality

SUMMARY

The aim of the analyses reported in this chapter was to determine levels of criminality amongst young people residing in detention schools in Ireland. The results show that levels of criminality amongst young people in detention are very serious.

LEVELS OF CRIMINALITY

Table 2.1 specifies the crimes constituting each category, the number of participants with charges for each crime and the total number of charges within each category. Histogram 2.1 provides a graphical representation of the number of offences perpetrated in each crime category.

Results show that participants committed acquisitive crimes most frequently. A total of 123 acquisitive charges were held by 25 of the 30 participants. One hundred and fourteen charges relating to property crimes were shared between 21 participants in The Offender Group. Thirty two charges relating to Driving Offences were held by nine participants and 23 charges relating to violent interpersonal offences had been accumulated by 12 individuals. Seven participants had a total of 13 charges in the failure to comply with a Garda / court category. Eleven participants had 29 charges in other crimes.

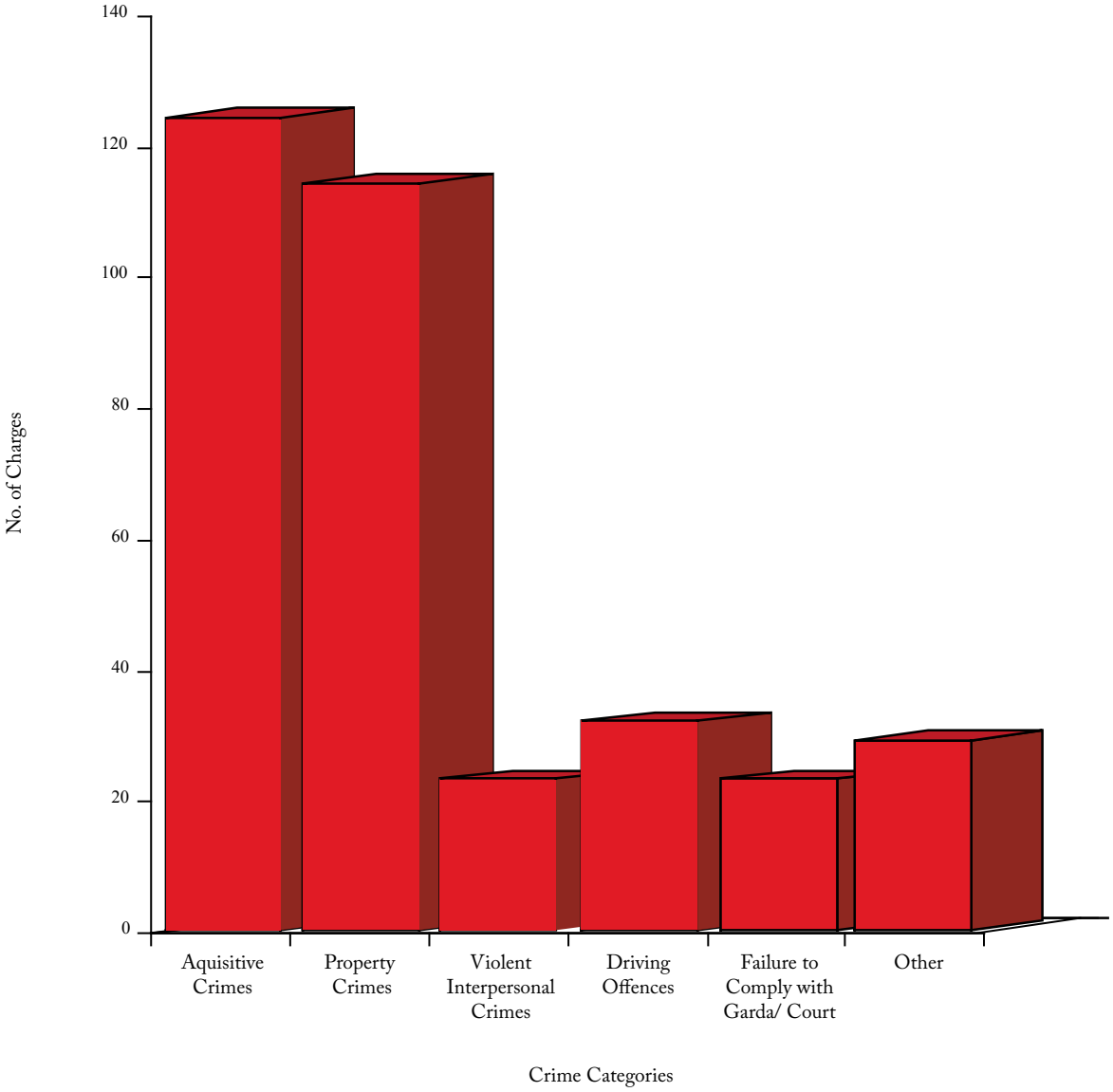
Table 2.1. Summary and Overview of The Number and Types of Crimes Committed by Participants.

Crime Category	*Number of Individuals	Total Number of Crimes
1. Acquisitive Crimes	**25**	**123**
Theft	15	83
Car Theft	5	18
Larceny	5	11
Handling Stolen Property	5	5
Burglary	3	5
Attempt to Steal	1	1
Robbery	1	1
2. Property Crimes	**21**	**114**
Criminal Damage	10	54
Trespassing	11	46
Damage to Property	3	8
Malicious Damage	4	5
Arson	1	1
3. Violent Interpersonal Crimes	**12**	**23**
Assault	9	12
Carrying / Possession of a Weapon	2	3
False Imprisonment	1	2
Threatening Behaviour	2	2
Sexual Assault	1	1
Rape	1	1
Violent Behaviour	1	1
Armed Robbery	1	1
4. Driving Offences	**9**	**32**
Dangerous / Reckless Driving	3	10
Passenger in a Stolen Car	5	8
Driving Without a Licence	2	5
Driving a Car Without Permission	3	4
Driving Without Insurance	2	3
Joyriding	1	1
Failure to Stop for a Garda	1	1
5. Failure to Comply with Gardai / Court	**7**	**13**
Failure to Appear in Court	4	10
Failure to Comply with Garda Instruction	2	2
Giving a False Name and Address	1	1
6. Other Offences	**11**	**29**
Breach of the Peace	9	19
Absconsion	3	7
Reckless Conduct	1	1
Intoxicated in a Public Place	1	1
Possession of a Controlled Substance	1	1

**Note: The overall total number of individuals in the seven crime categories is less than the total number of individuals within each subcategory as most individuals had more than one charge.*

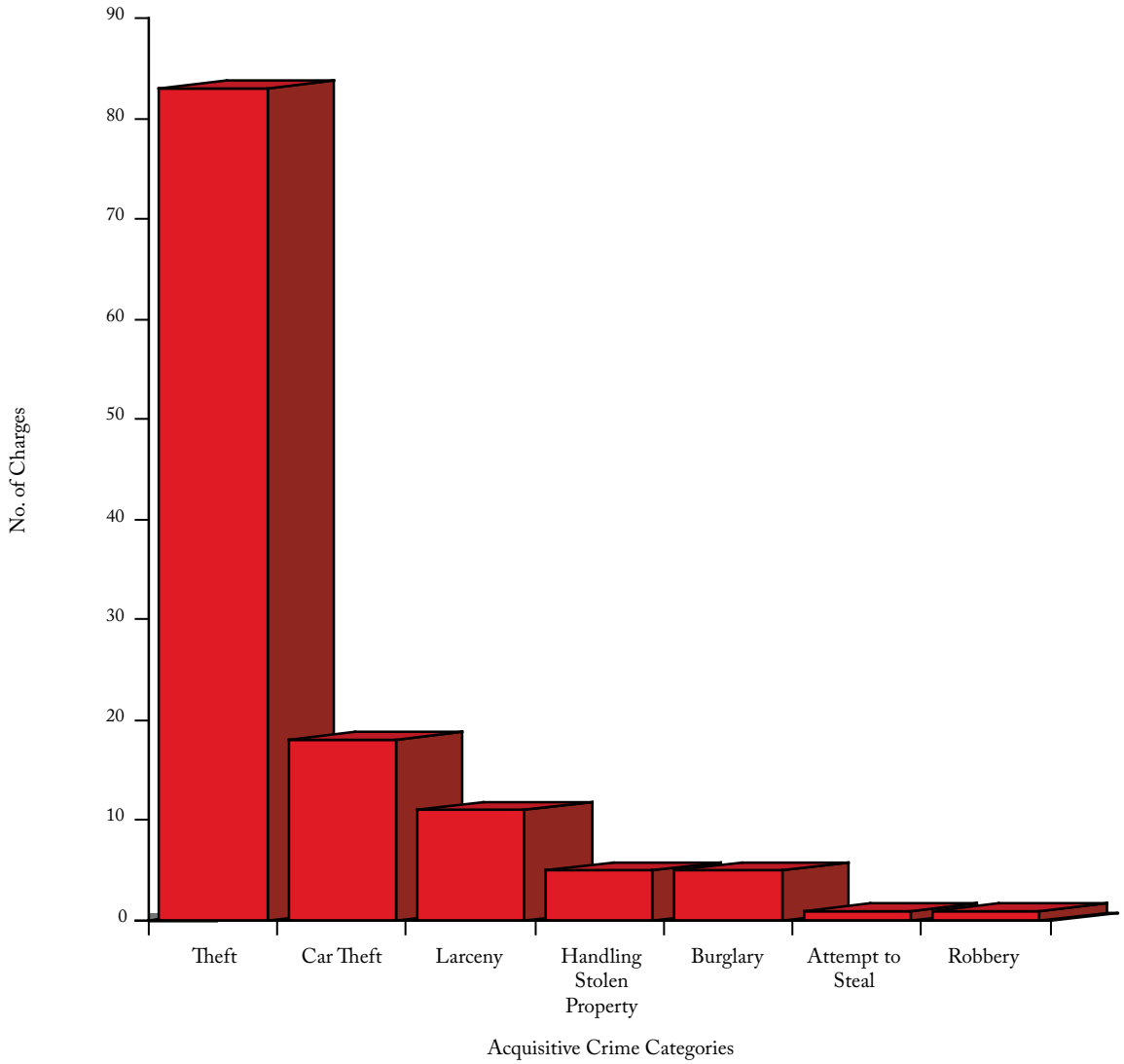
Histogram 2.1.

The Total Number of Charges Within Each Crime Category.



Histogram 2.2.

The Total Number of Charges in Offences Constituting The Acquisitive Crimes Category.

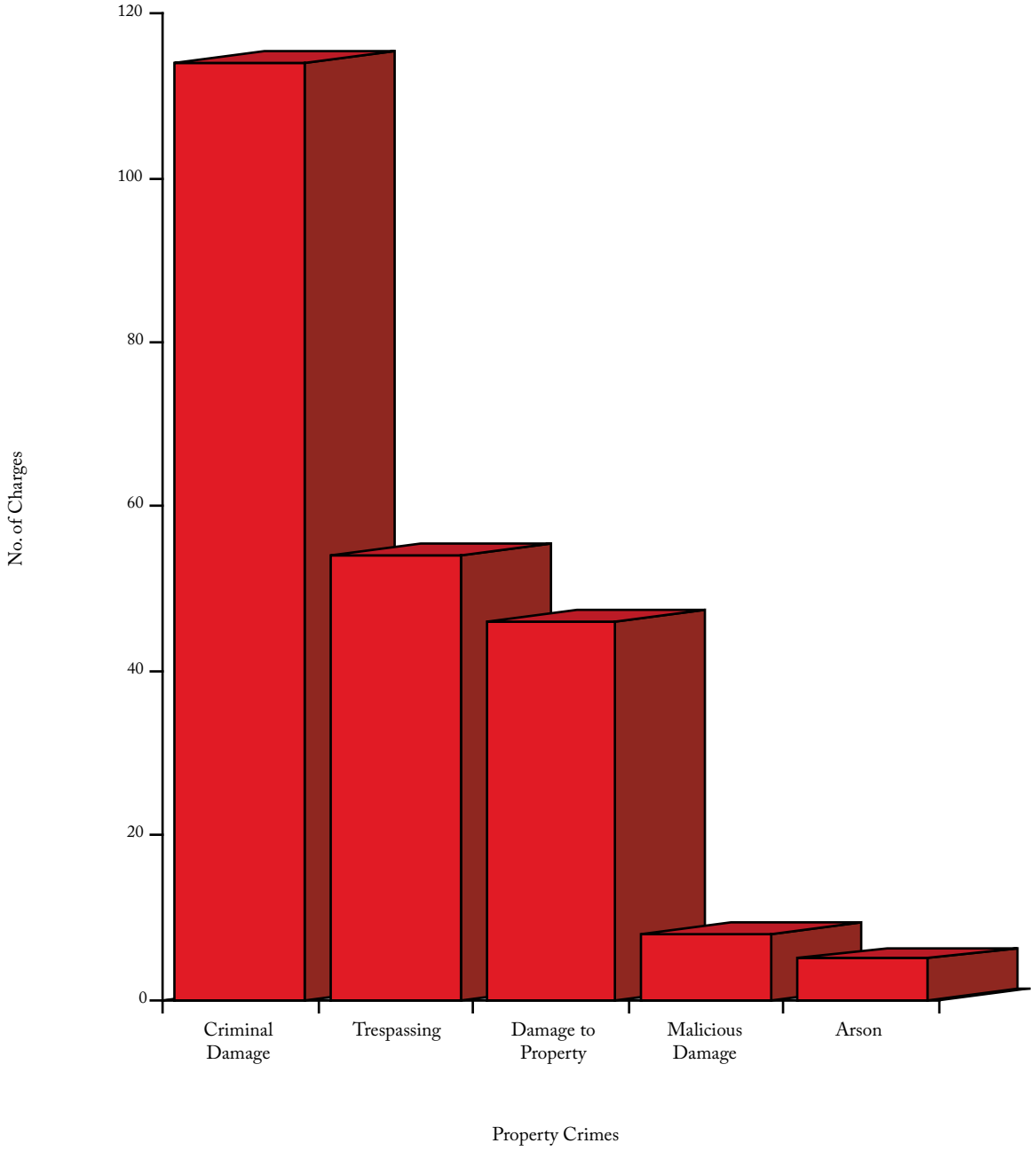


ACQUISITIVE CRIMES

A total of 123 charges within the Acquisitive Crimes Category were brought against 25 participants. There were 83 charges of 'theft' (n = 15), eighteen charges of 'car theft' (n = 15), 11 'larceny' charges (n = 5), five charges of 'handling stolen property' (n = 5), five 'burglary' charges (n = 3) and single charges of 'attempting to steal' (n = 1) and of 'robbery' (n = 1).

Histogram 2.3.

Charges For Offences in The Property Crimes Category.

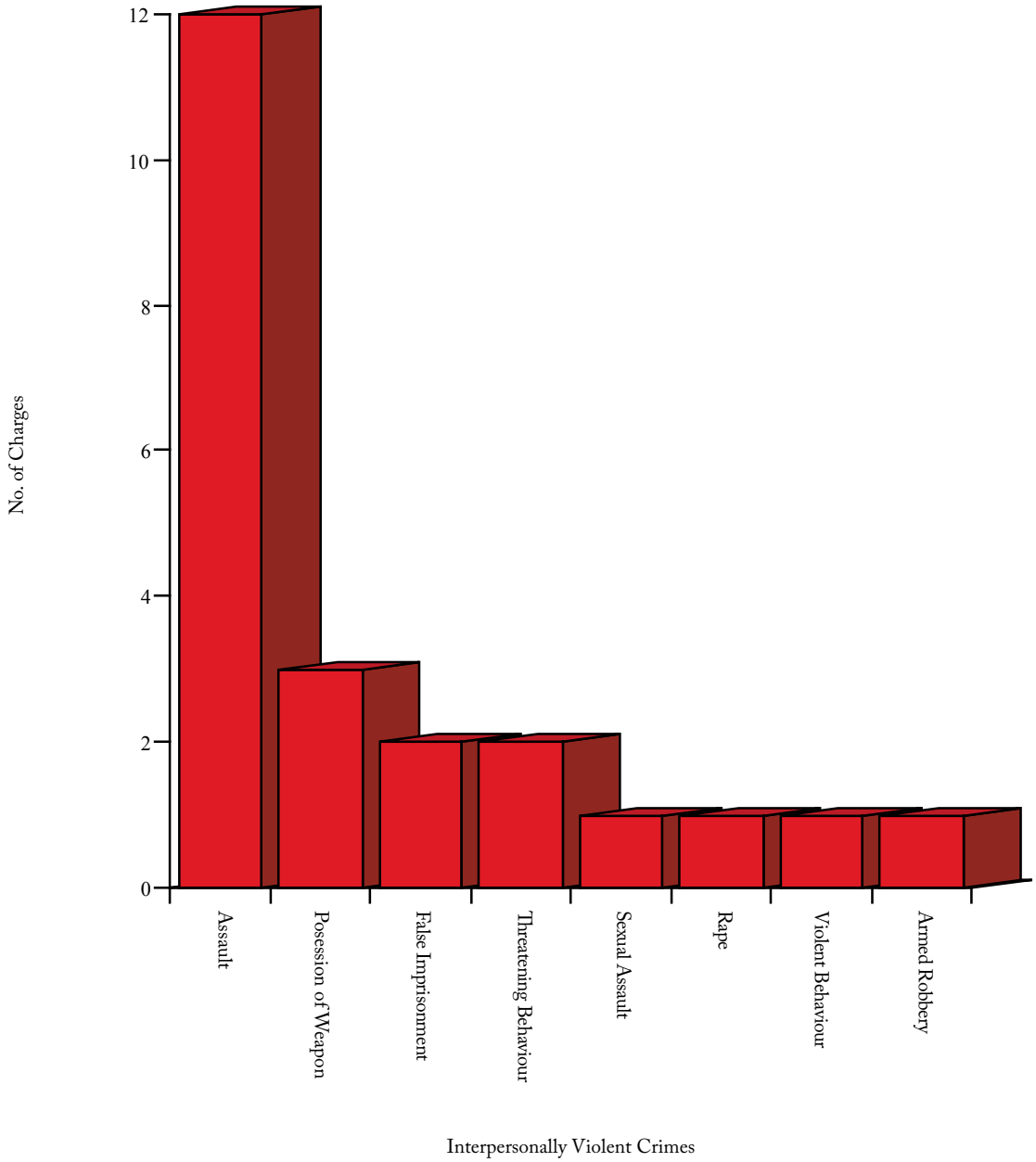


PROPERTY CRIMES

A total of 114 charges in the property crimes category were held by 21 participants. There were 54 counts of 'criminal damage' (n = 10), 46 charges of 'trespassing' (n = 11), eight charges of 'damage to property' (n = 3), five counts of 'malicious damage' (n = 4) and a single charge of 'arson' (n = 1).

Histogram 2.4.

Charges For Crimes in The Interpersonally Violent Crimes Category.

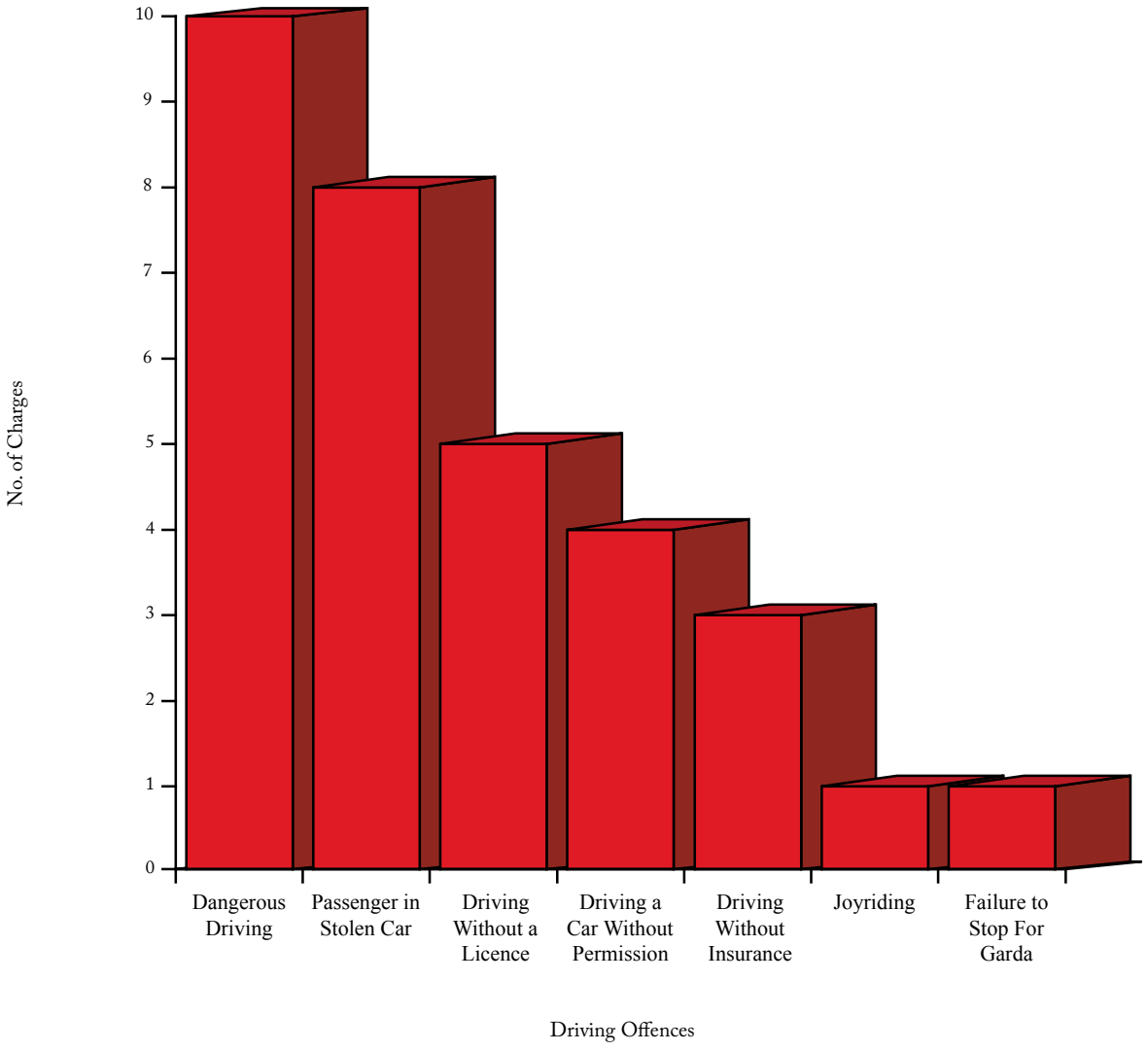


INTERPERSONALLY VIOLENT CRIMES

Twelve participants carried out a total of 23 interpersonally violent crimes. These offences included 12 charges of 'assault' (n = 9), three charges of 'carrying / possession of a weapon' (n = 2), two charges of 'threatening behaviour' (n = 2), two charges of 'false imprisonment' (n= 1) and one charge each of 'sexual assault' (n = 1), 'rape' (n = 1), 'violent behaviour' (n = 1), and 'armed robbery' (n = 1).

Histogram 2.5.

Charges For Crimes in The Driving Offences Category.

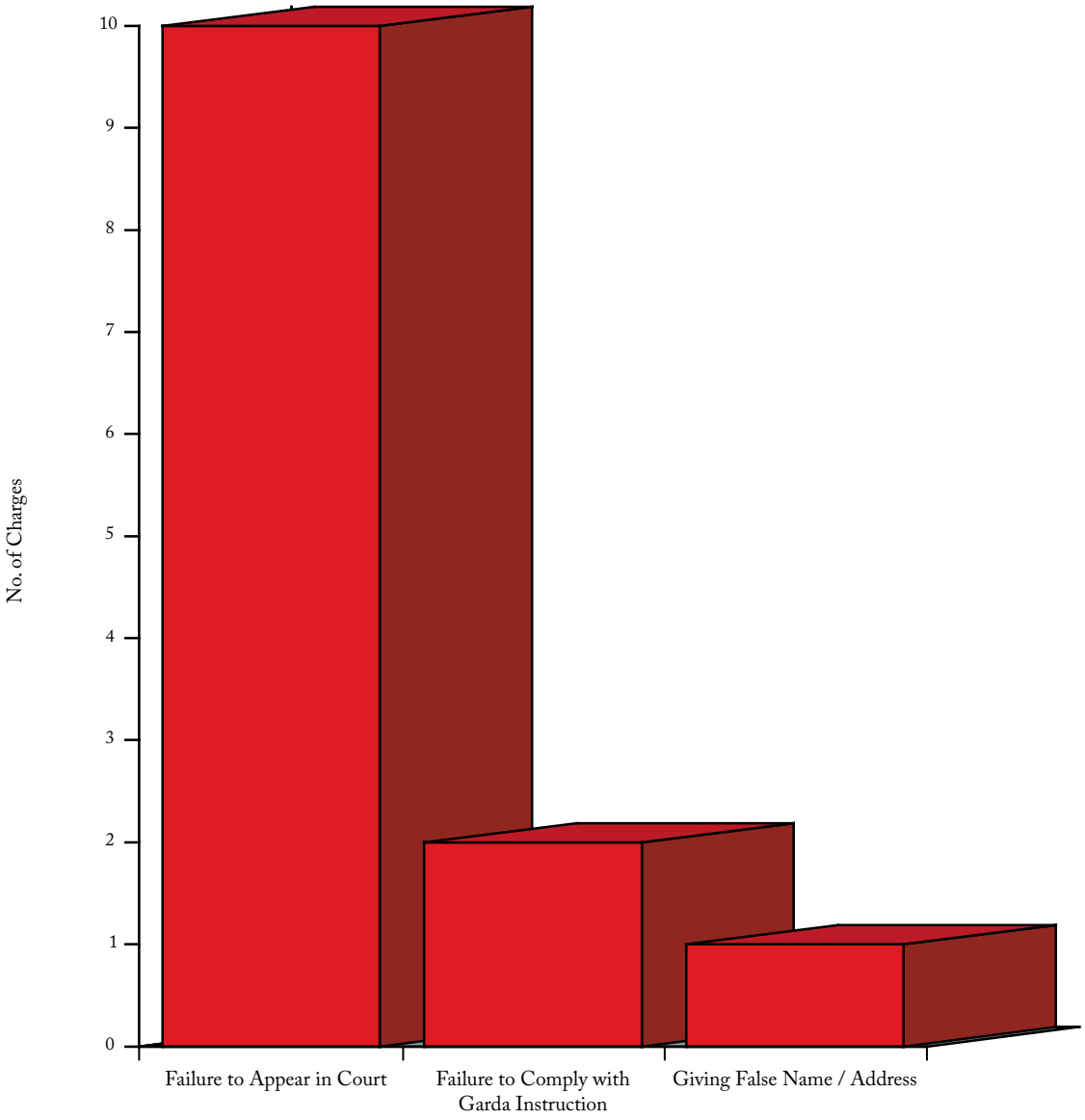


DRIVING OFFENCES

A total of 32 charges were brought against nine boys for crimes categorised as driving offences. These offences included ten charges of 'dangerous / reckless driving' (n = 3), eight counts of 'passenger in a stolen car' (n = 5), five charges of 'driving without a licence' (n = 2), four counts of 'driving a car without permission' (n = 3), three charges of 'driving without insurance' (n = 2) and single charges of 'joyriding' (n = 1) and 'failure to stop for a garda' (n = 1).

Histogram 2.6.

Charges Associated With A Failure to Comply With The Garda and/or The Courts.

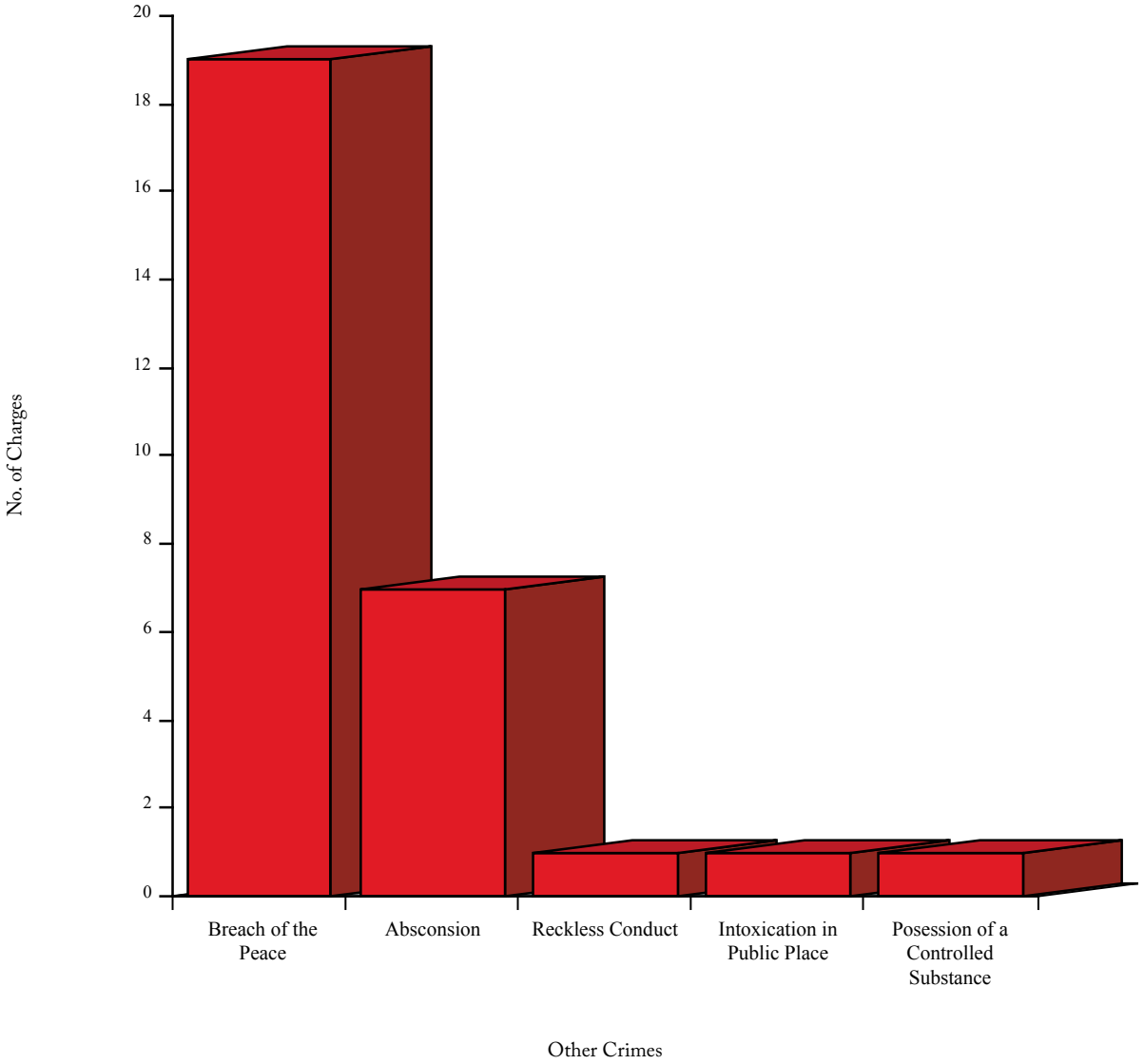


FAILURE TO COMPLY WITH GARDA / COURTS

Thirteen charges for failing to comply with the gardaí and / or the Courts were accumulated by a total of seven participants. These charges included ten counts of 'failure to appear in court' (n = 4), two charges of 'failure to comply with garda instruction' (n = 2) and a single charge of 'giving a false name / address to a garda' (n = 1).

Histogram 2.7.

Charges in The Other Crimes Category.



OTHER CRIMES

Twenty eight charges in the other crimes category were held by a total of eleven participants. These offences included 19 charges of 'breach of the peace' (n = 9), seven charges of 'absconsion' (from place of detention) (n = 3) and single charges of 'reckless conduct (n = 1) and 'intoxication in a public place' (n = 1). Only one boy was charged with a single drug related charge, which was 'possession of a controlled substance'. As will be seen in Chapter Four, this single charge is in contrast with the high levels of substance disorders prevalent within the sample.

CONCLUSIONS

The results show high levels of criminality amongst young people residing in detention schools in Ireland. The monetary, social and legal costs of these crimes is likely to be substantial. High rates of interpersonally violent crimes support the view that the level of criminality amongst youth in detention in Ireland is very serious. The results of this research suggest that one in three boys in detention had at least one charge relating to interpersonally violent crime. The nature of the interpersonally violent offences detected is a matter of grave concern. The charges included, assault, false imprisonment, sexual assault, rape, violent behaviour and armed robbery. It is likely that these offences had substantial psychological, psychosocial and monitory costs to the victims involved and resulted in substantial costs to society and to the legal system.

A number of specific findings relating to the charges held by participants require special attention. The finding that only one boy held a substance related charge (possession of a controlled substance) is incongruent with the very high rates of substance related disorders identified in the sample and described in Chapter Four. One possible explanation for this finding is the difficulty highlighted by An Garda Siochana (2005) in apprehending and successfully prosecuting individuals who commit drug related crimes.

The fact that nobody in The Offender Group held an alcohol related charge is also unusual, in light of the high rates of alcohol use and alcohol dependency identified and described in Chapter Four. These findings cannot be explained by a difficulty in apprehending young people for alcohol related charges, because 20% of the young people referred to the Juvenile Diversion Project in 2004 held such charges (An Garda Siochana, 2005). A possible explanation is that, in the cases of young people who are serious or repeat offenders, Gardaí pursue more serious offences rather than more minor drinking related charges.

CHAPTER THREE

Personal and Family Characteristics

SUMMARY

This chapter describes and compares the characteristics of young people in detention in Ireland to those of young people referred to a psychiatry service and to young people without offending or mental health difficulties. Results show that young people in detention have different family histories relating to offending behaviour and school related difficulties than their counterparts in the other groups.

CHARACTERISTICS OF YOUNG PEOPLE IN DETENTION SCHOOLS IN IRELAND

Table 3.1. Characteristics of young people in detention schools in Ireland.

Variable	Offender Group G1 n = 30	Mental Health Group G2 n = 20	Control Group G3 n = 30	X^2
Young person previously detained in a detention school other then the youth's current placement				
Previously detained				
Yes	23 (76.7%)	N/A	N/A	
No	7 (23.3%)			
Immediate / Extended Family History of Offending Behaviour				
Family member with a criminal conviction				
Yes	29 (96.70%)	6 (31.60%)	2 (6.70%)	$X^2 = 51.14^{***}$
No	1(3.30%)	13 (68.40%)	28 (93.30%)	
Family member who served a jail sentence				
Yes	27 (90.00%)	1 (5.30%)	0 (0.00%)	$X^2 = 63.60^{***}$
No	3 (10.00%)	18 (94.70%)	30 (100.00%)	
History of School Problems				
Sent to principal's office for bad behaviour				
Yes	21 (96.70%)	8 (42.70%)	6 (20.00%)	$X^2 = 37.08^{***}$
No	1 (3.30%)	11 (57.90%)	24 (80.00%)	
History of truancy				
Yes	25 (83.30%)	2 (10.50%)	11 (36.70%)	$X^2 = 27.24^{***}$
No	5 (16.70%)	17 (89.50%)	19 (63.30%)	
Suspended from school				
Yes	29 (96.70%)	6 (31.60%)	2 (6.70%)	$X^2 = 51.14^{***}$
No	1 (3.30%)	3 (68.40%)	8 (93.30%)	
Repeated a year in school				
Yes	10 (33.30%)	8 (42.10%)	1 (3.30%)	$X^2 = 11.85$
No	20 (66.70%)	11 (57.90%)	29 (96.70%)	
Received additional help with reading in school (either alone or with a small group of peers)				
Yes	15 (50.00%)	7 (36.80%)	2 (6.70%)	$X^2 = 13.81^{***}$
No	15 (50.00%)	12 (63.20%)	28 (93.30%)	

*Note: X^2 = derived from chi square test, * sig. at p < .05, **sig at p <.01 level, *** sig. at p < .001 ; n = number of participants.*

HISTORY OF OFFENDING BEHAVIOUR

Seventy seven percent of young people in The Offender Group reported that they had been previously detained in at least one other detention school, other than their current placement. Members of The Offender Group were significantly more likely to have an immediate and/or extended family member with a criminal conviction. Ninety seven percent of this group reported that this was the case. The opposite was true of The Control Group. They were significantly more likely to report that an immediate and/or extended family member did not have a criminal conviction. No significant association was found between The Mental Health Group and convictions among family members.

In addition, members of The Offender Group were significantly more likely to report that a family member had served time in jail, with 90% of participants reporting that this was the case. These results suggest that the convictions held by family members belonging to the young people in The Offender Group were sufficiently serious for 90% to serve custodial sentences. The Mental Health and Control Groups, on the other hand, reported that 94.7% and 100% respectively did not have a family member who served time in jail.

HISTORY OF SCHOOL PROBLEMS

Significantly more participants (96.7%) in The Offender Group reported that they were sent to the school principal's office for bad behaviour in the past than those who were not (3.3%). There was no significant association between The Mental Health Group and a history of being sent to the school Principal's office. Participants in the Control Group, on the other hand, were significantly more likely to report that they had never been sent to the principal's office for bad behaviour.

Truancy was significantly associated with The Offender Group, with 83.3% reporting that they had been truant from school in the past. The Mental Health Group were significantly more likely to report that they had not engaged in truancy, whereas there was no significant association with truancy and The Control Group.

Significantly more respondents in The Offender Group (96.7%) reported that they had been suspended from school in the past than those who did not. Participants in The Control Group, however, were significantly more likely to report that they had never been suspended. No significant association was noted between school suspension and The Mental Health Group.

Young people in The Offender Group were significantly more likely to report being expelled from school (86.7%) than not. The opposite was true of The Control and Mental Health Groups, 100% and 89.5% of whom reported respectively that they had never been expelled from school.

Participants in The Control Group were significantly more likely to report that they did not repeat a year in school (97.6%). However no significant associations were found between this variable and membership of the other two groups. Members of The Offender Group were more likely to report that they received extra tuition to support reading attainment in school (50%) than not. However, the opposite was true of The Control Group and there was not a significant association between reading support and membership of The Mental Health Group.

CONCLUSIONS

Young people detained for criminal conduct in Ireland have a number of significant family and school related characteristics that are not found amongst young people referred to a psychiatric service or amongst young people from the general community who do not have offending or mental health difficulties. Young people in detention come from criminalized families. It can be expected that over two thirds of young people in detention will have served time in a different detention school at another point in time. Furthermore, virtually all young people in detention will have a family member who holds a criminal conviction and at least one family member who has served time in jail. These family characteristics are not true of young people referred to a psychiatry service or young people from the general community who do not have offending or mental health problems. Young people in detention are likely to have a history of behavioural problems that manifested themselves in school. A history of truancy, school suspension and expulsion are all characteristics associated with young people in detention.

CHAPTER FOUR

Psychological Disorders

SUMMARY

The aim of the analyses reported in this section was to determine the prevalence of psychological disorders amongst young people in detention in Ireland. This chapter describes the overall levels and types of psychological disorders experienced by young people in detention in Ireland as well as rates of psychological co-morbidity. These rates are compared to those of young people referred to a psychiatry service. Results show that young people in detention in Ireland experience very high levels of psychological morbidity which is complicated further by high rates of co-morbidity.

OVERALL LEVELS OF PSYCHOLOGICAL DIFFICULTIES AMONGST YOUNG PEOPLE IN DETAINMENT IN IRELAND

A total of 82.76% of young people in The Offender Group met diagnostic criteria for at least one psychological disorder. This compared to 60% of young people in The Mental Health Group. Results showed that The Offender Group experienced significantly more psychological disorders than The Mental Health Group. On average each participant in The Offender Group met diagnostic criteria for 3.1 psychological disorders whereas, the average rate of disorder in The Mental Health Group was 1.3.

The types of psychological disorders being experienced by young people in The Offender Group were broken down into externalising disorders, internalising disorders and substance related disorders. Psychological disorders in the internalising category were separation anxiety disorder, motor / transient tic disorder, generalised anxiety disorder, social phobia, major depression, bipolar disorder, dysthymia and post traumatic stress disorder. The disorders making up the externalising category were conduct disorder, oppositional defiant disorder, attention deficit disorder and attention deficit hyperactivity disorder. Substance dependency and substance use disorders constituted the substance related disorders category.

Table 4.1. Psychological Morbidity in The Offender and Mental Health Groups.

	Offender Group		Mental Health Group		t - Test / Chi – Square	Interpretation
Overall Morbidity	n = 29		n = 20			
Total no. of people with a Disorder	n	%	n	%	$X^2 = 3.15$	G1 = G2
Yes	24	82.76%	12	60.00%		
No	5	17.24%	8	40.00%		
Total no. of disorders	91		27		t = 2.61**	G1 > G2
Mean	3.14		1.35			
SD	2.71		1.73			
Internalising Disorders	n = 29		n = 20			
Total no. of people with internalising disorders	n	%	n	%		
Yes	11	37.93%	7	35.00%	$X^2 = 0.44$	G1 = G2
No	18	62.07%	13	65.00%		
Total no. of internalising disorders	22		16		t = 0.11	G1 = G2
Mean	0.76		0.80			
SD	1.33		1.24			
Externalising / Disruptive Disorders	n = 28		n = 20			
Total no. of people with externalising/disruptive disorders	n	%	n	%	$X^2 = 6.70$**	G1 > G2
Yes	19	67.86%	6	30.00%		
No	9	32.14%	14	70.00%		
Total number of externalising / disruptive disorder	27		8		t = 2.32*	G1 > G2
Mean	0.96		0.40			
SD	0.92		0.68			
Substance Related Disorders	n = 27		n = 20			
Total number of people with substance related disorders	n	%	n	%	$X^2 = 6.18$*	G1 > G2
Yes	18	66.70%	6	30.00%		
No	9	33.30%	14	70.00%		
Total number of substance related disorders	42		3		t = 0.05*	G1 > G2
Mean	1.56		0.15			
SD	0.15		0.67			

*Note: t = Observed values from Independent t-test; X^2 = derived from chi square test, * sig. at p < .05, **sig at p <.01 level (Offender Group; Mental Health Group); *p<.05; **p<.01. G1 = Offender Group; G2 = Mental Health Group).*

Table 4.2. Internalising Disorders.

	Offender Group n	%	Mental Health Group n	%
Separation Anxiety Disorder				
Yes	6	20.00%	4	20.00%
No	24	80.00%	16	80.00%
Motor / Transient Tic				
Yes	5	17.24%	1	5.00%
No	24	82.76%	19	95.00%
Generalised Anxiety Disorder				
Yes	3	10.24%	2	10.00%
No	26	89.66%	18	90.00%
Social Phobia				
Yes	2	6.66%	3	15.00%
No	28	93.34%	17	85.00%
Major Depression				
Yes	2	6.90%	3	15.00%
No	27	93.10%	17	85.00%
Mania / Hypomania				
Yes	2	7.14%	0	0.00%
No	26	92.86%	20	100.00%
Panic Disorder				
Yes	1	3.33%	2	10.00%
No	29	96.67%	18	90.00%
Dysthymia				
Yes	1	3.57%	2	10.00%
No	27	96.43%	18	90.00%
Post Traumatic Stress Disorder				
Yes	0	0.00%	1	5.00%
No	29	100.00%	19	95.00%

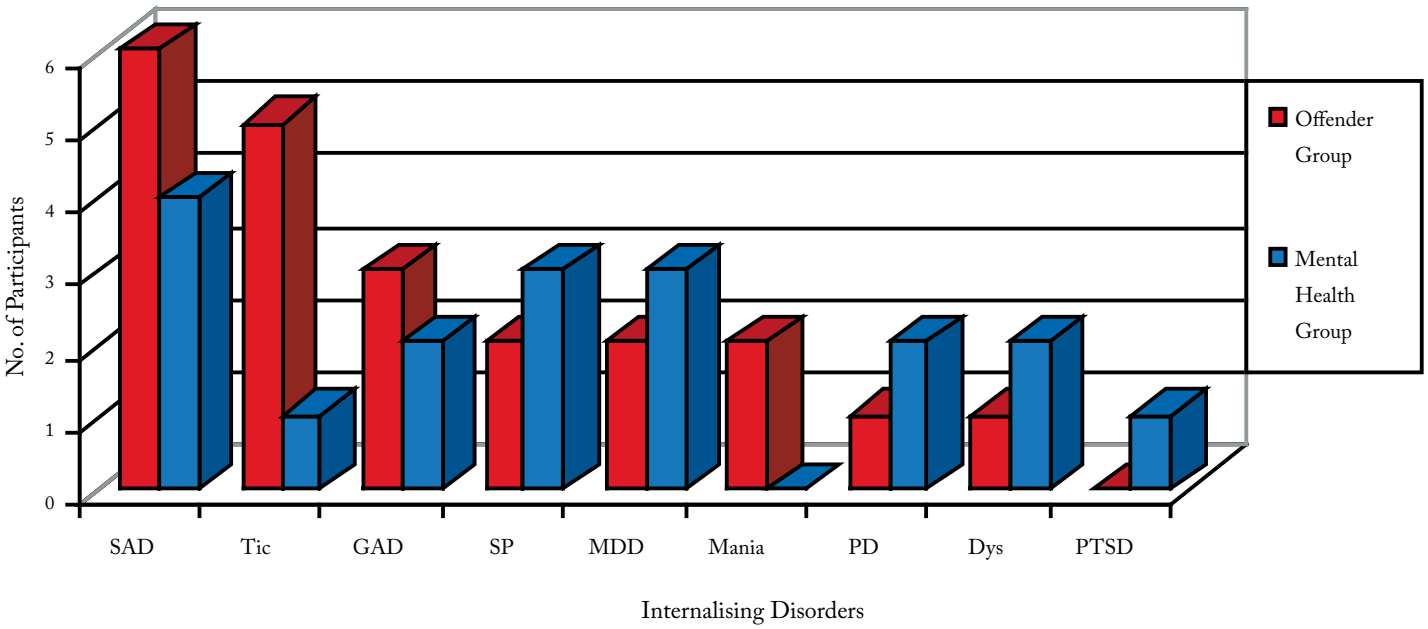
INTERNALISING PSYCHOLOGICAL DISORDERS

Thirty seven percent of participants in The Offender Group and 35% of individuals in The Mental Health Group met diagnostic criteria for at least one internalising psychological disorder. A total of 22 internalising psychological disorders were experienced by those in the Offender Group and 16 internalising psychological disorders were experienced by those in the Mental Health Group.

A number of disorders were prevalent in The Offender and Mental Health Groups. These were; separation anxiety disorder (Off Grp = 20%; MH Grp = 20%), motor / transient tic disorder (Off Grp = 17.2%; MH Grp = 5%), generalised anxiety disorder (Off Grp = 10.2%, MH Grp = 10%), social phobia (Off Grp = 6.7%; MH Grp = 15%), major depression (Off Grp = 6.9%; MH Grp = 15%), bipolar disorder (Off Grp = 7.1%; MH Grp = 0%), dysthymia (Off Grp = 3.6%,; MH Grp = 10%) and PTSD (Off Grp = 0%; MH Grp = 5%).

Histogram 4.1.

Internalising Disorders in The Offender and Mental Health Groups.



Note: SAD = Separation Anxiety Disorder; Tic = Transient / Motor Tic Disorder; GAD = Generalised Anxiety Disorder; SP = Social Phobia; PD = Panic Disorder; PTSD = Post Traumatic Disorder; MDD = Major Depressive Disorder; Dys = Dysthymia; Mania = Mania / Hypomania.

SUICIDAL IDEATION

Nineteen (18.5%) percent of young people in The Offender Group reported thoughts of suicide at the time of data collection. This compares to 15% of participants in The Mental Health Group. A total of 18.5% of participants in The Offender Group and 25% of those in The Mental Health Group reported at least one previous suicide attempt.

Table 4.3. Levels of Suicidality.

	Offender Group n = 27		Mental Health Group n = 20		Chi-Square Analyses	Interpretation
Suicidality	n	%	n	%		
Current suicidal thoughts						
Yes	5	18.51%	3	15.00%	X^2 = 1.01 n.s	G1 = G2
No	22	81.49%	17	85.00%		
Previous suicidal attempt						
Yes	5	18.51%	5	25.00%	X^2 = 0.29 n.s	G1 = G2
No	22	81.49%	15	75.00%		

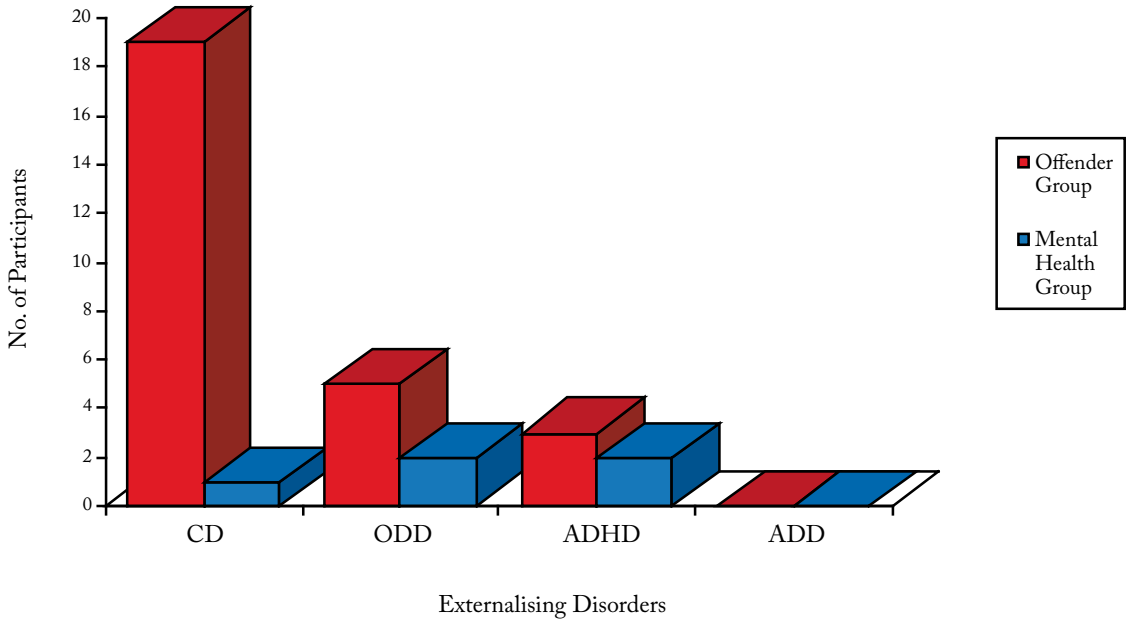
Note: X^2 = derived from chi square test; n.s. = not significant.

Table 4.4. Externalising Disorders.

	Offender Group G1 n	%	Mental Health Group G2 n	%
Conduct Disorder				
Yes	19	67.86%	1	5.00%
No	9	32.14%	19	95.00%
Oppositional Defiant Disorder				
Yes	5	17.86%	5	25.00%
No	23	82.14%	15	75.00%
Attention Deficit Hyperactivity Disorder				
Yes	3	10.71%	2	10.00%
No	25	89.29%	18	90.00%
Attention Deficit Disorder				
Yes	0	0.00%	0	0.00%
No	28	100.00%	20	100.00%

Histogram 4.2.

Externalising Disorders in the Offender and Mental Health Group.



Note: CD = Conduct Disorder; ODD = Oppositional Defiant Disorder; ADHD = Attention Deficit Disorder; ADD = Attention Deficit Disorder.

EXTERNALISING / DISRUPTIVE PSYCHIATRIC DISORDERS

Significantly more participants in The Offender Group (67.9%) met diagnostic criteria for an externalising disorder than those in The Mental Health Group (30%). Significant differences were noted also in rates of co-morbidity. A total of 27 externalising disorders were experienced by The Offender Group, whereas a total of eight externalising disorders were identified in The Mental Health Group.

A number of disorders categorised as externalising / disruptive disorders were prevalent in The Offender and Mental Health Groups. The disorders identified in The Offender and Mental Health Groups were conduct disorder (Off Grp = 67.9%, MH Grp = 5%), motor/transient tic disorder (Off Grp = 17.2%, MH Grp = 5%), oppositional defiant disorder (Off Grp = 17.9%, MH Grp = 25%) and ADHD (Off Grp = 10.7%, MH Grp = 10%).

Table 4.5. Drug and Alcohol Use.

	Offender Group G1 n = 25		Mental Health Group G2 n = 20	
Dependency Disorders	n	%	n	%
Total Substance / Alcohol Dependency (addicted)	14	56.00%	1	5.00%
Substance Dependency (addicted)	10	40.00%	1	5.00%
Marijuana Dependency (addicted)	12	48.00%	1	5.00%
Alcohol Dependency (addicted)	6	24.00%	0	0.00%
Use Disorders				
Total Substance / alcohol use (regular user, not addicted)	5	20.00%	1	5.00%
Substance Use (regular users, not addicted)	3	12.00%	0	0.00%
Marijuana Use (regular users, not addicted)	4	16.00%	0	0.00%
Alcohol Use (regular users, not addicted)	5	20.00%	1	5.00%
Sporadic Use Problems				
Total Sporadic users (irregular use in the last 12 months, not addicted)	5	20.00%	4	20.00%
Absence of Problems				
No substances / alcohol use whatsoever in last 12 months	1	4.00%	15	75.00%

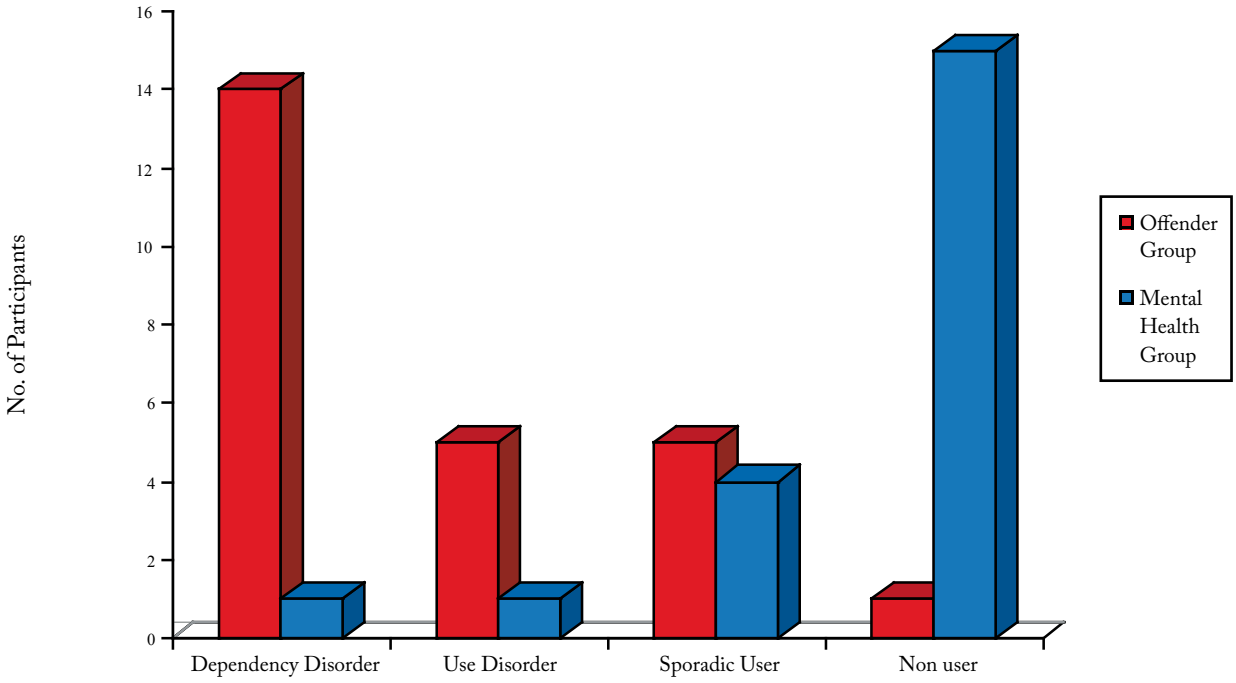
Note: If the number of participants meeting diagnostic criteria for substance disorders within each categories are summed, this figure exceeds the total number of participants assessed because in some instances a participant meets criteria for more than one disorder. G1 = Offender Group; G2 = Mental Health Group.

SUBSTANCE RELATED DISORDERS

Significantly more participants in the Offender Group met diagnostic criteria for at least one substance related disorder than did those in The Mental Health Group (Off Grp = 66%, n = 18; MH Grp = 10%, n = 2). The Offender Group also experienced significantly more substance related disorders than did the Mental Health Group. On average, each participant in The Offender Group met diagnostic criteria for 1.6 substance related disorders, whereas, the average rate of substance related disorders in the mental health participants was 0.15

Histogram 4.3.

Drug and Alcohol Use in Offender and Mental Health Groups.



Alcohol and Substance Problems

DEPENDENCY DISORDERS

A number of dependency disorders were prevalent in The Offender Group and Mental Health Groups. These were alcohol dependency (Off Grp = 24%, MH Grp = 5%), marijuana dependency (Off Grp = 16%, MH Grp = 5%) and addiction to other substances (Off Grp = 40%, MH Grp = 5%).

USE DISORDERS

Nobody in The Mental Health Group met diagnostic criteria for substance or marijuana use disorders. This compared to 12% and 16% respectively of young people in The Offender Group. Twenty percent of participants in The Offender Group met diagnostic criteria for substance use disorders, whereas 5% of The Mental Health Group met diagnostic criteria for alcohol use disorder.

SPORADIC USE OF ALCOHOL AND DRUGS

Five participants in The Offender Group reported drug use in the last 12 months but did not use sufficient amounts of substances to warrant a diagnosis of a substance use or substance dependency disorder (sporadic users). Four participants (20%) in The Mental Health Group were classified as sporadic users.

ABSENCE OF DRUG / ALCOHOL RELATED DIFFICULTIES

Only one participant in The Offender Group reported that he did not take any drugs or alcohol in the last twelve months. All other participants in The Offender Group either had a diagnosis of a dependency disorder, a use disorder, or had used alcohol or drugs sporadically over the last 12 months . Within The Mental Health Group, however, the majority of participants (75%) reported that they did not take any drugs or alcohol in the last 12 months.

THE TYPES OF SUBSTANCES BEING USED BY INDIVIDUALS WITH DEPENDENCY RELATED DISORDERS AND AGE OF FIRST USE.

Young people in the Offender Group with a dependency disorder, a use disorder and individuals who used drug sporadically were asked to report which substances they had used in the last 12 months. Participants were also asked to

Table 4.6. Breakdown of The Substances Used by Young People in the Offender Group and Age of First Use.

	Individuals with an addiction disorder n = 14			Individuals with a use disorder n = 5			Individuals who use substances sporadically n =5		
Substances used in the last year	No. of participants	Age of first use		No. of participants	Age of first use		No. of participants	Age of first use	
		Mean	SD		Mean	SD		Mean	SD
Class A									
Cocaine	12	13.58	1.62	2	14.00	1.41	2	14.40	0.10
Ecstasy	10	13.30	1.16	2	14.00	0.00	0	N/A	N/A
Hallucinogens	9	14.00	1.45	1	14.00	N/A	0	N/A	N/A
Methadone	1	15.00	N/A	0	N/A	N/A	0	N/A	N/A
Crack	1	13.00	N/A	0	N/A	N/A	0	N/A	N/A
Heroin	1	15.00	N/A	0	N/A	N/A	0	N/A	N/A
Morphine	1	15.00	N/A	0	N/A	N/A	0	N/A	N/A
Crystal Methadone	1	15.00	N/A	0	N/A	N/A	0	N/A	N/A
Class B									
Speed	7	13.14	1.46	0	N/A	N/A	0	N/A	N/A
Class C									
Cannabis	13	9.77	2.01	4	12.75	1.26	2	13.00	1.41
Sedatives / Tranquillisers	9	13.33	1.32	3	14.33	0.58	3	14.67	0.58
Other									
Inhalants	4	10.50	2.38	1	N/A	N/A	0	N/A	N/A
Alcohol	13	9.38	1.76	5	10.60	3.29	4	9.75	2.06

Note: N/A = Not Applicable

state at what age they first began to use each specified substance.

Alcohol (n =13) and cannabis (n = 13) were most frequently reported as the substances used by those in the Offender Group with a dependency disorder. This was followed by cocaine (n = 12), ecstasy (n = 10), hallucinogens (n = 9), sedatives / tranquillisers (n = 9), speed (n = 7), inhalants (n = 4), crack (n = 1), crystal methadone (n = 1), heroin (n = 1) and methadone (n = 1). Participants with dependency disorders reported that, on average they first used alcohol and cannabis at approximately nine years of age. They first used cocaine, ecstasy, sedatives / tranquillisers and speed on average at 13 years of age. Inhalants were reportedly first used by those with dependency disorders on average by ten years of age.

THE TYPES OF SUBSTANCES USED BY DETAINEES WITH SUBSTANCE USE DISORDERS

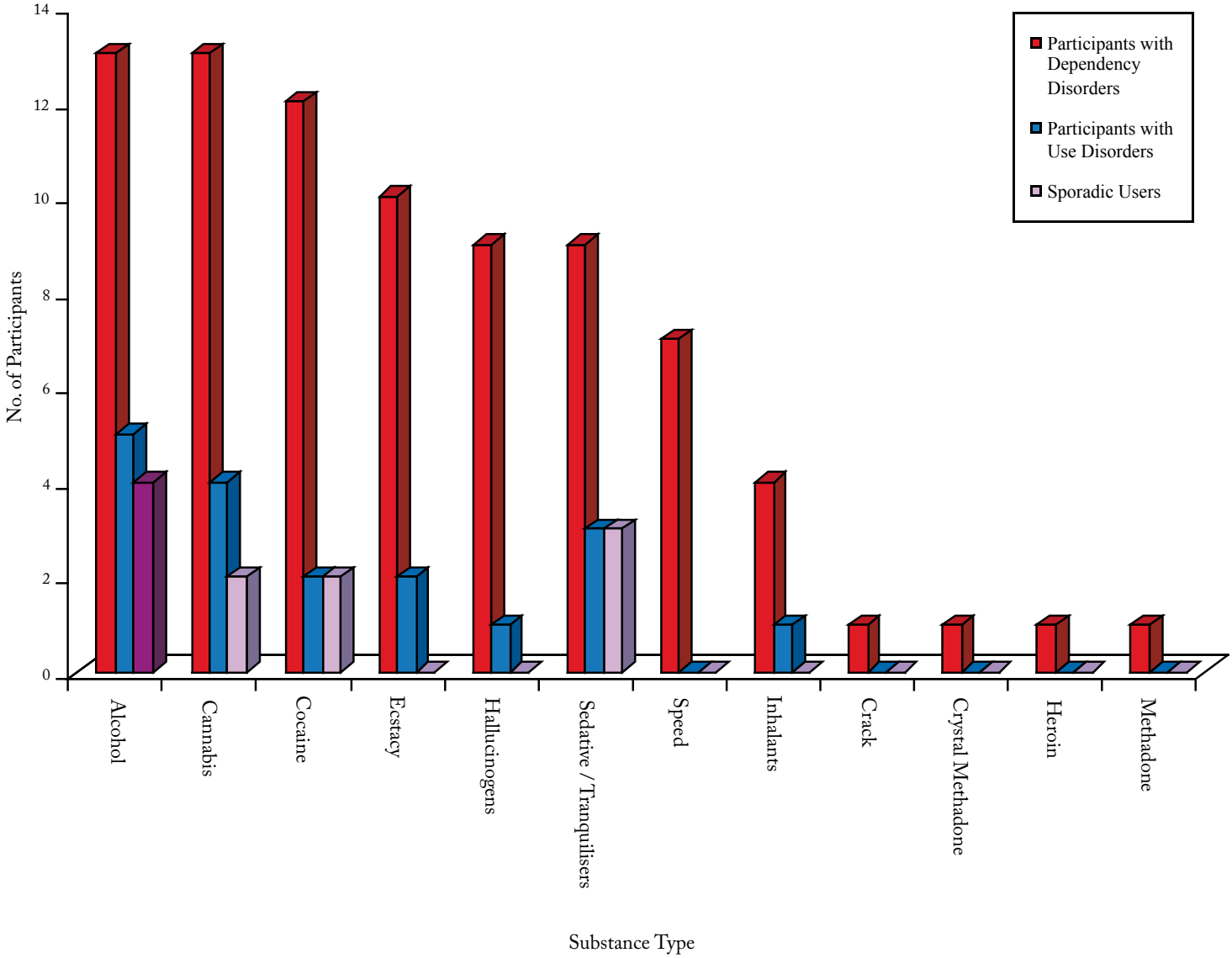
Individuals in the Offender Group with diagnoses of substance use disorders reported that they used alcohol (n = 5), cannabis (n = 4), sedatives / tranquillisers (n = 3), cocaine (n = 2), ecstasy (n = 2) and hallucinogens (n = 1). These participants reported that on average they first used alcohol at ten years of age, cannabis at 12 years and cocaine, ecstasy, hallucinogens and sedatives / tranquillisers at 14 years of age.

THE TYPES OF SUBSTANCES BEING USED BY DETAINEES WHO USE DRUGS SPORADICALLY

Individuals in the Offender Group who did not meet diagnostic criteria for a dependency or use disorder, but who used drugs sporadically, reported alcohol (n = 4), sedative / tranquilliser (n = 3), cannabis (n = 2) and cocaine use (n = 2). These participants reported that they first used alcohol on average, at nine years of age (SD = 2.06), cannabis at 13 years (SD = 1.41) and cocaine and sedatives / tranquillisers at 14 years of age (SD = 0.71; SD = 0.58).

Histogram 4.4.

Substances Used by Young People in The Offender Group in The Last 12 Months.



OVERALL LEVELS OF PSYCHOLOGICAL MORBIDITY - CONCLUSIONS

This research illustrates that the level of psychological disorder amongst young people who are in detention in Ireland is very high and is a matter of grave concern. At any given time detention schools in Ireland can expect that approximately eight of every ten boys in their care will be experiencing a clinically significant psychological disorder. Approximately 16.5% of the general adolescent population meet diagnostic criteria for at least one psychiatric disorder (Roberts et. al). It can be expected, therefore, that rates of psychological disorder amongst young people detained in detention schools will be approximately five times greater than in the general community. With regard to co-morbidity, young people in detention can be expected to experience twice as many psychological disorders as young people of the same age whose difficulties are considered so serious that they are have been referred to a community psychiatry service.

EXTERNALISING PSYCHOLOGICAL DISORDERS - CONCLUSIONS

The types of psychological disorders identified in the Offender Group warrants discussion. Almost two thirds of the young people in The Offender

Group met diagnostic criteria for conduct disorder (67.86%). Given the diagnostic overlap between conduct disorder and engagement in criminal acts, coupled with the high levels of criminality identified in the sample, it could be argued that the prevalence of conduct disorder, although high, was lower that expected. A likely explanation for this finding is that incarcerated youth have limited opportunities to offend. As current anti-social behaviour is one of the core diagnostic criteria of conduct disorder, it is unsurprising that one third of the detained young people sampled were not diagnosed with conduct disorder.

The rates of conduct disorder in the general population range from 4-14% (Brosnan and Carr, 2000), which indicates that conduct disorder amongst detainees in Ireland is approximately 5 to 16 times more prevalent than in the general population. The results also suggest that conduct disorder is significantly more prevalent amongst detainees than adolescents referred to a psychiatry service, 30% of whom were diagnosed with conduct disorder.

The results that 17.86% of detained young people meet diagnostic criteria for ODD and that 10.71% were diagnosed with ADHD is also of importance. The findings showed that a similar percentage of adolescents referred to the psychiatry service met diagnostic criteria for these disorders (ODD, 25% and ADHD, 10%). These findings suggest that similar levels of ADHD and ODD can be found in adolescents referred to a psychiatry service and adolescents in detention. Staff in detention centres can expect that ODD and ADHD will be frequently experienced by the young people in their care.

INTERNALISING PSYCHOLOGICAL DISORDERS - CONCLUSIONS

Detention schools in Ireland can expect that approximately one third of the young people in their care will experience at least one anxiety and / or depressive psychological disorder. It can also be expected that the level of internalising psychological morbidity will be so high that it will be comparable to the level of internalising psychological morbidity found amongst adolescent males who have been referred to a psychiatric service. Separation anxiety disorder, motor / transient tic disorder and generalised anxiety disorder can be expected to occur commonly in young people who are in detention in Ireland. Social phobia, major depression, panic disorder and dysthymia, bipolar disorder, although less common, can also be expected to be a common feature of this client group.

The finding that 7.14% per cent of the incarcerated young people in the present study met diagnostic criteria for bipolar disorder warrants further discussion. This finding indicates that a significant proportion of young people in detention in Ireland experience serious mental illness. Bipolar disorder in adolescents is rare. This research did not identify anybody in The Mental Health Group with bipolar disorder and the prevalence of bipolar disorder in adolescents in the general population is less than one per cent (Lewinsohn et al., 1995).

DRUG USE - CONCLUSIONS

The results of this research show that the numbers of young people in detention who are experiencing a substance related psychological disorder is very high. Staff in Irish detention schools can expect that approximately 3 out of every 4 young people in their care suffer from serious drug or alcohol use and/or have an addiction to one or more substances. It is estimated that between 5% and 10% of adolescents in the general population have drug problems serious enough to warrant clinical intervention (Cormack & Carr, 2000). Substance related disorders are, therefore, seven to thirteen times more prevalent in young people in detention in Ireland than they are in the general population. The present research found that young people in the Offender Group were significantly more likely to experience a substance related disorder than were young people in the Mental Health Group, (10% of whom met diagnostic criteria for such a difficulty). This indicates that substance related disorders are approximately seven times more prevalent amongst detainees than amongst adolescents attending psychiatry services. In sum, substance related disorders amongst young people residing in detention schools are worryingly high.

The results also suggest that despite the stringent supervision of these youths and the best efforts of staff, young people in detention schools find ways of obtaining alcohol and / or drugs that maintain their problems. It is possible that youths obtain drugs whilst on home leave, during family visits or during court appearances. It is also possible that youths circumvent detection of drug use through mandatory urine testing by using substances that are more difficult to detect through urine analysis or by giving urine samples obtained from unflushed toilets.

In light of the high rates of substance related disorders amongst young people in detention it is not surprising that acquisitive crimes were the offences most frequently engaged in by the majority of young people in this research. Taken in sum, these findings point to the possibility that the proceeds from acquisitive crimes could be associated with the funding of drug or alcohol use.

In addition to the high prevalence of substance related disorders amongst young people in detention schools, the findings also show that the types of substances being used by these young people is also a matter of grave concern. Young people in detention schools in Ireland can be expected to abuse dangerous class A drugs such as cocaine, ecstasy and hallucinogens in addition to softer drugs such as cannabis, sedatives / tranquillisers on a regular basis. The finding that approximately equal numbers of young people with dependency disorders reported using cocaine as did the numbers using alcohol is extremely worrying. Equally worrying is the finding that cocaine was used in the last 12 months by approximately half of respondents who had a substance use disorder and by those who used drugs sporadically. This is comparable to the numbers of individuals in each group who reported using cannabis in the proceeding twelve months.

The results of this research also suggest that drug abuse amongst detainees begins in early childhood. Young people

suffering with at least one substance disorder reported that they began first to use alcohol and cannabis at an average of just nine years of age. Cocaine use appears to have begun at an average of just 13 years of age. The results indicate also that the above young people first used ecstasy, speed and sedatives at an average of 13 years and hallucinogens at an average of 14 years of age. Young people who meet diagnostic criteria for at least one substance use disorder also reported that they began to use illicit substances in early childhood. On average, these participants reported first using alcohol at ten years of age, cannabis at 12 years and cocaine, ecstasy, hallucinogens and sedatives/tranquillisers at 14 years of age.

SUICIDALITY - CONCLUSIONS

Given that very high prevalence of psychological disorders and high rates of co-morbidity amongst detainees, it is not surprising that approximately one fifth (18.51%) of participants in the Offender Group reported that they were experiencing thoughts of suicide at the time of data collection. Results suggest that suicidal ideation is approximately equally prevalent amongst young people in detention schools and young people referred to a psychiatric service. These findings suggest that young people in detention are at serious risk of self-harm.

CHAPTER FIVE

Cognitive Functioning

SUMMARY

The aim of the analyses reported in this section were to identify what percentage of young people in the Offender Group had full scale IQ scores in the intellectual disability range. In addition, the researchers aimed to compare the overall levels of intellectual functioning amongst participants in the Offender Group to overall levels amongst participants in the Mental Health and Control Groups. Results show significant deficits in intellectual ability amongst young people in detention.

COGNITIVE FUNCTIONING AMONGST YOUNG PEOPLE IN DETENTION

Results showed that a total of 21.4% (n = 6) of participants in the Offender Group had Full Scale IQ scores in the intellectual disability range (below 70). No participants in the Mental Health Group obtained Full Scale IQ scores below 70

Table 5.1. Full Scale IQ Scores Below and Above 70 in The Offender and Mental Health Groups.

	FSIQ below 70		FSIQ over 70		Mann WhitneyTest	Interpretation
	n	%	n	%		
Offender Group	6	21.43%	22	78.57%	U = 220.00*	G1 > G2
Mental Health Group	0	0.00%	20	100.00%		

*Note: U = Observed values from Mann Whitney Test (Offender Group; Mental Health Group); *p < .05. G1 = Offender Group; G2 = Mental Health Group).*

Histogram 5.1.

Percentage of FSIQ Scores under and over 70 in the Offender and Mental Health Groups.

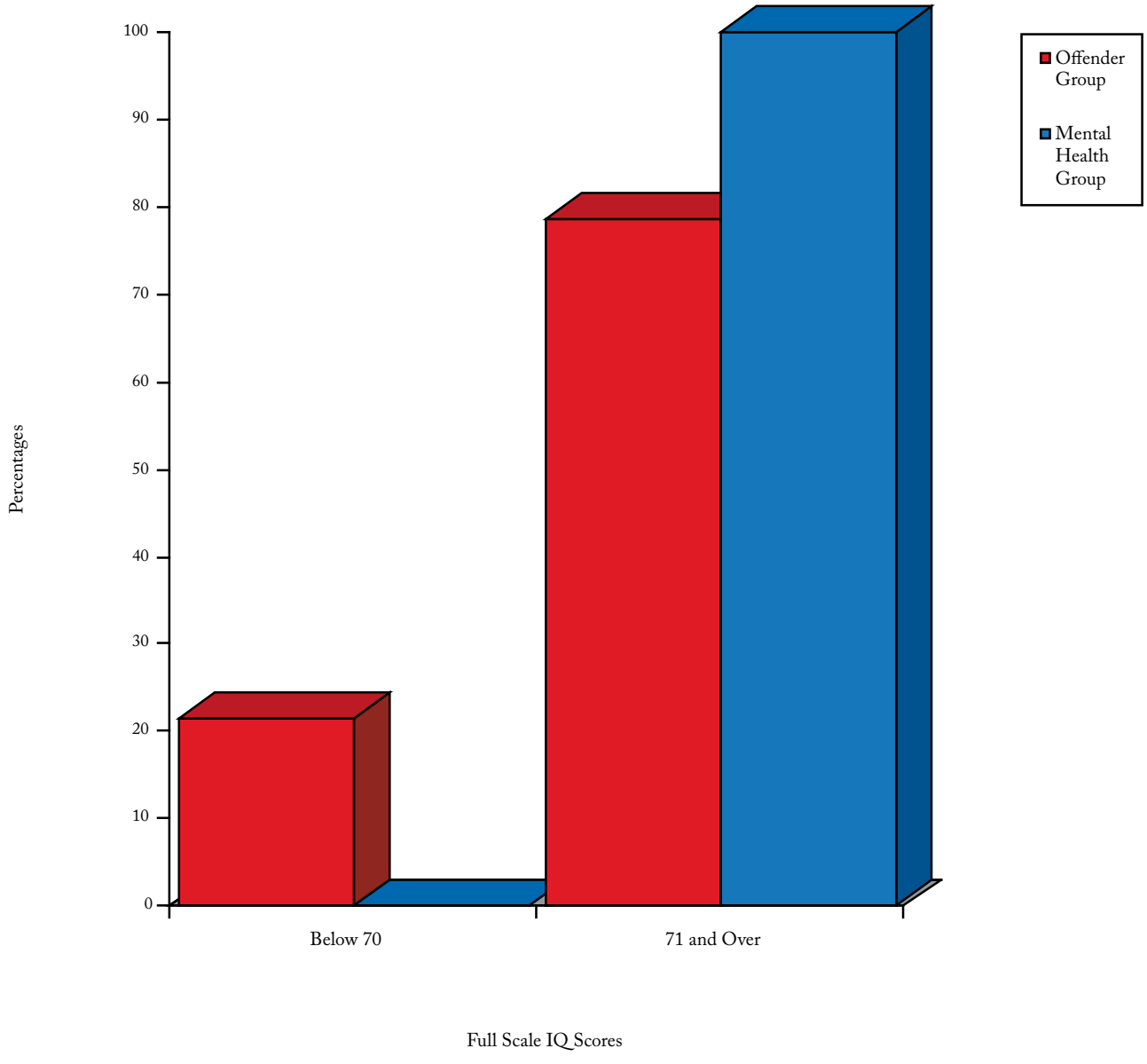


Table 5.2. Levels of Intelligence Across The Offender, Mental Health and Control Groups.

Measure	Offender Group G1 (n = 26)	Mental Health Group G2 (n = 20)	Control Group G3 (n = 30)	F	Interpretation
WASI					
Full Scale IQ					
Mean	79.46	95.30	107.28	32.92***	G1<G2; G1<G3; G2<G3
Standard deviation	13.29	14.72	10.86		
Verbal IQ					
Mean	80.42	94.95	111.13	39.93***	G1<G2; G1<G3; G2<G3
Standard deviation	12.60	14.36	11.98		
Performance IQ					
Mean	81.73	96.25	102.40	15.49***	G1<G2; G1<G3; G2=G3
Standard deviation	15.03	15.10	12.32		

*Note: F = Observed values from MANOVAs (Offender Group; Mental Health Group; Control Group); ***p < .001. G1 = Offender Group; G2 = Mental Health Group; G3 = Control Group).*

Results showed significant differences between the Offender, Mental Health and Control Groups on full scale IQ (FSIQ), verbal IQ (VIQ) and performance IQ (PIQ). The Offender Group had significantly lower mean FSIQ scores than the Mental Health Group and the Control Group. The Mental Health Group had significantly lower mean FSIQ scores than the Control Group.

Statistical Analyses revealed that The Offender Group also had significantly lower VIQ and PIQ scores than the Mental Health and Control Groups. The Mental Health Group had significantly lower VIQ than the control group, however, there was no significant difference between these two groups on PIQ.

CONCLUSIONS

Approximately one fifth of young people in detention schools in Ireland can be expected to have full scale IQ scores in the intellectual disability range. This compares to 2-3% of the general population (Carr, 2006). These findings indicate that young people with an intellectual disability are over-represented in Irish detention schools. The results also point to the presence of significantly more young people with intellectual disabilities in detention than those attending psychiatric services.

CHAPTER SIX

Trait & Ability Emotional Intelligence

SUMMARY

The aim of the analyses reported in this chapter was to determine whether young people with offending difficulties have different levels of trait and / or ability emotional intelligence than young people referred to a psychiatry service and young people without offending or mental health difficulties. Results show that young people in detention have significantly lower levels of ability emotional intelligence than do young people without offending or mental health problems. Boys in detention experience similar deficits in ability emotional intelligence to those found amongst young people referred to psychiatry service.

COMPARISONS OF TRAIT EMOTIONAL INTELLIGENCE

Reliability analyses showed that the Total EQ and Adaptability scores of the EQ-i:YV were the only reliable subtests on this measure. Therefore, the other subscales were excluded from any further analyses.

Results showed that there was no statistically significant difference between the Offender and Control Groups on mean Total EQ scores. The results indicated, however, that the Mental Health Group had statistically lower mean scores on Total EQ than the Control Group. There were no significant differences between the Groups on mean Adaptability scores.

Table 6.1. Levels of Trait Emotional Intelligence Across The Three Groups.

	Offender Group G1 (n = 25)	Mental Health Group G2 (n = 20)	Control Group G3 (n = 30)	F	Interpretation
Total EQ					
Mean	87.70	85.15	97.33	5.56 **	G1=G2; G1=G3; G2<G3
Standard deviation	17.48	10.33	12.30		
Adaptability					
Mean	37.13	86.20	95.23	2.24	G1=G2; G1=G3; G2=G3
Standard deviation	16.04	16.35	17.98		

*Note: F = Observed values from MANOVAs (Offender Group; Mental Health Group; Control Group); **p > .01; G1 = Group One, G2 = Group Two, G3 = Group Three.*

COMPARISONS OF ABILITY EMOTIONAL INTELLIGENCE

There was no significant difference between The Offender Group and the Mental Health Group on mean Total EI scores. The Offender Group had significantly lower mean scores on Total EI than The Control Group. The Mental Health Group had significantly lower Total EI scores than the Control Group.

EXPERIENTIAL EI

No significant difference was found on mean Experiential Emotional Intelligence scores between The Offender Group and The Mental Health Group. The Offender Group and The Mental Health Group each had significantly lower mean levels of Experiential Emotional Intelligence Score than The Control Group.

STRATEGIC EMOTIONAL INTELLIGENCE

No significant difference was found on mean Strategic Emotional Intelligence scores between The Offender Group and The Mental Health Group. The Offender Group and The Mental Health Group each had significantly lower mean scores on Strategic Emotional Intelligence than The Control Group.

PERCEIVING EMOTIONS

There was no significant difference on mean Perceiving Emotions scores between The Offender Group and The Mental Health Group. The Offender Group had significant lower mean scores than The Control Group, however, there was no significant differences between The Mental Health Group and The Control Group on mean Perceiving Emotions scores.

FACILITATING THOUGHT

No significant difference was found between The Offender Group and The Mental Health Group on mean Facilitating Thought scores. The Offender Group and The Mental Health Group each had significantly lower mean scores on this subtest than The Control Group.

MANAGING EMOTIONS

There was no significant difference on mean Managing Emotions scores between The Offender Group and The Mental Health Group. The Offender Group and The Mental Health Group had significantly lower mean scores in Managing Emotions than The Control Group.

Table 6.2. Ability Emotional Intelligence Scores in The Offender Mental Health and Control Groups.

	Offender Group G1 (n = 25)	Mental Health Group G2 (n = 20)	Control Group G3 (n = 30)	F	Interpretation
Total Emotional Intelligence					
Mean	180.28	195.20	227.41	32.94***	G1=G2; G1<G3; G2<G3
Standard deviation	30.64	23.21	20.52		
Area Score: Experiential Emotional Intelligence					
Mean	101.34	110.72	124.10	15.06***	G1=G2; G1<G3; G2<G3
Standard deviation	20.34	12.87	11.91		
Area Score: Strategic Emotional Intelligence					
Mean	79.38	84.47	103.30	26.65***	G1=G2; G1<G3; G2<G3
Standard deviation	12.99	13.63	12.69		
Branch Score: Perceiving Emotions					
Mean	47.34	54.07	60.20	9.56***	G1=G2; G1<G3; G2=G3
Standard deviation	15.21	8.18	7.58		
Branch Score: Facilitating Thought					
Mean	54.12	56.65	63.91	9.58***	G1=G2; G1<G3; G2<G3
Standard deviation	8.66	9.47	7.97		
Branch Score: Managing Emotions					
Mean	34.74	33.52	40.73	7.12**	G1=G2; G1<G3; G2<G3
Standard deviation	9.80	5.73	5.95		

*Note: F = Observed values from MANOVAs (Offender Group; Mental Health Group; Control Group); **p < .01, ***p < .001. G1 = Offender Group; G2 = Mental Health Group; G3 = Control Group).*

CONCLUSIONS

This is the first piece of research in the world to investigate levels of emotional intelligence amongst young people in detention for offending behaviour. The results of the current research suggest that young people who are incarcerated for offending behaviour do not differ on Total EQ or on levels of Adaptability when compared to young people with mental health problems or adolescents without offending or mental health problems.

With regard to ability emotional intelligence, however, young people with serious offending difficulties have significantly lower levels of ability emotional intelligence than young people who do not have offending or mental health problems. In comparison to young people without offending or mental health difficulties, adolescents who engage in serious criminality have a reduced ability to accurately perceive emotions in themselves and in others; have a reduced ability to use emotions to prioritise thinking and a reduced ability to regulate affect.

These findings raise the possibility that reduced levels of EI are associated with the development and/or maintenance of offending difficulties. There are a number of ways in which this could occur. Young people with a reduced capacity to identify feelings in others will find it more difficult to understand how offending behaviour is likely to make others feel. Such an understanding could serve as a protective factor against offending behaviour. Difficulty in using emotions to facilitate thought might impede the ability of a young person with offending problems to employ a sense of remorse to facilitate thinking on ways to overcome offending behaviour patterns.

It can be argued also that a reduced capacity to regulate emotions could maintain offending patterns of behaviour in detainees. Internet child sexual abuse, for example, is often preceded by unregulated negative feelings (Quayle et al., 2006). It is argued that the offending behaviour itself can become a means of

dissipating and regulating this negative affect. The finding that young offenders have a reduced capacity to regulate emotions appropriately raises the possibility that engagement in offending behaviour constitutes a dysfunctional but effective means of regulating negative emotions.

A reduced capacity to regulate emotions in young people with offending difficulties could also result in what Pizzaro and Salovey (2002) refer to as emotions exerting their full 'motivational force'. An inability to regulate a sense of anger could, therefore, result in an assault or in criminal damage. An inability to regulate the feeling of desire could contribute to theft. An inability to regulate sexual arousal could result in sexual assault.

A logical extension of this argument is that an ability to manage emotions appropriately should be associated with a reduced risk of offending behaviour. There is some evidence to support this hypothesis. Research has found that children with a good ability to manage their emotions are less likely than others to have aggressive outbursts (Eisenberg et al., 1987; Bohnert et al., 2003) and are more likely to engage in empathic acts (Shields & Cicchetti, 1998).

The results of the current research also suggest that young people who are in detention experience similar deficits in EI to young people referred to a psychiatry service. This is an interesting finding and deserving of further comment. The high rate of psychiatric morbidity in both groups raises the possibility that the presence of mental health difficulties is associated with reduced levels of EI. Empirical research suggests that an association between mental health problems and reduced EI is possible. It has been argued that the concept of alexithymia, which incorporates difficulty identifying emotions, is a similar construct to branch one of the EI theory (Parker et al., 2001; Taylor, 2001). Alexithymia is associated with people who suffer from eating disorders (Bourke et al., 1992; Corocs et al., 2000; Laquatra & Clopton, 1994), panic disorder (Cox et al., 1995; Parker et al., 1993; Zeitlin & McNally, 1992) and exists amongst psychiatric outpatients with anxiety and depression (Taylor et al., 1992). A reduced ability to identify emotions has been associated also with individuals who have bulimia (Sim & Zeman, 2004; Whiteside et al., in press). Impairment in the ability to regulate emotions has also been identified in children with internalising and externalising problems (Zeman et al., 2002) and in adults who present with anxiety disorders (Suveg & Zeman, 2004), bulimia (Whiteside et al., in press) and depression (Garnefski et al., 2004). One possible explanation, therefore, for the similar but reduced rates of EI in The Offender and Mental Health Groups is that the existence of mental health problems, shown to be prevalent in both groups, is associated with low EI.

CHAPTER SEVEN

Research Implications - Addressing The Psychological Needs Of Young People In Detention Schools

SUMMARY

This chapter summarises the main implications that this research has for policy and service development. It also describes the implications that this research has for assessment and intervention, for the early identification of youth at risk of offending and for future research.

WHY IS IT IMPERATIVE TO MEET THE IDENTIFIED PSYCHOLOGICAL NEEDS OF YOUNG PEOPLE OUTLINED IN THIS REPORT?

There are a number of reasons why it is imperative that the psychological needs of incarcerated young people identified in this report are met. In doing so, the Irish State will meet its ethical and legal obligation to meet the psychological needs of young people in its care. In addition, however, the assessment and treatment of mental health difficulties will significantly reduce the serious, debilitating effects that these difficulties have on emotional, cognitive, social and developmental functioning.

International research demonstrates that the presence of psychological disorders can contribute to misbehaviour during detainment and can thus interfere with rehabilitation (Wasserman et al., 2003). Effective psychological intervention will, therefore, reduce young people's misbehaviour during their incarceration period and make them more receptive to rehabilitation.

Furthermore, research shows that the treatment of psychological disorders, aids rehabilitation, reduces contact with the judicial system in the future and ultimately reduces recidivism (Wasserman et al., 2003). The effective assessment and treatment of psychological disorders during a young persons incarceration, therefore, would have a strong cost-benefit for the Irish State in terms of reducing crime related costs to society, the legal system and to victims.

POLICY DEVELOPMENT

Detainment of young people with serious offending difficulties serves a number of functions. Detention contains the offending behaviour of these boys and thus limits the ramifications that their offending behaviour has on others. Detention also conveys that there are serious consequences for engaging in criminal acts and holds young people accountable for their criminality.

However, results of the current study reveal that, in addition to serious levels of criminality, young people in detention experience very high levels of psychological morbidity and significant deficits in IQ and EI. To address these difficulties adequately, policy development that outlines the additional functions that detention can serve is needed.

Policy development should, therefore, clearly specify the role that detention has in meeting the psychological needs of young people who are incarcerated. To achieve this it should centre on the belief that detention provides circumstances in which considerable opportunities for therapy and rehabilitation could and should be exploited.

Policies are also needed to set high standards to guide how the psychological needs of young people in detention are met. Such policies should strictly guide the types of assessment and intervention procedures implemented to meet the psychological needs of young people. Evidence-based assessments and interventions, scientifically shown to be effective in the empirical literature, are the approaches that should be availed of. This will ensure successful and cost-effective outcomes for clients and ensure that limited resources are put to the very best of use. Policies that view detention as an opportunity to assertively target factors that have contributed to a young person's criminality and to deconstruct factors that increase the likelihood re-offending are also warranted.

EVIDENCE-BASED SERVICE DEVELOPMENT

This research clearly demonstrates that young people in detention have serious levels of criminality, complex and debilitating co-morbid psychological difficulties and deficits in IQ and EI. To address these issues adequately requires the development of multi-disciplinary assessment and intervention teams. This will ensure the comprehensive assessment and treatment of psychological difficulties and increased efficacy in breaking patterns of offending behaviour amongst young people in detention.

Due to the necessity to diagnose and treat psychological / psychiatric disorders amongst young people in detention, these teams should be co-ordinated and lead by a senior practitioner who is competent in the assessment, diagnosis and treatment of psychological disorders. The teams should incorporate a number of professionals including:

1. Senior / Principal Clinical Psychologist
2. Sessional psychiatrist
3. Multi-Systemic and / or Functional Family Therapist
4. Addiction Counsellor
5. Social Worker
6. Probation Officer
7. Clinical Nurse Specialist

MULTI-DISCIPLINARY TEAM ASSESSMENTS

1. Screening Detainees for The Presence of Mental Health or Cognitive Difficulties

The high rate of psychological morbidity identified in the current highlights the need to screen all young people for mental health difficulties on their entry to detention. This will enable the identification of children at risk of experiencing a psychological disorder. In addition, all new entrants to detention should be screened to detect those at risk of experiencing an intellectual disability.

Experts in the field of juvenile justice have identified a number of reliable and valid screening tools that have been used in juvenile offender populations (Wasserman et al., 2003). Such tools are the Youth Self Report (Achenbach & Rescorla, 1991), the Symptom Checklist-90-Revised (Derogatis, 1977), the Brief Symptom Inventory (Derogatis, 1993) and the Massachusetts Youth Screening Instrument 2 (MAYSI-2). A number of diagnostic interview schedules could also assist assessment. Recommended tools are the Diagnostic Interview Schedule for Children (version IV) and the Diagnostic Interview for Children and Adolescents (Reich, 2000). The Wechsler Abbreviated Scale of Intelligence (Wechsler, 1997) can be used as screening tool for intellectual disability.

2. Comprehensive Assessment

Assessment of Psychological Difficulties

Youths identified through the screening process as at risk of experiencing a mental health difficulty require a comprehensive, multi-disciplinary, evidence-based, assessment which follows best practice guidelines. It should, where at all possible, lead to a diagnosis because this will inform clinicians on the most effective treatment approach. The assessment should also identify important factors which have predisposed the child to developing the difficulties, factors which precipitated the onset, factors which maintain the difficulties and protective factors which have prevented further deterioration (Carr, 2006). This process should lead to a formulation of each child's psychological difficulties and guide the development of a comprehensive, evidence-based intervention program that targets key maintaining factors whilst exploiting identified protective factors (Carr, 2006).

To achieve this successfully, assessments should make use of multiple sources of information, clinical interview, observation, chart review and valid and reliable assessment tools (Carr, 2006). A full family history, development history, psychosocial history and medical history should be obtained (Carr, 2006). The use of multiple informants and obtaining full histories is imperative, as the young people themselves are likely to experience some difficulty in identifying their feelings accurately.

Assessment of Intellectual Disabilities

All youths identified as being at risk of experiencing an intellectual disability should receive a comprehensive, evidence-based assessment to determine whether they meet diagnostic criteria for an intellectual disability. This process should follow best practice guidelines and should include a full cognitive assessment and an assessment of the youth's adaptive functioning.

Assessment of Offending Difficulties

Regardless of each child's psychological profile on the screening assessment, all youths should receive a comprehensive assessment to identify precipitating, predisposing, maintaining and protective factors associated with their criminal conduct. This should also follow best practice guidelines. In addition, clinicians need to obtain a full criminal history including a history of previous incarcerations.

An assessment should lead to a formulation of each child's offending difficulties which comprehensively specifies the precipitating, predisposing, maintaining and protective factors associated with their criminal conduct. This should be used, in conjunction with evidence-

based, 'what works' literature, to develop intervention programs that will break patterns of offending behaviour.

3. Risk Assessment

The research findings highlighted in this report point to the need for specific psychological risk assessments to identify youth who may pose a risk to their own safety and / or to the safety of others.

The Risk of Self-Harm

A number of findings in this research support the view that young people in detention are at risk of self-harm. Results revealed high rates of psychological morbidity which place detainees at an increased risk of experiencing a personal crisis. The findings also show that at the time of assessment 18.5% of juvenile detainees expressed suicidal ideation and that 18.5% reported an attempted suicide on at least one occasion in the past. In addition, deficits in cognitive ability and EI could compound the level of risk of self-harm further. Detainees with these impairments are less likely to be able to problem solve effectively, less likely to successfully resolve a mental health crisis, less likely to come up with alternatives to self-harm and less likely to dissipate feelings of distress effectively.

The period following initial admission to a detention school is associated with an increased risk of suicide and self-harm (Hayes, 1999). All of these factors point to the necessity of a self-harm risk assessment being conducted within the first 24 hours of a young person's admission to a detention centre. The aim of this assessment should be to establish levels of risk and to identify interventions that will reduce risk levels.

Risk Posed to The Safety of Others

The results of this study revealed that 30% of detainees held interpersonally violent charges. A number of boys held charges relating to serious sexual offences (6.7%). On his entry to a detention school, staff are unlikely to know the level of risk that a new detainee poses to the safety of others. It is important, therefore, that a risk assessment should seek to identify the level of physical and/or sexual risk that a boy might pose to peers and/or to staff. This should also focus on the identification of interventions that will reduce the risk of harm.

Substance Dependency and Withdrawal

The findings of this research show very high levels of alcohol and drug dependency amongst boys detained by the State. Newly admitted detainees are unlikely to access drugs in the initial period following detention. It could be argued, therefore, that entry to incarceration is associated with a sudden discontinuation of drug use.

It can be potentially life threatening for a person to suddenly cease using certain illicit substances. Ninety two per cent of the young people identified with addictions in this research reporting using alcohol and 64% reported using sedatives / tranquillisers. Uncontrolled withdrawal from alcohol, valium and barbiturates is associated with Grand Mal Seizures which can endanger a person's life (Carr, 2006). A risk assessment should be conducted on arrival to ensure that a youth receives appropriate medical and psychological support to help him to manage withdrawal from illicit substances in a way that is both safe and controlled.

4. Assessment of Mental Health Needs Prior to Discharge

The high rates of co-morbid psychological difficulties amongst detainees identified in this research, coupled with deficits in IQ and EI point to the need for assessment of each youths psychological needs prior to discharge. The assessment should aim to identify the necessary steps to ensure as seamless a transition as possible from a highly structured institutional environment to often times a chaotic home environment. The assessment results should be used to inform staff about each youth's treatment needs and to make referrals to appropriate mental health services. The assessment should inform staff on the necessary steps to ensure continuity of care and the identification and successful resolution of placement decisions. It should also serve to identify the educational or occupational needs of young people, within the context of their levels of intellectual ability and personal strengths.

The high rates of substance disorders identified in this research highlight the importance of an assessment that takes full treatment history into account. The very nature of incarceration is likely to decrease drug use over the course of detainment. Substance disorder might therefore appear to have been resolved owing to incarceration. It can, however, re-emerge following release when there is increased access to drugs. As tolerance is likely to have decreased over the course of incarceration, the possibility of overdose following discharge is increased. It is essential, therefore, that assessment prior to release takes account of full treatment histories and is oriented towards identifying potential dangers that the youth may face following his discharge.

5. Reassessment

Due to high rates of psychological morbidity identified in this research, regular re-assessment is essential. Mental health difficulties are not static and they change over time (Kroll et al., 2002). The mental health difficulties identified in this research increase the risk of the development of additional disorders. Furthermore, the stress associated with incarceration is likely to exacerbate psychological symptoms (Wasserman et al., 2003). Regular reassessment of mental health and of emergent risk is recommended, therefore, particularly during periods of stress.

IMPLICATIONS FOR TREATMENT

1. Psychological Disorders

The aim of risk assessments should be to guide the development of intervention programs which decrease levels of risk. The aim of multi-disciplinary comprehensive assessments is to enable clinicians to devise intervention programs which will resolve or at the very least reduce the debilitating effects of mental health problems. The treatment of psychological disorders should be evidence-based. Therapeutic approaches that have been shown through empirical research to reduce specific types of psychological disorders are the treatments that should be delivered.

Criminality / Externalising Disorders

Empirical research has shown that multi-modal and structured intervention programs such as cognitive behavioural therapy that tackle personal, contextual and family related factors maintaining a youth's offending difficulties, are the treatments of choice for criminality (Borduin, et al., 1990; Hollin, 1999; Lipsey, 1995). Criminality and conduct disorder have also been shown to be effectively treated with functional family therapy and multi-systemic therapy (Aos et al., 1999; Borsnan & Carr, 2000; McMahon & Kolter, 2004).

The finding that the vast majority of young people in this research had a family member who was convicted of a criminal offence and / or was incarcerated suggests that family criminality is a significant predisposing and / or maintaining factor of a young persons criminality. Therefore, family therapy needs to be an essential component of intervention.

Substance Related Disorders

Treatment approaches found to significantly alleviate substance related disorders include cognitive behavioural therapy (Barrett-Waldon & Kern-Jones, 2004) and/or family therapy (Cormack & Carr, 2000). These should be the treatments of choice for treating substance related disorders amongst young people who are incarcerated.

Internalising Disorders

Anxiety disorders, including separation anxiety disorder, generalised anxiety disorder and social phobia should be treated with CBT (Gould, Otto & Pollock, 1995; Mattis & Pincus, 2004; Moore & Carr, 2000). Depressive disorders should also be treated with CBT (Moore & Carr, 2000; Seligman, Goza & Ollendick, 2004). Medication can also play an important role in the treatment of some psychiatric disorders. For example, medication in the treatment of serious mental illness such as psychosis or bipolar disorder is essential and for stimulant treatment of ADHD.

Treatment Delivery

Deficits in emotional intelligence amongst detainees, as identified in this research, have a number of implications for the manner in which treatment is delivered. Young people who find it difficult to perceive emotions, to understand emotions, to use emotions to facilitate thought and to regulate their emotions are likely to face challenges in therapy which often centre on these very abilities. Clinicians should, therefore, take care to match their therapeutic approach to clients' levels of emotional competence. In some instances, skills training to enhance EI should be considered as a possible prerequisite for therapy. This will assist in increasing the likelihood of successful engagement and sustainable treatment benefits.

2. Intellectual Disabilities

This research highlights the need for the development of specially designed educational and intervention programs for those with an intellectual disability. Back up support from specialists such as clinical psychologists and special educators is also very important. It is also likely that young people with intellectual disabilities will require additional supports to monitor and safeguard their rights whilst detained. These youth are perhaps more vulnerable to bullying.

3. Skills-Based Intervention Programs

The results of the current research point to the need for the automatic delivery of a number of evidence and skills-based programs to all young people in detention. These interventions should be aimed at enhancing emotional competency, anger management skills, relaxation skills and cognitive / CBT skills.

Skills training to increase EI competency will have a number of positive consequences. It will increase the likelihood of young people engaging in therapy and improve the likelihood of sustainable treatment effects. The development and delivery of effective and evidence-based EI skills programs will place Irish detention schools at the cutting edge of international practice in this area and will provide schools with a unique opportunity to become centres of excellence in the enhancement of EI amongst young people in detention.

4. Staff Training

The high levels of psychological morbidity and the significant deficits in IQ and EI highlighted in this research point to the need for staff training. This is required to assist staff in recognising psychological disorders and in increasing awareness about the interplay between psychological problems and a young person's behaviour within a detention school. Staff require training and support to implement strategies that will assist young people in overcoming their difficulties and that will assist young people in their day to day lives. Staff will benefit from on-going support to help them to manage difficult and stressful situations that will arise as a result of a young person' s emotional and behavioural problems. Training on intellectual disabilities and on how to manage difficulties associated with cognitive deficits is also required.

5. Early Intervention / Prevention

The high rates of criminality, psychological difficulties and cognitive and emotional deficits in this client group highlight the importance of the early identification of young people in community who are at risk of future offending and incarceration. In the interest of prevention, all young people who come to the attention of the Juvenile Diversion Program for engagement in criminality should be automatically referred to community psychology services for psychological assessment and treatment.

This research suggests that specific characteristics are associated with young people who are in detention in Ireland. Being part of a criminalised family, having a history of behavioural problems in school and poor school attainment are perhaps potential warning signs of the subsequent development of offending behaviour. School Principals, Education and Welfare Officers and professionals working in the National Educational Psychology Service (NEPS) should ensure that all young people who present with such difficulties are referred to a community care psychology service for psychological assessment and intervention. Staff from Probation, Education and the Health Service

Executive (HSE) should be vigilant for the identification of youths who are part of criminalised families. These families should receive co-ordinated supports from professionals in Health, Education and Probation.

IMPLICATIONS FOR SERVICE MONITORING AND EVALUATION OF SERVICE PROVISION

Systems that evaluate the effectiveness of assessment and intervention procedures and that lead to audits of the mental health services provided to young people in detention are required. This will ensure that the psychological needs of children are being met effectively and that services are cost-effective.

IMPLICATIONS FOR FUTURE RESEARCH

There is a dearth of quality, evidence-based, research relating to young people with offending difficulties and an urgent need for scientific studies which can reliably inform thinking on the most effective means of reducing youthful offending. A number of areas in particular warrant investigation:

Young People On The Cusp Of Criminality

All of the boys included in this research had serious levels of criminality which are likely to stem from deeply engrained patterns of offending behaviour. In the interest of early intervention and prevention, empirical research is required to identify the psychological needs of young people who are on the cusp of involving themselves in criminality. Research is needed to describe the function of such behaviour, to identify the factors that are likely to precipitate and maintain criminal behaviour and to analyse the psychological needs of such youths and their families. Research such as this will inform the development and delivery of community based services and clinical practice. It will help to inform the development of assessment and intervention strategies that are effective in reducing offending problems in the community.

Family Characteristics

A comprehensive empirical research project that describes the family characteristics of young people who are in detention is needed. The high levels of psychological morbidity, criminality and other difficulties highlighted in this research could only be maintained within the context of families who experience significant and similar difficulties. Research which is successful in identifying important family characteristics associated with youthful offending and mental health problems will guide and inform thinking on how best to treat young people with offending problems within the context of their families.

Emotional Competency

The development of skills based EI interventions are needed. This research should include an evaluation of the efficacy of such programs in increasing the emotional competency of young people who are incarcerated.

References

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual For The ASEBA School-Age American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., Text Rev.)*. Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders. Text Revision (Fourth edition)*. Washington D.C.: American Psychiatric Association.

An Garda Siochana. (2005). *Annual Report 2004.* Dublin: Government Publications.

Aos, S., Phipps, P., Barnoski, R., & Lieb, R. (1999). *The comparative costs and benefits of programs to reduce crime: A review of national research findings with implications for Washington State.* Olympia: Washington State Institute for Public Policy.

BarOn, R. (1997). *The Emotional Quotient Inventory (EQi Technical Manual*. Toronto: Multi-Health Systems.

BarOn, R. & Parker, J. D. A. (2000). *BarOn Emotional Quotient Inventory: Youth Version.* Technical Manual. New York: Multi Health Systems.

Barrett Waldron, H. & Kern-Jones, S. (2004). Treatment of substance abuse disorders in children and adolescents. In P. M. Barrett & T. H. Ollendick, (Eds.), *Handbook of interventions that work with children and adolescents. Prevention and treatments*. (329-342). West Sussex, England: John Wiley & Sons.

Bohnert, A. M., Crnic, K. A. & Lim, K. G. (2003). Emotional competence and aggressive behaviour in school age children. *Journal of Abnormal Child Psychology,* 31(1), 79-91.

Borduin, C. M., Henggeler, S. W., Blaske, D. M. & Stein, R. J. (1990). Multisystemic treatment of adolescent sex offenders. *International Journal of Offender Therapy and Comparative Criminology,* 34(2), 105-113.

Bourke, M. P., Taylor, G. J., Parker, J. D. A. & Bagby, R. M. (1992). Alexithymia in women with anorexia nervosa. *British Journal of Psychiatry*, 161, 240-243.

Brosnan, R. & Carr, A. (2000). Adolescent conduct problems. In Carr, A., (Ed.), *What works with children and adolescents? A critical review of the psychological interventions with children, adolescents and their families.* (131-154). London: Routledge.

Corcos, M., Guilbaud, O., Speranza, M., Paterniti, S., Laos, G., Stephan, P. & Jeammet, P. (2000). Alexithymia and depression in eating disorders. *Psychiatric Research*, 93(3), 263-266.

Cormack, C. & Carr, A. (2002). Drug abuse. In Carr, A., (Ed.), *What works with children and adolescents? A critical review of the psychological interventions with children, adolescents and their families*. (65-101). London: Routledge.

Carr, A. (2006). *The handbook of child and adolescent clinical psychology: A contextual approach (2nd Edition)*. London: Routledge.

Carr, A. (1999). *The handbook of child and adolescent clinical psychology: A contextual approach.* London: Routledge.

Carr, A., O' Reilly, G., Noonan-Walsh, P. & McAvoy, J. (2007). *The Handbook of Intellectual Disability and Clinical Psychology Practice.* London: Routledge.

Cox, R. P. (1995). An exploration of the demographic and social correlates of criminal behaviour among adolescent males. *Journal of Adolescent Health*, 19, 17-24.

Derogatis, L. R. (1977). *The SCL-90 manual I: Scoring, administration and procedures for the SCL-90.* Balitmore: John Hopkins University School of Medicine, Clinical Psychometrics Unit.

Derogatis, L. R. (1993). *Administration, scoring and procedures manual*. Minneapolis: National Computer Systems.

Eisenberg, N. & Miller, P. (1987). Empathy and pro-social behaviour. *Psychological Bulletin*, 17, 273-282.

Garland, A. F., Hough, R. L., McCabe, K. M., Yeh, M., Wood, P. A. & Aarons, G. A. (2001). Prevalence of psychiatric disorders in youths across five sectors of care. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40(4), 409-418.

Garnefski, N., Teerds, J.Kraaij, V., Legerstee, J. & Van den Kommer, T. (2004). Cognitive emotion regulation strategies and depressive symptoms: differences between males and females. *Personality and Individual Differences,* 36(2), 267-276.

Gould, R. A., Otto, M. W. & Pollack, M. H. (1995). A meta-analysis of treatment outcome for panic disorder. *Clinical Psychology Review,* 15(8), 819-844.

Hayes, L. M. (1999). *Suicide prevention on juvenile correction and detention centres: A resource guide for performance-based standards for juvenile correction and detention facilities*. Washington D.C.: Council of Juvenile Correctional Adminstrators.

Hinshaw, S. P., March, J. S., & Abikoff, H. (1997). Comprehensive assessment of childhood and attention deficit hyperactivity disorder in the context of multisite, multimodal clinical trial. *Journal of Attention Disorders*, 1, 217-234.

Hollin, C. R. (1999). Treatment programs for offenders. Meta-analysis, 'what works' and beyond. *International Journal of Law and Psychiatry*, 22(3), 361-372.

Kroll, L, Rothwell, J., Bradley, D., Shah, P., Bailey, S. & Harrington, R. C. (2002). Mental health needs of boys in secure care for serious or persistent offending: A prospective, longitudinal study. *The Lancet,* 359(8), 1975-1979.

Laquatra, T. A. & Clopton, J. R. (1994). Characteristics of alexithymia and eating disorders in college women. *Addictive Behaviour,* 19(4), 373-380.

Lipsey, M. W. (1995). What do we learn from 400 research studies on the effectiveness of treatment with juvenile delinquents? In J. McGuire (Ed.), *What works: Reducing reoffending. Guidelines from research and practice.* (pp.63-78). West Sussex: John Wiley & Sons.

Martin, M. & Carr, A. (2006). *The Clonmel Project Report. Mental Health Service Needs of Children and Adolescents in the South East of Ireland*. Kilkenny: Communications Department, HSE South.

Mattis, S. G. & Pincus, D. B. (2004). Treatment of SAD and panic disorder in children and adolescents. In P. M. Barrett & T. H. Ollendick, (Eds.), *Handbook of interventions that work with children and adolescents. Prevention and treatments*. (pp. 145-170). West Sussex, England: John Wiley & Sons.

Mayer, J. D., Salovey, P. (1997). What is emotional intelligence? In P. Salovey & D. Sluyter (Eds.), *Emotional development and emotional intelligence: Implications for educators* (pp.3-31). New York, Basic Books.

Mayer, J. D., Salovey, P. & Caruso, D. R. (May 2, 2006). *Test manual for the Mayer-Salovey-Caruso Emotional Intelligence Test-Youth Version (MSCEIT: YV), Version 0.8. Manuscript in Preparation*. Toronto, Canada: MHS.

Mayer, J. D., Salovey, P., & Caruso, D. R. & Sitarenious, G. (2003). Measuring emotional intelligence with the MSCEIT V2.0. *Emotion*, 3(1), 97-105.

McMahon, R. J. & Kolter, J. S. (2004). Treatment of conduct problems in children and adolescents. In P. M. Barrett & T. H. Ollendick, (Eds.), *Handbook of interventions that work with children and adolescents. Prevention and treatments*. (395-426). West Sussex, England: John Wiley & Sons.

Moore, M. & Carr, A. (2000). Anxiety disorders. In Carr, A., (Ed.), *What works with children and adolescents? A critical review of the psychological interventions with children, adolescents and their families*. (178-202). London: Routledge.

Moore, M. & Carr, A. (2000). Depression and Grief. In Carr, A., (Ed.), *What works with children and adolescents? A critical review of the psychological interventions with children, adolescents and their families.* (pp. 203-132). London: Routledge.

National Institute of Mental Health. (2000). *Diagnostic Interview Schedule for Children IV (NIMH DISC-IV)*. New York: State Psychiatric Division of Child and Adolescent Psychiatry.

National Institute of Mental Health. (2000). Diagnostic Interview Schedule for Children IV (NIMH DISC-IV). Description, Differences From Previous Versions, and Reliability of Some Common Diagnosis. *Journal of the American Academy of Child and Adolescent Psychiatry,* 39 (1), 28 – 38.

O' Reilly, G., & Carr, A., (2004). Theoretical models of sexually abusive behaviour.In O' Reilly, G., Marshall, W. L., Carr, A., & Beckett, R., (Eds). *The Handbook of Clinical Intervention with Young People who Sexually Offend*. London: Brunner Routledge.

Parker, J. D. A., Taylor, G. J., Bagby, R. M. & Acklin, M. W. (1993). Alexithymia in panic disorder and simple phobia: A comparative study. *American Journal of Psychiatry*, 150, 1105-1107.

Parker, J. D. A., Taylor, G. J. & Bagby, M. R. (2001). The relationship between emotional intelligence and alexithymia. *Personality and Individual Differences,* 30(1), 107-115.

Pizarro, D. A. & Salovey, P. (2002). *Being and becoming a good person: The role of emotional intelligence in moral develop ment and behaviour.* In J. Aronson (Ed) (2002). New York: Academic Press.

Quayle, E., Vaughan, M. & Taylor, M. (2006). Sex offenders, internet child abuse, images and emotional avoidance: The importance of values. *Aggression and Violent Behaviour*, 11, 1-11.

Reich, W. (2000). Diagnostic Interview for Children and Adolescents (DICA). In A. J. Rush, H. A. Pincus, M. B., First, (Eds.), *Handbook of Psychiatric Measures*. (pp. 314-318). Washington D. C.: American Psychiatric Association.

Seligman, L. D., Goza, A. B. & Ollendick, T. H. (2004). Treatment of ADHD in children and adolescents. In P. M. Barrett & T. H. Ollendick, (Eds.), *Handbook of interventions that work with children and adolescents. Prevention and treatments.* (pp. 301-328). West Sussex, England: John Wiley & Sons.

Wechsler, D. (1997). *WAIS-III: Wechsler Adult Intelligence Scale* (Third ed.). San Antonio, TX: The Psychological Corporation.

Shields, A. & Cicchetti, D. (1998). Reactive aggression among maltreated children: The contributions of attention and emotion dysregulation. *Journal of Clinical Child Psychology*, 27 (4), 381-395.

Sim, L. & Zeman, J. (2004). Emotional awareness and identification skills in adolescent girls with bulimia nervosa. *Journal of Clinical Child and Adolescent Psychology*, 33(4), 760-771.

Suveg, C. & Zeman, J. (2004). Emotion regulation in children with anxiety disorders. *Journal of Clinical Child and Adolescent Psychology*, 33(4), 750-759.

Taylor, G. J. (2001). *Emotional intelligence in everyday life: A scientific inquiry*. Philadelphia: Psychology Press.

Wasserman, G. A., McReynolds, L. S., Lucas, C. P., Fisher, P., & Santos, L. (2002). The Voice DISC-IV With Incarcerated Male Youths: Prevalence of Disorders. *Journal of the American Academy of Child and Adolescent Psychiatry,* 41 (3), 314 – 321.

Wasserman, G. A., Jensen, P. S., Ko, S. J., Cocozza, J., Trupin, E., Angold, A., Cauffman, E & Grisso, T. (2003). Mental health assessments in juvenile justice: Report on the consensus conference. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42(7), 752 – 761.

Wasserman, G. A., McReynolds, L. S., KO, S. J., Katz, L. M., Cauffman, E., Haxton, W., & Lucas, C. P. (2004). Screening for Emergent Risk and Service Needs Among Incarcerated Youth: Comparing MAYSI – 2 and Voice DISC – IV. *Journal of the American Academy of Child and Adolescent Psychiatry,* 43 (5), 629 – 639.

Wechsler, D. (1999). *Wechsler Abbreviated Scale of Intelligence. Manual*. San Antonio: Harcourt Brace & Company.

Wechsler, D. (1997). *WAIS-III: Wechsler Adult Intelligence Scale* (Third ed.). San Antonio, TX: The Psychological Corporation.

Whiteside, U., Chen, E. & Neighbours, C., Hunter, D., Lo, T. & Larimer, M. (in press). Difficulties regulating emotions: Do binge eaters have fewer strategies to modulate and tolerate negative affect? *Eating Behaviours Journal*.

World Health Organisation. (1992). *Multi-axial classification of child and adolescent psychiatric disorders: ICD 10*. Geneva: World Health Organisation.

Zeitlin, S. B. & McNally, R. J. (1992). Alexithymia and anxiety sensitivity in panic disorder and obsessive compulsive disorder. *American Journal of Psychiatry*, 150, 658-660.

Zeman, J., Shipman, K. & Suveg (2002). Anger and sadness regulation: Predictions to internalising and externalising symp toms in children. *Journal of Clinical Child and Adolescent Psychology*, 31(3), 393-399.

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