# Clinical Evaluation of Juvenile Delinquents: Who Gets Court Referred?

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**This study examines which alleged delinquents in a large urban juvenile court are selected for referral to the court's psychiatric clinic. A number of demographic factors, probation officer impressions, index charges, and past delinquency record variables were examined for all minor delinquency cases referred in a six-month period and for a random selection of nonreferred cases. In general, referral was associated with lower socioeconomic status (SES), and with a variety of probation impressions of child and family dysfunction. Little relation to index charge or past record was found. The authors interpret these results as showing that probation referrals appear to be made more on the basis of high risk than on the basis of favorable prognosis for treatment.**

Mental health clinicians who provide service to the legal system have complex roles. Understanding the complexities of these roles is especially difficult because of the wide variety of forensic clinicians and settings in which they practice. Because of this variety, clinicians are pressed into different roles in different circumstances and experience different problems as a result.[1]

This report addresses the question of how clinical expertise is used in a specific forensic mental health setting. It examines a large sample of youth alleged to be delinquent, some of whom were referred to the Boston Juvenile Court Clinic for evaluation. It explores a variety of demographic and forensic characteristics which differentiate youth selected for mental health attention from those who are not. Based on these differences, it makes inferences about how the court and its staff are using clinical expertise.

## Literature Review

Forensic mental health consultation is typically used in different ways in different legal settings.[2] It may focus on (1) narrow forensic issues, such as criminal responsibility or various competencies; (2) indications for treatment or commitment; or (3) signs of mental injury or disability. Programmatic or forensic considerations may lead different settings to focus on specially defined or

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This work was supported in part by the Massachusetts Trial Court and the Massachusetts Department of Mental Health, Forensic Mental Health Division.

limited populations. Among possible definers of appropriateness for clinical referral are such characteristics as mental illness; emergent status; diagnostic categories such as drug abuse, alcoholism, or mental retardation; or potential treatability.

In settings where referral criteria are not clearly defined by the program or the legal context, a forensic clinic may be open to a variety of uses. Early work from Massachusetts court clinics indicates that one possible role of a court clinic is to provide diagnosis and treatment for a subgroup of clients involved in court, selected for their capacity for treatment.[1,3] This selection may involve implicit or explicit SES or racial bias. Studies by Lewis and others[4,5] explored the question of bias, comparing conduct disordered youth who are processed by juvenile courts with others who find their way to the clinical system with similar conduct problems. They found that socioeconomic status (SES) and racial variables may contribute to which route is taken in a labeling or stigmatizing way. Important questions about such programs include whether court staff refer clients to a clinic on the basis of a suspicion of psychiatric disorder, or on the basis of likely responsiveness to a specialized mental health service. If they do, what proxy variables raise that suspicion or indicate treatability?

There are a few reports in the literature describing mental health consultation programs in juvenile or family court settings. There are some other reports studying specific characteristics of the clients of such programs. Most of these reports explain how the program appears to be used, but few define the population seen by the clinic in a manner which makes it possible to see how the referred population may differ from the general population of youth seen by the court. Thus, it is difficult to infer what kind of process is taking place when clients are selected for clinical attention.

Chamberlain and Awad[6] offered a thoughtful description of a juvenile court clinic program in Toronto but included no specific data regarding what cases were referred or not referred. White[7] reported similarly on a juvenile court program in Cambridge, Massachusetts, without offering findings on types of cases referred.

Nurnberg[8] described a psychiatric consultation for a family court in White Plains, New York, which saw seven percent of the court's cases. He described diagnostic impressions in these cases, finding a lower than expected incidence of major psychopathology, and speculated on possible reasons for this within the referral process. No comparison data were offered on cases not referred.

Kelley[9] described a crisis assessment program affiliated with the juvenile court in Detroit. The program set defined criteria for referral (youth detained; emotional disturbance as evidenced by aggressive or selfdestructive behavior; apparent family disturbance) in an explicit attempt to capture youth with a high prevalence of clinical disturbance. No data were presented comparing those referred with those not referred. Heller *et al.*[10] reported on a large

sample of adult and juvenile cases seen in consultation for the Court of Common Pleas in Philadelphia. A selection of these cases was reviewed with regard to diagnosis and type of crime, and it was found that there was no association between psychosis and violence. Subjects were not described in terms of age, so that it was not possible to see if the juvenile sample was in any way different from the group as a whole. It was not clear what portion of the court's case load was referred, or what distinguished cases referred from those not referred.

Jaffey *et al.*[11] described a family court clinic in London, Ontario. This clinic sees about 200 cases per year, or about 10 percent of the court's caseload. Considerable information was offered on the referred clients. Different explicit reasons for referral were noted between boys (aggressive behavior) and girls (school problems and emotional upset). However, since no data were offered on nonreferred cases, it is difficult to be sure that these differences represent a referral bias as the authors suggest.

The most detailed empirical studies of delinquents in a court clinic setting are by Lewis and colleagues[12] in New Haven. An early report describes this program as offering comprehensive psychiatric evaluation for youth referred from probation officers or judges (about 3% of the court caseload) for any reason. This report does not compare those referred with those not referred. A larger and more detailed study of this clinic population[13] included comparisons between referred and nonreferred clients and found no differences with regard to SES, race, gender distribution, or occurrence of treated parental psychopathology, but found that referred youth tended to be younger and to have more offenses. Both studies found high prevalences of psychotic symptoms in the clinic population. In work which directly compared referred and nonreferred youth on clinical variables, Lewis' group[14,15] discovered significantly more physical trauma (including child abuse) and more state-sponsored parental psychiatric care in the referred group.

## The Current Setting

The Boston Juvenile Court has an annual delinquency caseload of about 1,200 new individual cases. It also deals with even larger numbers of status offenses, and with about 300 new child dependency cases annually. The Court Clinic offers comprehensive psychiatric, psychological, and psychosocial assessment on all these types of cases, seeing about 1,000 new referrals annually.

Studying issues related to the use of clinical services in this setting offers the following advantages over other settings. It is a large court with a large delinquent population, a large probation staff, and a large clinic. There are no defined or implicit limits on clinic referrals because of scarce resources as in many programs, and no explicit policies have ever been stated about what constitutes an "appropriate" referral. Therefore, the judges and probation staff are enabled and encouraged to use the clinic in whatever ways they feel may be helpful.

There is a local policy in this court requiring that all delinquency cases

which could by statute be considered for transfer to adult criminal court be formally processed for such consideration. This consideration is referred to as a "transfer hearing."[16,17] Furthermore, all transfer hearing cases are referred mandatorily to the clinic. These cases generally involve youth over 14 but less than 17 (the age of adult criminal liability in Massachusetts) who are charged with an offense in which physical harm or the threat of harm is involved. Therefore, clinic referral is discretionary only in less serious cases, or in serious cases involving offenders younger than 14. Discretionary referrals are usually made at the initiative of a probation officer with the formal approval of a judge. Sometimes they are made at a judge's initiative. Delinquency cases not referred are processed without clinical evaluation.

The forensic practice in these discretionary referrals is quite informal. It is routinely understood that the purpose of the evaluation is to offer information and recommendations regarding psychiatric diagnosis and treatment to be used in dispositional planning.[18] If in the course of an evaluation questions arise regarding a need for psychiatric commitment for emergency treatment or (rarely) evaluation of competency, then the assessment is used for that purpose as needed. Otherwise, the results of the evaluation are held until after a finding is made in the case and then presented to the court at the disposition phase.

## Methods

This work has involved reviewing the records of 140 teens arraigned on delinquency matters in a six-month period in 1985. Eighty of these were youths referred to the clinic in that period on discretionary charges ("referred group"). The other sixty were a randomly selected sample of youths arraigned on nontransferable delinquency charges, who had not been selected for referral to the clinic. There were 591 new delinquency cases in this period, 77 of which were considered for transfer. Therefore, the randomly selected comparison group represented about 12 percent of the entire nonreferred nontransferable delinquency caseload. There is no reason to suspect that this random sample was not representative of that entire nonreferred caseload.

At the time of arraignment, a probation officer takes a history and fills out an intake sheet, covering background information and his or her immediate impressions about the case. The probation intake data on all 140 cases were reviewed and analyzed to determine what differences there were between youths who were selected for referral to the clinic and those that were not.

In addition, the delinquency record of each case was reviewed, to seek relationships between referral and (1) the nature of the current charge, (2) the total number of charges involved in the current appearance, (3) the total number of all delinquency appearances, and (4) the total number of charges for all appearances.

The probation intake sheets contained about 30 items of information, all of which were coded and analyzed. Table 1 lists the 19 of these 30 items for which

**Table 1**
**Probation Intake Items**

| |
|---|
| Neighborhood |
| Age |
| Race |
| Parents together? |
| Number of siblings |
| Number of siblings with record |
| Mother employed? |
| Father employed? |
| Parent education: |
| Number of grades completed: mother |
| Number of grades completed: father |
| Mother's occupation |
| Father's occupation |
| Annual family income |
| Child's grade in school |
| Special education involved before this year |
| Special education involved this year |
| School comment |
| Attitude comment |
| Health comment |
| Agency contact comment |
| Family comment |

half or more of the intake sheets had information available. These items formed the basis for the analyses of intake data.

Socioeconomic status of the youths' families was categorized into one of five classes according to the Hollingshead four factor index,[19] based on material provided in the probation intake form. The Hollingshead two factor index was used if information was not available on both parents. The families' total annual incomes were also included in the analysis when available.

Since there was wide variation in the degree to which these forms were actually complete, the number of items missing was also recorded, to see if there was any relationship between a case being referred and the completeness of the initially available information.

Some intake form answers were in the form of descriptive probation officer "comments" regarding a youth's agency involvement, attitude, health, family, and school functioning. These were reviewed in detail and discovered to show certain consistent features. These were then recorded as either present or absent. Results on each item were analyzed using a chi-square test for association to referral or nonreferral to the clinic. The nature of the charge(s) at arraignment (index charges) were similarly analyzed to determine if there was a relationship between specific charges and being referred. The total number of each specific charge on a youth's record (both in this court and in other courts) was analyzed in like fashion. The total number of charges and the total number of events of delinquency arraignment (multiple charges at one time constitute one event) were also analyzed. For these variables there appeared to be a more complex relationship with referral.

## Results

***Intake Data*** The demographic variables and probation officer impressions (intake data) which showed significant association with referral are presented in Table 2. None of the other intake data listed in Table 1 was related to referral.

There was a dramatic relationship between gender and referral, with girls disproportionately referred. A confounding variable is that at the time of this work, female delinquent cases were all handled by female probation officers, and males by males. Furthermore, the females' caseloads appeared to be smaller. There-

**Table 2**
**Intake Variables Associated with Referral**

| Variable | | N | No. Referred | No. not referred | $\chi^2$ |
|---|---|---|---|---|---|
| Gender | M | 99 | 49 | 50 | 0.006 |
| | F | 40 | 30 | 10 | |
| Age | ≥15 | 87 | 41 | 46 | 0.029 |
| | <15 | 43 | 29 | 14 | |
| Father's occupation | 3–9 | 30 | 11 | 19 | 0.039 |
| | 1, 2 | 23 | 15 | 8 | |
| Hollingshead class | 1–4 | 46 | 19 | 27 | 0.067 |
| | 5 | 41 | 25 | 16 | |
| Income | >10,000 | 32 | 12 | 20 | 0.058 |
| | <10,000 | 40 | 24 | 16 | |
| Past special education | No | 60 | 20 | 40 | 0.035 |
| | Yes | 18 | 11 | 7 | |
| Current special education | No | 64 | 23 | 41 | 0.054 |
| | Yes | 16 | 10 | 6 | |
| School comment | OK or grades | 62 | 22 | 40 | 0.000 |
| | Conduct, attendance | 58 | 41 | 17 | |
| Health comment | OK, illness | 101 | 47 | 54 | 0.001* |
| | Trauma, alcohol, drugs | 26 | 21 | 5 | |
| Agency comment | None/other | 106 | 52 | 54 | 0.056* |
| | DYS/DSS | 11 | 9 | 2 | |
| Family comment | No problem | 72 | 23 | 49 | <0.001* |
| | Discord | 29 | 25 | 4 | |
| No. items missing | <9 | 45 | 13 | 32 | <0.001 |
| | ≥9 | 95 | 67 | 28 | |

* Fisher's exact test, two-tailed.

fore, it cannot be determined whether the gender disproportion represents a difference in how girl and boy delinquents are generally perceived by probation officers, or whether it represents differences between male and female probation officers or their caseload size.

Younger teens and those with a history of involvement in special education programs were more likely to be referred than older ones and those with no special education involvement. Youth from families in Hollingshead's social class 5 were more likely to be referred than those from higher classes. This difference was a result of a significant difference in fathers' occupations between the referred and nonreferred groups, as there were not significant differences on the other three factors of the SES index (mother's occupation, and mother's and father's education). Youth from families with lower incomes were more likely to be referred, at a marginal level of significance.

Most probation officer comments were significantly associated with referral.

In reviewing comments on school function, it was noted that probation officers tended to mention problems with attendance, grades, and/or conduct. Comments mentioning attendance and/or conduct problems correlated

with referral and were aggregated. Simple problems with grades did not contribute to clinic referral.

Probation officers included a wide variety of concerns under a health comment, including acute or chronic illness, apparent drug or alcohol abuse, and a history of physical trauma. Probation impression of drug or alcohol abuse or physical trauma was associated with referral; illness was not.

Youth were described as having been involved with various agencies for service. Previous involvement with the state agencies providing social services or youth corrections were significantly related to referral, compared with either no agency or other agency involvement.

Probation officers described family functioning in different ways but consistently referred to the presence or absence of obvious discord or abuse in the family. Presence of apparent discord or abuse was strongly correlated with clinic referral.

"Attitude" referred to the youth's deportment in the probation interview, and problems in this area could all be subsumed under a youth being described in some way as mean or surly. This attitude problem was uncommon, and its association with clinic referral when present fell short of statistical significance.

The number of items missing in the probation intake was correlated with clinical referral. The referral profiles of individual probation officers were examined to determine (1) if there were a few probation officers who were primarily responsible for leaving out most of the missing intake data, and (2) if there were significant differences among probation officers in the variables associated with referral in their individual caseloads. There was very little variation among probation officers in the proportion of data missing in their intake sheets. There were some apparent individual differences among probation officers in the kinds of cases they referred, but they did not appear striking, and none approached statistical significance.

***Index Charges*** Index charges related to referral (Table 3) were few, and correlated more negatively than positively. For all other index charges there was no relation to referral or nonreferral.

***Aggregate Charges*** There was no relationship between increased numbers

**Table 3**
**Index Charges Associated with Referral**

| Variable | | N | No. Referred | No. not Referred | $\chi^2$ |
|---|---|---|---|---|---|
| Motor vehicle breaking and entering | Yes | 4 | 0 | 4 | 0.032* |
| | No | 136 | 80 | 56 | |
| Destruction of personal property | Yes | 11 | 3 | 8 | 0.055* |
| | No | 129 | 77 | 52 | |

* Fisher's exact test, two-tailed.

of charges and clinic referral for any specific individual charges, nor for the total number of all charges in the record.

A surprising relationship did appear between clinic referral and total number of all events of delinquency court involvement (Table 4). A medium number of events was correlated with clinic referral, but neither a small number nor a very high total number of events was.

Recognizing that many different variables appeared related to clinic referral, multivariant analysis was attempted. However, the number of missing data made it impossible to glean any significant results.

## Discussion

The results indicate that court staff select non-violent delinquent youth for clinical consultation on the basis of a variety of status variables, with little contribution from the nature of the index charges or from the youth's previous delinquency record.

Two types of status variables are involved: (1) explicit probation officer impressions of the adolescent and his or her family, and (2) demographic factors. The demographic factors may make an explicit contribution to the probation officer's impressions, or may be secondarily associated with whatever features in the youth or family actually motivate the referral decision.

Taken together, the demographic and impressionistic variables associated with referral portray a young adolescent from a poor family with significant school, conduct, and family problems, involved in court for a relatively minor delinquency charge, the specific nature of which is relatively unimportant. There appears to be no racial bias involved, either for or against clinic referral.

The characteristics of social, economic, and educational disadvantage in the referred group are fairly similar to characteristics found in youth who tend to be at high risk for developing delinquent and criminal careers, especially school problems, family discord, and drug and alcohol abuse.[20,21] They are clearly not the characteristics of youth and families who tend to respond unusually well to mental health intervention. Thus, it appears that in this setting referral to the clinic for assessment is not a reflection of a probation officer's impression that a youth might be a good candidate for therapy. Rather, it appears to reflect court staff's recognition that the youth is at high risk for developing further delinquency and the hope that a careful and thorough diagnostic assess-

**Table 4**
**Other Charge Factors Associated with Referral**

| Variable | | N | No. Referred | No. not Referred | $\chi^2$ |
|---|---|---|---|---|---|
| Total | 1 | 66 | 33 | 33 | |
| Number of All Events | 2, 3 | 36 | 26 | 10 | 0.013 |
| | 4 or more | 23 | 8 | 15 | |

ment can contribute to developing a broader plan of preventive intervention.

This interpretation is supported by the finding that cases are referred more when data are missing. Although it is possible that this finding reflects probation staff's transferring the work of data-gathering to the clinic, it is more likely that it reflects the difficulty of the cases selected for referral. These youths and their families are puzzling and it can be hard to get even simple information from them. This interpretation is also supported by the finding that the likelihood of referral goes down at higher levels of total events in the youths' records. It appears that in these cases court staff have less hope in the possibility of successful prevention.

It is interesting to note that the clinic itself has played very little role in providing any formal education to court staff, so that probation officers' selection of this high risk group of minor delinquents for referral is not a result of the clinic's attempting to develop that specific practice. It is not clear whether the practice represents the result of some formal education by which probation staff have learned to recognize risk factors, or whether it is simply the result of intuition or of professional experience.

There are two issues of obvious major importance which this work does not address. The first issue is whether the selection of youths with these high risk demographic and impressionistic characteristics for clinical assessment is an efficient process with regard to the discovery of specific psychopathology, treatable or not. Other work reviewing the psychological characteristics of delinquents suggests that it probably is. It is clear that youths who become seriously delinquent show a disproportionate prevalence of some thought disorder symptoms, hyperactivity, affective disturbance, and neurocognitive impairment.[22,23] It is likely that this referred group, showing the signs of high risk that it does, also has a disproportionate prevalence of these psychiatric problems. Certainly this is our clinical impression. Further work is planned to test this hypothesis, by exposing both referred and nonreferred youths to comparable clinical assessment.

The second issue is whether this use of clinical assessment works in terms of actual prevention. In planning and providing the broad range of psychosocial, educational, and psychiatric services which these youths appear to need, how much does basing these services on high quality rigorous clinical assessment actually improve their effectiveness? We believe that such assessment makes a significant contribution. However, we acknowledge that there seems to be little empirical information to provide firm support for this belief or to help us understand what aspects of clinical assessment may make what contributions to improving effectiveness of intervention for this type of population.

In summary, the staff of this large urban juvenile court make frequent use of mental health assessment of delinquent youths. They appear to select youths for this assessment not on the basis of their being good candidates for traditional psychotherapy. Instead, the

features of the youths referred suggest that they are selected because of being at high risk for developing more serious delinquency. The implicit expectation of the court in obtaining mental health consultation for these youths is that it may help in designing programs of more intensive specific service to prevent further problems. It remains to be seen whether this expectation is fulfilled.

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