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RACE, JUVENILE JUSTICE, AND MENTAL HEALTH: NEW DIMENSIONS IN MEASURING PERVASIVE BIAS

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I. INTRODUCTION

Delinquent Children, are those, who through Ignorance, Vice, Folly, Sport Carelessness, Thoughtlessness and in a hundred other ways, violate City Ordinances, Laws, statutes or the Rights of Others, for which there must be some method of Correction.

Defective Children, are those who are physically or mentally deficient, thereby becoming a charge upon the State, and therefore need the Protective Care of The State or Community in their misfortune; whether these physical or mental Defects are due to Heredity or otherwise, the best method of handling them is through the Juvenile Court, or one similar to it, after which they may be sent to the proper Institution, where the best care for the individual case may be given.[1]

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[1] WILLIAM MACDONALD, A STORY OF JUVENILE COURTS FROM THEIR INCEPTION TO THE PRESENT DAY, WITH COMMENTS UPON THE EXTENSION OF THE PROBATION SYSTEM AND A HISTORY OF THE JUVENILE COURT MOVEMENTS 6 (1912).

Almost from the moment of its inception in 1899,[2] the juvenile court has witnessed criticism of its handling of youths suffering from mental illness. Dr. William MacDonald made the point in a 1912 critique of the Connecticut juvenile justice system: "We should have a law creating a Juvenile Psychopathic Institute for Juvenile Offenders, Mental Defectives, and etc. Many of these Juvenile Offenders need the services of a good physician more than they do those of the jailor."[3]

As soon as states had begun to address Dr. MacDonald's concern,[4] criticism turned to the disposition of juvenile criminal offenders between the criminal justice and mental health systems.[5] The research has usually taken one of two forms. Most research has compared samples from the juvenile justice and mental health systems and concluded that race is "the most striking factor distinguishing the two groups."[6] Other researchers have compared the juvenile criminal justice and mental health population with the racial distribution of the general population and found an "absence of racial bias in admission" to the mental health facilities.[7]

Our study injects two new dimensions into the existing body of knowledge. First, it is the first study to compare only court-referred adolescents in the mental health system with those in the criminal justice system. This methodology offers a more

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[2] ANTHONY A. PLATT, THE CHILD SAVERS 9 (1969) (identifying the Illinois juvenile court established in 1899 as the first "official" juvenile court in the nation).

[3] MACDONALD, *supra* note 1, at 27.

[4] *See infra* Part II.B.

[5] *See* American Psychiatric Association, *APA Official Actions: The Psychiatrist and the Juvenile Court System*, 147 AM. J. PSYCHIATRY 1584, 1584 (1990) (chronicling the psychiatric profession's concern with the juvenile court from its inception).

[6] Dorothy Otnow Lewis et al., *Race Bias in the Diagnosis and Disposition of Violent Adolescents*, 137 AM. J. PSYCHIATRY 1211, 1211 (1980) [hereinafter Lewis et al., *Violent Adolescents*]. *See also* Dorothy Otnow Lewis et al., *Some Evidence of Race Bias in the Diagnosis and Treatment of the Juvenile Offender*, 49 AM. J. ORTHOPSYCHIATRY 53 (1979) [hereinafter Lewis et al., *Juvenile Offenders*]; Floyd Westendorp et al., *Variables Which Differentiate Placement of Adolescents Into Juvenile Justice Or Mental Health Systems*, 81 ADOLESCENCE 23 (1986). For a more detailed discussion of existing research, see *infra* Part II.A.

[7] Stuart L. Kaplan & Joan Busner, *A Note on Racial Bias in the admission of children and adolescents to State Mental Health Facilities versus Correctional Facilities in New York*, 149 AM. J. PSYCHIATRY 768, 771 (1992). For a more detailed discussion of existing research see *infra* notes 124-70 and accompanying text.

precise measurement than that offered by all of the previous research which compared the full correctional school population with the full psychiatric hospital population. Second, the study is also the first to compare clinically-referred patients with court-referred patients in the juvenile mental health system.

Our findings indicate that the racial profiles of the court-referred and clinically-referred juveniles in the mental health system are statistically indistinguishable. A comparison with 1990 Connecticut census data reveals that racial minorities are over-represented in both the state-operated facilities of the mental health and the juvenile justice systems.[8] The populations did, however, exhibit different psychiatric profiles. The clinically-referred were more likely to exhibit psychotic disorders while the court-referred were more likely to exhibit overt conduct disorders.[9]

Part II of this article places our study's findings in historical and jurisprudential context by outlining the history of juvenile court, chronicling the court's involvement in the placement of adolescents in the criminal justice and mental health systems, and summarizing the courts and processes that figured in the study results. Part III provides an exposition of the existing body of knowledge on the subject. Part IV outlines our study's methods and findings and concludes with a detailed comparison of the psychiatric profiles of the clinically-referred and court-referred patients in the mental health system. Part V closes the article with a discussion of the implications of our findings for the future of the juvenile justice and mental health systems.

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[8] *1990 U.S. Census* (visited Nov. 16, 1998) <http://venus.census.gov/cdrom/lookup>.

[9] *See infra* Part IV.A.2.b.iv for definitions of these diagnoses. *See infra* Parts IV.B.2.f for a discussion of these findings.

II. THE HISTORICAL AND JURISPRUDENTIAL CONTEXT

A. THE ESTABLISHMENT OF THE JUVENILE COURT

Although there are some antecedents,[10] scholars generally acknowledge that the Illinois legislature created the first juvenile court in 1899.[11] Before that year, American courts followed the English custom of subjecting juveniles over the age of fourteen to the same laws and tribunals as adults.[12] Children under the age of seven were deemed incapable of forming the intent necessary for criminal conviction.[13] Those between the ages of seven and fourteen benefited from a rebuttable presumption of incapacity to form the requisite intent.[14]

Juveniles convicted were subject to the same penalties as adults, including incarceration in the same facilities.[15] The result, one observer unhappily reported, was the incarceration of youths guilty of what might have been termed juvenile mischief alongside hardened, adult convicts:

> In Illinois in 1897, and especially in Chicago, the condition of these classes of Juveniles was deplorable, there being in Cook County alone, over 2,000 boys in prison, for offenses such as petty thefts, disorderly conduct, killing birds, fighting, truancy, stealing rides on cars, and similar offenses; These boys were sent to Jail or Prison to work out fines from One to One Hundred Dollars and Fifty cents per day . . .[16]

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[10] The legislatures of Massachusetts and New York enacted, in 1874 and 1892, respectively, legislation separating child trials from adult trials. PLATT, *supra* note 2, at 9. In 1868 for girls and 1879 for boys, the Connecticut legislature enacted legislation in 1868 enabling police courts to commit girls to an "institution of correction" for adolescents who were "in danger of falling into vicious habits or crime." MACDONALD, *supra* note 1, at 8.

[11] PLATT, *supra* note 2, at 9-10. For two detailed accounts of the history of the juvenile court, see generally Barry C. Feld, *The Transformation of the Juvenile Court*, 75 MINN. L. REV. 691 (1991) [hereinafter Feld, *Transformation*]; Barry C. Feld, *The Juvenile Court Meets the Principle of Offense: Punishment, Treatment and the Difference It Makes*, 68 B.U. L. REV. 821 (1988) [hereinafter Feld, *The Principle of Offense*].

[12] David R. Barrett et al., Note, *Juvenile Delinquents: The Police, State Courts, and Individualized Justice*, 79 HARV. L. REV. 775 (1966).

[13] *Id.*

[14] *Id.*

[15] PLATT, *supra* note 2, at 9-10.

[16] *Id.* at 8.

Those bent on reform, and who became known as the originators of the Progressive Movement, argued that all convicted of crimes and especially juveniles should receive "individualization of treatment and a progressive form of prison discipline."[17] That individualized focus led to the creation of a variety of criminal justice reforms, including probation, indeterminate sentences, and parole.[18] Its cornerstone, where juveniles were concerned, was the creation of the juvenile court.[19]

The juvenile court was to be part of a system that removed minors from the adult criminal justice system and created programs to address the needs of "delinquent, dependent, and neglected children."[20] In large measure, this was to be accomplished through substitution of rehabilitation for punishment:

> The problem for determination by the judge is not, Has this boy or girl committed a specific wrong, but What is he, how has he become what he is, and what had best be done in his interest and in the interest of the state to save him from his downward career.[21]

The change in ideology had an immediate, dramatic impact:

> The results, to give it briefly was [sic] as follows, after but a year and a half of operations under the new law, The District Attorney reported that instead of between two and three hundred cases of boys being brought before the Grand Jury, there were only ten or twelve such cases; and the Jailor reported that instead of Six Hundred boys at the Jail under Sixteen, there were only about twenty . . .[22]

Apparently impressed with these results and the aims of the Progressive Movement, all but two states had established juve-

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[17] *Id.* at 46 (quoting MAX GRUNHUT, PENAL REFORM 89 (1948)).

[18] Feld, *The Principle of Offense*, *supra* note 11, at 823.

[19] *See generally* Julian W. Mack, *The Juvenile Court*, 23 HARV. L. REV. 104 (1909).

[20] PLATT, *supra* note 2, at 10.

[21] Barrett et al., *supra* note 12, at 775 (quoting Mack, *supra* note 19, at 119-20).

[22] MACDONALD, *supra* note 1, at 8.

nile courts by 1925 and all states did so by 1945.[23] Guided by a positivist view of crime,[24] the reformers viewed delinquency as determined by the juvenile's environment and, instead of attempting to punish immoral behavior, crafted a system of justice that emphasized inquiry into the accused's background rather than the facts of the specific crime alleged.[25] As a result, the jurisdiction of the juvenile courts came to encompass "status" offenses such as truancy, smoking, and other immoral activity that the state viewed as worrisome, but which did not constitute crimes.[26] Concomitantly, the disposition did not need to be related to the severity of the offense, but could be fashioned to serve the juvenile's best interests.[27]

Although championed by its creators as "one of the greatest advances in child welfare that has ever occurred,"[28] the juvenile court came to be criticized by two groups. The first—the "legal moralists"—viewed the expansion of jurisdiction over children as an illicit attempt to increase the state's control over them.[29] Moreover, these critics contended, jurisdiction had been expanded to control not only specific acts, but specific classes of children.

It was not by accident that the behavior selected for penalizing by the child savers—drinking, begging, roaming the streets, frequenting dance-halls and movies, fighting, sexuality, staying out late at night, and incorrigibility—was primarily attributable to the children of lower-class migrant and immigrant families.[30]

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[23] ROBERT M. MENNEL, THORNS & THISTLES: JUVENILE DELINQUENTS IN THE UNITED STATES 1825-1940, at 132 (1973). For a recent summary of the status of the juvenile court, see Thomas F. Geraghty & Steven A. Drizin, Symposium on the Future of the Juvenile Court, *Foreword—The Debate Over the Future of Juvenile Courts: Can We Reach Consensus?*, 88 J. CRIM. L. & CRIMINOLOGY 1 (1997).

[24] For a summary of the tenets of Positivism, see DAVID MATZA, DELINQUENCY AND DRIFT 5 (1964).

[25] Feld, *The Principle of Offense*, *supra* note 11, at 825.

[26] *See id.* at 825 n.12.

[27] *Id.* at 825.

[28] PLATT, *supra* note 2, at 10 (quoting Charles L. Chute, *The Juvenile Court in Retrospect*, 13 FED. PROBATION 3 (1949)).

[29] *Id.* at 152.

[30] *Id.* at 139.

The second group—the "Constitutionalists"—focused on the process the courts employed rather than the acts and children that they addressed.[31] Because the courts addressed the "best interests" of the juveniles who came before them, they did not employ procedural safeguards such as the rights to an impartial hearing, to counsel, and to the privilege against self incrimination. As a result, contended these critics, the courts employed arbitrary procedures that unconstitutionally deprived juveniles of liberty.[32] This fact, asserted one critic in 1914, was not "changed by refusing to call it punishment or because the good of the child is stated to be the object."[33]

In its 1967 decision in *In re Gault*,[34] the Supreme Court sided with the Constitutionalists and, in doing so, ushered in a juvenile court system that conformed more closely to the views of the legal moralists. The Court first observed that the discretion that courts employed in the Progressive tradition of serving the juvenile's best interests was "a poor substitute for principle and procedure."[35] That principle and procedure, the Court held, entailed attaching constitutional safeguards such as the rights to counsel, to an impartial hearing, to confront and cross-examine witnesses, and the privilege against self incrimination to the hearing at which a juvenile is adjudicated a delinquent.[36] In essence, the Court shifted the inquiry of the proceeding from serving the juvenile's "best interests" to proof of the alleged crime.

In the years following *Gault*, the Court ruled that other elements of the adult criminal defendant's battery of constitutional rights, including the requirement of proof beyond a reasonable doubt[37] and the prohibition of double jeopardy,[38] attached to

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[31] *Id.* at 152-53.

[32] For a summary of other Constitutionalist literature, see PLATT, *supra* note 2, at 158 n.73.

[33] *Id.* at 158 (quoting Edward Lindsay, *The Juvenile Court Movement from a Lawyer's Standpoint*, LII ANNALS AM. ACAD. POL. & SOC. SCI. 145 (1914)). For a summary of other Constitutionalist literature, see PLATT, *supra* note 2, at 158 n.73.

[34] 387 U.S. 1 (1967).

[35] *Id.* at 18.

[36] *Id.* at 31-57.

[37] *In re* Winship, 397 U.S. 358, 368 (1970).

the juvenile criminal process. In 1971, however, the Court stopped short of implementing the "Constitutionalists" vision of parity between adult and juvenile criminal proceedings. In *McKeiver v. Pennsylvania*,[39] the Court held that the right to a jury trial does not apply to juvenile proceedings.[40] The Court emphasized that the treatment mission of the juvenile court necessitated more informal procedures than sanctioned by the punitive mission of the adult courts.[41]

If *Gault* signaled a shift from the Progressive "treatment" concept of juvenile justice back to the "punitive" concept originally administered by American courts, *McKeiver* symbolized a revitalization of the Progressive belief that juvenile criminal courts should serve a purpose very different from that served by adult criminal courts. That revitalization, however, was fleeting. During the past decade, state legislatures have begun to embrace a more punitive vision of criminal justice, enacting legislation making it easier to prosecute juveniles in adult criminal court.[42] Today, almost all states have statutes which authorize the use of adult courts for juveniles who commit serious crimes.[43] Some statutes have reduced the age for adult trial to thirteen,[44] a year younger than the common law presumptive age of adult capacity applied by American courts before the Progressive revolution of 1988.[45]

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[38] Breed v. Jones, 421 U.S. 519, 541 (1975).

[39] 403 U.S. 528 (1971) (plurality opinion).

[40] *Id.* at 550 (plurality opinion).

[41] *Id.*

[42] *See generally*, PATRICIA TORBET, U.S. DEP'T OF JUSTICE, STATE RESPONSES TO SERIOUS AND VIOLENT JUVENILE CRIME xii (1996). For other, recent commentaries on the state of the nation's juvenile courts, see e.g., Louise D. Palmer, *In court, youths losing their innocence: Demands for stricter punishment send more juveniles to adult jails*, BOSTON GLOBE, Jan. 24, 1999, at A10 ("In the past six years alone, 40 states have passed laws making it easier to prosecute children in adult criminal courts."); Vincent Schiraldi, *Prosecutorial zeal vs. America's kids*, CHRISTIAN SCI. MONITOR, Mar. 22, 1999, at 9; Fox Butterfield, *With Juvenile Courts in Chaos, Some Propose Scrapping Them*, N.Y. TIMES, July 21, 1997, at A1.

[43] David C. Anderson, *When Should Kids Go to Jail*, THE AMERICAN PROSPECT, May-June 1998, at 72.

[44] *Id.*

[45] *See supra* note 14 and accompanying text.

Although the juvenile court has come nearly full-circle in less than a century, it has been unable to shake any of its critics. Those who apparently pine for the days before the court's creation still criticize the court as insufficiently punitive.[46] Some echo the Constitutionalists and criticize the juvenile court as "procedurally bankrupt."[47] Others appear to echo the legal moralists by attacking the institution as an illicit assertion of control over juveniles.[48] Still others argue that the only way the court can succeed is to broaden its mission: "Juvenile judges need to exercise their authority to bring parents into the courtroom and make them take an active role in their kids' problems. . . . Judges need to bring schoolteachers, school counselors, ministers and community activists into the juvenile justice process and make them get involved."[49] Most recently, the debate has centered on whether to abolish the court and to try juveniles and adults in one, unified court.[50]

In sum, the issues that led to the court's creation hardly seem resolved.

B. JUVENILE COURTS AND ISSUES OF MENTAL HEALTH

Despite the recent attempts to make juvenile courts resemble adult criminal courts, they continue to serve quite a different purpose. In addition to trying and sentencing "delinquents" who commit crimes, the juvenile courts in all states also determine the fates of "status offenders" who come before the court charged with running away from home, truancy, and failing to yield to the control of their parents.[51]

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[46] *See, e.g.*, Alfred S. Regenery, *Getting Away with Murder: Why the Juvenile Justice System Needs an Overhaul*, POL'Y REV., Fall 1985, at 65.

[47] Mark Curriden, *Hard Times for Bad Kids*, A.B.A. J., Feb. 1995, at 67.

[48] *See* Janet A. Ainsworth, *Re-Imagining Childhood and Reconstructing Legal Order: The Case for Abolishing the Juvenile Court*, 69 N.C.L. Rev 1083, 1084 (stating the "perceptions of youth have changed in the late twentieth century, . . . undermin[ing] the ideological legitimacy of [maintaining] a separate juvenile court.").

[49] Curriden, *supra* note 47, at 69.

[50] For a summary of the arguments, see generally Marygold S. Melli, *Juvenile Justice Reform in Context*, 1996 WISC. L. REV. 375.

[51] *See* WALTER WADLINGTON ET AL., CASES AND MATERIALS ON CHILDREN IN THE LEGAL SYSTEM 602-48 (1983).

Given the broad range of reasons for which a juvenile may appear before the juvenile court, it is not surprising that substantial numbers display evidence of some mental health problem.[52] Thus, whether "handling" those with mental health problems through the juvenile court is the best method for addressing their needs,[53] many states have increasingly found it a necessary one.

States, communities, and the public have not always recognized this need. Colonial society did not systematically address the plight of the deviant or dependent.[54] And, although nineteenth century American society began to look to institutions to control and change the behavior of criminals,[55] it did not seek to address the mental health needs of troublesome youth.[56]

That view did not change with the creation of the juvenile court. Indeed, in 1923, the U.S. Bureau of the Census declared serious mental health problems non-existent among minors:

> Mental disease occurs principally in adult life. Psychopathic disorders appear in children, but as a rule these are not serious enough to require commitment to a hospital for mental disease. . . . It will be noted that only 0.2 per cent of the total patients were under 15 years of age and only 1.5 per cent were under 20 years.[57]

Thus, up until the end of World War II, few troubled youth were classified as in need of mental health services.[58] Rather, juveniles coming before the juvenile courts were invariably labeled either delinquent or dependent.[59] The delinquent—those adjudicated to have committed crimes—were placed in juvenile correctional institutions.[60] The dependent—those other-

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[52] *See* PAUL LERMAN, DEINSTITUTIONALIZATION AND THE WELFARE STATE 107-08 (1982).

[53] *See* MACDONALD, *supra* note 1, at 6.

[54] *See* DAVID J. ROTHMAN, THE DISCOVERY OF THE ASYLUM 4 (1971).

[55] *See id.* at 57-60.

[56] *See* LERMAN, *supra* note 52, at 109-10 ("Mental health . . . was only beginning to develop as a new resource in the 1920s.").

[57] *Id.* at 110 (quoting U.S. BUREAU OF THE CENSUS, PATIENTS IN HOSPITALS FOR MENTAL DISORDERS 26 (1923)).

[58] *See id.* at 133.

[59] *See id.* at 109.

nile correctional institutions.[60] The dependent—those otherwise in need of the state's care—were placed in the child welfare system.[61] Dependent and neglected children were originally housed in institutions for delinquents. At the turn of the century, however, private organizations began to form foster care centers and similar institutions to care for the dependent and neglected.[62] Only with the passage of the 1935 Social Security Act did government begin to take the primary role in caring for the dependent and neglected.[63]

Meanwhile, a third system—the mental health system—began to take shape. The presumption about the age of the onset of "insanity" reflected in that 1923 census report[64] eventually gave way, and after World War II reference of juveniles to inpatient psychiatric facilities began to increase.[65] The rate of institutionalization for people under twenty years of age increased from twenty-two per 100,000 in 1950 to forty-six in 1970.[66] And, the rate of institutionalization increased consistently from 1946 to 1975 only for those under the age of fifteen.[67]

In his classic *Deinstitutionalization and the Welfare State*, Paul Lerman concluded that the increased representation of juveniles in the mental health system appears to have resulted from changes in admission practices of mental health facilities rather than the emergence of traditionally recognized mental illnesses in a younger population. Reporting on 1975 data, he divided diagnoses between "classical symptoms"—organic brain disease, depression, schizophrenia, other psychoses, and neuroses—and "general/behavioral disorders"—personality disorders, childhood disorders, transitional situation disorders, and alcohol and

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[60] *See id.*

[61] *See id.*

[62] *See id.* at 110-11, 147-48.

[63] *See id.* at 148.

[64] *See supra* note 57 and accompanying text.

[65] *See* LERMAN, *supra* note 52, at 133.

[66] *See id.* at 134 (citing M. Kramer, *Psychiatric Services and the Changing Institutional Scene, 1950-1985, in* NATIONAL INSTITUTE OF MENTAL HEALTH, ANALYTICAL AND SPECIAL STUDY REPORTS, Series B, No. 12 (1977)).

[67] *See id.* at 134-35.

drug disorders.[68] Seventy-four percent of all ages were admitted to general hospital psychiatric units for classic mental illnesses, but only 42% of those under the age of eighteen were admitted with those diagnoses.[69] On the other hand, 57.2% of those under age eighteen were admitted with diagnoses of general/behavioral disorders, while 26% of all ages were admitted with those diagnoses.[70]

The data were even more striking for state and county mental health facilities. Twenty-seven percent of those under age eighteen and 53.1% of all ages were admitted with classic diagnoses.[71] Nearly 72% of those under age eighteen and 46.9% of all ages were admitted with general/behavioral diagnoses.[72] Thus, Lerman concluded, "The state hospitals, in particular, are probably admitting many youth who may be engaging in deviant behavior, but who are not mentally ill in a classical sense."[73]

Others have reached similar conclusions. Robert Miller and Emmet Kenney, for example, conducted a pioneering three-year study of the hospitalization of juveniles in state psychiatric facilities.[74] Finding that nearly 71% had been admitted for "socially deviant behavior,"[75] they concluded by asking whether "the psychiatric hospital is becoming more sociological than medical" in its psychiatric approach.[76]

In 1988, Lois Weithorn chronicled and critiqued this increasing admission of juveniles to mental health facilities.[77] She reported that admission of minors to mental health facilities increased more than eight-fold from the 1920s to the 1970s.[78] From 1971 to 1980, the rate continued to increase, with a shift

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[68] *See id.* at 135 tbl. 8-6.

[69] *See id.*

[70] *See id.* at 134-35

[71] *See id.* at 135 tbl. 8-6.

[72] *See id.*

[73] *Id.* at 135.

[74] *See* Robert Miller & Emmet Kenney, *Adolescent Delinquency and the Myth of Hospital Treatment*, 12 CRIME & DELINQ. 38 (1966).

[75] *Id.* at 43.

[76] *Id.* at 47.

[77] *See* Lois A. Weithorn, *Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates*, 40 STAN. L. REV. 773 (1988).

[78] *See id.* at 783.

from hospitalization in public facilities to private facilities. From 1980 to 1984, private mental health facility admissions of juveniles increased by more than four and one-half times.[79]

Weithorn criticized what she characterized as "rather vague and overly broad criteria"[80] that resulted in the admission of two-thirds of juveniles with diagnoses of "conduct disorder, personality or childhood disorder, or transitional disorder."[81] And she concluded that the increasing admission rates were the product of the admission of "'troublesome' youth who do not suffer from severe mental disorders."[82]

Others do not concur in Professor Weithorn's critique. The American Psychiatric Association (APA), for example, has contended that, "[w]hile the pendulum often swings from rejection of the rehabilitative and treatment model in corrections to recognition of the need for mental health clinical input, the importance of psychiatric involvement remains constant."[83] Indeed, and contrary to Weithorn's conclusion, the APA concludes that the problem is that too few troublesome youth are placed in mental health facilities.[84] Moreover, the APA adds, whatever direction that pendulum may swing in the future, "the importance of psychiatric involvement remains constant."[85]

In all events, rates of admission of juveniles to mental health facilities have climbed in recent decades. Moreover, juveniles are now admitted to mental health facilities with diagnoses not recognized as mental illnesses when the Census Department concluded in 1923 that mental health problems do not occur in juveniles.[86]

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[79] *See id.*

[80] *See id.* at 785.

[81] *Id.* at 789.

[82] *See id.* at 774.

[83] American Psychiatric Association, *supra* note 5, at 1584.

[84] *Id.* at 1584-85. The APA noted that 40% to 70% of incarcerated delinquents have some psychiatric "handicapping condition." *Id.* at 1584. "The scope of the problem is underscored by the fact that in 1987, 25,024 children and adolescents were incarcerated in state-operated juvenile institutions but fewer than half that number were patients in state mental hospitals." *Id.* at 1584-85 (citations omitted).

[85] *Id.* at 1584.

[86] *See supra* text accompanying note 57.

C. CONNECTICUT COURTS AND PROCESSES

In 1912, William MacDonald reviewed the treatment of juvenile criminal offenders by Connecticut's adult courts and concluded that creating a separate juvenile criminal court was the only method available to address successfully children's problems that he asserted were "becoming more and more complex."[87] Apparently heeding Mr. MacDonald's call, in 1921 the Connecticut legislature enacted legislation creating the state's first juvenile courts.[88]

Established in each of the then-existing 169 towns in Connecticut, the system suffered from a lack of uniformity[89] and a successful challenge to its constitutionality.[90] In 1935, the legislature set out to restructure the system, beginning by establishing two experimental, county-wide juvenile courts.[91] When the experiment apparently proved successful, the legislature dismantled the existing city-by-city system and substituted courts with territorial jurisdiction based on county boundaries.[92]

From these early days, the Connecticut juvenile courts differed in some respects from the courts of other states. While the courts of most states share the territorial boundaries of the states' adult courts,[93] beginning in 1941, Connecticut established a tradition of maintaining jurisdictional boundaries peculiar to juvenile courts. Initially, the legislature established three districts, with each comprised of two or three counties.[94] Judges traveled a circuit and held court in various cities within their

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[87] MACDONALD, *supra* note 1, at 26.

[88] *See* 1935 Conn. Pub. Acts § 697. For a summary of the history of the Connecticut juvenile courts, see generally David J. Frauenhofer et al., *Practice and Procedure of the Juvenile Court for the State of Connecticut*, 41 CONN. B.J. 201 (1967).

[89] Only four cities employed full-time staff in their courts. *Id.* at 209. (citing THE CONNECTICUT JUVENILE COURT, ITS STRUCTURE, PHILOSOPHY, PROCEDURE 2 (1959)).

[90] *See* Cinque v. Boyd, 121 A. 678 (Conn. 1923) (holding that the courts' ability to order the detention of a child during the pendency of an appeal violated the State's constitution).

[91] *See* 1935 Conn. Pub. Acts § 697(c).

[92] *See* CONN. GEN. STAT. § 17-54 (1958).

[93] For a summary of the territorial jurisdiction of the juvenile courts in the 50 states, see SANFORD J. FOX, JUVENILE COURTS IN A NUTSHELL 10-11 (1984).

[94] *Id.*

districts.[95] In 1976, effective in 1978, the legislature delegated the function of designating judicial districts to the superior court.[96] At the time of our study, the courts, through an agency entitled the Family Division Administration, had established thirteen juvenile judicial districts, comprised of entire counties, portions of counties, and districts that overlapped portions of two or more counties.[97]

At the time of our study,[98] the subject matter of the courts included proceedings concerning allegedly uncared-for,[99] neglected,[100] dependent,[101] and delinquent[102] children[103] and youth.[104] The juvenile courts were also empowered to hear cases concerning "families with service needs"—families of a child

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[95] Frauenhofer et al., *supra* note 88, at 210-211.

[96] CONN. GEN. STAT. ANN. § 46b-142 (West 1995).

[97] The Family Division Administration announces any changes in the juvenile judicial districts in its biannual report to the superior court. Telephone Interview with Frank Driscoll, Deputy Director of Connecticut Family Division Administration (July 10, 1995). The superior court publishes the districts in booklet form. *See, e.g.*, STATE OF CONNECTICUT JUDICIAL DIRECTORY 23 (Sept. 1994). The October 30, 1992 listing by the Family Division Administration, which lists thirteen districts, numbered one through fifteen, with numbers two, three, and eight omitted and one district not numbered, reveals the apparently informal process by which the districts are delineated.

[98] In 1995 the Connecticut General Assembly enacted legislation that changed in minor fashion some of the rules that follow. "An Act Concerning Juvenile Justice," 1995 Conn. Acts 225 (Reg. Sess.). The changes included the creation of an "Office of Alternative Sanctions" "charged with the duty of developing constructive programs for the prevention and reduction of delinquency and crime among juvenile offenders." *Id.* § 6.

That legislation made more substantial changes to the transfer rules discussed *infra*, notes 108-11 and accompanying text.

[99] An uncared-for child is one "who is homeless or whose home cannot provide the specialized care which his physical, emotional or mental condition requires." CONN. GEN. STAT. § 46b-120 (1995).

[100] A neglected child is one who "(A) has been abandoned or (B) is being denied proper care and attention . . . or (C) is being permitted to live under conditions, circumstances or associations injurious to his well-being, or (D) has been abused." *Id.*

[101] A dependent child is one "whose home is a suitable one for him, save for the financial inability of his parents, parent, guardian or other person maintaining such home, to provide the specialized care his condition requires." *Id.*

[102] A delinquent child is one who has "violated any federal or state law or municipal or local ordinance . . . " or "who has violated any order of the superior court." *Id.*

[103] A child is "any person under sixteen years of age." *Id.*

[104] A youth is "any person sixteen to eighteen years of age." *Id.*

who "has without just cause run away from home," "is beyond the control of his parents" or guardian, "has engaged in indecent or immoral conduct," is truant, or "is thirteen years of age or older and has engaged in sexual intercourse with another person and such other person is thirteen years of age or older and not more than two years older or younger than such child."[105]

In 1977, the legislature abolished the requirement that juvenile matters be heard in facilities separate from those housing other (adult) court business.[106] The legislation did, however, mandate that juvenile matters "be kept separate and apart from all other business of the superior court as far as practicable."[107]

At the time of our study,[108] the statutes provided for the transfer of children from the juvenile to the adult criminal docket, and vice-versa, under a variety of circumstances. The court automatically transferred those aged fourteen to sixteen accused of murder and those of that age accused of other serious felonies who had previously been adjudicated as delinquent to the adult criminal docket.[109] The court would initially process children aged sixteen to eighteen through the adult docket, but the court could transfer them to the juvenile docket if circumstances warranted such a transfer.[110] The court could also transfer others over the age of fourteen to the adult docket if "the child [was] a danger to society and requires more secure and longer term handling than the juvenile justice system is able to provide."[111]

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[105] *Id.*

[106] 1977 Conn. Acts 576 (Reg. Sess.).

[107] CONN. GEN. STAT. § 46b-122 (1995).

[108] Recent amendments to the Connecticut statutes have broadened the transfer rules. 1995 Conn. Acts 225 (Reg. Sess.). The rules now provide, for example, for the transfer of juveniles aged 14 and over accused of murder, particular acts committed with firearms, and lesser acts if the juvenile was previously adjudicated delinquent. *Id.* § 13. The study subjects entered the juvenile justice and mental health systems during 1993 and 1994. In this section of the article, we refer to the statutes and rules in effect at that time.

[109] CONN. GEN. STAT. § 46b-127 (1995).

[110] *Id.*

[111] CONN. GEN. STAT. § 46b-126 (1995). The child must have been accused of a class A felony or, if previously adjudicated delinquent, a class B or C felony. *Id.*

The juvenile criminal process was initiated by a petition to the superior court. Petitions alleging a neglected, uncared-for, or dependent child could be filed by the child, her attorney, a foster parent, a town or its manager or selectmen, a probation officer, or the commissioner of social services or child and family services.[112] Petitions alleging delinquency—the focus of this study—followed much the same procedure. They were initiated by petition to the superior court[113] filed by either a probation officer or a state's advocate.[114]

Petitions alleging a neglected, uncared-for, or dependent child were heard in the judicial district where the child resided.[115] Petitions alleging delinquency could, in the court's discretion, be heard in either the judicial district where the child resided or where the crime was alleged to have occurred.[116] The courts almost invariably, however, heard delinquency cases where the child resided.[117]

Prior to any disposition, which could include probation, "alternative incarceration," confinement at home, or placement in an institution or "wilderness school,"[118] the statute required that a probation officer conduct an inquiry into the child's "surroundings," "habits," parents, and "home conditions."[119] The probation officer was also required to schedule a meeting with the child and her parents to discuss the allegations of the complaint and, if the child denied the accusations, schedule a judicial hearing.[120]

In addition to requiring that the probation officer conduct a study, the Connecticut statutes also provided that, "[w]hen it is found necessary to the disposition," the court could order a

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[112] CONN. GEN. STAT. § 46b-129(a) (1995).

[113] CONN. CT. R. § 1027.1 (1994).

[114] CONN. CT. R. § 1023.1(l) (1994).

[115] CONN. GEN. STAT. § 46b-142 (1995).

[116] *Id.*

[117] Telephone Interview with Frank Driscoll, Deputy Director of Connecticut Family Division Administration (July 10, 1995).

[118] CONN. GEN. STAT. § 46b-140 (1995).

[119] CONN. GEN. STAT. § 46b-134 (1995).

[120] CONN. CT. R. § 1027.1 (1996).

mental examination.[121] That order could include "medical, psychiatric, neurological, learning disability and other diagnoses as the court deem[ed] necessary."[122]

In essence, these statutes enabled the courts to seek professional guidance in resolving the question that Mr. MacDonald raised in 1912: do some accused children "need the services of a good physician more than they do those of the jailor."[123] It was on the courts' initial action on this question—the decision whether to refer a child for a mental health evaluation—that the juvenile criminal justice system component of our study focused.

III. EXISTING BODY OF KNOWLEDGE

One leading author has summarized the existing empirical research regarding the disposition of juvenile criminal cases: "Although there is a relationship between offenses and disposition, most of the variation in sentencing juveniles remains unexplained."[124] Perhaps even less is known about the interrelationship of the juvenile criminal justice and mental health systems.

A. GENERAL RESEARCH ON THE JUVENILE JUSTICE SYSTEM

A number of observers, relying on a "labeling" theory contending that adolescents are subject to irrevocable stereotypes, have criticized the juvenile criminal justice system for its inequitable treatment of particular races and classes of children.[125] Others have reached inconsistent conclusions when seeking to provide empirical confirmation of these assertions. For example, in 1967, Robert Terry reported on an examination of all ju-

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[121] *Id.*

[122] *Id.*

[123] MACDONALD, *supra* note 1, at 27.

[124] Feld, *Transformation*, *supra* note 11, at 715.

[125] *See, e.g.*, JOHN M. MARTIN, U.S. DEP'T HEALTH, EDUC., & WELFARE, TOWARD A POLITICAL DEFINITION OF DELINQUENCY 3 (1970) ("[T]he juvenile justice labeling process works to single out adolescents from groups culturally alien to those in power."); EDWIN M. SCHUR, RADICAL NONINTERVENTION: RETHINKING THE DELINQUENCY PROBLEM 121 (1973) ("[T]he philosophy of the juvenile court . . . virtually ensures that stereotypes will influence judicial dispositions.").

venile court appearances during a six year period in Racine, Wisconsin.[126] Although his initial evaluation revealed more severe dispositions for members of minority and lower socioeconomic classes, the differences disappeared when he controlled for number of previous offenses and the seriousness of the current charge.[127]

Two subsequent studies reached contrary conclusions. In 1971, William Arnold reported on data drawn from juvenile courts in a variety of southern states.[128] Even when controlling for the number and seriousness of the offenses and other factors,[129] the study revealed a relationship between race and ethnicity and the severity of the disposition.[130] In 1973, Terence Thornberry reported similar findings on data obtained in Philadelphia.[131] In particular, he concluded that unlike previous studies the data he studied revealed that "Blacks and low [socioeconomic status] subjects were more likely than whites and high [socioeconomic status] subjects to receive severe dispositions" at all stages of juvenile criminal justice procedure.[132]

In 1975, Lawrence Cohen criticized all existing research, contending that because the studies focused on single courts or single variables, they provided little "empirical evidence to sustain or negate . . . " the charges of an inequitable juvenile justice system.[133] To fill this research void, Mr. Cohen offered a multi-

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[126] Robert M. Terry, *The Screening of Juvenile Offenders*, 58 J. CRIM. L., CRIMINOLOGY & POLICE SCI. 173 (1967).

[127] *Id.* at 177-78.

[128] William R. Arnold, *Race and Ethnicity Relative to Other Factors in Juvenile Court Dispositions*, 77 AM. J. SOC. 211 (1971).

[129] *Id.* at 214. Professor Arnold also controlled for the marital status of the offender's parents. *Id.*

[130] *Id.* at 217-23.

[131] Terence P. Thornberry, *Race, Socioeconomic Status and Sentencing in the Juvenile Justice System*, 64 J. CRIM. L. & CRIMINOLOGY 90 (1973). Professor Thornberry also controlled for prior record and severity of offense. *Id.* at 94.

[132] *Id.* at 97 (referring to the police, intake, and court disposition steps of the process).

[133] LAWRENCE E. COHEN, U.S. DEP'T OF JUSTICE, DELINQUENCY DISPOSITIONS: AN EMPIRICAL ANALYSIS OF PROCESSING DECISIONS IN THREE JUVENILE COURTS 14 (1975). Cohen analyzed the data for four types of dispositions—informal adjustment by the probation officer, case held open while juvenile received care at private facility, for-

ple regression study of data obtained from courts in Colorado, Tennessee, and Pennsylvania.[134] After finding a number of correlates with severity of offense—low socioeconomic status, "broken home," and nonwhite racial status, Mr. Cohen employed multi-variate techniques to control for prior offenses and the severity of the current offense. He concluded that neither socioeconomic status nor ethnicity were "major determinant[s] of disposition" of the juveniles he studied.[135]

Subsequent research has corroborated earlier studies and contradicted Mr. Cohen's conclusion.[136] As Barry Feld has summarized it, the literature supports two conclusions. "First, the present offense and prior record account for most of the variation in sentencing that can be explained. Second, after controlling for offense variables, individualized discretion is often synonymous with racial disparities in sentencing."[137]

These assertions lead to two conclusions regarding the function of the juvenile justice system. First, to the extent that offense variables like prior record and severity of offense are the best predictors of a sentence, then the juvenile criminal justice system has abandoned the goal of providing treatment according to the offenders' needs and has, instead, embraced the notion of punishment. Second, the juvenile criminal justice system appears to have produced inequity precisely to the extent that it has held true to its originally stated mission of basing disposition on characteristics of the offender rather than of the offense.

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mal supervised probation, and incarceration in juvenile facility or prosecution in adult court—of three, urban courts. *Id.* at 20 tbl. 2.

[134] *Id.* at 15-16.

[135] *Id.* at 53-54. Minority status correlated with disposition only for those who were formally petitioned in one court Cohen studied and for those who were not detained in another court. *Id.* at 54. Otherwise, Cohen apparently found that ethnicity was not correlated with disposition. *See id.*

[136] For a summary of recent research, see generally Carl E. Pope & William H. Feyerhern, *Minority Status and Juvenile Justice Processing: An Assessment of the Research Literature*, 22 CRIM. JUST. ABSTRACTS 527, 528 (1990).

[137] Feld, *Transformation*, *supra* note 11, at 714.

B. CORRECTIONAL VERSUS MENTAL HEALTH INSTITUTIONS.

Research on the relationship between the correctional and mental health systems mirrors the general research on disposition. It consists of conflicting reports on the presence of bias and reveals a system dependent on the caprice of individual judges.

In 1970, T.G. Tennent published one of the earliest articles that raised the issue whether there are differences between juveniles judged delinquent and those brought before the juvenile court for other reasons.[138] Studying all truancy and delinquency cases brought before the Inner London Juvenile Courts during the 1966-67 school year, Tennent reached two conclusions. He found significant psychiatric differences between the delinquent and truant populations appearing before the juvenile courts, as measured by a "psychiatrist's global clinical impression."[139] On the other hand, he asserted that "the problems and backgrounds of children appearing before Juvenile Courts," truant and delinquent alike, "are often closely similar" to those of children receiving treatment in mental health facilities.[140]

Research in this country has not always replicated Tennent's second finding. For example, in 1977, Shelley Shanok and Dorothy Lewis compared populations in a juvenile court psychiatric guidance clinic and a child psychiatric guidance clinic serving the same geographic region of Connecticut.[141] Although the children in both institutions exhibited similar "organic and psychotic symptoms," the researchers did find significantly different "characterological, adjustment, [and] neurotic symptoms."[142]

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[138] T.G. Tennent, *Truancy and Stealing: A Comparative Study of Education Act Cases and Property Offenders*, 116 BRIT. J. PSYCHIATRY 587 (1970).

[139] *Id.* at 592. Tennent derived the "global" impressions from psychiatric reports in the offenders' files. *Id.* at 588. An assessment method based on "six separate 'Area' scores compiled for each boy so as to yield an individual profile of adjustment," *id.* at 588, did not, however, reveal any difference between the populations. *Id.* at 592.

[140] Westendorp et al., *supra* note 6, at 239 (quoting Tennent).

[141] Shelley S. Shanok & Dorothy Otnow Lewis, *Juvenile Court Versus Child Guidance Referral: Psychosocial and Parental Factors*, 134 AM. J. PSYCHIATRY 1130, 1130 (1977).

[142] *Id.* at 1131.

In addition, they observed differences in social class and family composition between the two groups.[143]

In 1979, Lewis, Shanok, and another collaborator focused their attention on the racial disparities between the correctional and mental health systems.[144] Reporting on their clinical observations from the same juvenile court clinic on which they based their 1977 publication, the researchers recited a number of anecdotes of racial bias. For example, they asserted that "seriously disturbed black delinquents have trouble gaining admission to therapeutic facilities [and that] those who were admitted were quick to be discharged."[145] The researchers buttressed their observations with a modest amount of epidemiological evidence derived from a different study. Referring to a study of 109 children "known to the juvenile court,"[146] they reported racial differences in whether children or their parents had received psychiatric treatment.[147]

In 1980 Lewis, Shanok, and some collaborators published more direct epidemiological support for their contentions.[148] For a given year they examined the records of all adolescents from an urban area of Connecticut who entered the state correctional school and all adolescents from that same area who during that same year entered the state mental health facility.[149] They scrutinized the data using a multiple regression analysis of independent variables including numbers of accidents and injuries through age sixteen, number of face and head injuries through age sixteen, sex, and race. They concluded that "[t]he most powerful variable distinguishing the groups was race,

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[143] *Id.* at 1132. Eighty-six percent of the juvenile court clinic children came from families in lower socioeconomic classes; 74% of the child guidance clinic children did. *Id.* A statistically significantly greater percentage of the children in juvenile court clinics came from large families (three or more children). *Id.*

[144] Lewis et al., *Juvenile Offenders, supra* note 6.

[145] *Id.* at 54.

[146] *Id.* at 55. They referred to Dorothy Otnow Lewis et al., *Toward Understanding the Fathers of Delinquents: Psychodynamic Medical and Genetic Perspectives, in* A DEVELOPMENTAL APPROACH TO PROBLEMS OF ACTING OUT (Eveoleen N. Rexford, ed. 1982).

[147] Lewis et al., *Juvenile Offenders, supra* note 6, at 55-56.

[148] Lewis et al., *Violent Adolescents, supra* note 6.

[149] *Id.* at 1211-12.

which accounted for 18.1% of the variance."[150] When repeating the regression analysis and coding both accident and injury categories in binary "yes" or "no" fashion, the number of head or face injuries proved the most powerful predictor (30.2% of the variance) and race was the second best predictor (16.7% of the variance).[151]

In 1986 Westendorp et al. published the results of a similar study which they conducted in Michigan.[152] Attempting to build on the work of Lewis and Shanok,[153] the researchers compared the patients in six mental health treatment programs with adolescents from the same area placed in the juvenile justice program.[154] In sum, the researchers found that race, gender, and marital history of the parents (whether divorced) were significant in predicting whether an adolescent would enter the juvenile justice or mental health systems.[155] The variable social class was not significant.[156] In addition, other variables, including mental health history, current drug use, parental religious affiliation, MMPI depression scale, and CAAP productivity scales were significant.[157]

In 1992, Kaplan and Busner set out to test whether the findings of the Lewis and Westendorp research groups held in New York State.[158] Conducting the largest project on the subject to date, the researchers examined the records of all 1,474 children aged ten to eighteen admitted to state mental health facilities in 1988 and all 1,405 admitted to state juvenile justice facilities that same year.[159]

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[150] *Id.* at 1214.

[151] *Id.* The researchers subsequently published a similar study of delinquent and nondelinquent patients in the mental health facility. Shelly S. Shanok et al., *A Comparison of Delinquent and Nondelinquent Adolescent Psychiatric Inpatients*, 140 AM. J. PSYCHIATRY 582 (1983).

[152] Westendorp et al., *supra* note 6.

[153] Westendorp et al. cite their work, among others. *Id.* at 24.

[154] *Id.* at 26.

[155] *Id.* at 33.

[156] *Id.*

[157] *Id.* The MMPI measures personality and psychopathology; the CAAP measures social adjustment. *Id.* at 23.

[158] Kaplan & Busner, *supra* note 7.

[159] *Id.* at 769.

The initial findings were consistent with those of the Lewis and Westendorp groups: 23% of the children and adolescents in the mental health facilities were Black; 56% of those in the juvenile justice system were Black.[160] Thus, asserted Kaplan and Busner, had they employed the same types of statistical analyses as the other researchers, "[the] results would have been similar to theirs."[161]

Instead of comparing the two populations, however, Kaplan and Busner, using the Chi-square statistic, compared the racial distributions of the institutional samples with the distribution in the general population of the same age groups.[162] In so doing, they found no evidence of bias in the mental health system, but significant evidence of bias in the juvenile justice system.[163]

More recent research has criticized both the juvenile justice[164] and mental health systems[165] for racial and other biases. These studies have not, however, sought to compare the two systems and, thus, have not further illuminated the issue which Kaplan and Busner addressed.

C. THE INTERSECTION OF THE CRIMINAL JUSTICE AND MENTAL HEALTH SYSTEMS

Prior studies have shed substantial light on the juvenile justice and mental health systems. At the very least, they provide sufficient evidence to spur further research regarding the reasons for the apparent inequities in disposition. And, though inconsistent on the issue of racial disparity in mental health facilities, the studies have consistently found that racial minorities are overrepresented in the criminal justice system.

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[160] *Id.*

[161] *Id.* at 770.

[162] The researchers stipulated that, "[t]wofold or greater differences in population-corrected admission rates are considered meaningful." *Id.* at 769.

[163] *Id.* at 769-70.

[164] *See, e.g.*, Robert J. Sampson & John H. Laub, *Structural Variations in Juvenile Court Processing: Inequality, the Underclass, and Social Control*, 27 L. & SOC'Y REV. 285, 305 (1993).

[165] *See, e.g.*, Steven P. Cuffe et al., *Race and Gender Differences in the Treatment of Psychiatric Disorders in Young Adolescents*, 34 J. AM. ACAD. CHILD & ADOLESC. PSYCHIATRY 1536 (1995); Mark D. Kilgus et al., *Influence of Race on Diagnosis in Adolescent Psychiatric Inpatients*, 34 J. AM. ACAD. CHILD & ADOLESC. PSYCHIATRY 67 (1995).

Prior studies, however, have failed to illuminate the intersection of the juvenile justice and mental health systems. As Kaplan and Busner noted, the mental health and criminal justice systems "are largely independent."[166] On the one hand, juveniles enter the criminal justice system only by court order. On the other hand, in addition to entrance through court referral, they enter the mental health system through a number of referral sources, including "private hospitals, school systems, and parental referral."[167] Indeed, Kaplan and Busner found that the courts had referred only 17% of their mental health system study subjects.[168]

"Because there are different points of entry to the mental health and juvenile justice systems," Kaplan and Busner concluded, "the entry of a disproportionate number of black children and adolescents to the juvenile justice system does not imply racial bias on the part of the mental health system."[169] Determining whether a bias exists would entail studying a number of variables, including "the prevalence of psychiatric disorders in minority groups, help-seeking behaviors in minority groups, and gatekeepers' behavior," of which currently "there is little knowledge."[170]

By limiting its inquiry to a common path of entry into the two systems—the courts—our study avoided this limitation and, at least for the purposes of examining court-referrals for mental health evaluation, the need to study all of the variables that Kaplan and Busner identify. And, in so doing, this study illuminated another previously unstudied topic: the pre-disposition reference to the mental health system for psychiatric evaluation.

In addition, this study was the first to compare the court-referred and clinically-referred populations within the mental health systems. This facet of the study facilitated the first detailed comparison of the demographic attributes and psychiatric

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[166] Kaplan & Busner, *supra* note 7, at 770.
[167] *Id.*
[168] *Id.* at 770-71.
[169] *Id.*
[170] *Id.* at 771.

profiles of juveniles entering the mental health system through the two avenues.

IV. THE STUDY

A. METHOD

1. The Institutions

We examined the populations of two state institutions for the fiscal year running from July 1, 1993 through June 30, 1994. The state juvenile correctional school ("Correctional School") is a residential facility that, at any given time, serves approximately 200 of the state's most serious juvenile offenders. We studied all 229 adolescents that the state's courts referred to the school during the fiscal year who did not also receive a referral for psychiatric evaluation at the other institution we studied—the state psychiatric hospital (the "Hospital").

The Hospital is Connecticut's only state-operated psychiatric facility for children and adolescents. It is an eighty-four-bed free-standing psychiatric hospital for children and adolescents aged five to seventeen. We compared two samples admitted during the fiscal year. The first consisted of all 126 children and adolescents referred to the Hospital by clinicians ("clinically-referred"), including psychiatrists, psychologists and social workers. Admission criteria include danger to self or others, gravely disabled, and major psychiatric diagnosis or severe dysfunction.

The second Hospital sample consisted of all ninety-three adolescents that the state's courts referred to the Hospital for a thirty-day psychiatric evaluation.[171] Courts are encouraged to abide by the Hospital's admission criteria, but the Hospital is mandated to accept for evaluation all court-referred patients regardless of whether they meet the criteria.

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[171] The authorizing statute provides: "[When] it is found necessary to the disposition," the court may order a mental examination. That order may include "medical, psychiatric, neurological, learning disability diagnoses and such other diagnoses as the court deems necessary." CONN. GEN. STAT. § 46b-134 (1995).

2. The Data

a. The Correctional School

We obtained data from the Correctional School from a computer printout of the 241 subjects admitted during the study period.[172] The computer printout provided information on seven independent variables: gender, age, race, court district, family constellation, home town size, and criminal charge.

We coded family constellation in eleven categories: mother & father, mother only, father only, mother & stepfather, father & stepmother, grandmother & grandfather, grandmother, grandfather, foster home, child welfare agency ward, and other.

We coded the severity of criminal charge on a ten point scale ranging from running away to sexual assault and other violent offenses.[173]

b. The Hospital

We obtained the data from the hospital by a chart review of the ninety-three court-ordered and 126 clinically-referred pa-

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[172] To facilitate a comparison of those whom the courts referred for mental health evaluation with those whom the courts did not refer, we removed from the sample those 12 subjects who were referred to the Hospital for a psychiatric evaluation (they were counted in the Hospital sample), reducing the number of subjects to 229.

[173] We adapted our scale from COHEN, *supra* note 14 (1975). Cohen polled probation officers and judges to develop a hierarchy of seven categories of offenses ranging from "unruly offense" to "violent offense." *Id.* at 19 tbl.1.

In order to classify more subtly the offenses that might lead to a mental health referral but not to commitment to the Correctional School, we used a hierarchy of 10 categories of offenses: (1) running away, (2) truancy, (3) unruly behavior at home (including confrontations and difficulties with family members and what admission and referral notes termed "out of control behavior at home"), (4) suicidal behavior (included suicide attempts and suicidal ideation), (5) unruly behavior in the community and miscellaneous offenses (included breach of the peace, interference with police officers, criminal mischief, use of an automobile without the owner's permission, possession of burglary tools, cruelty to animals, violation of court and probation orders, one case of wrongful disinterment, and what admission and referral notes termed "out of control behavior at school or in the community"), (6) illegal use or possession of alcohol, (7) illegal use or possession of drugs or other controlled substances, (8) property and theft offenses (included robbery, larceny, burglary and all other forms of theft, trespassing, and possession of firearms), (9) sexual assault, and (10) other violent offenses (included all forms of assault and arson).

We classified charges of attempts and conspiracies to commit offenses in the category of the offense attempted or the subjects of the conspiracy.

tients admitted during the study period. We coded over thirty variables in four categories of independent variables.

i. Sociodemographic data and family and patient history

We obtained this information from the admission notes completed by the Hospital's admitting physician.

ii. Criminal charge

We obtained the information about criminal charge (for the court-ordered subjects) from several different sources. Three files contained police reports identifying the charges. Six contained the petition filed by the prosecutor stating the charges. Sixty-eight presented the charges in referral notes completed by the Hospital's social worker during a telephone conference with juvenile justice personnel. Fifteen presented the charges only in admission notes completed by the Hospital's admitting physician.[174]

iii. Patient functioning while in hospital

In addition to length of stay, we also sought to document violent or disruptive behavior. To this end, we recorded the number of seclusions and documented aggressive acts toward staff and peers in the first thirty days of hospitalization.

iv. Diagnostic information

The psychiatrist on our team obtained diagnostic information from the discharge summary completed by the admitting physician at the end of the patient's stay in the hospital. We employed a multi-faceted coding scheme to record the information. We began with a methodology that echoed the dichotomy between "classical" and "general/behavioral" disorders which Paul Lerham addressed in *Deinstitutionalization and the Welfare*

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[174] In most cases, the sources presented relatively consistent information. In two files the sources reported materially inconsistent information. The admission note in one file reported as the criminal allegation that the patient "has been getting into trouble in school, home, and in the community." The referral form reported first degree conspiracy to commit sexual assault and third degree wrongful constraint. The admission note in another file reported "long-standing behavior problems in home and school." The referral form reported charges of assault, possession of a weapon, and breach of peace. Whenever the information differed in any respect, we relied on the source least removed from the context of the original charges, resulting in the following source hierarchy: police report, court petition, referral note, admission note.

State.[175] Working from a modern adolescent psychiatry text, we assigned diagnoses to the "two broad band factors" which identify psychiatric disorders: internalizing and externalizing disorders.[176] The internalizing disorders include schizoid/anxious disorders, depression, obsessive-compulsive disorders, and social withdrawal.[177] The externalizing disorders include "hyperactivity, aggression, and delinquency."[178]

We recorded self-reported substance abuse and substance use disorder as articulated in the leading psychiatric diagnostic manual, DSM-IV: "a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances."[179]

We also obtained data on pervasive developmental disorders and psychotic disorders. DSM-IV defines a pervasive developmental disorder as "characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities."[180] DSM-IV defines psychotic disorders to include symptomatology such as "delusions, hallucinations, disorganized speech, [and] grossly disorganized or catatonic behavior."[181]

Finally, we recorded two variables which measure overall functioning level. DSM-IV provides that the Global Assessment of Functioning Scale (GAF) considers "psychological, social, and occupational functioning on a hypothetical [zero to one hundred] continuum of mental-health illness."[182] In addition,

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[175] *See supra* notes 68-73 and accompanying text for a discussion of Lerman's work.

[176] Vanshdeep Sharma et al., *Disruptive Behavior Disorders: Assessment and Differential Diagnosis, in* DISRUPTIVE DISORDERS 253, 257 (Laurence L. Greenhill, M.D., ed., 1994).

[177] *Id.* at 258.

[178] *Id.*

[179] AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 182 (4th ed., 1994) [hereinafter DSM-IV].

[180] *Id.* at 65.

[181] *Id.* The definition applies to unspecified psychotic disorders. *Id.* We included in this diagnosis all other specific DSM-IV psychotic disorders: brief psychotic disorder, shared psychotic disorder, psychotic disorder due to a general medical condition, and substance-induced and psychotic disorder. *Id.* at 302-15.

[182] *Id.* at 32.

we recorded the number of "stressors"—the uniformly recognized life events that impart stress—on a one-to-five scale.[183]

3. Analyses

We organized results in three parts. For those independent variables for which we had data for all three samples, we employed ANOVA, Chi-square, and logistic and multiple regression tests to measure differences among the samples. To conduct two-way comparisons between the criminal justice and mental health samples and the court-referred and clinically-referred samples, we used t-tests, Chi-square analyses, and a logistic regression.[184]

B. RESULTS

1. Three-Way Comparison

We obtained data for all three samples for the following independent variables: age, gender, race, and size of home town. As table 1 reveals, each was statistically significantly different among the samples. The clinically-referred Hospital patients were the youngest (13.27 years), the court-referred hospital patients were next oldest (14.13 years), and the Correctional School residents were oldest (14.66 years). All populations were predominantly male, but the Correctional School population was most dramatically so (84.7% male). Both Hospital samples were relatively evenly split between Whites and Non-whites (court-referred were 58% White and 42% Non-white, clinically-referred were 50% each); the Correctional School population was nearly 82% Non-white. Finally, approximately one fourth of both Hospital samples (21.51% of the Court-ordered and

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[183] *See* David A. Tomb, *Adjustment Disorder, in* CHILD AND ADOLESCENT PSYCHIATRY: A COMPREHENSIVE TEXTBOOK 727, 729 (Melvin Lewis, ed., 2d ed. 1996).

[184] For detailed definitions of the statistical tests see generally James T. McClave & Frank H. Dietrich, STATISTICS (5th ed., 1991). The T-test measures differences in means between samples. *Id.* at 391. An ANOVA performs the same test for more than two samples. *Id.* at 452. A Chi-square test measures variability between samples. *Id.* at 369. Regression formulas construct probabilistic models representing the relationship between an outcome variable and a number of independent variables. *See id.* at 638-39. For all measures, we employed the .05 convention of statistical significance. *See id.* at 330.

30.83% of the clinically referred) resided in communities with populations of 125,000 or larger; nearly half (44%) of the Correctional School sample resided in large communities.

Table 1
Basic Three-Way Comparison

	Court		Clinical		Correctional			
	No.	%	No.	%	No	%	Measure	Prob.
Number	93	--	126	--	229	--		
Age								
Mean	14.13	--	13.27	--	14.66	--		
Std. deviation	1.33	--	2.81	--	0.74	--		
Comparison							F= 5.72	.0001
Gender								
Males	57	61.3	71	58.20	194	84.7		
Females	36	38.7	51	41.80	351	15.3		
Comparison							χ^2= 35.54	.001
Race								
Caucasian	54	58.1	62	50.00	42	18.3		
Non-Caucasian	39	41.9	62	50.00	187	81.7		
Comparison							χ^2= 65.57	.001
Home Town								
≥125,000	20	21.51	37	30.83	99	44.00		
Smaller	73	78.49	83	69.17	126	56.00		
Comparison							χ^2= 16.169	.001

As shown in Table 2, our stepwise, multiple logistic regression model, which we employed to ascertain the interactions among our independent variables, revealed that only race (Chi-square of 21.32 and probability of .0001) and age (Chi-square of 12.32 and probability of .0004) are statistically significant in dis-

tinguishing among the three groups. This confirmed two findings that we have reported elsewhere with respect to only the Correctional School and court-ordered samples.[185] Size of home town was meaningful only because it reflected the racial makeup of the subjects' communities of residence.[186] In addition, gender differences appeared to be a proxy for the severity of the offense with which the subject had been charged.[187]

Table 2

Results of Stepwise Multiple Logistic Regression

	χ^2	Probability
Intercept (Group)	9.35	.0022
Race (bifurcated)	21.32	.0001
Age	12.32	.0004
Gender	1.87	.1715

2. Correctional School vs. Court-ordered Mental Health Referral

a. Severity of offense

The data regarding severity of offense, as reported in table 3, permitted several significant observations. First, when all conduct, including the first four categories of offenses which are essentially non-criminal "status" offenses were included,[188] the samples exhibited statistically significant different severity distributions (Chi-square of 77.206; probability of .001). The difference remained significant when those twenty Hospital subjects who committed these offenses were removed from the analysis (Chi-square of 29.073; probability of .001).

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[185] W. John Thomas & Dorothy E. Stubbe, *A Comparison of Correctional and Mental Health Referrals in the Juvenile Court*, 24 J. PSYCH. & L. 379 (1996).

[186] *Id.* at 388.

[187] *Id.* at 391-92.

[188] The subjects, of course, could not be referred to a correctional facility for these non-criminal "offenses." Twenty subjects were referred to the hospital for these "offenses."

Second, a greater percentage of the hospitalized subjects (15.1%) than the incarcerated subjects (2.6%) had been charged with sexual assault. On the other hand, a greater percentage of the incarcerated subjects (21%) than the hospitalized subjects (6.5%) had been charged with illegal drug usage. Additional investigation revealed that relationships between sexual assault and referral for mental health evaluation (chi-square of 16.91; probability of .001) and illegal drug usage and non-referral for mental health evaluation (chi-square of 10.52; probability of .001) were statistically significant.

Third, a greater percentage of the hospitalized subjects (32.26%) than the incarcerated subjects (19.28%) had been charged with violent assault. On the other hand, because one must be charged with a criminal offense to be incarcerated, a greater percentage of the incarcerated subjects (100%) than the hospitalized subjects (78.49%) had been charged with criminal offenses. The relationship between violent assault and referral for mental health evaluation (chi-square of 6.22; probability of .013) was statistically significant. Not surprisingly, the relationship between criminal offense and non-referral for mental health evaluating was also statistically significant (chi-square of 51.20; probability of .001).

Table 3:
Relationship Between Offense and Referral for a Mental Health Evaluation.

	Hospital		Correctional School			
	N	%	N	%	χ^2	Probability
Detailed Classification						
(1) running away	1	1.1	0	0.0		
(2) truancy	5	5.4	0	0.0		
(3) unruly at home	10	10.8	0	0.0		
(4) suicidal behavior	4	4.3	0	0.0		
(5) unruly in community	15	16.1	52	22.7		
(6) alcohol	1	1.1	3	1.3		
(7) drugs	6	6.5	48	21.0		
(8) property and theft	21	22.6	77	33.6		
(9) sexual assault	14	15.1	6	2.6		
(10) other violent	16	17.2	37	16.2		
Missing	--	--	6	2.6		
Comparison						
All offenses					77.206	.001
Criminal offenses					29.073	.001
Criminal Offense?						
Non-Criminal	20	21.51	0	0.00		
Criminal	73	78.49	223	100.00		
Comparison					51.20	.001
Sexual assault?						
Sexual assault	14	15.1	6	2.6		
All others	79	85.0	217	97.4		
Comparison					16.91	.001
Drug offense?						
Drugs	6	6.5	48	21.0		
All others	87	93.51	75	70.9		
Comparison					10.52	.001
Violent Offense?						
Violent	30	32.26	43	19.28		
All Others	63	67.74	180	80.72		
Comparison					6.22	.013

b. Multi-variate analysis: The regression model.

As Table 4 reveals, the four best predictors of referral for a mental health evaluation were, in descending order of significance, race (bifurcated between White and Non-white), whether the subject was accused of a sex offense, age, and severity of offense. The variables that appeared significant in bivariate analysis but not in the regression analysis—home town, judicial district, drug offense, and gender—were significantly associated with other independent variables (hometown, judicial district, and drug offense with race; severity with gender), but not with referral for mental health evaluation.

Table 4

Results of Stepwise Multiple Logistic Regression

	χ^2	Probability
Intercept (Group)	35.82	.0001
Race (bifurcated)	41.26	.0001
Sex Offense	19.71	.0001
Age	13.43	.0002
Severity of Offense	6.29	.0121

C. COURT-ORDERED VS. CLINICALLY REFERRED

1. Univariate Analysis

a. Basic demographic differences.

As table 5 reveals, age was the only demographic variable that proved statistically significant: the clinically-referred were younger (t value of 2.97 and probability of .003) than the court-ordered. Both samples were approximately 60% male (61.29% for court-ordered and 58.20% for clinically-referred) and approximately 75% of both (78.49% of the court-ordered and 69.17% of the clinically-referred) were from communities with populations of less than 125,000. Perhaps most dramatic, although we found statistically significant differences in the racial

makeup in comparing the correctional school and court-ordered hospital samples (Chi-square of 49.9 and probability of .001), for the same time period there was no statistically significant difference between that court-ordered sample and the clinically-referred sample admitted to the Hospital (Chi-square of 1.685 and probability of .194). The juveniles which the courts referred statistically mirrored those which clinicians referred.

The lone difference in these measures was whether state protective services were involved with the family. Curiously, the state agency was more likely to be involved with the families of the clinically-referred than with the court-ordered patients (64.75% vs. 41.76%; Chi-square of 11.133 and probability of .001). Perhaps state involvement leads to the involvement of a mental health professional which, in turn, results in a referral to the hospital. Those who do not receive the attention of the state agency instead end up in the criminal justice system.

Table 5
Sociodemographic Characteristics

	Court-Ordered		Clinically-Referred			
	No.	%	No.	%	χ^2 or t	Probability
Number	93	--	126	--		
Age						
Mean	14.13	--	13.27	--		
Standard deviation	1.33	--	2.81	--		
Missing		--	2	--		
Comparison					t=2.978	.003
Gender						
Males	57	61.29	71	58.20		
Females	36	38.71	51	41.80		
Missing	--	--	4	--		
Comparison					χ^2=0.21	.647
Race						
Caucasian	54	58.06	62	49.21		
Non-Caucasian	39	41.94	64	50.79		
Comparison					χ^2=1.685	.194
Size of Hometown						
≥125,000	20	21.51	37	30.83		
Smaller	73	78.49	83	69.17		
Missing			6	--		
Comparison					χ^2=2.326	.127

Table 6
Family Evaluation

	Court-Ordered		Clinically-Referred			
	No.	%	No.	%	χ^2	Probability
Family Involvement in Evaluation						
Yes	78	84.78	103	87.29		
No	14	15.22	15	12.71		
Missing	1	–	8	–		
Comparison					0.273	.602
State Protective Services Agency Involvement						
Yes	38	41.76	79	64.75		
No	53	58.24	43	35.25		
Missing	3	–	3	–		
Comparison					11.133	.001
Patient Lived with Family During Last Three Months						
Yes	59	67.82	66	55.93		
No	28	32.18	52	44.07		
Missing	6	–	8	–		
Comparison					2.972	.085
Has Family Moved in Past Twelve Months?						
Yes	21	24.71	15	23.44		
No	64	75.29	49	76.56		
Missing	8	–	52	–		
Comparison					0.032	.858

Table 7
Family Incarceration/Arrest History

	Court Ordered		Clinically Referred			
	No.	%	No.	%	χ^2	Probability
History of Incarceration/arrest in Mother						
Yes	17	21.25	17	21.79		
No	63	78.75	61	78.21		
Missing	13	–	48	–		
Comparison					0.007	.934
History of Incarceration/arrest in Father						
Yes	27	39.13	24	40.68		
No	42	60.87	35	59.32		
Missing	24	–	67	–		
Comparison					0.004	.952
History of Incarceration/arrest in Other Family Members						
Yes	29	44.62	20	40.00		
No	36	55.38	30	60.00		
Missing	28	–	76	–		
Comparison					0.2460	.620

Table 8

Family Psychiatric Illness History

	Court-Ordered		Clinically-Referred			
	No	%	No.	%	χ^2	Probability
History of Psychiatric Illness in Mother						
Yes	39	47.56	58	59.18		
No	43	52.44	40	40.82		
Missing	11	–	28	–		
Comparison					2.427	.119
History of Psychiatric Illness in Father						
Yes	20	29.85	22	37.29		
No	47	70.15	37	62.71		
Missing	26	–	67	–		
Comparison					0.7810	.377
History of Psychiatric Illness in Other Family Members						
Yes	49	69.01	56	72.73		
No	22	30.99	21	27.27		
Missing	22	–	49	–		
Comparison					0.2470	.619

Table 9
Family Substance Abuse History

	Court ordered		Clinically-referred			
	No.	%	No.	%	χ^2	Probability
History of Substance Abuse in Mother						
Yes	42	51.85	52	52.53		
No	39	48.15	47	47.47		
Missing	12	–	27	–		
Comparison					0.0080	.928
History of Substance Abuse in Father						
Yes	60	77.92	66	80.49		
No	17	22.08	16	19.51		
Missing	16	–	44	–		
Comparison					0.1590	.690
History of Substance Abuse in Other Family Members						
Yes	60	86.96	66	85.71		
No	9	13.04	11	14.29		
Missing	24	–	49	–		
Comparison					0.048	.827

d. Patient history.

As shown in Table 10, the study revealed a single difference between the histories of the clinically- and court-referred patients. The clinically-referred were more likely to have been hospitalized (Chi-square value of 31.542 and probability of .001). Yet, we observed no other distinguishing factors that would explain that early hospitalization. There were no significant differences regarding age of first psychiatric hospitalization, or histories of physical or sexual abuse or gang involvement.

Table 10
Patient History

	Court-Ordered		Clinically-Referred			
	No.	%	No.	%	χ^2 or t	Probability
Prior Psychiatric Hospitalization						
Yes	45	51.14	104	86.67		
No	43	48.86	16	13.33		
Missing	5	--	6	--		
Comparison					χ^2= 31.542	.001
Age of First Psychiatric Hospitalization						
Mean	10.96	--	9.76	--		
SD	10.15	--	4.04	--		
Missing	2	--	10	--		
Comparison					t=1.061	.291
Patient History of Physical Abuse						
Yes	44	50.57	68	63.55		
No	3	49.43	39	36.45		
Missing	6	--	19	--		
Comparison					χ^2= 3.311	.069
Patient History of Sexual Abuse						
Yes	40	45.98	58	58.00		
No	47	54.02	42	42.00		
Missing	6	--	26	--		
Comparison					χ^2= 2.696	.101
Patient History of Gang Involvement						
Yes	24	26.97	15	16.30		
No	65	73.03	77	83.70		
Missing	4	--	33	--		
Comparison					χ^2= 3.042	.081

Table 11
Patient Functioning in Hospital

	Court-Ordered		Clinically-Referred			
	No.	%	No.	%	χ^2 or t	Probability
Length of Stay (in days)						
Mean	51.26	–	131.24	–		
S.D.	48.89	–	117.71	–		
Missing	3	–	2	–		
Comparison					t= 6.801	.0001
Physically Aggressive Toward Staff						
Yes	8	9.09	29	27.10		
No	80	90.91	78	72.90		
Missing	5	–	19	–		
Comparison					χ^2= 10.190	.001
Patient Aggressive Toward Peers						
Yes	5	5.68	27	25.23		
No	83	94.32	80	74.77		
Missing	5	–	19	–		
Comparison					χ^2= 13.457	.001
Number of Seclusions						
Mean	1.80	–	4.41	–		
S.D.	4.05	–	10.74	–		
Missing	3	–	5	–		
Comparison					t= -2.422	.0165

e. Patient functioning in hospital.

All of our measures of functioning in the hospital indicated that the court-referred patients were better behaved during the first thirty days of stay, and that these differences were statisti-

cally significant.[189] As Table 11 shows, the court-referred patients exhibited fewer incidents of aggression toward staff (Chi-square value of 10.19 and probability of .001), and peers (Chi-square value of 13.457 and probability of .001), and fewer seclusions (t value of -2.422 and probability of .0165). As a former juvenile justice system probation officer put it, "the courts have scared these kids."[190] Faced with negative consequences in the juvenile justice system, the court-referred may have exhibited better self-control while hospitalized.

f. Psychiatric diagnoses.

There were no statistically significant differences between the samples with respect to internalizing disorders, developmental disorders, or diagnosed substance abuse disorders. As shown in Table 12, there were differences with respect to self-reported substance abuse: the court-referred patients were more likely to report abuse (Chi-square value of 12.351 and probability of .001). Evidently, clinicians did not perceive any differences.

Our most notable finding concerned the patients' central psychiatric diagnoses. The court-referred patients were more likely to be diagnosed with externalizing disorders (Chi-square value of 19.059 and probability of .001). On the other hand, the clinically referred patients were more likely to be diagnosed with psychotic disorders (Chi-square value of 17.273 and probability of .001). Thus, the court-referred patients were more likely to suffer from hyperactivity and aggression[191] while the clinically-referred were more likely to suffer from delusions or hallucinations.[192]

Finally, we observed no statistically significant differences on our two measures of overall functioning. Over 60% of both the court-referred and clinically-referred exhibited four to five stres-

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[189] We recorded events of aggression or violence for the first thirty days of stay. *See supra* Part IV.A.2.b.ii.

[190] Audience member, presentation at the March, 1997 grand rounds of the Yale Child Study Center.

[191] *See supra* text accompanying note 178 for a definition of externalizing disorders.

[192] *See supra* text accompanying notes 180-81 for a definition of psychotic disorders.

sors. In addition, both groups had GAF scores just above forty. That score indicates that a majority of both samples exhibited serious symptoms of psychiatric illness such a suicidal ideation or suffered a serious impairment in functioning at school, work, or in the family.[193]

2. Multiple Logistic Regression Analysis.

As Table 13 indicates, a stepwise logistic regression confirmed our univariate findings that four variables distinguished the court-referred and clinically-referred samples: Age (the clinically-referred were younger—Chi-square value of 8.806 and probability of .003), whether the patient had been previously hospitalized in a psychiatric facility (the clinically-referred were more likely to have been hospitalized—Chi-square value of 22.599 and probability of .0001), whether the patient had been diagnosed with a externalizing disorder (the court-referred patients were more likely to be so diagnosed—Chi-square value of 5.481 and probability of .0192), and whether the patient had been diagnosed with a psychotic disorder (the court-referred patients were more likely to be so diagnosed—Chi-square value of 12.519 and probability of .0004).

[193] DSM-IV, *supra* note 179, at 32.

Table 12
Diagnostic Groupings

	Court Referred		Clinically Referred			
	No.	%	No.	%	χ^2 or t	Probability
Internalizing Disorders						
Yes	54	58.70	84	67.20		
No	38	41.30	41	32.80		
Missing	1	--	1	--		
Comparison					χ^2=1.656	.198
Externalizing Disorders						
Yes	79	85.87	73	58.40		
No	13	14.13	52	41.60		
Missing	1	--	1	--		
Comparison					χ^2=19.059	.001
Developmental Disorders						
Yes	30	32.61	53	42.40		
No	62	67.39	72	57.60		
Missing	1	--	1	--		
Comparison					χ^2=2.151	.142
Diagnosed Substance Abuse Disorder						
Yes	34	36.96	32	25.81		
No	58	63.04	92	74.19		
Missing	1	--	2	--		
Comparison					χ^2=3.094	.079
Self-reported Substance Use						
Yes	57	61.96	40	37.04		
No	35	38.04	68	62.96		
Missing	1	--	18	--		
Comparison					χ^2=12.351	.001
Psychotic Disorders						
Yes	2	2.17	27	21.60		
No	90	97.83	98	78.40		
Missing	1	--	1	--		
Comparison					χ^2=17.273	.001

(Table continued on following page)

	Court-Ordered		Clinically-Referred			
	No.	%	No.	%	χ^2 or t	Probability
Stressors						
0-1	0	0.00	1	00.80		
2	9	9.78	6	04.80		
3	26	28.26	28	22.40		
4	54	58.70	75	60.00		
5	3	3.26	15	12.00		
Missing	1	--	1	--		
Comparison					χ^2=8.265	.082
Bifurcated Stressors Variable						
0-3	35	38.04	34	27.42		
4-5	57	61.96	90	72.58		
Missing	1	--	2	--		
Comparison					χ^2=2.742	.098
GAF Score						
Mean	41.84	--	43.18	--		
S.D.	9.55	--	14.57	--		
Missing	2	--	1	--		
Comparison					t=1.061	.291

Table 13

Stepwise Multiple Logistic Regression

	χ^2	Probability
Intercept	19.358	.0001
Age	8.806	.0030
Whether prior hospitalization	22.599	.0001
Externalizing disorder	5.481	.0192
Psychotic disorder	12.519	.0004

V. IMPLICATIONS

Our research has implications in two contexts. First, the racial data permit observations about bias by both the courts and clinicians in referring patients to the state-operated Hospital. Second, a comparison of the clinically- and court-referred patients within the Hospital permits observations about the psychiatric differences between adolescents who enter the criminal justice system before entering the Hospital and those referred by clinicians before they are intercepted by the courts.

A. THE THREE-WAY COMPARISON: JUDICIAL AND CLINICAL RACIAL BIAS

Our findings on racial bias inject two new dimensions into the existing body of empirical research. First, like many others, we found statistically significant differences in the racial makeup of the correctional school and court-referred hospital samples.[194] Only 18% of the correctional school sample were White; 58% of those who the courts referred to the hospital were White. By considering only the court-referred patients, our observation is more precise than that offered by all of the previous research which compared the full correctional school population with the full psychiatric hospital population.[195]

We did not, however, find a similar, statistically significant difference between the court-referred and clinically-referred samples within the hospital. The clinically-referred were approximately 50% White, statistically indistinguishable from the just over 58% White distribution of the correctional school (Chi-square value of 1.685 and probability of .194).[196]

Of course, we may have obtained this result because the courts rely on clinician recommendations in making referrals to the hospital. The governing statute, however, does not require clinician input.[197] Moreover, many courts, especially those located outside of Connecticut's three largest cities, typically do

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[194] *See supra* Part III.B.

[195] *See supra* text accompanying notes 125-65 for a discussion of this prior research.

[196] *See supra*, Table 5.

[197] CONN. GEN. STAT. §§ 46b-140 (court "may" order mental examination) & § 46b-143 (order "may" require psychiatric evaluation) (1995).

not consult mental health professionals in deciding whether to refer a juvenile for a mental health evaluation.[198]

The bias that results in fewer juveniles of racial minorities receiving treatment in the mental health system goes beyond the courts and may be much broader than other research has suggested. Our data suggest that the bias is systemic to the juvenile mental health system. Both points of referral to the state child and adolescent psychiatric hospital operate to create a hospital population which contains a smaller representation of racial minorities than the state juvenile correctional school. At the very least, our findings suggest that future research should address whether the bias of the juvenile courts differs from the bias which clinicians exhibit.

The second dimension that our research introduces broaches an even broader racial issue. Although courts and clinicians refer a population to the hospital that represents fewer minorities than the correctional school population, the hospital population still over-represents racial minorities. On this topic, our conclusion goes beyond even that of Kaplan and Busner.[199]

In 1992, comparing correctional school and psychiatric hospital populations with the general population of New York State, they found minorities over-represented in the correctional system but found no bias in the mental health system.[200]

Our findings are contrary. The 1990 Connecticut census reports a state population which is 87% White.[201] The hospital population, whether court- or clinically-referred is less than 50% White. Minorities are over represented in the mental health system as well as the juvenile justice system.

At first glance, this finding may suggest inconsistent dispositions by the courts and clinicians. The courts appear to discriminate in favor of Whites by selecting a disproportionate

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[198] Statement of social worker for the Connecticut Department of Children and Families, made at March, 1997 grand rounds presentation at the Yale Child Study Center.

[199] *See* Kaplan & Busner, *supra* note 7 and accompanying text.

[200] *See supra* notes 158-163 and accompanying text for a discussion of Kaplan and Busner's findings.

[201] U.S. Census Bureau, *1990 CENSUS* (visited Mar. 10, 1999) http://venus.census.gov/cdrom/lookup/910827678>.

number from a mostly Non-white population. Clinicians, on the other hand, select a disproportionately Non-white contingent from a mostly White population.

A consistent, but perhaps more troubling explanation may apply. Both actors may have acted consistently by assigning the least restrictive available setting to White subjects. In the juvenile justice system, White subjects receive a disproportionate number of the less restrictive hospital slots. In the general public, Whites also are more likely to receive the less restrictive slot: outpatient therapy or inpatient therapy at private hospitals. In both cases, the Nonwhites suffer an adverse result.

Our findings are subject to two qualifications. First, our data are incomplete. To ascertain whether any disparate impact exists, we would need to identify the disposition of all of Connecticut's adolescents who are diagnosed with a psychiatric condition. Without knowing the racial composition of those who receive outpatient therapy, residential treatment, and inpatient treatment in all possible therapeutic settings, we cannot definitively determine whether clinicians discriminate against those they refer to the hospital. But, at least we have raised this issue for future researchers.

Second, our findings are confined to the institution we studied—Connecticut's lone state-operated child and adolescent psychiatric hospital. Because that hospital features a population which abounds with Medicaid patients,[202] our results may speak to socioeconomic status as much as to race. Indeed, this points out a significant limitation in our research. Because neither the hospital nor the correctional school maintained data on the socioeconomic status of their populations, we could not measure the effect of that status on court or clinical referral. Whether racially or socioeconomically based, however, the import of our study is clear. Although court and clinical decision mirror one another on demographic measures, both send a population to the state psychiatric hospital that differs starkly from the Connecticut general population.

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[202] Telephone interview with Leslie Siegal, M.D., Director of Medicine, Riverview Hospital, March, 1998.

B. CLINICALLY- AND COURT-REFERRED

1. Family and Patient Profiles

Like our measure of racial composition, our measures of patient and family history revealed indistinguishable correctional school and hospital populations, which resemble Connecticut's general population. For example, over 35% of both the court-referred and clinically-referred reported substance use (62% of the court-referred reported use) and over 25% received a substance abuse disorder diagnosis. Yet, in 1995, 10.9% of the nation's adolescents between the ages of twelve and seventeen reported using drugs.[203] Slightly over 21% reported use of alcohol.[204] And that 50% of all mothers and 75% of all fathers and other family members had a history of substance abuse is at least equally distressing.[205]

Both the court-referred and clinically-referred samples also exhibited an alarming incidence of family incarceration and arrest history. In both samples, nearly 22% of the mothers and 40% of the fathers had been arrested or incarcerated.[206] Yet, national arrest statistics indicate that less than 6% of the population was arrested in 1995.[207] Although the subjects' reports may represent an accumulation of arrests over several years, in dramatic fashion the numbers still appear to differentiate both the court-referred and clinically-referred populations from the general public.

Some characteristics of the subjects' histories may not distinguish them from the general public, but may still be cause for concern. The study revealed that approximately 50% of all mothers, 25% of all fathers, and 75% of other family members

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[203] Substance Abuse and Mental Health Services Administration (SAMHSA), *1996 National Household Survey on Drug Abuse: an annual survey conducted by SAMHSA* (visited Mar. 31, 1999) <http://www.samsha.gov/oas/nhsda/hitemp/96hsfinl.htm#eloel. >

[204] Substance Abuse and Mental Health Services Administration, U.S. Dep't of Health and Human Services, (*Press Release*, on file with the *Journal of Criminal Law & Criminology*).

[205] *Id.*

[206] *See supra*, Table 7.

[207] Federal Bureau of Investigation, U.S. Dep't of Justice, (*Press Release* Oct. 13, 1996) (reporting a rate of 5807 arrests per 100,000 population).

had a history of psychiatric illness.[208] Early 1990s data indicate that 30% of the public had experienced recent mental disorder. By 1995, one study reported that the prevalence of a mental disorder sometime in a person's life had risen to 48%.[209]

Finally, both court-referred and clinically-referred subjects exhibited an alarming incidence of abuse. More than 50% had histories of sexual and physical abuse.[210] National studies have concluded that 4.7% of children are reported to have suffered some mistreatment.[211] Social service workers confirm mistreatment in about a third of those cases, or in 1.5% of children.[212]

2. *Diagnostic Similarities and Differences*

In most ways, the court-referred and clinically-referred were statistically indistinguishable. For example, the two samples were equally impaired on most measures of psychiatric disturbance, averaging over three psychiatric diagnoses each.[213] Because psychiatric diagnoses, especially the externalizing disorders, in adolescents often are accompanied by multiple diagnoses,[214] this factor is not notable.

The samples did differ in two basic respects. Prior psychiatric hospitalization is the independent variable that most significantly differentiated the court-referred from the clinically-referred patients.[215] This may indicate such severe psychiatric disturbance that the patient requires hospital-level care to maintain safety. It may also suggest a clinical bias toward hospitalization for these patients.

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[208] *See supra*, Table 8.

[209] David Brown, *Between Madness and Badness: A Reflection on Medicine, Morals and the Mind of the Criminal*, WASH. POST, Mar. 1, 1998, at C1.

[210] *See supra*, Table 10.

[211] Prevent Child Abuse America, *Child Abuse and Neglect Statistics, Apr., 1998* (visited April 1, 1999) <http://www.childabuse.org/facts97.html>

[212] *Id.*

[213] *See supra*, Table 12.

[214] *See, e.g.*, Jeffrey H. Newcorn & Jeffrey M. Halperin, *Comorbidity Among Disruptive Behavior Disorders, in* CHILD AND ADOLESCENT PSYCHIATRIC CLINICS OF NORTH AMERICA 227 (Laurence L. Greenhill, ed. 1994) (observing that Comorbidity "is the rule rather than the exception").

[215] *See supra*, Table 10.

The court-referred and clinically-referred also differed in mean age, the lone demographic variable that differentiated the samples.[216] This undoubtedly reflects the legal status of non-culpability assigned by statute to young children.

Most significantly, the samples differed in primary diagnosis. Not surprisingly, patients with externalizing disorders—conduct problems—were more likely to be court-referred patients. These disorders, sometimes equated with "delinquency,"[217] are associated with the same demographic "risk factors"[218] that are associated with juvenile arrest and detention.[219]

Patients with psychotic disorders were more likely to be clinically-referred. This result raises the question whether these adolescents are referred by other public (schools) or private (families and physicians) actors before the adolescents encounter criminal justice officials, do not exhibit behaviors that lead to arrest, or are so manifestly disturbed that criminal justice officials refer them to the hospital rather than arrest or prosecute them.

These findings might offer some consolation to Lois Weithorn. To be sure, Professor Weithorn would add the court-referrals to the rolls of "troublesome" youth diagnosed with a variety of conduct disorders in the nation's psychiatric hospitals.[220] But that they originated and may return to the juvenile justice system and that those who enter the hospital through clinical referral are more likely to be diagnosed with a psychotic disorder, a disorder Weithorn explicitly recognized as an "acute

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[216] *See supra*, Table 13 and accompanying text.

[217] *See, e.g.*, Vanshdeep Sharma et al., *Disruptive Behavior Disorders, Assessment and Differential Diagnosis, in* CHILD AND ADOLESCENT PSYCHIATRIC CLINICS OF NORTH AMERICA 253, 258 (Laurence L. Greenhill ed., 1994).

[218] *See, e.g.*, Jose J. Bauermeister et al., *Epidemiology of Disruptive Behavior Disorders in* CHILD AND ADOLESCENT PSYCHIATRIC CLINICS OF NORTH AMERICA 171, 191 (Laurence L. Greenhill ed., 1994).

[219] *See, e.g.*, Barry C. Feld, *Justice by Geography: Urban, Suburban, and Rural Variations in Juvenile Justice Administration*, 82 J. CRIM. L. & CRIMINOLOGY 156, 166-69 (1991); Robert J. Sampson & John H. Laub, *Structural Variations in Juvenile Court Processing: Inequality, the Underclass, and Social Control*, 27 LAW & SOC'Y REV. 285, 305 (1993).

[220] *See* Weithorn, *supra* note 77, at 785, 789.

or severe mental illness,"[221] might blunt her criticism of the mental health system.

Of course, that youths presenting conduct disorders are more likely to end up in the criminal justice system than the mental health system may raise a host of problems of its own.

C. CONCLUSION.

> De guy wid de whiskers what sat up on the high bench, looked over to the Cop, and de Cop says to him, dis is a very bad kid, and he went into Smith's barber shop and took two razors, and he admits it yer honor; and what does de guy do, but hikes me right off to Golden before I had a chance to say a word.[222]

Our findings have broad implications for any discourse regarding the juvenile criminal justice and mental health systems. Certainly the Progressives who championed the "best interests of the adolescent" should not be pleased with findings that indicate that race may be a significant factor in both court and clinical dispositions.[223] Legal Moralists and other critics of illicit state assertion of control over adolescents might well wish to broaden their survey to include the mental health system.[224] And, the Constitutionalists who once critiqued the criminal justice system as procedurally bankrupt might wish to reconvene to consider the substantive legitimacy of the activities of both the courts and clinicians.[225]

Some aspects of our findings may please all of these parties. That the mental health system is more likely than the criminal justice system to be populated with adolescents suffering "severe or acute mental illness" should provide some solace to the critics, regardless of perspective. The racial findings, on the other hand, may suggest that, like the 1930s English judge described in the child's quote that opened this conclusion, both modern-day juvenile court judges and mental health clinicians may not

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[221] *Id.* at 788-89.

[222] *See* MACDONALD, *supra* note 1, at 5 (quoting from a trial in the Old Bailey Court of London in 1933).

[223] *See supra* notes 17-27 and accompanying text.

[224] *See supra* note 29 and accompanying text.

[225] *See supra* notes 31-33, 46 and accompanying text.

be effectively listening to or attending to the needs of the adolescents which they serve.