ON THE INTERFACE BETWEEN PSYCHIATRY AND LAW: THE WINNIPEG JUVENILE COURT CLINIC

by

VALERIE MARIE MICHAUD

A thesis
presented to the University of Manitoba
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ABSTRACT

This study examined the nature of the working relationship between Children's Forensic Services and the Winnipeg Juvenile Court. Two major dynamics of the interprofessional process were investigated: (a) the intake procedure in the juvenile court clinic and (b) the use that the court makes of psychiatric reports in the sentencing process. The major determinants of entry into the court clinic population and the independent influence of the psychiatric report on the sentencing process were identified by contrasting a sample of court clinic referrals (N=106) to a comparable sample of court clinic non-referrals (N=659).

The findings indicated that the court clinic referrals were different from the general population of juveniles offenders -- that is, they were more likely to have legal representation, to demonstrate problems in social functioning and to be heavily involved in delinquent behavior. In practical terms, the logical implication was that these offenders required unique forms of intervention. Indeed, it was found that their assumed need for assistance resulted in more severe dispositions. The court concurred more often with the more restrictive psychiatric recommendations than the less restrictive psychiatric recommendations; and overall, offenders who were sentenced with a psychiatric report were treated more harshly by the court than those who did not have a psychiatric report.

On the whole, the findings revealed that the input of lawyers and mental health professionals in the juvenile court setting resulted in more severe dispositions for the court clinic referrals. Juveniles who had legal representation were more likely to be referred to the court clinic, and in turn, offenders who were sentenced with a psychiatric report received harsher dispositions than those who were sentenced without a report. It was concluded that future research should assess whether the imposition of more severe dispositions for the court clinic referrals yields any positive effets such as improved family relations or school performance and reduced recidivism. When this research problem is addressed, lawyers and mental health professionals will be better able to evaluate whether they are fulfilling their professional roles appropriately.

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CHAPTER I

STATEMENT OF THE PROBLEM AND REVIEW OF THE LITERATURE

A. The Problem

The relationship between psychiatry and law has generated much discussion primarily with regard to issues such as the insanity plea, competence to stand trial and criminal responsibility. The present intent is to focus on a subject area that has received minimal consideration in the literature -- namely, the nature of the interface between psychiatry and law within the context of the juvenile justice system. The complex nature of this relationship can be most fully understood by drawing upon the contributions in the sociology of work and occupations, the sociology of complex organizations, the sociology of deviance, and, of course, the sociology of medicine.

More specifically, the subject will be addressed by situating psychiatry, as a medical specialty, within the realm of professionalism, and considering all that this status implies for the organization of work. Furthermore, the organization of professional performance within a specific setting, the juvenile court clinic, will be examined to explicate the dynamics of the interprofessional process -- that is, the process by which professionals representing different disciplines manage to forge working relationships. It is proposed that organizational pressures for efficiency have led to negotiations between law and psychiatry as to their respective territories of assumed competence, and that standardized procedures have evolved which facilitate the process of "getting the work done".

What is of crucial sociological import, is that by specifying the form and content of this collaborative relationship between the criminal justice and mental health systems, one can begin to address some of the concerns raised by societal reaction theorists. Assuming that the designation of a particular behavioral sequence as a "crime" or an "illness" is problematic, one can enquire into the conditions governing the entrance into one role or the other. It can be determined whether there are social contingencies, that is, factors other than the accused's behavior, that are crucial determinants of entry into the criminal and sick roles. The extent to which the operative factors reflect primarily psychiatric instead of legal concerns, will demonstrate to what extent, if any, the judicial sphere has experienced a loss of influence to psychiatry. The use that the court makes of psychiatric reports in the sentencing process will further indicate whether a portion of the judiciary's authority has been usurped by psychiatry.

B. Literature Review

1. The Profession of Medicine

The professions have generally been conceived as a select body of superior occupations. Although their identity has often been, and still is, in dispute, for purposes of analysis, it may be assumed that if any occupation "is" a profession, it is contemporary medicine. Such an assumption, contends Freidson (1970), serves a purely analytical intent in that by carefully examining the characteristics of the medical profession in contrast to those of other occupations, one may determine in what sense, if any, the social construct "profession" serves a viable heuristic function.

In their efforts to delineate the formal criteria of a profession, sociologists have most commonly addressed themselves to distinguishing professions from other occupations in terms of objectively determinable attributes. The general consensus is that there are essentially two "core characteristics" of professions, from which other characteristics relating to autonomy are derived (Goode, 1960). The first core characteristic -- "a prolonged specialized training in a body of abstract knowledge" -- refers to physicians' claims of special expertise, which serve as the main prerequisite for justifying control over the content of work; and the second core characteristic -- "a collectivity or service orientation" -- refers to physicians' claims of ethicality, which serve as a prerequisite for being trusted to control the economic and organizational or social terms of work without taking advantage of such control (Freidson, 1970; p. 77). In this characterization of the professions, the "derived characteristics" which relate to autonomy over the content and terms of work, are presumably

"caused" by the core characteristics which refer to a distinctively superior skill, theoretical learning and ethical stance.

An alternative formulation has been developed, however, in which the elements of professionalization referred to above, are related to each other in a significantly different manner (Freidson, 1970). The point of contention centers on whether a prolonged specialized training in a body of abstract knowledge and a collectivity or service orientation, are indeed "core" characteristics which are objectively unique to professions. It is claimed that: (a) with regard to training, what clearly distinguishes professions from other occupations is not the objective content and duration of training as such, but rather only the issue of autonomy and occupational control over this training; and (b) with regard to a collectivity or service orientation, this ethical stance is espoused by both the medical profession and other occupations in the medical division of labor that have not been granted professional status (nurses, lab technicians, dieticians). It is argued that, in the final analysis, the most strategic distinction between a profession and other occupations, is that a profession is granted legitimate organized autonomy over the technical content of its work and often over the economic and organizational or social terms of work:

> There is no stable institutional attribute which inevitably leads to a position of autonomy. In one way or another, through a process of political negotiation and persuasion, society is led to believe that it is desirable to grant an occupation the professional status of self-regulative autonomy. The occupation's training institutions, code of ethics, and work are attributes which frequently figure prominently in the process of persuasion but are not individually or in concert, invariably, or even mostly, persuasive as objectively determinable attributes (Freidson, 1970; p. 83).

In this sense, autonomy is not a derived characteristic; it is the core characteristic of the professions, which implies that professions are more easily distinguished from other occupations not on the basis of objective characteristics (specialized training, service orientation), but in terms of the success that the former group has had in persuading the public that these characteristics are unique to their occupational group.

The major implication of the fact that medicine has been granted a monopoly over its work, resides in the exclusive jurisdiction that it has obtained over the definition and cure of illness. The perception and designation of a given state as "illness" is presumably free of lay evaluation and control, so that, "medicine's monopoly may be said to include the right to create illness as an official social role" (Freidson, 1970; p. 206). If one subscribes to the ontology of medicine, that is, the conception of illness as biological deviance that can be objectively diagnosed and managed, irrespective of the social circumstances in which it occurs, the exclusive jurisdiction granted to medicine is not regarded as problematic. On the other hand, if it is asserted that illness is a matter of social definition, then the label of illness itself and the authority granted to those agents whose task includes the recognition and treatment of illness are rendered problematic.

The conventional stance has been to adopt the former approach to illness. However, an increasing body of literature has developed in which concerns have been expressed about the results of this unquestioned consensus. The major concerns are: (a) that the presence and influence of medicine, and the labels "healthy" and "ill", are

increasing in every part of public life, so that the trend has been to incorporate within the domain of medicine a variety of forms of behavior that had previously been conceptualized as "crime" or "sin" (Dibble, 1962; Bittner, 1968; Freidson, 1970; Zola, 1972; Zola, 1975; Hawkins & Tiedeman, 1975; Conrad, 1979; Conrad & Schneider, 1980; Miller, 1980); and (b) that there is a tendency for agencies traditionally associated with legal forms of control to redefine their clients' behavior and hence, their own work, to conform to the medicalized view (Chalfant, 1977; Edelman, 1974). As such, the recurring theme is the ascendancy of medicine as an institution of social control and the loss of influence of the more traditional institutions of religion and law. Consequently, both the ministry and jurisprudence must face the fact that the increasing emphasis on the label of illness has been at the expense of alternative labels such as sin and crime.

The dissemination of medical ideology to all spheres of society has been linked to the direction that the concept of "health" gives to medicine's influence. By developing ecumenic ideas (Dibble, 1962), an occupation is able to link its parochial goals and claims to values held in common throughout a society, thus facilitating the diffusion of the occupational ideology to other groups in society. The ideal of health, which has unsurpassed evaluative priority in modern life, has served this function for medicine. Hence, in their strivings for this value -- health -- physicians are, "oriented to seeking out and finding illness" (Freidson, 1970; p. 252) preferring to err in the direction of, "retaining a patient when he is not ill . . . rather than dismissing a patient when he is actually ill" (Scheff, 1966; p. 110). Similarly,

non-medical segments of society have demanded that physicians become involved in understanding, diagnosing and treating social problems since this, "leads to their removal from religious and legal scrutiny and thus from moral and punitive consequences . . . and their placement under medical and scientific scrutiny" (Zola, 1972, p. 489; Bittner, 1968; Conrad, 1979; Zola, 1975; Miller, 1980). The steady expansion of medicine's jurisdiction, therefore, has been facilitated by processes both within and without the profession. The physician functions as a moral entrepreneur (Becker, 1963) oriented to conferring the "sick role" in instances where that interpretation was previously lacking, while the public reciprocates by seeking medical advice.

Another crucial dimension of the process is the role that the semi-professions have played in promoting medical ideology within their own spheres of work. Chalfant (1977) suggests that semi-professionals (probation officers, social workers) have actively participated in the medicalization of deviant behavior, "out of the need that they have to confirm and enhance their emerging status with regard to the more established professions and the limited amount of autonomy they hold" (p. 79). These conclusions were based, in part, on a content analysis of articles in the journal Federal Probation, for the years 1951-1955, 1971-1975 and 1966-1976. Upon examination of the 218 articles that were published in this journal for the period 1966-1976, it was determined that a high proportion of the articles (71.5%) were devoted to either one or both of the following topics: (a) the conceptualization of offenses in terms of the sick role, and (b) approaches to dealing with offenders that follow therapeutic models (transactional analysis, group therapy, behavior modification).

Moreover, analysis of the articles from the two time periods 1951 - 55 and 1971 - 75, indicated a significant increase in the proportion of articles that presented a medicalized view of both the offender and the nature of probation work (40.4% to 58.9%).

In sum, concerns about the medicalizing of society stem from two sources -- the extent to which medicine has ventured to deal with forms of behavior that previously had been perceived as outside the boundaries of medical expertise, and the extent to which semi-professionals outside the profession have come to adopt the medical perspective. The ascendancy of medicine, which has been facilitated by the legitimate organized autonomy granted to the profession, is increasingly regarded as a disturbing trend --

> . . . when health becomes not only a paramount value in society, but also a phenomenon whose diagnosis and treatment has been restricted to a certain group . . . this means that that group, perhaps unwittingly, is in a position to exercise great control and influence about what we should and should not do to attain that 'paramount value' (Zola, 1972; p. 498).

As such, the more traditional institutions of religion and law are rendered vulnerable, by the possibility that the increasing emphasis on the labels of health and illness, may eventually bring about the displacement of alternative labels such as sin and crime.

Particularly in the realm of juvenile justice, where the rehabilitative ideal is emphasized, there seems to be a strong tendency to redefine both offenders' behavior and the work of juvenile court personnel (especially probation officers) to conform to the medicalized view. Accordingly, it would be expected that, having been exposed to the diffusion of medical ideology, probation officers (and perhaps lawyers and judges) would be sensitive to clinical concerns, and that

this would be reflected in the nature of the referrals that are made to the court clinic. In turn, court clinic staff would address these concerns and present recommendations for treatment to the court.

The imagery of the juvenile justice system presented above is based on what could be expected to prevail in a medicalized society. The literature to be reviewed in the next section suggests that this portrait of the juvenile justice system requires modification. Juvenile court personnel and court clinic staff may be so constrained by the demands of the legal bureaucracy, that judicial concerns may often prevail over clinical concerns.

2. The Social Organization of Work

Specifying the nature of organized medicine, has made it apparent that the strategic distinction between the profession and other occupations, lies in the legitimate organized autonomy that has been granted to the former. This mandate, which grants to medicine status as the official designator of the sick role, has been identified as the major force which has facilitated the steady expansion of medicine's jurisdiction and the diffusion of medical ideology to non-medical segments of society. However, as Freidson (1970) suggests, designation of the formal criteria of a profession is not sufficient if the intent is to understand medical performance or behavior as such:

> Formal criteria of profession establish the framework within which the behavior of all professional individuals takes place. But they are not able to specify whether or not individuals differ in their work performance, whether or not there are systematic differences, and, if so, what is the nature and source of systematic difference (p. 83).

The concrete settings in which medical work takes place, therefore, must be analyzed in order to determine if structured variation in medical performance can be linked to the unique requirements of different work settings.

The professional typically participates in two systems -- the work group and the work place -- which often prescribe divergent behavioral performances for their members. This engenders role strains:

> The professional person employed by a bureaucratic organization is the modern marginal man, his feet uncertainly planted in two different and partially conflicting institutional environments (Scott, 1969; p. 89).

Since bureaucratically organized professional practice is on the increase, much research has attempted to assess the impact that

particular work settings may have, on the degree to which an occupation can attain or maintain a self-regulative and autonomous status (Scott, 1966; Scott, 1969; Hall, 1973; Decker, 1979; Ben-David, 1958; Engel, 1969; Sudnow, 1978; Toren, 1969; McCleary, 1975). The focus in much of this empirical work has been on documenting the extent to which, and, the manner in which, particular work settings may constrain the professional's discretion in the use of his/her expertise.

Hall (1973) examined the relationship between professionalization and bureaucracy, by having subjects from a variety of occupational groups found in a variety of organizational settings, complete two series of items which measured their professional attitudinal attributes, and their perception of the degree of bureaucratization in their respective organizations. The occupational groups were distributed into three categories according to the type of setting in which their work is performed: (a) the autonomous professional organization where the work of the professional is subject to his own control (medical clinic, law firm, accounting firm, advertising agency), (b) the heteronomous (semi-professional) organization in which employees are subordinated to an administrative framework not of their own making (social work agencies, schools, nurses, stockbrokers), and (c) the professional department which is part of a larger organization (legal, engineering, personnel, accounting). The findings indicated that on all dimensions of bureaucracy (hierarchy of authority, division of labor, presence of rules, procedural specification, impersonality), except the technical competence dimension, the autonomous organizations were less bureaucratic than the other two types.

Moreover, the relationships between the attitudinal variables

measuring professionalism (use of the professional organization as a major reference, belief in service to the public, belief in self regulation, sense of calling to the field, feeling of autonomy) and the bureaucratic dimensions were generally negative, indicating, that "higher levels of professionalization are related to lower levels of bureaucratization and vice versa" (p. 503). Strong negative relationships were found between the autonomy variable and the bureaucratic dimensions, (hierarchy of authority - .767; division of labor - .575; rules - .554; procedures - .603; impersonality - .489) which suggests that professional autonomy is threatened by increased bureaucratization. These results suggest that the areas of conflict that emerge when professionals participate in bureaucratic organizations, are more applicable to the semi-professions which have not attained the same degree of autonomy as the established professions.

Toren (1969) argues that the issue should be formulated in a different manner. Instead of developing an a priori classification of those professions which are autonomous, heteronomous, or otherwise, emphasis should be placed on specifying which aspects of the professional's work are controlled:

> Closer scrutiny may reveal that the assumption of the intimate association between semi-professionalism and heteronomy, and between full-fledged professionalism and autonomy, is not a one-to-one relationship (p. 154).

By adopting this approach the description of any profession should become more complex and less ideal-typical.

The majority of empirical research has focused on examining the adaptation of a single semi-profession (Scott, 1969; McCleary, 1975) or profession (Decker, 1979; Ben-David, 1958; Engel, 1969; Sudnow, 1978)

to a given organizational structure. McCleary and Scott demonstrate that in carrying out their duties, parole officers and social workers, often do not do what they want to do, but what they have to do. Case decisions are often determined by organizational demands that are not necessarily congruent with client needs. The parole officer's discretionary powers are constrained by insistence on the part of officials from the Department of Corrections that, "client loyalty be subordinated to organizational loyalty" (McCleary, 1975; p. 210). Regardless of guilt or innocence, a "fair" parole officer is loyal to his clients only until the situation becomes hopeless, and hopelessness is defined in terms of the potential that the case presents for generating adverse publicity. Similarly, caseworkers in the public assistance agency, protested that legal requirements and procedural regulations, "interfered with their discretionary response to the differing problems of individual clients . . ." (Scott, 1969; p. 112). These findings suggest that individual performance can be deliberately controlled and shaped so that it is in accord with organizational imperatives.

Organizational control over the bases for decision-making has also been identified as a significant constraint within the domain of professional practice. Ben-David (1958) conducted interviews with physicians whose medical practice was situated in a bureaucratic setting. The physicians' perception was that they had suffered a loss of independence due to administrative interference with their medical work. Engel's research (1969) was addressed to further specification of the above relationship, and the findings indicated that, "a moderately bureaucratic setting provided more professional autonomy for the

physician than either a non-bureaucratic or a highly bureaucratic setting" (p. 34). In light of the advances in knowledge that have occurred in medicine, these findings were taken to indicate that bureaucratically structured organizations can more successfully, than the physician in solo practice, provide ready access to various facilities that are crucial to patient care (equipment, technical personnel). It was concluded that it is not bureaucracy per se but the degree of bureaucratization that can restrict professional autonomy. While the administrative characteristics of an organization can limit autonomy, to a certain degree the provision of physical facilities, can enhance the autonomy of the professional by facilitating the delivery of medical care.

Decker (1979) examined psychiatric decision-making in two Florida State Mental hospitals, in order to determine whether organizational context had any effect on the legal status of mental patients. The findings indicated that changes in the patients' status from involuntary to voluntary commitment did not follow from psychiatric evaluations that indicated a change in the patient's condition. Rather, these status changes were effected purely for administrative convenience; that is, they allowed the hospital to circumvent reviews that were required by law after a six month period of involuntary hospitalization. Hence, psychiatric practice in these hospitals did not conform to the professional ideal. Decisions concerning the legal status of mental patients were susceptible to administrative manipulations, that sought to minimize the number of potentially disruptive occurrences in the institution.

Sudnow (1978) examined the nature of the working relationship that

develops between public defenders and district attorneys, in a judicial system where expeditious processing of cases is a crucial requirement. The findings indicate that what develops is not an adversary relationship but a cooperative enterprise. The public defender and district attorney agree on a set of procedures for reducing original charges to lesser offences, in order that the number of guilty plea dispositions may be maximized. The nature of these procedures further indicates that they are a response to the demands of bureaucratic organization. Attorneys develop conceptions of "typical" offences that can be appropriately reduced to certain lesser offences, which are not necessarily or situationally included in the original charge (for instance "molesting a minor" is often reduced to "loitering around a schoolyard").

Sudnow identifies these "typical offences" as normal crimes -- "those occurrences whose typical features, for example, the ways they usually occur and the characteristics of persons who commit them, as well as the typical victims and typical scenes, are known and attended to by the public defender" (p. 216). Incoming cases are scrutinized to determine whether there is a sufficient correspondence with the applicable category of normal crime. This facilitates the processing of cases, since attorneys do not attend to all the details of the case but only to those elements which are relevant to their conceptions of the "typical case".

The above studies have focused on a diverse group of occupations but they are linked by a common theme; that is, the notion that in developing explanations of behavior, attention must be paid not only to the personal characteristics and attitudes of individuals but also to

the work settings in which their performance takes place. As Feeley (1973) suggests, the lines of action that develop within an organizational setting are based primarily upon cooperation, negotiation and adaptation, so it is to be expected that, "the efficacious 'rules' followed by the actors are not necessarily the ideal, professional rules . . . " (p. 413). These concerns with the constraints that members of single professions face within their arenas of practice, have led to the development of research interests in the nature of working relationships that are forged, in those contexts where multi-professional interventions are the norm.

Lefton and Rosengren (1966) have developed a model of formal organizations that proves quite useful in organizing any discussion of inter-professional collaboration. They proposed that organizational interests in the client vary along two major dimensions: first, such interests may range from a short span of time to a lengthy period of time (the longitudinal dimension); and second, interest in the client's social biography may be limited or extensive (the lateral dimension). Logically, these dimensions can be combined to produce four different arrangements that represent the way organizations typically intervene in the life course of their clients. Each of these arrangements has a significantly different impact upon the internal functioning of organizations, as well as upon inter-organizational relationships.

What is of particular relevance here is that the nature of the organization's interests in the client, is regarded as an integral factor which influences the likelihood that a potential collaborative relationship will materialize:

> We would expect that a similarity in laterality or

> longitudinality would be likely to enhance formal collaboration, while contrasting types would be inhibited in collaboration and even experience open conflict (p. 809).

In the event that a collaborative relationship is established, the nature of the organization's interests in the client, is also related to the conflict which typically arises amongst staff members with regard either to means or to ends. For instance, organizations such as the juvenile court and the court psychiatric clinic, that have an extended interest in the client's social functioning (lateral orientation) and a limited interest in the client's biography (longitudinal orientation), are more likely to encounter problems of staff consensus over means rather than ends. Court and clinic staff can agree on an ambiguous goal such as treatment, but encounter problems in determining how their efforts should be directed to achieve this end.

Problems with staff consensus in inter-agency exchanges have been linked to conflict over occupational territory (Hawkins & Tiedeman, 1975). While participants may be able to agree on highly ambiguous goals, there is often considerable disagreement over means to the end, since one party's definition of appropriate occupational boundaries of expertise, may encroach upon the other's perception of its legitimate territorial claims. It is contended that organizational demands for efficiency bring about complex exchange processes between the collaborating parties:

> We propose that organizational pressures lead to negotiation and exchange processes which overcome territorial and definitional boundary disputes. These negotiations themselves may be time consuming, so standardized procedures evolve to stabilize the . . . process. Processing stereotypes serve this standardization and facilitative function (Hawkins & Tiedeman, 1975; p. 229).

The basic assumption underlying the notion of processing stereotypes is that organizations generate simplified images of their clients, in order that processing agents can find some semblance of order in their working environment. By developing categorical systems of "typical" cases and "typical" lines of action that are warranted for those types of cases, uncertainty and ambiguity are reduced and the smooth flow of individuals through the system is facilitated. The specific form and content of these processing stereotypes is dependent on the nature of the compromises that are negotiated between the collaborating parties.

The limited amount of research that has examined the nature of medical collaboration with other institutions, has focused on the role of the psychiatrist in civil commitment hearings (Scheff, 1966), in the military (Daniels, 1978), and in the juvenile court (Emerson, 1969). Some elements of medical social control are usually taken out of their traditional frame of reference and "borrowed" by the collaborating institutions (Christie, 1971). This combination of roles is enhanced by the need that legal and military personnel have to understand the actor; that is, they share with psychiatry some concern for the client's social space. Moreover, this shared lateral orientation to the client's biography, can often generate dissensus among collaborating parties as to means to the end (Lefton & Rosengren, 1966). Hence, it is essential to describe the standardized procedures that have evolved in negotiations between medicine and its collaborating institutions. The specific form and content of these procedures, will demonstrate to what extent the psychiatrist's freedom in the use of his/her expertise, is constrained by the demands of the collaborating institution (Conrad, 1979).

Scheff (1966) conducted intensive observations of legal and psychiatric screening procedures, in those four courts in a Mid-western state, that had the largest number of petitions for psychiatric hospitalization. The findings indicated that the average psychiatric examination was completed in 10.2 minutes and that rarely were there any recommendations for discharge. Observations of interviews between patients and their court-appointed lawyers, indicated that the lawyers did not inform them of their rights and were not likely to take the patient's side, concurring with psychiatric recommendations for hospitalization instead. The final step in the process, the judicial hearing, was largely ceremonial in nature. In one of the courts observed, the average length of a hearing was 1.6 minutes. Overall, in each of the four courts, all of the cases where hospitalization was recommended resulted in commitment.

The judicial decision to involuntarily commit patients, therefore, was routine and largely based on the presumption of illness. Moreover, it was found that within this multiagency setting, there were organizational pressures which reinforced such use of the medical decision rule by both psychiatric examiners and court officials. Psychiatrists and lawyers were paid a flat fee per case, which presented them with a financial incentive to maximize case volume -- hence, the primacy of the medical decision rule. In sum, the court subtly encouraged psychiatric procedures which promoted the effective disposition of cases. That psychiatrists were rewarded for behavior that is in accord with traditional definitions of medical practice, does not negate the fact that their performance was organizationally

constrained.

On the other hand, Daniels (1978) found that in the military the medical decision rule was reversed; that is, psychiatrists were constrained to under-diagnose the incidence of mental disorder in order that the men could be kept on duty. More specifically, what was deemed to constitute "mental disorder" in the military, was not necessarily equivalent to mental disorders as they are defined in traditional psychiatric nosology. It was found that the usual task of the psychiatrist was, "to discriminate between understandable mental breakdowns (combat neuroses), which provide a reasonable excuse, and unacceptable breakdowns (character and behavior disorders, immaturity reactions) which do not" (p. 167). In order to be considered mentally ill the patient's symptoms had to occur within an "appropriate" context. A man was relieved from duty only if he had an acceptable combat history. Those who presented symptoms too early in their combat experience were denied medical excuse by the psychiatrists. As such, a specific configuration of symptoms and social criteria figured prominently in this conception of a "reasonable" breakdown. Psychiatrists were constrained to designate as mentally ill only a portion of those men who presented psychiatric symptoms.

Emerson (1969) examined the role of the psychiatrist within the juvenile court setting. He found that the court practice of psychiatry was conducted on terms that recognized the legal function of the court. Court officials selected cases for referral to the clinic, and the psychiatrists routinely drew their recommendations for disposition, from the "reasonable" alternatives that were posed by court personnel.

With regard to the clinic referrals, the findings indicated that

the court used psychiatric expertise to accomplish several aims. The court routinely processed cases on the basis of assessments of moral character, which served to differentiate the normal, criminal, and disturbed offenders. As might be expected, those juveniles who were judged to be disturbed were referred to the court clinic.

Other uses were made of the court clinic. The court referred cases where the moral character of the youth remained obscure and there was conflict over the disposition of the case. Nelson (1972) suggests that in these instances the psychologist or psychiatrist, "is not utilized as much as he is 'used' to resolve two conflicting opinions usually between the probation officer and the child's attorney" (p. 29).

The court also refers cases that are considered to be criminally "hopeless", that is, it seeks psychiatric confirmation of its perception that, "to-be-incarcerated delinquents are fundamentally of such moral character that they should be committed ..." (Emerson, 1969; p. 248). Bohmer (1973) suggests that these referrals reflect the court's intention to use the report as support for imposing a serious sentence. Hence, psychiatric evaluations may be used by the court, "to protect itself from community criticism and reprisal in the event that a particular disposition (whether severe or lenient) proves to be unsuccessful" (Nelson, 1972; p. 29).

The nature of the clinic referrals discussed above would seem to indicate that psychiatric reports are ordered primarily with the concerns of the court in mind, not those of psychiatry. Emerson insists that, "clinic referrals reflect certain kinds of organizational problems for the court and are accompanied by pressures to make evaluations on terms relevant to these court interests" (1969, p. 249). Whatever the

psychiatrists' intentions it would seem that they are pressured to concern themselves with the needs of the court.

Furthermore, psychiatric recommendations to the court are often restricted to those alternatives that are considered "reasonable" by the court. This may be due, in part, to the problems that psychiatrists face in obtaining information from distrustful clients, or the amount of time that is available to interview clients may also be a limiting factor. Whatever the case may be, Emerson (1969) claims that, as a general rule, probation officers have a near monopoly on information relevant to a given case. This implies that they set the trend in terms of identifying what courses of action are open to discussion -- "to the extent that the psychiatrist routinely 'goes along' with the probation officer's disposition of the case, he is led to accept and therefore validate previously established assessments of the delinquent's moral character" (p. 260). Hence, the court's perception of the case remains unchallenged.

Lewis et al. (1973) would argue that Emerson's study demonstrates, that when a new system tries to collaborate with and influence an established system, "the incoming group must establish its credentials according to the criteria of the established group" (p. 112). In other words, court clinic staff are constrained to meet the immediate needs of the court, before any consideration will be given to their own unique goals.

Accordingly, the above literature review would suggest that semi-professionals and professionals alike, are significantly constrained by the organizational context in which their work takes place. Within the context of the juvenile court clinic, it would be

expected that the nature of psychiatric practice would be influenced by the unique requirements of the legal bureaucracy.

3. The Social Construction of the Role of the Mentally Ill

The preceding literature review has generated two alternative models, which predict that the collaborative relationship between the criminal justice and mental health systems, will assume significantly different forms. The literature on the profession of medicine suggests that the psychiatrist functions as an expert within the multi-agency setting, "observing, diagnosing, prescribing and treating in the medical tradition" (Greenley, 1975; p. 35). The literature on the social organization of work is congruent with an alternative view of the psychiatrist's role, which stresses that decisions are not made so much by an expert, as through a complex process of negotiation among all collaborating parties; that is, "the psychiatrist functions in large part to supply medical-psychiatric explanations or rationales for decisions often made on other grounds by other people" (Greenley, 1975; p. 35). These alternative views of the psychiatrist's role are especially relevant to societal reaction theorists, who have undertaken to identify those factors that are most likely to lead to an imputation of mental illness.

If it is assumed that the psychiatrist in a collaborative relationship continues to practice according to the dictates of medical tradition, then it would be argued that the court would rely more heavily on an assessment of treatment needs as opposed to other considerations, in the designation of the mentally ill status. The treatment orientation clearly calls on the mental health professional to examine the causes of an individual's behavior. Thus, it is conceivable that the court would assume that treatment needs are related to socio-demographic variables (sex, age, race, employment/student status,

living arrangements), and that these factors may figure more prominently in the imputation of mental illness than other variables (for instance, in the context of the juvenile court, legalistic variables such as seriousness of offence and prior record). On the other hand, if it is assumed that psychiatric practice is significantly constrained by the demands of collaborating parties, then it would be argued that the crucial determinants of entry into the sick role will be congruent with organizational concerns (legalistic variables) rather than the treatment needs of the client. The process by which juveniles come to be referred for psychiatric assessment may be regarded as problematic.

Scheff (1966) draws attention to the process by which labels are created and applied, stressing that one of the most urgent tasks for a sociological theory of mental disorder, is the development of a classificatory scheme which incorporates the wide variety of contingencies that influence the nature of the societal reaction. He presents a classification of the contingencies which focuses on the following dimensions: (1) the nature of the rule breaking, (2) the nature of the rule breaker and (3) the nature of the community in which the rule breaking occurs. Furthermore, he notes that the severity of the societal reaction is a function of,

> first, the degree, amount and visibility of the rule-breaking; second, the power of the rule-breaker and the social distance between him and the agents of social control; and finally, the tolerance level of the community, and the availability in the culture of the community of alternative non-deviant roles (pp. 96 - 97).

Scheff concludes that research should be addressed to determining the importance of the first two contingencies (the amount and degree of rule-breaking), relative to the remaining contingencies. To the extent

that the five latter contingencies are found to be independent determinants of entry into and exit from the status mentally ill, the status of the mental patient can be considered to be partly ascribed rather than completely achieved. That is, if the major determinants of entry to the status mentally ill are behavioral contingencies (factors that relate to the patient's rule-breaking behavior), then the status is an achieved status; however, if the crucial determinants include social contingencies (factors that are external to the patient's behavior such as sex, age, race, and socioeconomic status), then the status is, at least in part, an ascribed status. The empirical question to be addressed, therefore, is as follows: "To what extent is entry to and exit from the status of mental patient independent of the behavior or 'condition' of the patient?" (Scheff, 1966; p. 129).

There are two distinct bodies of literature, which have some bearing on the question of whether psychiatric or extra-psychiatric variables, are most salient in the official designation of the mentally ill role. The first group consists of those studies that are routinely cited in any discussion of the merits (or lack thereof) of the societal reaction and psychiatric perspectives (Scheff, 1967; Scheff, 1975; Greenley, 1972; Linsky, 1970; Rosenhan, 1980; Rushing, 1978; Rushing and Esco, 1977; Wenger and Fletcher, 1969; Wilde, 1968). These studies assess the importance of behavioral and non-behavioral contingencies in involuntary hospitalization (Scheff, 1967; Scheff, 1975; Greenley, 1972; Wenger and Fletcher, 1969; Wilde, 1968) and voluntary hospitalization (Rosenhan, 1980). Furthermore, voluntary and involuntary admissions are compared, in order to isolate those factors that influence the severity of the societal reaction (Rushing, 1978;

Rushing and Esco, 1977). The findings from these investigations are explicitly discussed in terms of their relevance for a sociological theory of mental disorder.

The second group consists of those studies that have sought to identify the factors that affect the referral of defendants to juvenile court clinics (Atcheson & William, 1956; Stephensen, 1971; Lewis, 1973; Kahn & Nursten, 1963; Prins, 1975; Prins, 1976) and adult court clinics (Davis et al., 1970 - 71; Bohmer, 1976; Smith, 1976; Warner, 1980; Prins, 1975; Prins, 1976). These studies are not theoretically informed; that is, the factors that influence referral for clinical evaluation are delineated, without any consideration given to the implications that these findings may have for a sociological theory of mental disorder. Similarly, societal reaction theorists have not recognized the insight that these studies provide with regard to the processes involved in the imputation of the status mentally ill.

Hence, the strategy here will be to (a) review those factors that have been identified as crucial determinants in the civil commitment process and in the court clinic referral process and (b) to situate those factors within Scheff's classification of contingencies. The findings should suggest whether it can be justifiably contended that the status of the mentally ill is partly ascribed rather than completely achieved.

Those studies that have investigated the psychiatric and judicial screening procedures involved in petitions for involuntary commitment, have demonstrated that extra-psychiatric variables are the most crucial determinants of entry into the mentally ill role. Wenger and Fletcher (1969) observed admission hearings to a state mental institution to

detect whether the presence of legal counsel would affect the commitment decision. The findings indicated that not only were the hearings with legal counsel over twice as long as those without counsel, but there was also a high positive association between the presence of legal counsel and the decision not to commit, when patient condition was controlled.

Wilde (1968) examined the screening process of the Mental Health Center in Western States Southern County. His general hypothesis was that the approval of a petition of mental illness depended not so much on the behavior of the pre-patient but rather on the responses of others. It was found that when the condition of the pre-patient was controlled, the approval of the commitment petition was associated with both the diligence of the petitioner (i.e. whether or not an appointment had been made with the Center) and the identity of the interviewer.

Scheff (1967) discussed the social conditions underlying the variation in procedures for hospitalizing and committing persons alleged to be mentally ill, in metropolitan and non-metropolitan jurisdictions. The findings indicated that there was a degree of rationality in the non-metropolitan courts (i.e. there was some attempt to investigate and assess the circumstances surrounding a case), while there was a lack of substantial rationality in the metropolitan courts (i.e. psychiatric examinations and judicial hearings were ceremonial in character with no attempt to ascertain the circumstances of the case). That is, due to a variety of factors, (time, amount of political pressure, degree of personal familiarity with the case, degree of psychiatric sophistication on the part of the judges, patient resources) the presumption of illness was more prevalent in metropolitan as compared to non-metropolitan jurisdictions. The decision to commit was based on contingencies that

were external to the patient.

Scheff (1975) explored the screening by court psychiatrists and judges of persons alleged to be mentally ill. In the first phase of the study, hospital psychiatrists were asked to rate a sample of incoming patients according to the legal criteria for commitment: dangerousness and degree of mental impairment. These ratings were used to determine whether there was any legal uncertainty about the patients' commitability and it was found that this held for 63% of the patients.

In the second phase of the study, the procedures utilized in committing patients were observed, specifically the psychiatric examination by court psychiatrists and the formal commitment hearing. The purpose was to ascertain how court psychiatrists and judges reacted to uncertainty. The observations indicated that all of the psychiatric examinations and court hearings were conducted in a perfunctory, assembly-line manner, and that every hearing resulted in a recommendation for commitment. Again, these findings would seem to indicate that the presumption of illness provides the impetus in commitment hearings, and that the condition of the patient is largely irrelevant.

Linsky (1970) focused on the consequences of community structure (extent of common culture) for mental hospitalization rates. The three facets of common culture that were measured included political consensus, common economic interests and racial-ethnic homogeneity. A composite index of common culture was developed by combining the above measures, and the 27 community areas under study were grouped into "homogeneous counties", "intermediate counties", and "hetereogeneous counties" based on their respective ranks on this index. An index of

psychopathology was also developed to measure the incidence of mental illness within the homogeneous and hetereogeneous communities under study. The findings indicated that rates of hospitalized mental illness were higher in culturally homogeneous communities, because of greater consensus as to what constituted abnormal behavior. Further specification of the findings revealed that the impact of community structure on mental hospitalization rates operated chiefly for the less severe mental disorders.

Extra-psychiatric variables have also been identified as crucial determinants in exit from the status of the mentally ill. Greenley (1972) examined the influence of the family's desires for discharge or further hospitalization, on the timing of patients' release from state mental institutions. The findings indicated that the patient's behavior and judged psychopathology were less important in terms of release decisions than family desires. When degree of psychiatric impairment, dangerousness, and professional judgment as to need of further hospitalization were controlled, the significant relationship between family desires and length of hospitalization remained unchanged.

Rosenhan (1980) conducted a study which demonstrated that in the case of voluntary hospitalization, the salient factors that lead to commitment are also external to the patient. In this field experiment, a varied group of pseudopatients gained admission to twelve different mental hospitals located in five different states. The pseudopatients reported that they had been hearing voices, but beyond that no alteration of their life history was made. They were all admitted with a diagnosis of schizophrenia. Upon admission to the psychiatric ward, they ceased simulating any symptoms of abnormality. Nevertheless, their

status was not suspected, and eventually each pseudopatient was discharged with a diagnosis of schizophrenia "in remission". This study attests to the merits of the view that irrespective of behavioral contingencies, the presumption of illness on the part of psychiatrists, serves to propel the patient into the social role of the mentally ill.

Rushing (1978) and Rushing & Esco (1977) assessed the influence of psychiatric and social variables on the type of mental hospital admission (voluntary versus involuntary). By comparing the nature of voluntary and involuntary admissions, they sought to determine whether patients with greater social resources could more successfully resist involuntary commitment. That is, their concern was to determine whether the relative power of the patients affected the type of societal reaction. The findings were based on an examination of all 21 - 64 year old first admissions to all state mental hospitals in Tennessee between the years 1956 and 1965.

Rushing (1978) examined the influence of socio-economic status (measured by educational status), type of diagnosis (functional or organic), and level of impairment (mild, moderate, severe) on the type of mental hospital admission. All relationships were examined with age and sex controlled. The following three hypotheses were supported:

(1) The number of involuntary admissions relative to voluntary admissions will increase as socio-economic status decreases.

(2) The direct effect of socio-economic status on type of mental hospital admission will be stronger for functional than for organic disorders.

(3) The direct effect of socio-economic status on type of mental hospital admission will be stronger for the minimally impaired than for those who are severely impaired.

More specifically, the findings indicated that socio-economic status had

a direct effect on type of mental hospital admission even when psychiatric diagnosis and behavioral deviance were controlled. Moreover, it was found that illness-deviance and social characteristics interacted in their effects on type of mental hospital admission. Both behavioral and non-behavioral contingencies, therefore, were identified as factors that affected the type of societal reaction.

Rushing and Esco (1977) assessed the influence of marital status (married, disrupted-estranged, never married), and level of impairment (mild, moderate, severe) on the type of mental hospital admission. The following hypothesized main and interaction effects received support:

(1) There will be a negative relationship between marital status and type of mental hospital admission.

(2) The proportion of involuntary admissions should be highest for those judged to be severely impaired and least for those judged to be mildly impaired.

(3) The effects of behavioral deviance on type of mental hospital admission will be smaller when marital resources are low.

Again the findings indicate that persons who occupy statuses with more resources, and engage in less serious forms of deviance, are less apt to be involuntarily committed to mental hospitals. Moreover, status resources and level of behavioral deviance interact in their effects on type of mental hospital admission. The authors conclude that it is overly simplistic to contend that individuals are hospitalized because they have engaged in deviant behavior or because they have certain social characteristics. The status of the mental patient is imputed on the basis of both ascribed and achieved characteristics.

The above studies have identified a wide variety of contingencies that affect the possibilities of entry into and exit from the status mentally ill. Though the majority of these contingencies can be

situated within Scheff's classificatory scheme, there are others that defy classification. For instance, it is not readily apparent how factors such as the presumption of illness (Scheff, 1967; Scheff, 1975; Rosehan, 1980), the diligence of the petitioner and the identity of the interviewer (Wilde, 1968), could be integrated into Scheff's classification of contingencies. Notwithstanding these difficulties, the remainder of the contingencies can be classified as follows:

A. Nature of the Rule Breaking

(1) degree of the rule breaking

- type of diagnosis (Rushing, 1970)
- level of impairment (Rushing, 1978; Rushing & Esco, 1977)

B. Nature of the Rule Breaker

(2) power of the rule breaker

- presence of counsel (Wenger & Fletcher, 1969)
- family desires (Greenley, 1972)
- socio-economic status (Rushing, 1978)
- marital status (Rushing & Esco, 1977)

C. Nature of the Community

(3) tolerance level of the community

- community homogeneity (Linsky, 1970)

Categorized in this fashion, the research findings present compelling evidence that the status of the mental patient is dependent not only on the patient's behavior, but on factors that are external to the patient. As Becker stresses, whether or not an individual becomes mentally ill, "depends not so much on what he does as what others do" (1963; p. 31). Entry into the status mentally ill is not solely determined by the inherent properties of the rule breaking; rather it is, at least in part, a function of the societal reaction to that rule breaking. The above research findings have demonstrated that the nature of this

societal reaction is dependent on the social characteristics of the rule breaker. The major implication is that rule breakers who have more social resources (for instance: high socioeconomic status, supportive family, legal representation) are more likely to be subject to diagnosis and treatment in private psychiatric practice. Szasz (1970) refers to this as contractual psychiatry. On the other hand, the legal restrictions and social stigma of involuntary commitment (what Szasz terms institutional psychiatry) are reserved for clients who have inadequate social resources. This state of affairs is unacceptable, particularly in view of the risks that may be involved with involuntary psychiatric treatment.

Similarly, research findings that have been presented on the intake procedure in the adult/juvenile court clinic provide further insights on the processes involved in the imputation of the status mentally ill. By assessing the relative impact of behavioral and non-behavioral contingencies on the court clinic referral process, it can be determined to what extent entry into the status mentally ill is independent of an individual's rule breaking behavior. Behavioral contingencies refers to current and previous rule breaking behavior, while non-behavioral contingencies refers to the social characteristics of the offender. If non-behavioral contingencies are included among the major determinants of entry to the court clinic population, then the status mentally ill is, at least in part, ascribed on the basis of factors that are external to the offender's behavior. Again, it is important to identify the factors that are influential in the court clinic referral process, and to consider the practical implications of psychiatric referral for this subset of offenders. The benefits and costs of psychiatric involvement

in the judicial decision making process must be assessed. Psychiatric hospitalization has had unintended and negative consequences for the mental patient. Are there any risks associated with the referral of offenders to a court clinic?

Studies that have investigated the nature of the court clinic referral process have been done in Canada (Atcheson & Williams, 1956; Stephensen, 1971), the United States (Lewis et al., 1973; Davis et al., 1970 - 71; Bohmer, 1976; Smith, 1976), England (Kahn & Nursten, 1963; Prins, 1975; Prins, 1976) and Australia (Warner, 1980). Four of these studies focused on the functioning of juvenile court clinics, four others on the functioning of adult court clinics, and the remaining two examined the referral processes in both adult and juvenile court clinics. Half of the above studies systematically compared the nature of the court clinic referrals and non-referrals, while the others did not have the benefit of control groups. As such, the findings of the former group are more instructive than the latter, because of the more rigorous methodological design that was used in those studies.

Atcheson & Williams (1956) examined the referral procedure of the Judges of the Toronto Juvenile and Family Court. Clinic referrals were compared to non-referrals for a twelve month period July 1, 1951 to June 30, 1952. The findings indicated that the nature of the charge influences the referral decision. Referral was more likely for those charges which involved behavior disorders (abduction, incorrigible, truant) and sex offences. Nuisance charges (breach of by-law, disorderly disturbance, trepass) and theft charges exerted no significant effect on the referral decision.

Stephensen (1971) compared 40 juveniles who had been referred for

psychiatric evaluation between March 1968 and March 1969, to a random sample of 50 other juveniles, in order to assess the factors governing the referral decisions of the Probation Officers at Vancouver Children's Court. The findings indicated that a greater proportion of cases with psychiatric disability were found in the referred group (60%) than in the control group (32%); a greater proportion of offenders charged with sexual offences and incorrigibility were found in the referred group (13%, 20% respectively) than in the control group (2%, 0% respectively); a greater percentage of recidivists were present in the referred group (52%) than in the control group (34%); a greater proportion of offenders with IQ's in the dull-normal range were found in the referred group (30%) than in the control group (6%); school behavior problems were more prevalent for offenders in the referred group (76%) than in the control group (42%) and offenders in the referred group were more likely to be school dropouts (28%) than offenders in the control group (18%); a greater proportion of offenders in the referred group (45%) than in the control group (30%) were described as being disobedient at home; a smaller proportion of parents of offenders in the referred group than in the control group, demonstrated an accepting attitude to their child (Father - 10%, 38% respectively; Mother - 20%, 36% respectively); and, finally, a greater proportion of offenders in the referred group than in the control group came from broken (40%, 14% respectively), poverty-stricken homes (50%, 32% respectively). Theft and auto theft offences exerted no significant effect on the referral decision, since a smaller proportion of these offences were found in the referred group than in the control group.

Davis et al. (1970 - 71) compared the populations of adult

offenders who were referred and not referred to the Kansas State Reception and Diagnostic Center for the years 1963, 1966 and 1969. The findings indicated that offenders were more likely to be referred to the Center if they had entered a guilty plea, if they were before the court on less serious offences, and if their prior record also consisted of less serious offences. Referral was also more likely for younger offenders, mentally retarded offenders, and known users of alcohol or drugs.

Bohmer (1976) conducted a study over a five year period (1966 - 1970), on the factors affecting psychiatric referral for adult sex offenders in the Common Pleas Court of Philadelphia. Offenders for whom a report was ordered and those sentenced without a report were compared. The seriousness of the offence, number of total charges before the court, and age of the victim were factors that were found to be significantly related to the ordering of a report. The more serious the offence and the greater the total number of charges before the court, the more likely a referral would be made to the court clinic. Psychiatric evaluation was also more likely for the offender who victimized either a very young or old person. Factors that were not significantly related to the referral decision included the age of the offender, the race of the offender, prior record of the offender and differences in race between the victim and the offender.

Prins (1975) sought the views of magistrates and probation officers in a city in the North of England, on the subject of psychiatric contributions to the juvenile and adult courts. Respondents were requested to list the types of offenses for which they would seek a psychiatric opinion, and furthermore, to indicate whether there were any

factors other than the nature of the offence that would influence them in their requests for psychiatric evaluations. The probation officers' opinions about what factors should govern the referral process were then compared to the actual practice of the adult and juvenile courts.

The interviews indicated that both magistrates and probation officers considered that sex offenders and drug abusers should be referred for clinical evaluation, but these views were not reflected in the actual practice of the courts. The data indicated that violent offenders were more likely to be referred to the clinic. This practice was in accord with indications from the probation officers that they would seek psychiatric opinion for those offenders who had engaged in aggressive offences.

The probation officers and magistrates indicated a variety of other factors that would influence them in their decisions to seek a psychiatric report, but no determination was made as to whether these factors were operative in the actual practice of the courts. Nonetheless, the survey results suggest that the following factors may distinguish court clinic referrals from the non-referrals: a history of mental illness in the defendant or in the family background; conduct out of keeping with previous behavior; demeanor; and the court's intention to consider whether removal from the home would be an appropriate disposition. Since the attitudes expressed by probation officers and magistrates may not coincide with their behavior, further research is required to assess whether these factors are indeed crucial determinants of entry into the court clinic population.

Lewis et al. (1973) examined the nature of the referrals that came through a child psychiatric clinic established for the Juvenile Court of

the Second District of Connecticut. The referral process was examined for one year from the date that the clinic began operations (July 1, 1971). The findings indicated that the children seen by the court clinic staff were mainly of lower socio-economic status and that they came from families in which one or both parents were severely psychiatrically disturbed. Moreover, 17% of the clinic population were diagnosed as psychotic.

Kahn and Nursten (1963) described the nature of the first 25 cases that were referred to a Child Guidance Clinic located in a metropolitan centre in England. The findings indicated that the local juvenile court provided the largest number of referrals for psychiatric reports, and the court referred cases to the clinic because of recidivism and when removal from home was under consideration.

Smith (1976) undertook a review of a sample of 150 cases (adult offenders) that were processed by the North Carolina Presentence Diagnostic Committee during the years 1971 - 73. The findings indicated that the cases referred to the Committee consisted of younger offenders, offenders charged with less serious offences, and offenders who had entered guilty pleas. Only 20% of the offenders were diagnosed as having a specific mental disease entity (neurosis, depression, psychosis), with the preponderance of diagnoses indicating personality disorders.

Warner (1980) studied the reports and court records of all adult offenders referred for psychiatric reports by the courts of petty sessions in Hobart, and the Supreme Court of Tasmania, in the years 1969, 1970, 1974 and 1975. The findings indicated that the proportion of sex offenders remanded to the clinic was greater than any other

category of offender; a greater percentage of offenders with prior convictions than offenders with no prior convictions were found in the remand group; a significant proportion of offenders in the remand group had a previous psychiatric history; and, of those offenders that were given an intelligence test (50% of the remand group), a substantial proportion were of below average intelligence, and between 10 to 20% were subnormal. With regard to the sex of the offender, it was found that in 1969 - 70 judges and magistrates remanded a significantly greater proportion of female offenders for psychiatric reports than male offenders. In 1974 - 75 the findings indicated that this differential treatment no longer existed.

Prins (1976) examined all cases from both the adult and juvenile courts in a metropolitan centre in England, that were remanded for psychiatric reports during the year October 1, 1968 to September 30, 1969. The findings indicated that a greater proportion of female offenders than males were remanded for psychiatric reports; over half of the court clinic referrals had below average IQ and school behavior problems; for all cases, except one, the researchers classified the quality of family life as decidedly adverse; and, for over half the cases, removal from home was offered as a recommendation for disposition.

The above studies have identified a wide variety of contingencies that affect the possibilities of entry into the court clinic population. We can have more confidence in the findings of those studies that systematically compared the nature of court clinic referrals and non-referrals (Atcheson & Williams, 1956; Stephensen, 1971; Davis et al., 1970 - 71; Bohmer, 1976; Prins, 1975), than the studies that did

not have the benefit of control groups (Lewis et al., 1973; Kahn & Nursten, 1963; Smith, 1976; Warner, 1980; Prins, 1976).

Nevertheless, different conclusions arose, both within and between these two groups of studies, as to the influence of given factors in the court clinic referral process. More specifically, Davis et al. (1970 - 71) and Smith (1976) indicated that offenders who committed less serious offences were more likely to be referred to the court clinic, while Bohmer (1976) found that offenders who committed more serious offences were more likely to be referred. Atcheson and Williams (1956), Stephensen (1971) and Warner (1980) concluded that sexual offenders were more likely to be referred for psychiatric evaluation than any other category of offender, while Prins (1975) claimed that sexual offences exerted no significant effect on the referral decision. Stephensen (1971), Kahn and Nursten (1963) and Warner (1980) suggested that offenders with prior convictions were more likely to appear in the court clinic population than offenders with no prior convictions, while Bohmer (1976) claimed that there was no significant relationship between the presence or absence of prior record and the decision to order a psychiatric report. Smith (1976) and Davis et al. (1970 - 71) indicated that younger offenders were more likely to be referred for clinical evaluation, while Bohmer (1976) found that age had no bearing on the referral decision. With regard to the other factors that were investigated by two or more researchers, the findings indicated that there was agreement as to the influence that these factors had on the court clinic referral process.

The findings of the court clinic studies are applicable to Scheff's discussion of the contingencies that govern entry into the role of the

mentally ill. The factors that have been identified as crucial determinants of entry into the court clinic population, can be situated within Scheff's classificatory scheme as follows:

A. Nature of the Rule Breaking

(1) Degree of the Rule Breaking

- nature of current offence (Atcheson & Williams, 1956; Stephensen, 1971; Warner, 1980; Prins, 1975)
- seriousness of current offence (Davis et al., 1970 - 71; Smith, 1976; Bohmer, 1976)
- seriousness of prior charges (Davis et al., 1970 - 71)

(2) Amount of the Rule Breaking

- current psychiatric disability (Stephensen, 1971; Smith, 1976; Lewis et al., 1973)
- psychiatric history (Warner, 1980; Prins, 1975)
- number of current charges (Bohmer, 1976)
- presence/absence of prior record (Stephensen, 1971; Kahn & Nursten, 1963; Warner, 1980; Bohmer, 1976)

B. Nature of the Rule Breaker

(3) Power of the Rule Breaker

- socio-economic status (Stephensen, 1971; Lewis et al., 1973)
- age (Smith, 1976; Davis et al., 1970 - 71; Bohmer, 1976)
- race (Bohmer, 1976)
- sex (Prins, 1976; Warner, 1980)

However, there remain a variety of other factors that cannot be integrated into Scheff's classification of contingencies. They can be summarized as follows:

A. Other Behavior/Characteristics of the Offender

- type of plea entered (Smith, 1976; Davis et al., 1970 - 71)
- IQ (Stephensen, 1971; Davis et al., 1970 - 71; Warner, 1980; Prins, 1976)
- alcohol/drug use (Davis et al., 1970 - 71)
- school behavior problems (Stephensen, 1971; Prins, 1976)
- school dropout (Stephensen, 1971)

B. Home/Living Situation of the Offender

- child disobedient (Stephensen, 1971)
- parental attitude to child (Stephensen, 1971; Prins, 1976)
- psychiatric disturbance (parents) (Lewis et al., 1973)

C. Victim Characteristics

- age (Bohmer, 1976)
- race (Bohmer, 1976)

D. Dispositional Alternatives under Consideration by the Court

- removal from home (Kahn & Nursten, 1963; Prins, 1976)

Categorized in this fashion, the research findings suggest that entry into the court clinic population is facilitated by factors that relate to: (a) current and previous rule breaking behavior (nature of current offence, seriousness of current offence, seriousness of prior charges, current psychiatric disability, psychiatric history, number of current charges, presence/absence of prior record) (behavioral contingencies), (b) social characteristics of the offender (socio-economic status, age, sex, IQ, adjustment at school, home situation), (c) victim characteristics (age), and (d) organizational needs of the court (search for a suitable disposition) (non-behavioral contingencies). Moreover, it is readily apparent, as D'Arcy suggests, that, "Scheff's attempt to integrate the plethora of contingencies into a coherent and articulated conceptual framework is unsuccessful" (1976; p. 52).

Nonetheless, as a whole, the findings strongly suggest that both behavioral and non-behavioral contingencies are crucial determinants of entry into and exit from the social role of the mentally ill. This implies that the psychiatrist in a collaborative relationship cannot continue to practice in the medical tradition; rather she/he is compelled to address problems that are considered to be relevant by the

court. Legal and extra-legal variables (social contingencies) have both been identified as crucial factors that precipitate entry into the court clinic population. Given that psychiatrists are constrained to concern themselves with the needs of the court in the official designation of the mentally ill role, it would also be expected that in the formulation of psychiatric court reports, they would be pressured to make evaluations on terms that are relevant to the court.

4. The Psychiatric Court Report

Divergent perspectives have been presented in the literature with regard to the impact of psychiatric intervention in the courts. On the one hand, concerns have been expressed about the active role that both medicine and agencies traditionally associated with legal forms of control, have taken in the medicalization of deviance (Dibble, 1962; Bittner, 1968; Freidson, 1970; Zola, 1972; Zola, 1975; Hawkins & Tiedeman, 1975; Conrad, 1979; Conrad and Schneider, 1980; Miller, 1980; Chalfant, 1977; Edelman, 1974). The recurring theme is the ascendancy of medicine as an institution of social control and the loss of influence of the more traditional institutions of religion and law. As such, the prevailing fear is that the psychiatrist may be usurping the judge's role as sentencer (Bohmer, 1976). The increasing encroachment of psychiatry into the legal system, is regarded as an indication that the judge's authority is being invaded, and that legal decision rules are being displaced by medical decision rules. Court personnel, equating psychiatry with "permissiveness", have voiced concerns that court clinics promote unwarranted leniency (Lewis et al., 1973). The harshest critics, however, categorically state that psychiatric power must be limited, and that one avenue to pursue would be to prohibit the presentation of recommendations as to sentence, in psychiatric court reports (Schiffer, 1976).

On the other hand, studies that have assessed the degree to which particular work settings may constrain the professional's discretion in the use of his/her expertise (Scott, 1969; McCleary, 1975; Decker, 1979; Ben-David, 1958; Engel, 1969; Sudnow, 1978), suggest that the omnipotence often attributed to the court psychiatrist may be largely

overstated. It has been noted that often the court has a strong possessive attitude toward the clinic (Chamberlain & Awad, 1975), which implies that psychiatrists are pressured to identify with the needs of the court. Within the context of the juvenile justice system, the role expectations of the psychiatrist have usually included: (a) the resolution of conflicting opinions that arise between probation officers and attorneys as to appropriate dispositions (Nelson, 1972), (b) confirmation of the court's perception that a serious sentence (for example incarceration) is warranted (Bohmer, 1973; Emerson, 1969; Nelson, 1972) and (c) evaluation of those juveniles that the court has judged to be disturbed (Emerson, 1969). The nature of these tasks demonstrates that psychiatrists are expected to address organizational problems that are faced by the court. The primary function of psychiatric court reports may be to explore judicial and not clinical concerns.

Research on judicial acceptance of recommendations in psychiatric reports, has indicated that dispositions concur with recommendations in the vast majority of cases. With the exception of Bonta (1981) and Bohmer (1976) who reported concurrence rates of 48% and 50% respectively, all other studies have reported concurrence rates of over 70% (Smith, 1976 - 80%; Markey et al., 1957 - 86%; Kahn & Nursten, 1963 - 84%; Bluglass, 1979 - 70%; Prins, 1976 - 95%; Warner, 1980 - 70% for 1969 - 70 and 76% for 1974 - 75). Campbell (1981) cites concurrence rates reported in a further group of studies that were not reviewed here (de Berker, 1960 - 92%; Bearcroft & Donovan, 1965 - 92%; Sparks, 1966 - 90%; Gibbens, Soothill & Pope, 1977 - 77%; Woodside, 1976 - 80%; Bowden, 1978 - 80%). Upon initial inspection, these high

concurrence rates would seem to suggest that the psychiatrist has usurped the judge's role as sentencer. However, further examination of the nature of psychiatric recommendations and judicial dispositions, would seem to indicate that high concurrence rates do not necessarily imply deference to psychiatric experts (Carter & Wilkins, 1967). Psychiatrists may be "second-guessing" the court disposition by making recommendations which are anticipated to be acceptable to the court.

Emerson (1969) has suggested that psychiatrists are compelled to draw their recommendations for disposition from the "realistic" alternatives that are posed by court personnel. Assuming that the court is unwilling to give serious consideration to courses of action that could be perceived as "mollycoddling", it would be expected that psychiatrists are constrained to offer dispositional recommendations of a more serious nature. Campbell (1981) has indicated that, indeed, many psychiatric recommendations do not necessarily involve leniency (probation, psychiatric probation, psychiatric treatment, imprisonment). Furthermore, Morash (1982) has suggested that the mental health professionals' extensive training in the treatment orientation, in and of itself, may encourage the use of more severe recommendations. A study was conducted to examine the decision making process in a juvenile court before and after the employment of mental health professionals to prepare pre-sentence reports. The change in personnel from bachelors level probation officers to master's level social workers and psychologists allowed for a comparison of the two groups in terms of the severity of their pre-sentence recommendations. The findings indicated that mental health professionals recommended probation and committal for a higher proportion of juveniles (54%, 10% respectively) than the

probation officers (32%, 8% respectively). Conversely, the probation officers were more likely to favor dismissal (60%) than the professionals (36%). Moreover, when legalistic and demographic variables were statistically controlled, the data indicated that mental health professionals still made more severe recommendations than probation officers. Overall, the work done by Emerson (1969) and Morash (1982) suggests that while psychiatrists may be constrained by the court to offer dispositional recommendations of a more severe nature, in many instances, this course of action may be consistent with the treatment/casework orientation which calls for increased intervention to deal with the causes of juvenile delinquency.

What is perhaps the most telling about the function that the psychiatric report serves for the court, is the finding that the more restrictive recommendations are more readily accepted by the court than the less restrictive recommendations. Bohmer (1976) reported that judicial dispositions concurred with psychiatric recommendations of different severity as follows: medical probation (54%), prison (42%) and probation (37%). Campbell (1981) cited the findings of Gibbens, Soothill and Pope (1977) which demonstrated that concurrence rates were higher for custodial recommendations (94%) than non-custodial recommendations (69%). Woodside (1976) reported that concurrence rates were higher for custodial recommendations (91%) than probation recommendations (77%) and lowest for discharge recommendations (17%). Bonta (1981) found that the court concurred more often with recommendations for placement outside of the home (83%) than with recommendations for placement into the home (72%). It would seem that psychiatric reports are being used by the court to legitimize the

imposition of serious sentences. In sum, further specification of the nature of psychiatric recommendations, and the types of recommendations that are most likely to be accepted by judges, has revealed that the traditional concerns of the court have not been displaced with the introduction of psychiatric services.

The above studies have demonstrated that the fate of court clinic referrals is shaped by the needs of the court, not those of psychiatry. Factors other than suspected emotional instability prompt the court to order psychiatric assessments. Moreover, the court is selective in its consideration of recommendations made by the clinic staff; that is, it heeds the severe recommendations more often than the less intrusive forms of intervention that are offered as dispositional alternatives. Given this circumstance, the logical question that arises is whether the psychiatrist exercises any influence in the sentencing process. If the psychiatrist has assumed a portion of the judge's authority, differences in the dispositions of comparable court clinic referrals and non-referrals would be expected. On the other hand, if the presence of a psychiatric report does not affect the type of sentence that is imposed by the court the implication is that the advice of the psychiatrist is essentially being ignored. The court is using the report to buttress decisions that were already under serious consideration prior to the referral.

Bohmer (1976) compared the dispositions of those offenders for whom a report was ordered and those disposed of without a report. The findings indicated that there were significant differences between the dispositions of offenders sentenced with and without a report, for only 3 out of 15 offense categories. In two of these cases the presence of a

psychiatric report resulted in a higher proportion of serious sentences. Generally, however, the findings demonstrated that the presence of a psychiatric report did not affect the type or length of sentence imposed by the court. Conversely, Morash (1982) found that juveniles who had a pre-sentence report prepared by a mental health professional received more serious dispositions than those who had a pre-sentence report prepared by a probation officer. The findings indicated that a higher proportion of juveniles who were assessed by a mental health worker were placed on probation or committed to an institution (62%, 10% respectively) than juveniles who were seen by a probation officer (32%, 8% respectively). Juveniles who were seen by a probation officer were more likely to have their charges dismissed (60%) than juveniles who were assessed by a mental health professional (28%). Moreover, when legalistic and demographic variables were statistically controlled, the professional training of the person preparing the report still had a significant impact on the severity of judicial dispositions.

In sum, contradictory findings are presented in the literature relating to the input of the psychiatrist in the judicial decision making process. The findings reported by Bohmer (1976) would seem to indicate that judges have been unwilling to relinquish much (if any) of their role as sentencer into the hands of the psychiatrist. If this is the case, it is probable that psychiatric reports are being ordered because the court is more interested in the social control, rather than the therapeutic function, that psychiatry can provide. On the other hand, the findings presented by Morash (1982) indicate that the psychiatrist exerts a definite influence in the sentencing process. It is unclear, therefore, whether the authority of medicine is being used

to legitimize the actions of the court, or whether the judiciary has indeed experienced a loss of influence to psychiatry.

C. Hypotheses

The preceding literature review has presented two alternative perspectives, which predict that the collaborative relationship between the criminal justice and mental health systems, will assume significantly different forms. Psychiatry, as a medical specialty, has been situated within the realm of professionalism, and the implications for the organization of work that derive from this status have been considered. The strategic distinction between the profession and other occupations, has been identified as the legitimate organized anutonomy that has been granted to the former. This mandate, which grants to medicine status as the official designator of the sick role, has been regarded as the major force which has facilitated the steady expansion of medicine's jurisdiction, and the diffusion of medical ideology to non-medical segments of society.

It has been demonstrated that: (a) a variety of forms of behavior that had previously been conceptualized as "crime" or "sin" are presently being incorporated within the domain of medicine; and (b) agencies traditionally associated with legal forms of control are redefining their clients' behavior to conform to the medicalized view. Consequently, the major concern that has been expressed, is that the ascendancy of medicine as an institution of social control corresponds with the loss of authority of the more traditional institutions of religion and law. Within the context of the juvenile justice system, the prevailing fear is that legal decision rules are being displaced by medical decision rules.

It has also been stressed that it is crucial to situate the psychiatrist not only within the realm of professionalism, but also

within the concrete settings in which medical work takes place. Since bureaucratically organized professional practice is on the increase, much research has focused on documenting the extent to which, and, the manner in which, particular work settings may constrain the professional's discretion in the use of his/her expertise.

Studies that have examined the nature of medical collaboration with other institutions, have demonstrated that organizational control over the bases for decision-making, significantly constraints the nature of professional practice. Scheff (1966) revealed, that in civil commitment hearings, psychiatric examiners and court officials were reinforced for basing their decisions on the presumption of illness, since this promoted the effective disposition of cases. Daniels (1978) found that military psychiatrists were obliged to designate as mentally ill only a portion of those men who presented psychiatric symptoms, in order that the majority of men could be kept on duty. Emerson (1969) demonstrated that the court practice of psychiatry was conducted on terms that recognized the legal function of the court. Court officials selected cases for referral to the clinic, and the psychiatrists routinely drew their recommendations for disposition, from the "reasonable" alternatives that were posed by court personnel.

These findings suggest that professionals are significantly constrained by the organizational context in which their work takes place. Within the context of the juvenile justice system, it would be expected that the nature of psychiatric practice would be influenced by the unique requirements of the legal bureaucracy. Contrary to the predictions that have arisen from the literature on the profession of medicine, the literature on the social organization of work, suggests

that legal decision rules are not being displaced by medical decision rules, but rather that some elements of medical social control are being "borrowed" by collaborating institutions in order to serve organizational needs.

These competing interpretations of the psychiatrist's role are related to the divergent perspectives that have been presented with regard to the factors that are most likely to lead to an imputation of mental illness. If the court is sensitive to the underlying principles of the treatment orientation, it can be assumed that the goals of the mental health professional and, presumably, the treatment needs of the client, are seriously considered. Thus, it is probable that clients with particular social characteristics are assumed to have a greater need for assistance, and hence, are more likely to be referred for psychiatric assessment. The implication is that non-behavioral (social) contingencies (such as sex, age, race, employment/student status, living arrangements and socio-economic status) may figure more prominently as determinants of entry into the social role of the mentally ill than behavioral contingencies (such as seriousness of offense and prior record). On the other hand, if a more legalistic orientation is advocated by the court, it can be assumed that mental health professionals are constrained to consider the organizational needs of the court. Moreover, the court's response to the client is more likely to be based on an assessment of behavior rather than treatment needs. The implication is that behavioral contingencies (such as seriousness of current/prior offenses; number of current/prior offenses) may be more important predictors of entry into the sick role than social contingencies. Generally, it is proposed that, in the

designation of the mentally ill status, courts which function in accordance with the treatment orientation will attach greater significance to variables related to social functioning, than those that are more legalistic in orientation.

The findings from those studies that have investigated the influential factors in the civil commitment process and in the court clinic referral process, suggest that entry into the social role of the mentally ill is facilitated by factors that relate to: (a) current and previous rule breaking behavior (nature of current offence, seriousness of current offence, seriousness of prior charges, current psychiatric disability, type of diagnosis, level of impairment, psychiatric history, number of current charges, presence/absence of prior record) (behavioral contingencies), (b) social characteristics of the offender (socio-economic status, age, sex, IQ, adjustment at school, home situation, family desires, presence/absence of counsel), (c) victim characteristics (age), and (d) organizational needs of the court (search for a suitable disposition) (non-behavioral contingencies). Both behavioral and non-behavioral contingencies have been identified as crucial determinants of entry into the social role of the mentally ill, which suggests that psychiatric practice is influenced by the interests of collaborating parties.

> HYPOTHESIS 1: There are no significant differences in the effect of behavioral and non-behavioral contingencies on the decision to refer juveniles to the court clinic.

The literature on the social construction of the role of the mentally ill, has suggested that psychiatrists are constrained to concern themselves with the needs of the court in the official designation of the mentally ill role. As such, it would be expected

that, in the preparation of psychiatric court reports, there would be similar pressures to make evaluations on terms that are relevant to the court.

Research on judicial acceptance of recommendations in psychiatric reports, has indicated that dispositions concur with recommendations in the vast majority of cases. Initially, these high concurrence rates would seem to suggest that the psychiatrist has usurped the judge's role as sentencer. However, further specification of the nature of psychiatric recommendations, and the types of recommendations that are most likely to be accepted by judges, reveals that judges are selective in their consideration of recommendations made by psychiatrists. Psychiatrists are constrained to offer dispositional recommendations of a more serious nature (Campbell, 1981), and these more restrictive recommendations are more likely to be accepted by the court than the less restrictive recommendations (Bohmer, 1976; Bonta, 1981; Campbell, 1981; Woodside, 1976). It is probable, therefore, that psychiatric reports are being used by the court to legitimize the imposition of serious sentences.

> HYPOTHESIS 2: The concurrence rates between psychiatric recommendations and judicial dispositions will vary for recommendations of differing severity, with the more restrictive recommendations being more readily accepted by the court than the less restrictive recommendations.

The literature on the judicial acceptance of psychiatric recommendations, has suggested that psychiatric court reports are ordered primarily with the concerns of the court in mind, not those of psychiatry. In the final analysis, the question that must be addressed, is whether there are any significant differences in the dispositions of

comparable court clinic referrals and non-referrals. If the psychiatrist is influential in the sentencing process, the dispositions received by the clinic referrals should differ from those of the non-referrals. On the other hand, if the authority of the psychiatrist is being used to legitimize the actions of the court, there should be no significant differences between the dispositions of the court clinic referrals and non-referrals. Contradictory findings are presented in the literature with regard to the role of the psychiatrist in the judicial decision making process. Bohmer (1976) indicated that there were no significant differences between the dispositions of offenders that were sentenced with and without a psychiatric report. Conversely, Morash (1982) reported that juveniles who were assessed by mental health professionals received more severe dispositions than those who were evaluated by probation officers. In sum, it is unclear whether the court is merely availing itself of the social control function that psychiatry can provide, or whether psychiatry has assumed a portion of the judiciary's authority.

> HYPOTHESIS 3: When legalistic and socio-demographic variables are controlled, no significant differences will be found between the dispositions of offenders who are sentenced with and without a psychiatric report.

CHAPTER II

METHODOLOGY

A. Sample

Data were collected on two distinct populations: (a) the control group which consists of a 20% random sample of all court clinic non-referrals that were processed by the Winnipeg Juvenile Court in 1979 (N = 1,000) and (b) the experimental group which consists of all referrals that were made to Children's Forensic Services in 1979 (N = 106). The random sample of court clinic non-referrals was drawn from the daily statistics sheets of all probation districts for the months of January to December 1979. For the purposes of the study, only a portion of the cases in the control group (N = 659) were compared to the population of clinic referrals. Cases that were diverted from the formal court process (non-judicials, referrals to the Children's Aid Society, referrals to the police voluntary class) were not included in the analysis. With regard to the court clinic referrals, particular types of cases were not included in the sample. Juveniles who were before the court on reconsiderations were excluded from the sample, because these types of cases had not been examined in the file study of all cases processed by the Winnipeg Juvenile Court (control group). Cases where the court consulted with Children's Forensic Services, but no specific recommendations as to disposition were included in the psychiatric report, were excluded, as well as those cases where consultative conferences were requested with the psychologist/psychiatrist after a disposition had been implemented.

Overall, the sample consisted of 765 cases -- 659 court clinic non-referrals and 106 court clinic referrals.

Characteristics of Offenders:

The socio-demographic characteristics of the juvenile offenders are presented in Tables 1 to 8. The overwhelming majority of all juveniles were male (84%), and most offenders were 16 years of age or older (57%). For those cases in which data on race were available, almost half of the juveniles were Native offenders (49%). A very large majority of all juveniles were either in school or worked on a full-time basis (73%). More than half of all offenders did not come from a two-parent family (56%), with almost a third of the sample residing in a one-parent home (32%). The majority of all juveniles came from families with effective control structures (55%).[1] Most offenders came from middle-class families (49% based on mother's occupational scores and 71% based on father's occupational score), according to the scarce data that were available on parental occupation.[2]

TABLE 1

Sex of Juvenile Offenders

	N	%
Male	640	84
Female	124	16
Total	764	100

TABLE 2

Age of Juvenile Offenders

	N	%
17	256	33
16	181	24
15	129	17
14	111	15
13	54	7
12 and under	33	4
Total	764	100

TABLE 3

Race of Juvenile Offenders

	N	%
Caucasian	137	44
Native	150	49
Other	23	7
Total	310	100

TABLE 4

Employment/Student Status of Juvenile Offenders

	N	%
Student	454	60
Employed full-time	93	13
Employed part-time	21	3
Unemployed	176	24
Total	744	100

TABLE 5

Living Arrangements of Juvenile Offenders

	N	%
Two parents	334	44
One parent	239	32
Relatives	30	4
Foster-group home	93	12
Institution	29	4
Independent	27	4
Total	752	100

TABLE 6

Parental Control of Juvenile Offenders

	N	%
No	209	45
Yes	261	55
Total	470	100

TABLE 7

Socio-Economic Status of Juvenile Offenders (Mother's Occupation)

	N	%
Low	100	36
Medium	141	49
High	41	15
Total	282	100

TABLE 8

Socio-Economic Status of Juvenile Offenders (Father's Occupation)

	N	%
Low	23	8
Medium	211	71
High	62	21
Total	296	100

Characteristics of Offences:

The characteristics of the juveniles' current and prior offences are presented in Tables 9 to 18. Half of all the juveniles in the sample had a single charge before the court. Only about one-tenth of the sample had six or more current offences (11%), with a maximum of 41. Most offenders had a property offence as their most serious current charge (60%). Moreover, the majority of all juveniles had serious current offences (55%) compared with 32% who had less serious offences and 13% who had status offences.[3] About one-tenth of all offenders engaged in offences that involved violence (14%), and a handful committed offences that involved the use of a weapon (7%). The great majority of all victims were under 40 years of age (73%). Five per cent of all victims were under 10 years of age and 7% were over 60 years old. The youngest victim was 2 years old and the oldest was 80 years old. Over two-thirds of all juveniles entered a delinquent plea to their most serious current offence (69%), and a large majority appeared in court without legal representation (72%). Most offenders had prior offences (74%). Forty-two percent of all juveniles had 1 to 5 prior charges. Sixteen per cent of the sample had 11 or more prior charges, with a maximum of 89. A large majority of the offenders had serious prior charges (65%), compared with 31% who had less serious offences and 4% who had status offences.[4]

TABLE 9

Total Number of Current Offences Committed by Juvenile Offenders

	N	%
1	382	50
2	153	20
3	74	10
4	46	6
5	24	3
6 - 10	46	6
11 or more	39	5
Total	764	100

TABLE 10

Nature of Current Offences Committed by Juvenile Offenders

	N	%
Person	114	15
Property over $200	177	23
Property under $200	284	37
Status	97	13
Drug	40	5
Impaired driving	23	3
Other	30	4
Total	765	100

TABLE 11

Seriousness Ranking of Most Serious Current Offences Committed by Juvenile Offenders

	N	%
Status	98	13
Less serious	245	32
More serious	422	55
Total	765	100

TABLE 12

Use of Violence by Juvenile Offenders

	N	%
No	655	86
Yes	103	14
Total	758	100

TABLE 13

Use of Weapons by Juvenile Offenders

	N	%
No	697	93
Yes	50	7
Total	747	100

TABLE 14

Age of Persons Victimized by Juvenile Offenders

	N	%
20 and under	60	37
21 - 40	59	36
41 - 60	32	20
Over 60	11	7
Total	162	100

TABLE 15

Type of Pleas Entered by Juvenile Offenders

	N	%
Delinquent	472	69
Not delinquent	97	14
No plea taken	113	17
Total	682	100

TABLE 16

Representation of Juvenile Offenders by Counsel

	N	%
No	488	72
Yes	190	28
Total	678	100

TABLE 17

Total Number of Prior Offences Committed by Juvenile Offenders

	N	%
0	196	26
1 - 5	324	42
6 - 10	125	16
11 or more	120	16
Total	765	100

TABLE 18

Seriousness Ranking of Most Serious Prior Offences Committed by Juvenile Offenders

	N	%
Status	21	4
Less serious	175	31
More serious	372	65
Total	568	100

An assessment was made of the extent to which the above offender and offence characteristics can be assumed to reflect accurately the composition of the total population of juvenile offenders processed by the Winnipeg Juvenile Court in 1979. Notwithstanding some minor sampling problems, the court clinic referrals and non-referrals are representative of their respective populations. In terms of the sample of court clinic non-referrals, all cases were randomly selected with the exception of a few cases (3% of all randomly selected cases) that had to be replaced because the names of the offenders on the population list were unreadable. A few cases were excluded from the population of clinic referrals (reconsiderations, post-disposition assessments) in order to ensure that the sample was comparable to the non-referrals.

B. Data Collection

The data collection period was from May 1980 to April 1981 for the control group, and September to December 1982 for the experimental group. The data recorded from probation and psychiatric files included information about the offender, the offense(s), and assessments and recommendations concerning the case written by various court actors (see the data collection instrument presented in Appendix I). Additional information that applies only to the court clinic referrals was obtained from the psychiatric reports. These reports identified the reasons why the juvenile was referred to the court clinic, and often rationales were presented by the psychiatrist/psychologist in order to support the formulation of particular dispositional recommendations.

For all cases, therefore, information on legal and extra-legal variables was extracted from both probation files and psychiatric files. The information that was presented on the face sheet in the probation file, was checked to ensure that it was consistent with what was indicated in the police reports and pre-disposition reports. If there was conflicting information, the data presented in the pre-disposition report was recorded (probation officers are likely to be more concerned about the accuracy of reports that will be presented to the court, and less concerned with the completion of face sheets that are required primarily for statistical purposes). On the whole, before responses were coded, an attempt was made to verify that information on the variable in question was consistently recorded in a variety of documents (police report, pre-disposition report, psychiatric report, social study, group home report). Despite this thorough examination of the files, as was expected for a large number of cases there was incomplete

data on race, parental occupation, degree of parental control and victim characteristics.

C. Operationalization of Variables

The hypotheses that were tested required (a) between-group analysis of the court clinic referrals and non-referrals (hypotheses 1 and 3) and (b) within-group analysis of the court clinic referrals (hypothesis 2).

> HYPOTHESIS 1: There are no significant differences in the effect of behavioral and non-behavioral contingencies on the decision to refer juveniles to the court clinic.

Court clinic referrals and non-referrals were systematically compared to assess the influence of the following variables on the referral process:

Behavioral Contingencies

(a) Total number of Current Offences - Juveniles who had 6 or more offences before the court were combined into a single category for the purposes of statistical analyses.

(b) Nature of Current Offence - The nature of the juveniles' most serious current offence was classified as follows: (i) person (utter threats, assault, possess offensive weapon, robbery, public indecency, gross indecency and attempted murder), (ii) property over $200 (theft over $200, break enter and theft over $200, wilful damage and arson), (iii) property under $200 (theft under $200, break enter and theft under $200, wilful damage, trespassing, forgery and possession of stolen goods), (iv) status (minor consume or possess liquor and sniffing), (v) drug (possession of marijuana, possession of marijuana for the purpose of trafficking, trafficking marijuana and possession of heroin), (vi) impaired driving (dangerous driving, drive while impaired and drive when blood alcohol level exceeds .08) and (vii) other (leave the scene of an

accident, drive under age, while disqualified or without auto insurance and public mischief).

(c) Seriousness of Current Offence - All of the juvenile's current offences were assigned a seriousness ranking according to the Sellin and Wolfgang (1964) index of delinquency. On the basis of these rankings, the most serious charge was selected to represent the juveniles' current court experience.[5] Offenders were assigned to one of two categories based on the seriousness ranking of their most serious current charge: (i) juveniles with a less serious current offence (theft under $200, break enter and theft under $200, wilful damage under $1,000, possession of stolen goods, drive while under age, minor possess or consume liquor, possession of marijuana and trespassing) and (ii) juveniles with a more serious current offence (theft over $200, break enter and theft over $200, wilful damage over $1,000, impaired driving, leave scene of accident, forgery, assault, possess offensive weapon, robbery, public indecency, gross indecency and attempted murder/rape).

(d) Use of Violence - Juveniles who had verbally threatened and/or physically assaulted their victims were classified as violent offenders.

(e) Use of Weapons - Police reports were examined in order to determine whether the offender used a weapon.

(f) Total Number of Prior Offences - Prior record was defined as the total number of prior charges, with or without a finding of delinquency. Offenders were assigned to one of the following

categories: (i) no prior offences, (ii) 1 to 5 prior offences, (iii) 6 to 10 prior offences and (iv) 11 or more prior offences.

(g) Seriousness of Prior Offence - All of the juveniles' prior offences were assigned a seriousness ranking according to the Sellin and Wolfgang (1964) index of delinquency. On the basis of these rankings, the most serious charge was selected to represent the juveniles' prior court experience. As indicated in (c) above, offenders were assigned to one of two categories based on the seriousness ranking of their most serious prior charge: (i) juveniles with a less serious prior offence and (ii) juveniles with a more serious prior offence.

Non-behavioral Contingencies

(a) Sex

(b) Age - Juveniles who were 13 years of age and younger were combined into a single category for the purposes of statistical analyses.

(c) Race - Juveniles were classified into one of three categories: (i) Caucasian, (ii) Native and (iii) Other (Negroid, Asian).

(d) Employment/Student Status - Offenders were assigned to one of two categories based on their activity status at the time that the most serious current offence was committed: (i) full-time student or employed full-time and (ii) employed part-time or unemployed.

(e) Living Arrangements - Offenders were classified into one of three categories according to where they resided at the time that the most serious current offence was committed: (i) two parent home, (ii) one parent home and (iii) other living arrangement (relative, foster/group home, institution or independent living).

(f) Parental Control - Juveniles were assigned to one of two categories based on the parents' and/or probation officers' assessments of the type of control structure that existed in the family: (i) ineffective supervision and (ii) effective supervision.

(g) Socio-economic Status - Each of the juveniles' parents was assigned a score according to Blishen and McRobert's (1976) socio-economic index for occupations. Occupational status was coded as follows: (i) low - welfare or unemployed, (ii) medium - employed with a Blishen scale category up to 49 and (iii) high - employed with a Blishen scale category of 50 or higher. Housewives, students and parents with pension income were excluded from the analysis. The "medium" category includes occupations such as waiter, receptionist, salesclerk, bank teller, nurse's aide, mechanic, carpenter and salesman. The "high" category includes managerial, supervisory and administrative positions as well as the professions (teacher, nurse, social worker, pharmacist, physician, lawyer, accountant and professor).

(h) Type of Plea - The type of plea that juveniles entered on their most serious current charge was classified as follows: (i) delinquent plea, (ii) not delinquent plea and (iii) no plea taken.

(i) Legal Representation - The presence or absence of legal counsel was recorded for the juveniles' most serious current offence.

(j) Age of Victim - The age of persons who were verbally and/or physically assaulted by juvenile offenders was recorded and coded as follows: (i) 20 years of age and under, (ii) 21 - 40 years of age, (iii) 41 - 60 years of age and (iv) over 60 years of age.

HYPOTHESIS 2: The concurrence rates between psychiatric recommendations and judicial dispositions will vary for recommendations of differing severity, with the more restrictive recommendations being more readily accepted by the court than the less restrictive recommendations.

The nature of the recommendations that were offered by psychiatrists and psychologists, and the dispositions that were handed down by judges, resulted in the use of 16 codes to identify single recommendations/dispositions and 27 codes to identify multiple recommendations/dispositions. The multiple disposition categories were limited to two responses. Where three or more recommendations/dispositions were offered, the two most serious responses were selected. In sum, 43 recommendation/disposition codes were used.

To test the above hypothesis these recommendations/dispositions were ranked according to their degree of severity. Assuming that the most serious recommendations/dispositions are those that result in the greatest intrusion in the offender's life, the following categories were utilized to rank recommendations/dispositions from the least restrictive to the most restrictive:

1.) Less Severe

- stay of proceedings
- adjourned sine die with a finding of delinquency
- adjourned sine die with no finding of delinquency
- write essay
- period of progress
- suspended disposition
- fine
- attend Remand Attendance Centre
- probation
- refer to Youth Psychiatric Services
- fine and prohibit driver's license
- probation and restitution
- probation and fine
- probation and counselling
- probation and attend Remand Attendance Centre

- do not transfer to adult court
- do not transfer, refer to Youth Psychiatric Services
- do not transfer, refer to Remand Attendance Centre
- do not transfer, probation
- move out of neighborhood and return to family

2.) Severe

- permission to place out of the home
- commit to the Children's Aid Society
- other juvenile institution
- permission to place and probation
- permission to place and counselling
- permission to place and Youth Psychiatric Services
- commit to Children's Aid Society and restitution
- commit to Children's Aid Society and Youth Psychiatric Services
- commit to Children's Aid Society and Adjourn Sine die
- commit to Children's Aid Society and probation
- other juvenile institution and Youth Psychiatric Services
- do not transfer, permission to place
- do not transfer, commit to Children's Aid Society
- do not transfer, other juvenile institution and probation

3.) More Severe

- commit to Seven Oaks/Agassiz
- transfer to adult court
- Agassiz and permission to place
- Agassiz and probation
- Agassiz and Youth Psychiatric Services
- Agassiz and commit to Children's Aid Society
- Agassiz and cosmetic changes
- do not transfer, commit to Agassiz
- do not transfer, Agassiz and peer culture

The relationship between psychiatric/psychological recommendations and judicial dispositions, was defined as concurrent if (a) dispositions were identical to recommendations or (b) the dispositions imposed by the court were equally serious as the recommendations offered by the psychiatrist/psychologist; and non-concurrent if (a) the dispositions imposed by the court were either more or less serious than the recommendations offered by the psychiatrist/psychologist.

HYPOTHESIS 3: When legalistic and socio-demographic variables are controlled, no significant differences will be found between the dispositions of offenders who are sentenced with and without a psychiatric report.

The dispositions that were received by the court clinic referrals and non-referrals, resulted in the use of 17 codes to identify single dispositions and 36 codes to identify multiple dispositions. The multiple disposition categories were limited to two responses. Where three or more dispositions applied to a single charge, the two most serious dispositions were selected. In sum, 53 disposition codes were used. In order to determine whether offenders sentenced with a psychiatric report receive less serious dispositions, more serious dispositions, or equally serious dispositions, than offenders who are sentenced without a psychiatric report, the following categories were utilized to rank dispositions from the least restrictive (Category #1) to the most restrictive (Category #5):

1.) - stay of proceedings
- charges withdrawn
- charges dismissed

2.) - ASD with no finding of delinquency
- ASD with a finding of delinquency
- ASD with no finding of delinquency and an apology

3.) - prohibit driver's licence
- suspend disposition
- fine
- restitution
- community work order
- contribution to charity
- suspend disposition and informal restitution
- suspend disposition and adjourn sine die
- fine and reprimand
- fine and court costs
- fine and adjourn sine die
- fine and prohibit driver's licence
- fine and not own firearm
- fine and apology
- restitution and pay witness fees

- restitution and contribution to charity
- restitution and community work order
- restitution and fine
- restitution and prohibit driver's licence
- restitution and ASD with a finding
- informal restitution and ASD
- informal restitution and stay of proceedings
- community work order and ASD
- contribution to charity and ASD
- victim-offender reconciliation program and ASD

4.) - refer to Youth Psychiatric Services
- probation
- probation and restitution
- probation and fine
- probation and court costs
- probation and prohibit driver's licence
- probation and community work order
- probation and attend Remand Attendance Centre
- period of progress and ASD
- period of progress and restitution

5.) - other juvenile institution
- Seven Oaks/Agassiz
- commit to the Children's Aid Society
- transfer to adult court
- Agassiz and permission to place
- Agassiz and fine
- Agassiz and probation
- Agassiz and commit to Children's Aid Society
- commit to Children's Aid Society and restitution
- permission to place and probation
- permission to place and restitution
- treatment panel CWA and suspend disposition

D. Data Analysis

To test the first hypothesis, court clinic referrals and non-referrals were compared to assess the influence of behavioral and non-behavioral contingencies on the referral process. The relationships between the dependent variable (measured at the nominal level) and each of the independent variables are presented in cross-tabulation tables in Chapter Three. Some of the independent variables were measured at the nominal level (for example: sex, race, employment/student status, living arrangements) while others were measured at a higher level (for example: number of current/prior offenses, seriousness of current/prior offenses, age, mother's/father's occupation).

In most instances, gamma was employed to summarize the strength and direction of the relationships between the variables. The numerical value of gamma represents the magnitude of the association, and the sign indicates whether the association is positive or negative. Ordinal-level measurement is usually required for both variables when gamma is used as a measure of association. However, this measure may also be applied to tables composed of nominal variables, providing that the variables are dichotomous in nature: "a dichotomy can be treated as either a nominal, ordinal or interval-level measure depending upon the research situation" (Nie et al., 1975; p. 6). Where one of the nominal variables in the table had three or more categories, Cramer's V was used as a measure of association. This statistic indicates the strength, but not the direction, of the relationship between two variables. The strength of the association between two variables was interpreted as follows:

No association	less than .01
Negligible association	.01 - .09
Low association	.10 - .29
Moderate association	.30 - .49
Substantial association	.50 - .69
Very high association	.70 and over

Chi-Square was used as a test of statistical significance between the dependent and independent variables. This test indicates the likelihood that an observed relationship could have happened by chance; that is, the test is used to determine whether the cross-tabulated variables are statistically independent or systematically related to each other. An observed relationship which had a probability of occurring by chance no more than 5% of the time was accepted as a statistically significant relationship.

A multivariate analysis was also undertaken in order to evaluate the importance of individual independent variables while controlling for the other independent variables. As mentioned above, the dependent variable is nominal (consists of two groups - (1) the court clinic non-referrals and (2) the court clinic referrals) and the independent variables are mixed - some are nominal while others are measured at the ordinal level. Discriminant analysis was selected as the most appropriate statistical technique (as opposed to multiple regression analysis), because the dependent variable is qualitative not quantitative. The nominal independent variables were entered into the analysis as dummy variables (for example: (0) female, (1) male).

The basic objective of discriminant analysis is, "to weight and linearly combine the discriminating (independent) variables in some fashion so that the groups are forced to be as statistically distinct as possible" (Nie et al., 1975; p. 435). The standardized discriminant

function coefficients that are associated with each independent variable, represent the relative contribution of each predictor variable to that function. These coefficients serve to identify the variables which contribute most to the separation of the two groups. In this sense, their interpretation is analogous to that of beta weights in multiple regression; that is, the magnitude of the coefficient identifies those independent variables that are the best predictors of the dependent variable, and the sign of the coefficient indicates whether the association is positive or negative.

A stepwise discriminant analysis was performed to ensure that the best set of discriminating variables were selected. Independent variables were selected for inclusion if the probability of F-to-enter did not exceed the .05 significance level. This method ensured that independent variables which did not sufficiently contribute to discrimination between the groups, were excluded from the equation.

Finally, statistical analyses for the first hypothesis were supplemented with qualitative data that were compiled from the psychiatric reports.

To test the second hypothesis, the concurrence between judicial dispositions and psychiatric/psychological recommendations (a dichotomous Yes/No variable) was cross-tabulated with the severity of psychiatric/psychological recommendations (categorized as less severe/severe/more severe). Again, gamma was used as the measure of association and chi-square as the test of statistical significance.

To test the third hypothesis a multiple regression analysis was performed in order to assess the independent influence of the psychiatric report on the severity of judicial dispositions, while

controlling for legalistic and socio-demographic variables. All nominal independent variables were entered into the equation as dummy variables. The variable which measured the presence/absence of a psychiatric report was entered last in the regression to see if a significant change in R^2 (the proportion of variance in the dependent variable that is explained by the independent variables) would occur. A significant change in R^2 would indicate that the psychiatric report exerts an independent influence on the sentencing process. Finally, the magnitude of the beta weights for each independent variable were compared in order to identify the best predictors of disposition. An observed relationship was accepted as a statistically significant relationship if the .05 significance level was not exceeded.

CHAPTER III

FINDINGS

HYPOTHESIS 1: There are no significant differences in the effect of behavioral and non-behavioral contingencies on the decision to refer juveniles to the court clinic.

This analysis focused on identifying the variables that are most influential in the court clinic referral process. The dependent variable was whether or not the juvenile was referred to the court clinic. The relationships between the dependent variable and each of the behavioral and non-behavioral contingencies are presented in bivariate tables. In addition, discriminant function analysis was employed in order to assess the effects of individual independent variables while controlling for the other independent variables.

Behavioral Contingencies

(a) Total number of current offences:

Juveniles who had a larger number of current offences were more likely to be referred to the clinic than those who had fewer current charges (Table 19). Fifty-two percent of all juveniles with 6 or more current offences were referred to the clinic, compared with 29 percent of those with 5 offences, 20 percent with 4 offences, 23 percent with 3 offences, 9 percent with 2 offences and 4 percent with a single offence. A gamma of .70 indicates that there is a very strong positive correlation between the number of current offences and referral to the court clinic. The relationship is significant at the .05 level.

(b) Nature of current offence:

Juveniles who had a person offence as their most serious current charge were more likely to be referred to the clinic than those with other types of charges (Table 20). Thirty-three percent of all juveniles with a person offence were referred to the clinic, compared with 26 percent of those with an impaired driving charge, 19 percent with a property over $200 charge, 17 percent with another type of charge (leave scene of an accident, drive while disqualified, disorderly conduct), 7 percent with a property under $200 charge, and 2 percent with a status or drug offence. The association between the nature of the most serious current offence and referral to the court clinic is moderate, with a Cramer's V of .30. The relationship is significant at the .05 level.

(c) Seriousness of current offence:

Juveniles who had more serious current offences were more likely to be referred to the clinic than those with less serious current offences (Table 21). Twenty-three percent of all juveniles with a more serious offence were referred to the clinic, compared with 3 percent of those with a less serious offence. A gamma of .81 indicates that there is a very strong positive association between the seriousness of current charges and referral to the court clinic. The relationship is significant at the .05 level.

(d) Use of violence:

Juveniles who had uttered verbal threats or physically assaulted their victims were more likely to be referred to the clinic than those with current charges that did not involve the use of violence

(Table 22). Thirty-five percent of all juveniles who were verbally or physically abusive were referred to the clinic, compared with 10 percent of those who were not abusive. A gamma of .64 indicates that there is a strong positive association between the use of violence and referral to the court clinic. The relationship is significant at the .05 level.

(e) Use of weapons:

Juveniles who had used weapons in the course of committing their current delinquencies were more likely to be referred to the clinic than those who did not use weapons (Table 23). Thirty-eight percent of all juveniles who used weapons were referred to the clinic, compared with 12 percent of those who did not use weapons. A gamma of .64 indicates that there is a strong positive correlation between the use of weapons and referral to the court clinic. The relationship is significant at the .05 level.

(f) Total number of prior offences:

Juveniles who had a larger number of prior offences were more likely to be referred to the clinic than those who had fewer prior charges (Table 24). Thirty-four percent of all juveniles with 11 or more prior offences were referred to the clinic, compared with 24 percent of those with 6 to 10 prior offences, 9 percent with 1 to 5 prior offences and 4 percent with no prior charges. A gamma of .61 indicates that there is a strong positive association between the number of prior charges and referral to the court clinic. The relationship is significant at the .05 level.

(g) Seriousness of prior offence:

Juveniles who had more serious prior offences were more likely to be referred to the clinic than those with less serious prior offences (Table 25). Twenty-two percent of all juveniles with a more serious offence were referred to the court clinic, compared with 8 percent of those with a less serious offence. A gamma of .55 indicates that there is a strong positive correlation between the seriousness of prior charges and referral to the court clinic. The relationship is significant at the .05 level.

In sum, all of the behavioral contingencies were strongly and significantly associated with the decision to refer juveniles to the court clinic. Two of the relationships were very strong (gammas of .70 and over), four were strong (gammas between .50 and .69) and one was moderate (a Cramer's V of .30). The total number of current offences and seriousness of current offences were very strongly related to the decision to make a referral to the court clinic. The total number of prior offences, seriousness of prior offences and use of violence/ weapons were strongly related to the court clinic referral process. Finally, the nature of the juveniles' most serious current offence had a moderate influence on the court's decision to refer to the clinic. All of these relationships were significant at the .05 level.

TABLE 19

Total Number of Current Offences by Whether Juvenile Was Referred to the Court Clinic

(In Percent) (N=764)

	Number of Current Offences					
Court Clinic Referral	1	2	3	4	5	6 or more
No	96	91	77	80	71	48
Yes	4	9	23	20	29	52
	100	100	100	100	100	100
N	(382)	(153)	(74)	(46)	(24)	(85)

Gamma = .70

Chi-Square = 147.69 (significance = .001)

TABLE 20

Nature of Most Serious Current Offence by Whether Juvenile Was Referred to the Court Clinic

(In Percent) (N=765)

Court Clinic Referral	Nature of Current Offence						
	Person	Property over $200	Property under $200	Status	Drug	Impaired Driving	Other
No	67	81	93	98	98	74	83
Yes	33	19	7	2	2	26	17
	100	100	100	100	100	100	100
N	(114)	(177)	(284)	(97)	(40)	(23)	(30)

Cramer's V = .30

Chi-Square = 70.23 (significance = .001)

TABLE 21

Seriousness Ranking of Most Serious Current Offence
by Whether Juvenile was Referred to the Court Clinic

(In Percent) (N=765)

	Seriousness Ranking	
Court Clinic Referral	Less Serious	More Serious
No	97	77
Yes	3	23
	100	100
N	(343)	(422)

Gamma = .81

Chi-Square = 60.70 (significance = .001)

TABLE 22

Use of Violence by Offender by Whether Juvenile was Referred to the Court Clinic

(In Percent) (N=758)

	Use of Violence	
Court Clinic Referral	No	Yes
No	90	65
Yes	10	35
	100	100
N	(655)	(103)

Gamma = .64

Chi-Square = 42.44 (significance = .001)

TABLE 23

Use of Weapon by Offender by Whether
Juvenile was Referred to the Court Clinic

(In Percent) (N=747)

	Use of Weapon	
Court Clinic Referral	No	Yes
No	88	62
Yes	12	38
	100	100
N	(697)	(50)

Gamma = .64

Chi-Square = 25.26 (significance = .001)

TABLE 24

Total Number of Prior Offences by Whether Juvenile was Referred to the Court Clinic

(In Percent) (N=765)

	Number of Prior Offences			
Court Clinic Referral	0	1 - 5	6 - 10	11 or more
No	96	91	76	66
Yes	4	9	24	34
	100	100	100	100
N	(196)	(324)	(125)	(120)

Gamma = .61

Chi-Square = 77.00 (significance = .001)

TABLE 25

Seriousness Ranking of Most Serious Prior Offence by Whether Juvenile was Referred to the Court Clinic

(In Percent) (N=568)

	Seriousness Ranking	
Court Clinic Referral	Less Serious	More Serious
No	92	78
Yes	8	22
	100	100
N	(196)	(372)

Gamma = .55

Chi-Square = 18.31 (significance = .001)

Non-behavioral Contingencies

(a) Sex:

The sex of the juvenile was not found to be an influential factor in the court clinic referral process (Table 26). Equal proportions of males and females (14% respectively) were referred to the clinic. A gamma of -.01 indicates that there is a very weak association between the sex of the juvenile and referral to the court clinic. The relationship is not significant at the .05 level.

(b) Age:

The age of the juvenile was not found to be an influential factor in the court clinic referral process (Table 27). Fifteen percent of all juveniles who were 13 years of age and under were referred to the clinic, compared with 12 percent of those who were 14 years old, 15 percent of the 15 year olds, 18 percent of the 16 year olds and 11 percent of the 17 year olds. A gamma of -.06 indicates that there is a very weak negative correlation between the age of the juvenile and referral to the court clinic. The relationship is not significant at the .05 level.

(c) Race:

Natives and juveniles from other backgrounds (Asian, Negroid) were more likely to be referred to the clinic than Caucasians (Table 28). Thirty-one percent of all Natives and 26 percent of all juveniles from other backgrounds were referred to the court clinic, compared with 19 percent of all Caucasians. The association between race and referral to the court clinic is weak, with a Cramer's V of .13. The relationship is not significant at the .05 level. These results should be

interpreted with caution because data on race were not available for about 59 percent of all cases.

(d) Employment/Student status:

Juveniles who were unemployed or employed on a part time basis were more likely to be referred to the clinic than those who were actively engaged in school or work on a full time basis (Table 29). Twenty-seven percent of all idle juveniles were referred to the court clinic, compared with 9 percent of those who were working or attending school. A gamma of .56 indicates that there is a strong inverse correlation between activity status and referral to the court clinic. The relationship is significant at the .05 level.

(e) Living arrangements:

Juveniles who resided in a one-parent home or other living arrangement (foster group home, institution, relative, independent) were more likely to be referred to the clinic than those who resided in a two-parent home (Table 30). Thirty percent of all juveniles in other living arrangements and 11 percent of all juveniles in a one-parent home were referred to the court clinic, compared with 7 percent of those in a two-parent home. The association between living arrangements and referral to the court clinic is weak, with a Cramer's V of .27. The relationship is significant at the .05 level.

(f) Parental control:

Juveniles who came from families where parental control was poor were more likely to be referred to the clinic than those who came from families with effective control structures (Table 31). Thirty-two

percent of all juveniles who were out of their parents' control were referred to the clinic, compared with 5 percent of those who were effectively supervised. A gamma of -.80 indicates that there is a very strong negative correlation between parental control and referral to the court clinic. The relationship is significant at the .05 level. These results should be interpreted with caution because data on parental control were not available for about 38 percent of all cases.

(g) Socio-economic status (mother's/father's occupation):

Juveniles who came from working class backgrounds were more likely to be referred to the clinic than those who came from middle or upper class families (Tables 32 and 33). On the basis of occupational scores assigned to the mothers, it was found that 25 percent of all juveniles from working class backgrounds were referred to the clinic, compared with 13 percent of those from middle class families and 22 percent of those from upper class families. A gamma of -.17 indicates that there is a weak negative association between social class and referral to the court clinic. The relationship is significant at the .05 level.

Similarly, on the basis of occupational scores assigned to the fathers, it was found that 35 percent of all juveniles from working class backgrounds were referred to the clinic, compared with 13 percent of those from middle class families and 14 percent from upper class families. A gamma of -.20 indicates that there is a weak negative correlation between social class and referral to the court clinic. The relationship is significant at the .05 level. These results should be interpreted with caution because data on mother's occupation and father's occupation were not available for 60 percent and 44 percent of

all cases, respectively.

(h) Type of plea:

Juveniles who had not entered a plea were more likely to be referred to the clinic than those who had entered a delinquent or not delinquent plea (Table 34). Nineteen percent of all juveniles who did not enter a plea were referred to the clinic, compared with 16 percent of those who entered a delinquent plea and 7 percent who entered a not delinquent plea. The association between type of plea and referral to the court clinic is very weak, with a Cramer's V of .09. The relationship is significant at the .05 level.

(i) Legal representation:

Juveniles who were represented by counsel were more likely to be referred to the clinic than those who did not have legal representation (Table 35). Fourty-four percent of all juveniles with counsel were referred to the clinic, compared with 4 percent of those without counsel. A gamma of .90 indicates that there is a very strong positive correlation between legal representation and referral to the court clinic. The relationship is significant at the .05 level.

(j) Age of victim:

Juveniles who had committed offenses against older victims were more likely to be referred to the clinic than those who had victimized younger persons (Table 36). Forty-five percent of all juveniles who victimized a person over the age of 60 were referred to the court clinic, compared with 22 percent of those who victimized someone 41 to 60 years of age, 24 percent who victimized someone 21 to 40 years of

age, and 23 percent who victimized someone 20 years of age or younger. A gamma of .09 indicates that there is a very weak association between the age of the victim and referral to the court clinic. The relationship is not significant at the .05 level. These results must be interpreted with caution because data were not available on the age of the victim for about 55 percent of all cases.

In sum, three of the eleven non-behavioral contingenices were strongly and significantly associated with the decision to refer juveniles to the court clinic. Two of these relationships were very strong (gammas of .70 and over) and one was strong (a gamma of .56). Legal representation and parental control were very strongly related to the court's decision to refer to the clinic, while the juveniles' employment/student status was strongly related to the referral process. These relationships were significant at the .05 level. The results that have been presented with regard to the influence of parental control on the court clinic referral process must be interpreted with caution due to the number of missing cases on this variable.

The remaining non-behavioral contingencies were weakly associated with the decision to refer juveniles to the court clinic. Four of these relationships were weak (gamma or Cramer's V of .10-.29) and four were very weak (gamma or Cramer's V of .01-.09). The juveniles' race, living arrangements and socioeconomic status (mother's/father's occupation) were weakly related to the court's decision to refer to the clinic. The victim's age and the juveniles' sex, age, and plea were very weakly related to the referral process. Four of these relationships were significant at the .05 level. The findings that have been presented

with regard to the influence of race, mother's/father's occupation and victim's age on the court clinic referral process must be interpreted with caution due to the number of missing cases on these variables.

Overall, the results of the bivariate analysis indicated that behavioral contingencies are more influential factors in the court clinic referral process than non-behavioral contingencies. All of the behavioral contingencies were strongly and significantly associated with the decision to refer juveniles to the court clinic, compared with three of the eleven non-behavioral contingencies. The other eight non-behavioral contingencies were weakly related to the decision to make a referral to the court clinic, and only four of those relationships were significant at the .05 level.

TABLE 26

Sex of Juvenile by Whether Juvenile
was Referred to the Court Clinic

(In Percent) (N=764)

	Sex	
Court Clinic Referral	Male	Female
No	86	86
Yes	14	14
	100	100
N	(640)	(124)

Gamma = -.01

Chi-Square = 0.0 (significance = 1.00)

TABLE 27

Age of Juvenile by Whether Juvenile was Referred to the Court Clinic

(In Percent) (N=764)

	Age				
Court Clinic Referral	13 and under	14	15	16	17
No	85	88	85	82	89
Yes	15	12	15	18	11
	100	100	100	100	100
N	(87)	(111)	(129)	(181)	(256)

Gamma = -.06

Chi-Square = 4.85 (significance = .30)

TABLE 28

Race of Juvenile by Whether Juvenile
was Referred to the Court Clinic

(In Percent) (N=310)

	Race		
Court Clinic Referral	Caucasian	Native	Other
No	81	69	74
Yes	19	31	26
	100	100	100
N	(137)	(150)	(23)

Cramer's V = .13

Chi-Square = 5.21 (significance = .07)

TABLE 29

Juvenile Employment/Student Status by Whether Juvenile was Referred to the Court Clinic

(In Percent) (N=744)

	Employment/Student Status	
Court Clinic Referral	Student or Employed Full-Time	Unemployed or Employed Part-Time
No	91	73
Yes	9	27
	100	100
N	(547)	(197)

Gamma = .56

Chi-Square = 34.74 (significance = .001)

TABLE 30

Juvenile Living Arrangements by Whether Juvenile was Referred to the Court Clinic

(In Percent) (N=758)

	Living Arrangements		
Court Clinic Referral	Two Parents	One Parent	Other
No	93	89	70
Yes	7	11	30
	100	100	100
N	(334)	(239)	(185)

Gamma = .27

Chi-Square = 57.14 (significance = .001)

TABLE 31

Parental Control by Whether Juvenile
was Referred to the Court Clinic

(In Percent) (N=470)

	Parental Control	
Court Clinic Referral	No	Yes
No	68	95
Yes	32	5
	100	100
N	(209)	(261)

Gamma = -.80

Chi-Square = 56.83 (significance = .001)

TABLE 32

Socio-Economic Status (Mother's Occupation) by
Whether Juvenile was Referred to the Court Clinic

(In Percent) (N=282)

	Mother's Occupation		
Court Clinic Referral	Low	Medium	High
No	75	87	78
Yes	25	13	22
	100	100	100
N	(100)	(141)	(41)

Gamma = -.17

Chi-Square = 6.22 (significance = .04)

TABLE 33

Socio-Economic Status (Father's Occupation) by
Whether Juvenile was Referred to the Court Clinic

(In Percent) (N=296)

	Father's Occupation		
Court Clinic Referral	Low	Medium	High
No	65	87	86
Yes	35	13	14
	100	100	100
N	(23)	(211)	(62)

Gamma = -.20

Chi-Square = 7.93 (significance = .02)

TABLE 34

Type of Plea by Whether Juvenile was Referred to the Court Clinic

(In Percent) (N=682)

	Plea		
Court Clinic Referral	Delinquent	Not Delinquent	No Plea Taken
No	84	93	81
Yes	16	7	19
	100	100	100
N	(472)	(97)	(113)

Cramer's V = .09

Chi-Square = 6.00 (significance = .05)

TABLE 35

Legal Representation by Whether Juvenile was Referred to the Court Clinic

(In Percent) (N=678)

	Counsel	
Court Clinic Referral	No	Yes
No	96	56
Yes	4	44
	100	100
N	(488)	(190)

Gamma = .90

Chi-Square = 166.31 (significance = .001)

TABLE 36

Age of Victim by Whether Juvenile
was Referred to the Court Clinic

(In Percent) (N=162)

	Age of Victim			
Court Clinic Referral	20 years or less	21 - 40	41 - 60	over 60
No	77	76	78	55
Yes	23	24	22	45
	100	100	100	100
N	(60)	(59)	(32)	(11)

Gamma = .09

Chi-Square = 2.78 (significance = .43)

Correlation and Causation

The existence of a correlation between two variables does not imply that there is a cause and effect relationship between them. The stability of the bivariate relationships presented above must be tested by introducing control variables. It is necessary to determine whether the relationships between each of the behavioral and non-behavioral contingencies and the decision to refer to the court clinic, are not the result of the effects of a third variable. It could be argued that the reason non-behavioral contingencies were found to be influential in the court clinic referral process, was that juveniles with particular types of social biographies had particular types of offence histories. That is, it was the nature of the juvenile's current and prior court record that explained the referral decision.

For instance, Natives may have been referred to the court clinic more often than Caucasians because they had lengthier and/or more serious offence histories. The same may be said of offenders who came from families with poor control structures, juveniles who were either employed on a part-time basis or unemployed, and juveniles who did not reside in a two-parent home. This suggests that the control variables (total number of current/prior offences; seriousness of current/prior offences) are intervening variables which interpret the mechanism through which the independent variable has an influence on the dependent variable: the independent variable (race, parental control, employment/student status or living arrangement) affects the intervening control variable (length and seriousness of current/prior record), which in turn affects the dependent variable (referral to the court clinic). In this sense, the original relationships are genuine causal relationships. The

intervening variables clarify the nature of the causal process.

A different argument can be made as to why the presence of legal counsel was strongly related to the referral decision. In the Winnipeg court, juveniles who had lengthy records and/or serious offences were more likely to be considered by the Crown for placement out of the home, committal to an institution, or transfer to adult court. In such situations, the judges insisted that the offenders have legal representation. If necessary, legal aid was provided. The court also made an immediate referral to the Children's Forensic Service for a psychiatric assessment. For cases such as these, therefore, the strong relationship between legal representation and referral to the clinic was explained by the bureaucratic practices of the court. This suggests that the control variables (total number of current/prior offences; seriousness of current/prior offences) are antecedent variables which have a causal effect on both the independent (legal representation) and dependent variable (referral to the court clinic). In this sense, the original relationship between presence of counsel and referral to the clinic is not a genuine causal relationship.

A multivariate analysis was performed to assess the independent effects of the behavioral and non-behavioral contingencies on the court clinic referral process. More specifically, it was possible to determine whether the juveniles' social characteristics, in and of themselves, affected the court's referral practices. An assessment was made of the extent to which entry into the court clinic population was independent of the offender's current and prior offence history. Similarly, it was possible to determine whether or not the relationship between the presence of counsel and referral to the clinic was merely

the product of their coincidental relationship to the offender's current and prior offence history. If legal representation had an independent influence on the court clinic referral process, the implication would be that lawyers actively sought the opinions of the psychiatrist. If legal counsel was not identified as a significant predictor, this would suggest that lawyers were consulting with the psychiatrist at the insistence of the court. Finally, the independent influences of race, parental control, mother's/father's occupation, plea, victim's age, and seriousness of prior record on the court clinic referral process were not assessed because of the number of missing cases on these variables. It was not possible to confirm or reject the results of the bivariate analysis. Future studies should use multivariate procedures in order to evaluate whether Natives, juveniles who come from families with poor control structures, juveniles who come from working class families, juveniles who do not enter a plea, juveniles who victimize older persons and juveniles who have serious prior records are more likely to be referred to the court clinic than their respective counterparts.

Multivariate Analysis

Discriminant function analysis was employed to assess the influence of individual independent variables while controlling for the other independent variables. The following variables were entered into a stepwise discriminant analysis:

1. Number of current offences
2. Seriousness of current offence
3. Use of violence
4. Use of weapons
5. Number of prior offences
6. Sex
7. Age
8. Employment/student status
9. Living arrangements
10. Legal representation.

Standardized discriminant function coefficients are presented for the independent variables which contributed most to the separation of the court clinic referrals and non-referrals (Table 37). The magnitude of the coefficient represents the relative contribution that each independent variable makes in discriminating between the two groups. A positive sign signifies a direct association to referral to the court clinic. Five of the 10 independent variables contributed to discrimination between the court clinic referrals and non-referrals at the .05 level of significance. The most important predictor of referral to the court clinic was the presence of counsel. Juveniles who had legal representation were more likely to be referred for psychiatric evaluation. The second most influential factor in the court clinic referral process was the total number of current offences before the court. Juveniles who had a large number of current offences were more likely to be referred to the clinic. The third most important predictor was juvenile living arrangements. Juveniles who resided in a one parent

home or other living arrangement (foster/group home, institution) were more likely to be referred for clinical assessment. The fourth most important predictor of referral to the clinic was the juvenile's activity status. Juveniles who were unemployed or employed on a part time basis were more likely to be referred for psychiatric evaluation. Finally, the fifth significant predictor was the total number of prior offences. Juveniles who had lengthy records were more likely to be referred to the clinic.

The canonical correlation coefficient for the discriminant function was .58. This measure squared is equivalent to an R^2 in multiple regression which means that 34% of the variance in the discriminant function was explained by the composition of the groups. The adequacy of the derived discriminant function was assessed by, "classifying the cases used to derive the function in the first place and comparing predicted group membership with actual group membership" (Nie et al., 1975; p. 445). The proportion of correct classifications indicates how well the discriminating variables separated the groups. As shown in Table 38, the discriminant function was relatively successful in classifying juveniles into the court clinic referral and non-referral groups. Overall, 88.03% of the grouped cases were correctly classified by the derived discriminant function.

TABLE 37

Standardized Discriminant Coefficients for
Discriminant Function of Two Groups of Juveniles:
Court Clinic Referrals and Court Clinic Non-Referrals

(N = 644)

Variable	Coefficient
Legal Representation	.63
Number of Current Offences	.41
Living Arrangements	.21
Employment/Student Status	.18
Number of Prior Offences	.16

Wilks' lambda = .668, d.f. = 5, $p < .001$

Canonical Correlation = .58

TABLE 38

Classification Results for Discriminant Function of
Court Clinic Referrals and Court Clinic Non-Referrals

(In Percent) (N = 660)

	Predicted Group Membership	
Actual Group	Court Clinic Non-Referral	Court Clinic Referral
Court Clinic Non-Referral	93	7 (560)
Court Clinic Referral	38	62 (100)

In sum, the results of the multivariate analysis indicated that behavioral and non-behavioral contingencies were equally influential in the court clinic process. The set of discriminating variables that contributed most to the separation of the court clinic referrals and non-referrals, consisted of two behavioral and three non-behavioral contingencies. The two most important predictors of referral to the court clinic included one of each type: legal representation and number of current offences. Living arrangements, employment/student status and number of prior offences were the other variables that contributed to discrimination between the clinic referrals and non-referrals. The statistical analysis confirmed that offence characteristics, offender characteristics and legal representation each had an independent influence on the court clinic referral process. That is, the effects of juvenile living arrangements and employment/student status on the court's referral decision were direct effects. They were not indirect effects that were mediated by an intervening variable. Similarly, the presence of counsel had a direct effect on the referral process. The relationship was not spurious. This suggests that legal counsel consulted with the psychiatrist not because bureaucratic principles demanded that they do so (eg. juveniles who have lengthy and/or serious records must have counsel and must be referred to a psychiatrist), but because they desired to do so. Counsel actively sought the opinions of the psychiatrist. Finally, the results indicated that seriousness of current offence, use of violence/weapons, sex, and age did not significantly contribute to the separation of the clinic referrals and non-referrals, when statistical controls were introduced.

The qualitative data that were compiled from the psychiatric

reports confirm that behavioral and non-behavioral contingencies influenced the court's decision to refer juveniles to the clinic. The "reasons for referral" that were indicated on the referral document that is sent to Children's Forensic Services were noted and classified. As shown in Table 39, the reasons for referral were almost evenly divided into the behavioral (47%) and non-behavioral (53%) categories. The most common reasons for referral to the clinic were as follows: (a) crown is considering committal to a training school, (b) crown is considering transfer to adult court, (c) juvenile has a large number of current offences and/or serious current offences, (d) juvenile has psychological problems, and (e) juvenile is not functioning well at home or in placement.

In conclusion, the results provided support for the first hypothesis. More accurately, the data failed to reject the null hypothesis of no difference between the effects of behavioral and non-behavioral contingencies on the decision to refer juveniles to the court clinic. Behavioral and non-behavioral contingencies were equally important determinants of entry into the court clinic population.

TABLE 39

Reasons for Referral to Children's Forensic Services

	N	%
Behavioral Contingencies:		
Seriousness/number of current offences	24	9.6
Seriousness/number of prior offences	12	4.8
Aggressive behaviour	11	4.4
Prior and/or present involvement with probation or training school	7	2.8
Crown is considering transfer to adult court	27	10.8
Crown is considering committal to a training school	30	11.8
Court is requesting a recommendation for disposition	8	3.1
	(119)	(47.3)
Non-behavioral Contingencies:		
Negative statements about school/work	8	3.1
Negative statements about the home/living situation	15	6.0
Psychiatric/Psychological concerns	27	10.8
Use of drugs or alcohol	4	1.6
Running away from home	3	1.2
Negative statements about other behavior of the juvenile	10	4.0
Negative attitude	4	1.6
Assess level of comprehension (IQ)	5	2.0
Prior and/or present involvement with Children's Aid Society	7	2.8
Prior and/or present involvement with psychiatrist	9	3.6
Court requests an appropriate plan for placement outside of the home	14	5.6
Court requests an appropriate treatment plan	14	5.6
Assessment requested by defense counsel	7	2.8
Juvenile is young	5	2.0
	(132)	(52.7)
TOTAL	251	100.0

HYPOTHESIS 2: The concurrence rates between psychiatric recommendations and judicial dispositions will vary for recommendations of differing severity, with the more restrictive recommendations being more readily accepted by the court than the less restrictive recommendations.

This analysis focused on determining whether concurrence rates between psychiatric recommendations and judicial dispositions varied according to the severity of the recommendation. The dependent variable was the concurrence rate between psychiatric/psychological recommendations and judicial dispositions. As shown in Table 40, the court agreed with the recommendations of the psychiatrist/psychologist in 60 percent of all cases. When the court did not concur with the recommendations of the psychiatrist, the most common course of action was to impose dispositions that were less serious than the recommendations that were put forth by the clinic staff (Table 41). Twenty-seven percent of all juveniles received dispositions that were less serious than the recommendations offered by the psychiatrist, compared with 13 percent who received more serious dispositions. This suggests that the psychiatrist recommended increased intervention in the life-space of juvenile offenders in order to deal with the causes of delinquency. The court, on the other hand, exercised more restraint in this regard. The independent variable was the severity of the psychiatric/psychological recommendation. As shown in Table 42, 29 percent of all recommendations were less severe, compared with 37 percent that were severe and 34 percent that were more severe.

The concurrence between psychiatric/psychological recommendations and judicial dispositions was found to vary as a function of the severity of the recommendation (Table 43). Overall, the concurrence rate was higher for the more restrictive recommendations than for the

less restrictive recommendations. Eighty-three percent of the more severe recommendations were accepted by the court, compared with 44 percent of those that were severe and 52 percent of those that were less severe. A gamma of .43 indicates that there is a moderate association between the severity of psychiatric/psychological recommendations and concurrence rates. The relationship is significant at the .05 level. This relationship needs to be qualified in view of the fact that the "less severe" recommendations were accepted by the court more often than the "severe" recommendations. This indicates that the concurrence rate between psychiatric recommendations and judicial dispositions did not increase steadily as the severity of the psychiatric recommendation increased. In other words, the recommendations that fell into the extreme categories (less severe, more severe) had higher concurrence rates than those that were assigned to the middle category (severe). The relationship between the concurrence rate and the severity of the psychiatric recommendation, was curvilinear, not linear.

A possible explanation for this relationship stems from the diverse postures that judges have adopted towards the psychiatric approach to crime. Some judges adhere to the legalistic model, while others are definitely psychiatrically oriented. It is possible that these two "types" of judges use the psychiatric report to achieve different ends.[6] For instance, judges who are legalistic in orientation may order psychiatric reports for serious cases that seem to warrant severe dispositions. In this type of situation, the judges would be using the psychiatric report to legitimize the imposition of serious sentences. It would seem that this is the group of judges that would concur most often with the "more severe" psychiatric recommendations. On the other

hand, judges who are psychiatrically oriented, may order psychiatric reports when they are not sure whether they should impose a severe disposition or opt for a less intrusive alternative. They would use the psychiatric report in borderline cases, not for cases that "obviously" require severe dispositions. In this type of situation, the judges would be influenced by the psychiatric report because a decision "had not been reached" prior to the referral. It would seem that this group of judges would concur most often with the "less severe" recommendations. Given that the "less severe" and "more severe" psychiatric recommendations were accepted more often by the court than the "severe" recommendations, it could be argued that two distinct approaches were used by the judges in their consideration of psychiatric court reports. Future studies should examine the relationship between the severity of psychiatric recommendations and concurrence rates, with the orientation of the judge introduced as a control variable.

In conclusion, the data provided support for the second hypothesis. Although the court (a) imposed dispositions that were more lenient than the recommendations offered by the psychiatrist for about a quarter (27 percent) of all assessed juveniles, and (b) accepted the "less severe" recommendations more frequently than the "severe" recommendations, overall, the findings indicated that the more restrictive recommendations were more readily accepted by the court than the less restrictive recommendations.

TABLE 40

Concurrence Between Psychiatric/Psychological Recommendations and Judicial Dispositions

	N	%
No	43	40
Yes	63	60
Total	106	100

TABLE 41

Concurrence Between Pyschiatric/Psychological Recommendations and Judicial Dispositions

	N	%
No, disposition less serious than recommendation	29	27
No, disposition more serious than recommendation	14	13
Yes, disposition equally serious as recommendation	42	40
Yes, disposition identical to recommendation	21	20
Total	106	100

TABLE 42

Severity of Psychiatric/Psychological Recommendations

	N	%
Less Severe	31	29
Severe	39	37
More Severe	36	34
Total	106	100

TABLE 43

Concurrence Between Psychiatric/Psychological Recommendations and Judicial Dispositions By Severity of Psychiatric/Psychological Recommendations

(In Percent) (N = 106)

	Severity of Recommendation		
Concurrence	Less Severe	Severe	More Severe
No	48	56	17
Yes	52	44	83
	100	100	100
N	(31)	(39)	(36)

Gamma = .43

Chi-square = 13.38 (significance = .001)

HYPOTHESIS 3: When legalistic and socio-demographic variables are controlled, no significant differences will be found between the dispositions of offenders who are sentenced with and without a psychiatric report.

This analysis focused on determining whether the psychiatric court report influenced the judicial decision making process. The dependent variable was the severity of judicial dispositions. As shown in Table 44, dispositions were ranked into the following five categories: (i) stayed, dismissed, or withdrawn; (ii) adjourned sine die; (iii) suspended disposition, fine, community work order, contribution to charity or restitution; (iv) probation, period of progress or Youth Psychiatric Services; and (v) transfer to adult court, institutionalization, or committal to Children's Aid Society.[7] The independent variable was whether or not the juvenile had a psychiatric court report. The relationship between the dependent and independent variables was examined in two ways -- one set of statistics included the stayed, withdrawn, or dismissed category in the dependent variable, while the other did not. This method was used because factors other than the presence of a psychiatric report or the characteristics of offenders/offenses may be the influential determinants of terminations prior to adjudication (for instance, insufficient evidence, failure to locate witnesses). In this sense, the stayed, withdrawn, or dismissed category is not a disposition. Statistical analyses were performed with and without this category of outcomes in order to determine whether the findings would differ in any way.

As shown in Table 45, juveniles who had a psychiatric court report received more serious dispositions than those who did not have a report. Fifty-six percent of all juveniles who had a psychiatric report were

transferred to adult court, institutionalized, or committed to the Children's Aid Society, compared with 3 percent of those who did not have a psychiatric report. Nineteen percent of all juveniles who had a psychiatric report were placed on probation compared with 14 percent of those who did not have a psychiatric report. Conversely, 37 percent of all juveniles who did not have a psychiatric report were assessed a fine or restitution compared with 3 percent of those who had a psychiatric report; 27 percent of all juveniles who did not have a psychiatric report had their most serious charge adjourned sine die compared with 10 percent of those who had a psychiatric report; and 19 percent of all juveniles who did not have a psychiatric report had their most serious charge stayed, withdrawn, or dismissed compared with 12 percent of those who had a psychiatric report. A gamma of .63 indicates that there is a strong association between the presence of a psychiatric court report and the severity of judicial dispositions. The relationship is significant at the .05 level. When the cases that were stayed, dismissed, or withdrawn were excluded from the analysis (Table 46), the magnitude of the gamma increased from .63 (strong association) to .79 (very strong association) and the relationship remained significant at the .05 level.

Again, correlation does not imply causation. The stability of the strong positive correlation between the presence of a psychiatric court report and the severity of judicial dispositions must be tested by introducing control variables. It could be argued that this relationship is spurious because offenders who have lengthy records and/or serious offences, are more likely to be referred for a psychiatric assessment (independent variable), and also more likely to

receive severe dispositions (dependent variable). That is, the causal effects of the legalistic variables may have preceded both the independent and dependent variables. A multivariate analysis was performed to determine whether the psychiatric court report had an independent influence on the sentencing process.

TABLE 44

Judicial Dispositions Received by the Court Clinic
Referrals and Non-Referrals

	N	%
Stayed, withdrawn or dismissed	138	18
Adjourned sine die	188	25
Suspended disposition, fine or restitution	247	31
Probation	111	15
Transfer, institutionalization or committal to CAS	81	11
Total	765	100

TABLE 45

Severity of Judicial Dispositions by Whether Juvenile Had a Psychiatric Court Report

(In Percent) (N = 765)

	Psychiatric Court Report	
Disposition	No	Yes
Stayed, withdrawn or dismissed	19	12
Adjourned sine die	27	10
Suspended disposition, fine, restitution	37	3
Probation	14	19
Transfer, institutionalization or committal to CAS	3	56
	100	100
N	(659)	(106)

Gamma = .63

Chi-Square = 283.14 (significance = .001)

TABLE 46

Severity of Judicial Dispositions (Excluding Stayed, Withdrawn, Dismissed) by Whether Juvenile Had a Psychiatric Court Report

(In Percent) (N = 627)

	Psychiatric Court Report	
Disposition	No	Yes
Adjourned sine die	33	12
Suspended disposition, fine, restitution	46	3
Probation	17	22
Transfer, institutionalization, committal to CAS	4	63
	100	100
N	(534)	(93)

Gamma = .79

Chi-Square = 264.91 (significance = .001)

Multivariate Analysis

Multiple regression analysis was employed to assess the independent influence of the psychiatric report on the severity of judicial dispositions, while controlling for legalistic and socio-demographic variables. The following variables were entered into a regression analysis:

1. Number of current offences
2. Seriousness of current offence
3. Use of violence
4. Use of weapons
5. Number of prior offences
6. Sex
7. Age
8. Employment/student status
9. Living arrangements
10. Presence/absence of psychiatric report.

Seriousness of prior record, race, parental control, mother's/father's occupation, plea, legal representation and victim's age were excluded from the analysis because of the number of missing cases on these variables.[8]

Standardized regression coefficients (beta weights) are presented for each independent variable when the dependent variable included all categories of disposition (Table 47), and when the cases that were stayed, dismissed, or withdrawn were excluded from the analysis (Table 48). When all five categories were included in the dependent variable, the significant predictors of disposition were presence/absence of psychiatric report, number of current offences, seriousness of current offence, use of violence, number of prior offences and employment/student status. Juveniles who had a psychiatric report, a large number of current offences, a serious current offence and a lengthy prior record were more likely to receive severe

dispositions. Juveniles who were unemployed or employed on a part time basis and juveniles who were not violent also received the most serious dispositions. Males, younger juveniles, juveniles who used weapons, and juveniles who lived in a two parent home were more likely to be treated harshly by the court than their respective counterparts, although these relationships were not found to be significant at the .05 level. Overall, the most important predictor of disposition was the presence/absence of a psychiatric report. When this variable was entered last in the regression a significant change in R^2 ($p = .001$) occurred, indicating that the psychiatric report exerted an independent influence in the sentencing process. The sign of the beta coefficient indicated that referral for psychiatric assessment resulted in more severe dispositions.

When the cases that were stayed, dismissed or withdrawn were excluded from the analysis, the significant predictors of disposition were presence/absence of psychiatric report, number of current offences, seriousness of current offence, number of prior offences and employment/student status. The direction of the relationships between these independent variables and the dependent variable remained unchanged. Conversely, use of violence resulted in more severe dispositions, although this relationship was not significant at the .05 level. The proportion of explained variance in the dependent variable increased from 21 percent to 44 percent, with the exclusion of the stayed, dismissed, withdrawn category. Again, the most important predictor of disposition was the presence/absence of a psychiatric report. Juveniles who had psychiatric reports were treated more harshly by the court than those who were not referred for assessment.

TABLE 47

Multiple Regression of Presence/Absence of Psychiatric Report, Legalistic and Socio-Demographic Variables on Severity of Judicial Dispositions

(N = 720)

Variable	Zero-order Correlation	Beta
Presence/absence of psychiatric report	.39	.28*
Number of current offences	.33	.16*
Seriousness of current offence	.25	.10*
Use of violence	.08	-.10*
Use of weapons	.11	.06
Number of prior offences	.22	.08*
Sex	.06	.02
Age	-.03	-.03
Employment/student status	.17	.09*
Living arrangements	.10	-.04

$R = .46$

$R^2 = .21$

* $p < .05$

TABLE 48

Multiple Regression of Presence/Absence of Psychiatric Report, Legalistic and Socio-Demographic Variables on Severity of Judicial Dispositions (Excluding Stayed, Dismissed, Withdrawn)

(N=593)

Variable	Zero-order Correlation	Beta
Presence/absence of psychiatric report	.50	.28*
Number of current offences	.48	.19*
Seriousness of current offence	.40	.17*
Use of violence	.25	.01
Use of weapons	.24	.05
Number of prior offences	.44	.23*
Sex	.15	.06
Age	-.03	-.02
Employment/student status	.24	.08*
Living arrangements	.16	-.05

$R = .66$

$R^2 = .44$

* $p < .05$

Psychiatric ideology and the bureaucratic practices of the court may have both contributed to the differences that were found between the dispositions of offenders who were sentenced with and without a psychiatric report. It could be argued that the mental health professional is more willing than the court to intrude in the life of juvenile offenders, in order to deal with the causes of delinquency. The treatment/casework orientation calls for increased intervention, and in the context of the juvenile court, it might be expected that this would translate into more severe dispositions. Indeed, Morash (1982) found that mental health professionals made more severe recommendations than probation officers, and that judges gave more serious dispositions to offenders who had been referred for psychiatric assessment. These actions can be understood as attempts to address the social needs of the offender. To ensure that the social worker has a legal mandate to intrude into the offender's personal life, the psychiatrist offers more severe recommendations and the court obliges by imposing at least a term of probation.

Moreover, it could be argued that there is also a bureaucratic principle at work. That is, the use that the court makes of the clinic and its resources, influences the severity of the psychiatric recommendations and judicial dispositions. For instance, when juvenile offenders are referred to the clinic after they have accumulated lengthy current and/or prior records (as was the case in this study), legal concerns demand that they be dealt with severely. For these types of cases, there is a narrow range of dispositional alternatives that are acceptable to the court. In other words, by the time these offenders

are referred to the court clinic, almost all of the resources in the juvenile court system have been exhausted. There are few options left for the psychiatrist to choose from. In this sense, psychiatrists are constrained to offer severe recommendations because of the referral practices of the court. The characteristics of the offenders' current/prior offence history "obviously" call for severe interventions.

In conclusion, the data rejected the null hypothesis of no difference between the dispositions of offenders who were sentenced with and without a psychiatric report. Juveniles who had psychiatric reports received more serious dispositions than those who did not have a report. The presence/absence of a psychiatric report was the most important predictor of disposition. This suggests that the more severe dispositions received by the court clinic referrals are due, at least in part, to the independent influence that the psychiatrist has on the sentencing process.

CHAPTER IV

CONCLUSIONS

This study examined the nature of the interface between psychiatry and law within the context of the juvenile justice system. The literature that was reviewed presented two alternative perspectives on the type of collaborative relationship that could be expected to emerge between the criminal justice and mental health systems. The literature on the profession of medicine suggested that the judicial sphere has experienced a loss of influence to psychiatry. Concerns about the ascendancy of medicine as an institution of social control were said to stem from two sources: (a) the extent to which medicine's jurisdiction has steadily expanded to include forms of behavior that previously were defined as crime or sin; and (b) the extent to which the medical perspective has been adopted by agencies that were traditionally associated with legal forms of control. Within the context of the juvenile justice system, the major implication is that legal decision rules are being displaced by medical decision rules. This suggests that court psychiatrists actively seek to involve themselves with the problems of juvenile offenders, and that they are strong influential figures in the juvenile court. They work as consultants in order to provide the court with expert advice about the treatment needs of their patients. In sum, it can be argued that the psychiatrist functions as a protector of the interests of the patient.

On the other hand, the literature on the social organization of work suggested that professional practice is significantly constrained by the organizational context in which the work takes place. Within the

context of the juvenile justice system, the major implication is that the nature of psychiatric practice is being influenced by the unique requirements of the legal bureaucracy. This suggests that psychiatrists are drawn into the juvenile justice system so that the authority of medicine can be used to serve organizational needs. Psychiatrists are not free to concern themselves solely with the treatment needs of their patients, and in this sense, their power is tempered by the court. In sum, it can be argued that the psychiatrist functions as a protector of the interests of the court.

The relative merits of these two competing interpretations were assessed not on the basis of judges' and psychiatrists' perceptions of their own, and each other's professional roles, but in terms of the type of working relationship that was forged between the members of these two disciplines. In short, this study focused on behavior -- what they do, not what they say. Two major dynamics of the interprofessional process were examined: (a) the intake procedure in the juvenile court clinic; and (b) the use that the court makes of psychiatric reports in the sentencing process.

The Social Construction of the Role of the Mentally Ill

Investigation of the intake procedure in the court clinic allowed for a test of Scheff's (1966) sociological theory of mental disorder.[9] Scheff suggests that studies should assess the influence of behavioral and non-behavioral contingencies in the official designation of the mentally ill status. "Behavioral contingencies" refers to current and previous rule breaking behavior. "Non-behavioral contingencies" refers to the social characteristics of the offender. By assessing the

relative impact of these factors in the court clinic referral process, it can be determined to what extent entry into the status mentally ill, is independent of the person's behavior.[10]

The alternative views of the psychiatrist's role (that is, the psychiatrist functions as an expert versus the psychiatrist is constrained in the use of his expertise by the needs of the court) are related to the divergent perspectives that have been presented with regard to the factors that are most likely to lead to an imputation of mental illness. If the psychiatrist in a collaborative relationship continues to practice in the medical tradition, then the referral of offenders to the court clinic would be based on an assessment of treatment needs. It is probable that clients with particular social characteristics are assumed to have a greater need for assistance, and therefore, are more likely to be referred for psychiatric assessment. The implication is that non-behavioral (social) contingencies may be more important determinants of entry into the status mentally ill than behavioral contingencies. On the other hand, if psychiatric practice is constrained by the needs of the court, then the referral of offenders to the court clinic would be based on an assessment of behavior rather than treatment needs. The determinants of entry into the sick role would be congruent with organizational concerns (legalistic variables) rather than the treatment needs of the client. The implication is that behavioral contingencies may be more important predictors of entry into the status mentally ill than social contingencies.

The findings failed to reject the null hypothesis of no difference between the effects of behavioral and non-behavioral contingencies on the decision to refer juveniles to the court clinic. Behavioral and

non-behavioral contingencies were equally important determinants of entry into the court clinic population. The bivariate analysis suggested that behavioral contingencies figured more prominently in the court clinic referral process than non-behavioral contingencies. Nevertheless, the multivariate analysis indicated that the set of variables which helped to discriminate between the court clinic referrals and non-referrals included both types of contingencies. The most important predictor of referral to the court clinic was a non-behavioral contingency (legal representation), while the second most important predictor was a behavioral contingency (number of current offences). The qualitative data that were compiled from the psychiatric reports confirmed that entry into the sick role was associated with a wide variety of behavioral and non-behavioral contingencies.

The results of this study were relatively consistent with previous research findings on the factors that are influential in the civil commitment and court clinic referral processes. First, the findings on the influence of behavioral contingencies are summarized below. As reported by Bohmer (1976), offenders who had a large number of current offences before the court were more likely to be referred to the clinic. The finding that violent offenders were more likely to be referred for psychiatric evaluation (Prins, 1975) was supported. Offenders who had a person offence as their most serious current charge (violence and/or weapons were used) were more likely to be referred to the court clinic than any other category of offender. As indicated by Bohmer (1976), offenders who had serious current offences were more likely to be referred to the clinic. This finding contradicts the results of research by Davis et al. (1970-71) and Smith (1976). As reported by

Kahn and Nursten (1963), Stephensen (1971) and Warner (1980), offenders who had lengthy prior records were more likely to be referred for psychiatric assessment. Bohmer (1976), on the other hand, found no significant relationship between the presence or absence of a prior record and the decision to order a psychiatric report. Contrary to the results presented by Davis et al. (1970-71), offenders who had serious prior offences were more likely to be referred to the court clinic.

Second, the findings on the influence of non-behavioral contingencies are summarized below. As reported by Warner (1980), the sex of the offender had no influence on the court's decision to remand for a psychiatric report. This finding contradicts the results of research by Prins (1976). As reported by Bohmer (1976), the age of the offender had no bearing on the court clinic referral process. This finding contradicts the results of research by David et al. (1970-71) and Smith (1976). Natives and offenders from other backgrounds (Negroid, Asian) were more likely to be referred for psychiatric evaluation than Caucasians. The relationship was weak and not significant at the .05 level. This is consistent with Bohmer's (1976) finding that the race of the offender had no influence on the court's decision to remand for a psychiatric evaluation. As reported by Stephensen (1971), offenders who were not actively engaged in school or work were more likely to be referred to the court clinic. Offenders who resided in a one parent home or other living arrangement (foster-group home, institution) were more likely to be referred for psychiatric assessment than those who resided in a two parent home. This finding is consistent with the results of research by Kahn and Nursten (1963) and Prins (1976). As indicated by Stephensen (1971), offenders who were out

of their parents' control were more likely to be referred to the clinic than those who were effectively supervised. As reported by Rushing (1978), Stephensen (1971) and Lewis et al. (1973), offenders who came from working class families were more likely to be referred for psychiatric evaluation. Contrary to the results presented by Davis et al. (1970-71) and Smith (1976), offenders who had not entered a plea were more likely to be referred to the court clinic. Offenders who were represented by counsel were more likely to be referred for psychiatric assessment. This is inconsistent with Wenger and Fletcher's (1969) finding that the presence of counsel was associated with a decision not to proceed with involuntary commitment. Finally, as reported by Bohmer (1976), offenders who had victimized older persons were more likely to be referred to the court clinic.

None of the above studies assessed the influence of individual independent variables while controlling for the effects of the other independent variables. In the present study, the multivariate analysis indicated that the significant predictors of referral to the court clinic were as follows: (a) legal representation, (b) number of current offences, (c) living arrangements, (d) employment/student status and (e) number of prior offences. Seriousness of current offence, use of violence/weapons, sex and age did not contribute to discrimination between the court clinic referrals and non-referrals.

Overall, the findings indicated that both legal (behavioral contingencies) and extra-legal (non-behavioral contingencies) variables were crucial determinants of entry into the court clinic population. The court's response to offenders was based on an assessment of behavior and treatment needs. Offenders who had a lengthy record of current

and/or prior involvements created organizational problems for the court, and the clinic staff were pressured to concern themselves with the needs of the court. Nevertheless, the court was sensitive to the treatment philosophy. The most influential factor in the court clinic referral process was the presence of legal representation. This suggests that the opinions of the psychiatrist were actively sought by legal counsel, in their efforts to provide clients with help and guidance. Offenders who had problems functioning at home or in placement were referred for psychiatric assessment, as well as those who were not involved in conventional activities such as school or work. These offenders were assumed to be in need of assistance, and the psychiatrist was called upon to develop an appropriate treatment plan. In sum, it can be concluded that psychiatrists were constrained to attend to the immediate needs of the court; however, they were also able to address some of their own concerns. The referral practices of the court demonstrated that the judiciary was interested in both the law-breaking behavior and the social functioning of the juvenile offender.

The Psychiatric Court Report

The alternative views of the psychiatrist's role (influential expert versus agent of the court) also lead to different expectations about the use that the court will make of the psychiatric report. The first issue to be addressed is whether concurrence rates between psychiatric recommendations and judicial dispositions vary according to the severity of the recommendation. If the court is sensitive to the underlying principles of the treatment orientation, and confident of the

psychiatrist's expertise, then the concurrence rates between psychiatric recommendations and judicial dispositions would not be expected to vary as a function of the severity of the recommendation. That is, all psychiatric recommendations, regardless of severity, would have equal weight before the court. On the other hand, if the court is availing itself of psychiatric "expertise" in order to serve organizational needs (for instance, to legitimize the imposition of serious sentences), then it would be expected that the more restrictive psychiatric recommendations would be accepted by the court more often than the less restrictive recommendations. That is, only the psychiatric advice that was congruent with organizational imperatives would be accepted by the court.[11]

Overall, the findings indicated that the psychiatrist's discretion in the use of his/her expertise, was constrained by the use that the court made of the psychiatric report. The court used the report to serve organizational needs. Although the court agreed with the recommendations of the psychiatrist in the majority of cases (60%), it was selective in its consideration of these recommendations. That is, the psychiatrists' recommendations were more persuasive when severe forms of intervention were suggested. Eighty-three percent of the "more severe" recommendations were accepted by the court, compared with 44 percent of those that were "severe" and 52 percent of those that were "less severe". Aside from the fact that the "less severe" psychiatric recommendations were accepted by the court more often than the "severe" recommendations, these findings support the results of previous research (Bohmer, 1976; Campbell, 1981; Woodside, 1976; Bonta, 1981). It would appear that the court uses the psychiatric report to legitimize

the imposition of serious sentences, although the exception to the general rule suggests that some judges may be searching for (or at least, willing to consider) less intrusive dispositional alternatives.

The second issue to be addressed is whether the psychiatrist exercises any influence in the sentencing process; that is, are there any differences in the dispositions of comparable court clinic referrals and non-referrals? If the psychiatrist has assumed a portion of the judge's authority, differences between the dispositions of comparable court clinic referrals and non-referrals would be expected. On the other hand, if the authority of the psychiatrist is being used to legitimize the actions of the court, there should be no significant differences between the dispositions of the court clinic referrals and non-referrals.

The findings rejected the null hypothesis of no difference between the dispositions of offenders who were sentenced with and without a psychiatric report. Juveniles who were sentenced with a psychiatric report received more severe dispositions than those who were sentenced without a report (legalistic and socio-demographic variables were statistically controlled). While this finding supports the results of Morash's (1982) study, it contradicts the result of Bohmer's (1976) research. Moreover, the regression analysis indicated that the presence/absence of a psychiatric report was a more important predictor of disposition than legalistic (number of current offences, seriousness of current offence, number of prior offences) or socio-demographic (employment/student status) variables. That is, of all the significant predictors of disposition, the presence of a psychiatric report contributed most to the explanation of differences in the severity of

judicial dispositions. This suggests that the court seriously considered, and acted upon, the recommendations for disposition that were formulated by the clinic staff. Indeed, if the court had been using psychiatric reports to buttress decisions that "had already been made" prior to the referral, the presence/absence of a psychiatric report would not have been identified as a significant predictor of disposition. The results clearly indicate that the psychiatrist was an influential figure in the judicial decision-making process. It would appear that a portion of the judiciary's authority has been usurped by psychiatry.

To summarize, investigation of the inter-professional processing of cases by the judiciary and psychiatry, has indicated that the psychiatrist is neither an omnipotent, nor a servile figure, in the juvenile court. The court psychiatrist fulfills a professional role that embraces both legal and psychiatric requirements. The dynamics of the intake procedure in the juvenile court clinic revealed that the judiciary addressed both judicial and clinical concerns. Offenders who created organizational problems for the court because of their lengthy current and prior records were referred to the clinic, as well as those who demonstrated problems in social functioning (problems at home or in placement; not involved in conventional activities such as school or work). These referral practices indicate that the court's response to offenders was based on an assessment of law breaking behavior and treatment needs. Similarly, the court made use of the psychiatric report to achieve two very different objectives. On the one hand, the court used the authority of the psychiatrist to legitimize the imposition of serious sentences. That is, the court was selective in

terms of the type of advice that it accepted from the psychiatrist -- psychiatric recommendations were more persuasive when severe forms of intervention were offered as dispositional alternatives. Nevertheless, while the court used the psychiatric report to serve organizational needs, the findings also indicated that psychiatric intervention did make a difference in the judicial decision making process. That is, the psychiatrist had an independent influence on the sentencing process. Juveniles who were sentenced with a psychiatric report were treated more harshly by the court than those who were sentenced without a report. These differences might have been due, at least in part, to the fact that the treatment orientation calls for increased intervention to deal with the causes of delinquency. On the whole, the findings suggest that while the court clinic staff were constrained to attend to the immediate needs of the court, they were also able to address some of their own concerns.

Suggestions for Future Research

The results of the present study have indicated that the small subset of offenders who were selected for referral to the court clinic were different from the general population of juvenile offenders. The court clinic referrals were more likely to have legal representation, to demonstrate problems in social functioning and to be heavily involved in delinquent behavior than the non-referrals. In practical terms, the logical implication was that these offenders required unique forms of intervention. Indeed, the findings indicated that their assumed need for assistance resulted in more severe dispositions. That is to say, juvenile offenders who had access to extra professional resources (legal

representation, psychiatric evaluation) received the most severe sentences that were meted out by the court.

Are lawyers aware of these consequences when they refer their clients for psychiatric assessment? Similarly, do psychiatrists know full well the effects of their intervention in the judicial decision making process? Indeed, if they were cognizant of their influence how would they view their professional roles? Campbell (1981) suggests that forensic psychiatrists would be disturbed with this state of affairs since they usually advocate, "lenient, individualized and non-custodial treatment for the offender" (p. 96). Likewise, it could be argued that few lawyers would assume that their clients reap any benefits from severe dispositions (such as committal to a training school/Children's Aid Society or transfer to adult court). In this sense, neither the psychiatrists nor the lawyers may feel that they are fulfilling their professional roles appropriately.

On the other hand, it might be premature to conclude that the court psychiatrist (and lawyer, for that matter) could not possibly see what they are doing as having anything to do with treatment. That is, it could be argued that they would assess the suitability of a disposition, not on the basis of its leniency or severity, but in terms of how effective it is in dealing with the problems of the juvenile offender. Critics of the treatment orientation have argued that it is unjust to punish offenders because they need help with their problems. Yet, is it more fitting to guarantee legal rights and disregard social needs? Perhaps the greatest injustice that psychiatry and the judiciary could inflict on juveniles who are referred for psychiatric assessment, would come to pass when these offenders are favored with more severe

dispositions in the name of treatment, and subsequently denied the wherewithal to cope with their problems. This study did not assess whether juveniles who were referred to the court clinic had in fact been failed by the juvenile justice system. A number of crucial questions must be addressed in future studies. What kinds of returns have the court clinic referrals obtained from more interventionist dispositions? Have they acquired any benefits (in terms of improved social functioning) that may partially offset the costs of restricted freedom? When answers to these questions are produced, lawyers and mental health professionals will be better able to evaluate whether they are satisfied with their input in the judicial decision making process.

An empirical assessment of this problem would culminate in a costly and lengthy research endeavour. Offenders who were treated harshly by the court (court clinic referrals) would be compared to those who were dealt with less severely (court clinic non-referrals), in order to assess the effects of increased intervention. This would be accomplished by using a longitudinal design. For instance, any changes that occurred in family relationships, school performance or recidivism after the implementation of the disposition would be noted for both groups of offenders. This would indicate whether there were any differences between the two groups, in terms of acquired benefits such as improved social functioning or reduced recidivism. In sum, it would be possible to determine whether the court clinic referrals did worse (increased intervention resulted in fewer benefits), as well as (equal benefits), or better (additional benefits) than the non-referrals. The use of more intrusive dispositional alternatives for the clinic referrals can be justified only if they make a more positive difference

in the offender's life than the less intrusive measures.

Future studies may indicate that juvenile offenders do not receive any benefits from their referral to the court clinic, other than more severe dispositions. Should the court be unwilling to alter the function of the clinic, it would be wise (and more importantly, ethical) if psychiatrists dissociated themselves from that setting, and strove to do better work elsewhere. Perhaps within the context of the child welfare system, the psychiatrist would have more of an opportunity to focus on preventive services, and to work towards the early identification and resolution of problems faced by troubled children. Yet, the suggestion that the psychiatrist might accomplish more in the child welfare system is more a declaration of faith than a statement of fact. The dynamics of the child welfare system must also be thoroughly investigated. The frightening possibility that the psychiatrist might have no greater opportunity to provide for social needs in the child welfare system than in the juvenile justice system should not be overlooked. In the final analysis, helping professionals who are frustrated in their efforts to provide adequate services for their patients may be regarded as victims; but the most needy victims will always be the children.

NOTES

[1]The type of control structure that existed in the family was assessed on the basis of information provided in the pre-disposition reports. Statements by the parents and/or probation officer that the child was out of control were assumed to indicate that the family had poor control structures.

[2]Each of the offender's parents was assigned a score according to Blishen and McRobert's (1976) socioeconomic index for occupations. Occupational status was coded as follows: (i) low -- welfare or unemployed, (ii) medium -- employed with a Blishen scale category up to 49 and (iii) high -- employed with a Blishen scale category of 50 or higher. Occupations such as waiter, receptionist, salesclerk, mechanic, carpenter, and salesman were included in the medium category. Information on mother's/father's occupation was not available for 60 percent and 44 percent of all cases, respectively.

[3]Each of the offender's current offences was assigned a seriousness ranking according to the Sellin and Wolfgang (1964) index of delinquency. On the basis of these rankings, the most serious charge was selected to represent the offender's current court experience. Offenders were assigned to the following current offence categories: (i) status -- minor possess or consume liquor; (ii) less serious - theft under $200, break, enter and theft under $200, possession of stolen goods, etc.; and (iii) more serious -- theft over $200, break, enter and theft over $200, impaired driving, assault, etc.

[4]Seriousness of prior offence was measured in the same manner as seriousness of current offence.

[5]Two measures were used to summarize the nature of the juveniles' current involvement with the court: (a) the total number of current offences and (b) the seriousness ranking of the juveniles' most serious current charge. Selection of the most serious current charge on file produced current court records that varied in severity. Some offenders had a consumption of liquor charge as their most serious offence, while others had a theft, break and enter or assault charge (see Table 11). The juveniles' prior court experience was measured in the same manner. Any distortion that may have been introduced by selecting a single charge to represent the juveniles' court experience would apply to all cases; that is, the errors would be constant as opposed to random errors. It is likely that this method underrepresented the seriousness of the juveniles' current/prior court records.

[6]Bohmer (1976) classified the judges in her sample as (a) not at all, (b) somewhat or (c) definitely psychiatrically oriented. This corresponds to the marked differences that may be found between judges who have "legalistic", "middle of the road", or "psychiatric" orientations. In order to argue that judges with different orientations order psychiatric reports for different reasons, and hence are receptive

to different types of recommendations, I chose to compare the polar extremes.

[7]The procedures that were used to rank dispositions are discussed in Section C of the Methodology chapter.

[8]Regression analyses were also undertaken with legal representation included in the set of independent variables. This resulted in a further loss of cases. When the regression included all categories of disposition, the N was equal to 644, compared to 543 when the cases that were stayed, dismissed, or withdrawn were excluded from the analysis. Nevertheless, when the findings from the regressions that included legal counsel were compared to those from the regressions that excluded legal counsel (Tables 47 and 48), no differences were found. The direction, magnitude, and significance of the relationships between each of the independent variables and the dependent variable remained unchanged. The presence/absence of a psychiatric report was again identified as the most important predictor of disposition.

[9]As argued by D'Arcy (1976), it was found that Scheff's theoretical statement on the nature of the contingencies that affect entry into the status mentally ill, cannot be subjected to a rigorous empirical test. It was impossible to deal systematically with the contingencies because they are inadequately conceptualized and classified. Many factors that were identified as important determinants of entry into the court clinic population, could not be situated within Scheff's classification of the contingencies (for instance: type of plea, intelligence quotient, alcohol/drug use, school behavior problems, child disobedience and victim characteristics). Only by sticking to the "safe contingencies" (degree/amount of the rule breaking, power of the rule breaker) was it possible to work within Scheff's theoretical framework. As concluded by D'Arcy (1976), this is far from an adequate test of the societal reaction theory of mental illness -- "such research activity ignores the question of the relationship between the contingencies and treats these contingencies statically rather than dynamically" (p. 49).

[10]The assumption underlying Scheff's (1966) theoretical framework is that psychiatrists who practice in the medical tradition are concerned only with the behavior or condition of their patients (behavioral contengencies). Hence, if psychiatric diagnoses are found to be dependent on factors that are external to the patient's behavior (non-behavioral contingencies), then the status mentally ill can be regarded as a social status, as opposed to a medical one. Indeed, Scheff draws a contrast between "psychiatric" and "social" contingencies, equating behavioral contingencies with the former and non-behavioral contingencies with the latter. Conversely, the present argument is that within the context of the juvenile justice system, it is the court that is concerned with the deed (behavioral contingencies) and the psychiatrist who is concerned with the doer (non-behavioral contingencies). It is the psychiatrist who is most interested in the relationship between environmental factors and the misbehavior of young offenders. For the court psychiatrist, the "psychiatric contingencies" are the social characteristics of the offender, not the characteristics

of his/her rule breaking behavior. In sum, investigation of the intake procedure in the court clinic allows for a test of the societal reaction theory of mental illness, although a different set of assumptions about the professional role of the psychiatrist may apply in this setting.

[11]For that matter, it could be argued that when the political climate becomes increasingly conservative, the court may find it necessary to legitimize the imposition of lenient sentences. In such instances, the less restrictive psychiatric recommendations would be accepted by the court more often than the more restrictive recommendations. Nevertheless, the results of previous research (Bohmer, 1976; Campbell, 1981; Woodside, 1976; Bonta, 1981) have suggested that the court is more interested in legitimizing the imposition of serious sentences. Whatever the case may be, if the court is selective in its consideration of recommendations made by the clinic staff, the implication is that the psychiatrist is constrained in the use of his/her expertise by the needs of the court.

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APPENDIX I

DATA COLLECTION SCHEDULE

Schedule Number _____

Department of Sociology
University of Manitoba
Winnipeg, Manitoba

File Study of the
Winnipeg Juvenile Court

CASE IDENTIFICATION SHEET

Probation file number _____

Psychiatric file number _____

FILE STUDY OF THE WINNIPEG JUVENILE COURT

OFFENDER CHARACTERISTICS

Date of birth: _____
year month day

Sex:

1 Male
2 Female
9 Missing

Race:

1 Caucasian
2 Asian
3 Negroid
4 Native
5 Other
9 Missing

Employment status:

1 Employed full-time
2 Employed part-time
3 Unemployed
4 Student
5 Employed full-time/part-time student
6 Employed part-time/student
9 Missing

If full-time student:

Present grade /___/___/
or
13 Remedial class
14 Other (specify) _____
88 N/A
99 Missing

If not a student:

Highest grade /___/___/
or
13 Remedial class

14 Other (specify) _____
88 N/A
99 Missing

Child's living arrangements:

1 Two parents
2 One parent
3 Relative
4 Foster home/group home
5 Institution
6 Independent
7 Married
8 Other
9 Missing

According to statements made by parents/guardians, are they able to control the child:

1 No
2 Yes
9 Missing

Legal status:

1 Parental
2 Temporary CAS or Director
3 Permanent CAS or Director
4 On probation
9 Missing

Parent's occupation:

Mother: _____

Father: _____

CURRENT OFFENCE(S)

Number of offences being disposed of at the same time: _____

Offence:

	Year	Month	Day
Date of offence			
Date of laying charge			
Date of first appearance			
Date of adjudication			
Date of final disposition			

Written description: _____

Number of counts: _____

Seriousness ranking: _____

Charged under:

1 C. C.
2 N. C. A.
3 F. D. A.
4 H. T. A.
5 L. C. A.
6 J. D. A.
7 Other (specify) _____
8 N/A
9 Missing

Section: _____

Subsection: _____

Paragraph: _____

Specify drug offence (note: can be more than one):

1 Cocaine
2 Heroin
3 L.S.D.
4 M.D.H.
5 Marijuana

6 Hashish (cannabis resin)
7 Phencyclidine
8 Other (specify) _____
88 N/A
99 Missing

Who initially made the complaint about the youth:

1 Parents
2 Police
3 Private citizen
4 Social service agency
5 School officials
6 Other (specify) _____
7 Victim
8 N/A
9 Missing

Agency referring child:

1 R.C.M.P.
2 City Police
3 Other (specify) _____
8 N/A
9 Missing

Judge's Number _____

P.O.'s Number _____

Situation prior to court:

1 Detained
2 Not detained
3 Pre-court release
4 Indicated as detention by police, but may be (3)
8 N/A
9 Missing

Plea:

1 Delinquent
2 Not delinquent
3 No plea taken
8 N/A
9 Missing

Represented by counsel:

1 No
2 Yes
8 N/A
9 Missing

Reports requested by judge (note: may be more than one):

Predispositional requirements
1 Predispositional report
2 Other
3 None

Predispositional recommendations
4 Psychiatric assessment
5 Psychological assessment
8 N/A

Adjudication:

1 Found delinquent
2 Dismissed
3 Withdrawn
4 Adjourned sine die (Section 16)
5 Adjourned repatriated
6 Stay of proceedings
7 Unfit to stand trial
8 Transferred to adult court
9 Non-judicial
10 Referred to CAS
11 Referred to Voluntary Class
88 N/A
99 Missing

Number of adjournments:

/ / /
88 N/A
99 Missing

Disposition (note: can be more than one for a single charge):

1 Reprimand
2 Adjourned (Section 20)
3 Conditional discharge
4 Absolute discharge
5 Suspended disposition
6 Probation
7 Fine amount $_____
8 Restitution amount $_____
9 Seven Oaks or Agassiz

10 Other juvenile institution
11 Other (specify) _____
88 N/A
99 Missing

Number of people involved in the offence, excluding juvenile in question:

Adults
0 None
1 One
2 Two
3 Three or more
9 Missing

Juveniles
0 None
1 One
2 Two
3 Three or more
9 Missing

Was there a formal statement made by co-defendent/accomplice regarding the accused:

1 No
2 Yes, it implicated the accused
3 Yes, it cleared the accused
8 N/A
9 Missing

What was the sex of victim 1:

1 Male
2 Female
8 N/A
9 Missing

What was the age of victim 1: _____

What was the prior relationship between victim 1 and the offender:

1 Family
2 Friend or acquaintance
3 Stranger
8 N/A
9 Missing

Is any information available concerning the preferences of victim 1 (specify):

_____

_____

What was the sex of victim 2:

1 Male
2 Female
3 N/A
9 Missing

What was the age of victim 2: _____

What was the prior relationship between victim 2 and the offender:

1 Family
2 Friend or acquaintance
3 Stranger
8 N/A
9 Missing

Is any information available concerning the preferences of victim 2 (specify):

_____

_____

Was stolen property recovered:

1 No
2 Yes, partially recovered
3 Yes, totally recovered
4 Yes, recovered but damaged
8 N/A
9 Missing

Was eyewitness identification available:

1 No
2 Yes
8 N/A
9 Missing

Was there any evidence presented which cleared the juvenile:

1 No
2 Yes
8 N/A
9 Missing

FOR ALL CURRENT OFFENCES

Was Violence Used:

By Offender

1 No
2 Yes
9 Missing

By Co-Offender(s)

1 No
2 Yes
8 N/A
9 Missing

Were weapons used:

1 No
2 Yes, by offender
3 Yes, by co-offender(s)
4 Yes, by offender and co-offender(s)
9 Missing

If yes, was weapon(s) recovered:

1 No
2 Yes
8 N/A
9 Missing

PRIOR RECORD

Previously adjudicated delinquent:

1 No
2 Yes
9 Missing

Has youth ever been detained before:

1 No
2 Yes
9 Missing

Has youth ever been on probation:

1 No
2 Yes
9 Missing

Has juvenile ever been transferred to adult court:

1 No
2 Yes
9 Missing

Has juvenile ever been declared unfit to stand trial:

1 No
2 Yes
9 Missing

Number of prior charges including number of counts (whether found delinquent or not delinquent)

_____

How many were:

nonjudicial _____

CAS _____

Voluntary class _____

Number of prior charges including number of counts (found or admit delinquency)

_____

Of all these previous charges, how many were:

Property related _____

Person related _____

Status _____

Other _____

For the two most serious prior offences:

First Offence

Written description: _____

Seriousness ranking: _____

Number of counts: _____

Charged under:

1 C. C.
2 N. C. A.
3 F. D. A.
4 H. T. A.
5 L. C. A.
6 J. D. A.
7 Other (specify) _____
8 N/A

Section: _____

Subsection: _____

Paragraph: _____

Plea:

1 Delinquent
2 Not delinquent
3 No plea taken
8 N/A
9 Missing

Outcome (note: may be more than one):

1 Reprimand
2 Adjourned
3 Conditional discharge
4 Absolute discharge
5 Suspended final disposition
6 Probation
7 Fine amount $_____
8 Restitution amount $_____
9 Seven Oaks or Agassiz
10 Other juvenile institution
11 Other (specify) _____
12 Non-judicial

13 Referred to CAS
14 Referred to Voluntary Class
15 Stay of proceedings

Second Offence

Written description: _____

Seriousness ranking: _____

Number of counts: _____

Charged under:

1 C. C.
2. N. C. A.
3 F. D. A.
4 H. T. A.
5 L. C. A.
6 J. D. A.
7 Other (specify) _____
8 N/A

Section: _____

Subsection: _____

Paragraph: _____

Plea:

1 Delinquent
2 Not delinquent
3 No plea taken
8 N/A
9 Missing

Outcome (note: may be more than one):

1 Reprimand
2 Adjourned
3 Conditional discharge
4 Absolute discharge
5 Suspended final disposition
6 Probation
7 Fine amount $_____
8 Restitution amount $_____
9 Seven Oaks or Agassiz
10 Other juvenile institution
11 Other (specify) _____
12 Non-judicial
13 Referred to CAS
14 Referred to Voluntary Class

15 Stay of proceedings

INFORMATION

Describe as many as are in the file.

Non-judicial Summary

1 No
2 Yes

Sources of information:

1 Subject
2 Mother
3 Father
4 Police reports
5 Probation file
6 Other (specify) _____
7 Other (specify) _____
8 N/A
9 Missing

Was demeanor noted:

1 No
2 Yes, positive
3 Yes, neutral
4 Yes, negative
8 N/A
9 Missing

Pre-disposition report (short form)

1 No
2 Yes, 1 report
3 Yes, more than 1 report

Length _____ pages

Sources of information:

1 Subject
2 Mother
3 Father
4 Police reports
5 Probation file
6 Other (specify) _____
7 Other (specify) _____

8 N/A
9 Missing

Assessment (recommendation) (only if related to current offence):

_____

_____

_____

Was demeanor used:

1 No
2 Yes, positive
3 Yes, neutral
4 Yes, negative
8 N/A
9 Missing

Pre-disposition report (comprehensive)

1 No
2 Yes

Length _____ pages

Source of information:

1 Subject
2 Mother
3 Father
4 Police report
5 Probation file
6 Other (specify) _____
7 Other (specify) _____
8 N/A
9 Missing

Assessment (recommendation) (only if related to current offence)

_____

_____

_____

Was demeanor noted:

1 No

2 Yes, positive
3 Yes, neutral
4 Yes, negative
8 N/A
9 Missing

Psychiatric Report

1 No
2 Yes

Length _____ pages

Prepared by _____

Source of information:

1 Subject
2 Mother
3 Father
4 Police report
5 Pre-disposition report
6 Other (specify) _____
7 Other (specify) _____
8 N/A
9 Missing

Assessment (recommendation) (only if related to current offence)

_____

_____

_____

Psychological Report

1 No
2 Yes

Length _____ pages

Prepared by _____

Sources of information:

1 Subject
2 Mother
3 Father
4 Police report

5 Pre-disposition report
6 WISC
7 G-H Drawing
8 Other (specify) _____
9 Other (specify) _____
88 N/A
99 Missing

Assessment (recommendation) (only if related to current offence)

_____

_____

_____

Other Reports

1 No
2 Yes

Type _____

Number _____