DELINQUENT CHILDREN IN JUVENILE CORRECTIONAL INSTITUTIONS

State Administered Reception and Diagnostic Centers

Compiled and Edited by

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With a Foreword by

JAMES W. SYMINGTON
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Juvenile Delinquency and
Youth Crime

Describes a new type of state juvenile institution, the Reception and Diagnostic Center which is already playing a vital role in the diagnosis and care of delinquent children. The contributors include material on the history and philosophy of these centers and describe in detail how the various mental health disciplines of psychiatry, psychology, and social work are utilized in the diagnostic process.

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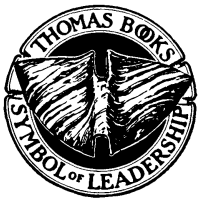

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DEDICATION

This book is dedicated to the memory of Thomas J. S. Waxter, Director of the State Department of Public Welfare of Maryland from 1953 until his untimely death in 1963. "Jake," as he was called by his many friends and admirers, was intensely interested in the problems and needs of maladjusted children and youth. He provided impetus to the development of the Maryland and the national programs in the war against delinquency.

Lawyer, administrator, humanitarian, and gentleman, "Jake" left an impressive legacy. His life in service to children should inspire those of us still active in youth work and those readying themselves for careers in the field of juvenile corrections.

FOREWORD

DURING THE PAST decade, juvenile delinquency has steadily increased in our society and public concern has mounted proportionately. This concern, so recently re-emphasized by President Johnson, was indicated by President Kennedy when he appointed the President's Committee on Juvenile Delinquency in May of 1961. Since that time, much has been accomplished. Federal funds have been expended for the training of correctional personnel and for demonstration projects in the prevention of delinquency and the rehabilitation of delinquent children. A review of the evidence of rising delinquency, however, makes it clear that the national effort to prevent and control it must be intensified in the years ahead.

A welcome development has been the growing determination of state governments to expand and coordinate their juvenile delinquency programs. The subject matter of this book is a discussion of the resources and services of a relatively new type of facility for the diagnosis of delinquent youth—the reception and diagnostic center. Only a few such facilities exist at the present time; many more are needed since they serve an extremely vital function in delinquency control. Many, if not most, dangerous and seriously maladjusted delinquent children who come to the official attention of the police and the courts are placed in institutions which detain more effectively than they diagnose and treat. Society is and should be concerned about the rate of recidivism among young offenders. It is inconsistent not to be equally concerned over inadequacies in diagnosis and treatment that result in recidivism.

At present there is no vaccination to "prevent" delinquency or no pill to "cure" it. Its "causes," multiple, complex and

inter-related, remain veiled. And prevention and cure must mark time until the veil is lifted by diagnosis. This is why the twelve states which have established such centers are to be commended and why the remainder should be encouraged to join them. I am confident that this book will provide just such encouragement.

JAMES W. SYMINGTON
Executive Director
President's Committee on Juvenile Delinquency and Youth Crime

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THE EDITORS WISH to express their warmest thanks to Miss Shirley Smith, Mrs. Josephine V. Angarita, and Miss Mary A. Sturm, the efficient manuscript typists. Appreciation is extended to the U. S. Children's Bureau and to Miss Esther Bubley for the use of some of the photographs. Particular thanks are extended to the gentlemen who contributed chapters and generously provided additional photographs, suggestions, and the time and effort which made this book possible.

W.E.A.
R.L.M.

CONTENTS

DELINQUENT CHILDREN IN JUVENILE CORRECTIONAL INSTITUTIONS

Chapter I

INTRODUCTION

William E. Amos and Raymond L. Manella

IN ITS MARCH 10, 1965 issue, the *Washington Post*, a leading newspaper in the nations capital, carried the following story on criminal activity in America.

> Serious crime increased 13% in the United States last year, as compared with a 10% increase the previous year, the FBI reported yesterday. This meant an increase of more than 250,000 serious offenses in 1964. Southern states had the greatest overall increase—17%. Northeastern and Western states had increases of 13% each and the North Central states were up 10½%. The sharpest increase again was in the suburbs. They had 18% more serious crime than in 1963. Cities with 100,000 or more population were up 11%. Rural areas had a 9% increase, mostly in crimes against property. All serious crime showed an increase. Nationally, murder was up 9%, forcible rape 19%, aggravated assault 18% and robbery 12%. Property crimes continued their upward trend with increases of 12% in burgulary, 13% in larceny of $50 and over, and 16% in auto theft. **There was a 13% jump in arrests of persons under 18 years of age. The juvenile population aged 10 through 17 increased by 4%.** While an increase in police strength is not the sole answer to the crime problem, the need is apparent in many areas, the report said. The preliminary report showed that in 18 cities of 500,000 to one million population, including Washington, the average rate of serious crime increase was 13%.

Another federal agency which publishes delinquency statistics is the United States Children's Bureau, which reported that the number of cases involving delinquent children (excluding traffic)

totaled about 601,000 in 1963. The Bureau revealed that the increase in delinquency cases in 1963 over 1962 was 8 per cent. The child population in America 10 to 17 years of age increased 4 per cent. Thus, the trend continued upward as it had each year beginning with 1949, except for 1961. Again, as in most previous years in the past decade, the increase in delinquency cases exceeded the increase in the child population 10 to 17 years of age.

Police arrests of children under 18 totaled about 1,200,000 in 1964, exclusive of traffic cases (except for those driving while intoxicated). Experts estimate that if present trends continue, as many as three million children under 18 in America will have appeared before the courts by 1970, charged with some type of non-traffic offense.

Institutional superintendents, judges, law enforcement officials, probation, parole and correctional administrators report that delinquency is not only increasing in terms of the absolute numbers of children involved, but in addition, the children are more difficult to control and contain than ever before. The number of delinquent children who pose a serious threat to the welfare and security of the community is larger than at any other time. In 1965, in response to pressure from an aroused citizenry, a Commission on Crime and Law Enforcement was appointed by the President to probe the dimensions of the problems of delinquency and crime in the United States and directed to prepare recommendations for action.

Much is being done by federal, state and local governments in attacking the problem of juvenile delinquency. New institutions are being built, new legislation enacted, and additional staff employed to man police, probation, detention, institutional, prevention and aftercare programs. Much thought and effort are being given to the demonstration of new prevention and treatment approaches, with a great deal of money being invested not only in these demonstrations, but also in research and training areas. Private foundations as well as federal, state and local governments are providing funds for similar activities, which are extremely varied in nature. Some have taken on major proportions and implications for the future of delinquency control in the United States.

The purpose of this chapter is to discuss—against a back drop of increasing crime and delinquency in the United States—the emergence and the nature of a new type of juvenile institution—the state administered reception and diagnostic center. In addition to historical facets, the authors discuss some of the philosophical aspects underlying these centers. Information is included regarding the location of these institutions, selected general and specific characteristics, their official names, location, capacities, and whether they are co-educational. Reference is made to the process within states which sometimes leads to the establishment of these centers. Although a number of juvenile correctional institutions, such as training schools, operate reception and diagnostic units on their campuses, this chapter does not include any detailed discussion of them.

Because of their importance, various legal and administrative aspects regarding state administered reception and diagnostic centers are discussed in Chapter IX. However, before presenting information regarding the general and specific characteristics of these residential juvenile institutions for delinquent children, it is necessary to set forth briefly the rationale upon which state governments based their decisions to construct and operate these specialized institutions.

Generally speaking, the state legislatures which enacted the legislation and appropriated funds for the construction and operation of reception and diagnostic centers did so upon the urging of jurists, correctional experts, citizen leaders, and both state and national correctional organizations. Legislative commissions, press, and public argue that the prevention and control of delinquency cannot be effective unless a state agency is created with sufficient authority, facilities, staff and resources to provide for the proper diagnosis, classification, assignment, and treatment of delinquent children—regardless of where they happen to reside in the state. It was concluded that the old patterns would not suffice. Diagnosing and treating the delinquent child had depended upon local municipal or county government involvement with autonomous institutions, and a crazy-quilt pattern of services ranging from their nonexistence in some rural counties and cities to a few richly equipped municipal or county programs. The key to this new approach is the provision for the orderly

diagnosis and treatment of delinquent children by a single state agency, their classification into appropriate treatment categories, and their rehabilitation both in institutions and in the community following release under aftercare supervision.

California was the first state to experiment with reception and diagnostic facilities for juveniles. Between the passage of the Youth Corrections Act and the opening in 1947 of the Northern Reception Center and Clinic just outside Sacramento, the Youth Authority established a reception and diagnostic unit in one of the juvenile institutions. Minnesota operated a cottage at the Red Wing Training Schools as a reception and diagnostic center from 1947 until the opening of its new center at Lino Lakes in 1963. The centers in Washington, Michigan, Wisconsin, Maryland, Illinois, and Ohio were opened in the 1950's and 1960's.

An inventory on March 1, 1965, revealed that twelve states were operating reception or diagnostic centers for delinquent children. The findings of the inventory are as follows, with the dates of establishment in parenthesis.

In California, the Department of the Youth Authority operates two institutions; the Southern California Reception Center and Clinic for boys at Norwalk (1954) with a capacity of 340 beds and the coeducational Northern California Reception Center and Clinic at Perkins (1954) with a capacity of 270 beds (214 for boys, 56 for girls).

In Illinois, the Illinois Youth Commission administers two reception and diagnostic centers; the Illinois State Training School for Girls and Reception Center for Girls at Geneva, with a capacity of 275 beds, and the Reception and Diagnostic Center for Boys at Joliet, with a capacity of 216 beds (1959).

In Kentucky, the Department of Child Welfare operates a coeducational State Reception Center at Lyndon, with a capacity of 100 beds (1956).

In Maryland, the Department of Public Welfare operates the Maryland Children's Center at Arbutus, with a capacity of 50 beds (1959), and the Thomas J. S. Waxter Center near Laurel, Maryland, with a capacity of 40 beds (1962).

In Massachusetts, the State Department of Education (Youth Services Board) operates two institutions: the Reception-

Detention Center for Boys in Boston (1955), with a capacity of 100 beds, and the Reception-Detention Center for Girls in Boston (1957), with a capacity of 30 beds.

In Michigan, the State Department of Social Welfare operates, at Whitmore Lake, a Reception and Diagnostic Unit, near the Boys' Training School, with a capacity of 62 beds (1962.

In Minnesota, the Department of Corrections operates the coeducational Lino Lakes Central Reception and Diagnostic Center at Circle Pines (1963), with a capacity of 144 beds (48 for girls and 96 for boys).

In New Jersey, the Department of Institutions and Agencies operates the Diagnostic Center at Menlo Park, with a capacity of 90 beds.

In Ohio, the Youth Commission operates the coeducational Juvenile Diagnostic Center at Columbus, with a capacity of 367 beds, of which 275 are used for diagnostic cases.

In Texas, the Texas Youth Council operates a Reception-Diagnostic Center for Boys at Gatesville, with a capacity of 177 beds (1963).

In Washington, the State Department of Institutions operates two coeducational centers; the Ft. Worden Diagnostic and Treatment Center at Port Townsend (1956), with a capacity of 260 beds, of which 140 are for diagnosis, and the Juvenile Reception-Diagnostic Center at Tacoma (1963), with a capacity of 200 beds, of which 150 are for boys and 50 for girls.

In Wisconsin, the Department of Public Welfare operates two reception and diagnostic centers: the Wisconsin School for Boys at Wales, and the Wisconsin School for Girls at Oregon.

The juvenile institutions vary considerably from state to state in terms of size, architecture, location, functions, and the manner in which they are staffed and organized. More detail relating to the content of enabling legislation, internal administration of these institutions, and the way in which they fit into the overall governmental organization is provided in the chapter on the juvenile court (Chapter IX).

No uniform architectural concept governs the design of these facilities. Most are provided, however, with exterior and interior architectural restraints such as security doors, window sashes and screens, fences or walls, security equipment and

hardware. The state officials who manage these institutions seem to agree that security architecture is required. They cite as major reasons the heavy flow of children in and out, the lack of information about these delinquents, some of whom are quite dangerous and poor security risks, the necessity of retaining them in custody for observation and study purposes, the protection of the delinquents and the community, as well as the need to relieve staff of watchdog and custodial duties. In terms of architecture and staffing, these centers resemble the detention centers in some of the large cities and urban counties of America. In his book, *Detention Practice*,[1] Sherwood Norman discusses these institutions, some of which provide diagnostic services to delinquents.

In terms of specic functions not directly related to reception-diagnosis, these institutions vary a great deal. Some attempt short-term treatment. A few accept children for overnight detention without study. Some detain children awaiting transfer to another institution or return to another jurisdiction. One or two have developed research and staff training programs. The average length of stay for delinquents admitted varies from a few days to three months or longer. Some of these centers are richly staffed with medical and allied personnel. The centers in California operate small hospitals which serve not only the children being diagnosed, but children requiring medical or dental care transferred from other correctional institutions in the state system.

In Minnesota, Illinois, and California, the juvenile paroling authorities meet at the reception centers and make decisions regarding the planning, the placement, and the parole or revocation of parole of delinquent children. The centers usually admit juvenile parole violators or recidivists.

The more generously staffed centers show a ratio of one full time employee for every child under care on a given day. Annual operating costs vary considerably, with the most expensive single variable being that of staff. Costs of over $6,000 a year per bed are not uncommon. In 1960, California reported an opera-

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[1] Sherwood Norman: *Detention Practice*. National Council on Crime and Delinquency, 44 East 23rd Street, New York, New York.

tional budget of $1,300,000 for a reception center clinic which averaged 338 delinquents—294 boys and 44 girls. This meant that with an average stay of 6 weeks, the cost approximated $544 per child. Costs have risen considerably since then. In New Jersey costs average between $20 to $25 a day per child or over $8,000 a year per bed.

Construction costs vary considerably. They tend to be higher than for other types of juvenile institutions with the exception of some detention and security facilities. Square footage costs have exceeded $25 in some institutions, while per bed costs have exceeded $20,000. Security architecture, site acquisition costs, the provision of special facilities, specially designed equipment, furnishings and other factors contribute to these construction costs. The publication previously mentioned, *Detention Practice*, provides much valuable information regarding municipal and county detention centers which feature some of the architecture found in state reception and diagnostic centers.

It would require a separate book to discuss in detail all the variations and similarities which are encountered in making a study of America's state reception and diagnostic centers. Some administrators believe in a rich educational program for delinquents held at these centers during their diagnosis. Others do not. One school of thought contends that the diagnostic experience should be as short as possible and every effort made to complete the study within 3 weeks. In other states a longer period of up to 3 months is felt to be essential.

A few common features are worthy of mention. All these juvenile institutions are administered by state governments. All are residential, although a few do offer limited, non-resident diagnostic services to courts, agencies, and parents. In terms of architecture, the trend is toward the construction of single story buildings with, as pointed out above, secure custody architecture. The living units for children are usually limited to no more than 20 beds. Single rooms are provided for sleeping and recreational uses, and central food service, educational, religious, medical, and clinical facilities are provided. Outside play areas are enclosed by fences or walls. Liberal space provisions are made

for offices, conference rooms, storage and mechanical-electrical control systems.

One of the issues regarding these reception and diagnostic institutions is whether they exert any therapeutic impact. One group contends that because of the short stay and other factors, they do not and should not be operated on treatment basis. Most administrators of reception and diagnostic institutions contend that any institutional experience for a delinquent child, no matter how short, is potentially therapeutic or destructive. The editors agree with the latter school of thought since confinement of a delinquent child in a secure custody institution is a crucial legal, social, and psychological matter. To ignore the therapeutic aspect and potential of the experience would handicap effective diagnosis and rehabilitation. It is known that failure to apply knowledge and skills at any level in the rehabilitative process—for both children and adult offenders—can reinforce rather than weaken the criminal or delinquent behavior patterns acquired. The argument as to whether the diagnostic experience carries any major treatment potential is expressed clearly by Dr. William Healy in the following statement:

> Moreover, by its very rationality and fairness, it (the diagnostic period) makes a deep impression upon the offender, and this is part and parcel of the treatment process. But, it must not be supposed that this is the end of all diagnosis of the individual's needs. In the institution to which he is sent it may be discovered that he has certain special needs—for some particular kind of physical up-building, for the development of some interests or capabilities that have come to light, and very often for the unburdening of emotional conflicts about himself or his family. These findings partake of the nature of a continuing diagnostic study.[2]

Much thought, time, effort, and money have been expended in an effort to type delinquents. Unless correctional workers know what is causing the social and psychological maladjustment of delinquent children, effective treatment cannot be provided. Much confusion and disagreement exist as sociologists,

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[2] William Healy: "Principles of Diagnosis, Treatment and Prognosis." *Law and Contemporary Problems,* Duke University School of Law, Vol. IX, No. 4, 1962, p. 688.

psychiatrists, anthropologists, social workers, educators, and jurists, as well as other behavioral and legal experts, propose solutions. One frustrating observation is that a great deal of the knowledge and experience which have been accumulated in the field of juvenile corrections over the past half century by social scientists and clinicians is being ignored or ineffectively applied.

Many correctional officials, jurists, and criminologists feel that reception and diagnostic centers can meet the problem and are an essential feature of modern state juvenile correctional programs. They reason that the centers are an effective means for receiving, diagnosing and classifying delinquents, and represent the second step in the process of rehabilitation. Since a major stumbling block to the solution of the problem of juvenile delinquency in America has been the failure to formulate a general theory of causation, the emergence of state agencies and state reception and diagnostic centers represents to many experts a major step forward in the quest for such a general theory.

The proponents of state administered reception and diagnostic centers assert that these institutions provide more effective procedures for controlling, diagnosing, classifying, and treating delinquent youth. They contend that the centers can play a strategic role in the total community program for the prevention and correction of delinquency. Further, they can serve as research and training centers and provide a means for bringing together the various disciplines and applying the accumulated knowledge about delinquency. These institutions also provide a means for planning the individual treatment of children adjudged delinquent—regardless of whether they live in highly industrialized and culturally complex, densely populated urban centers, or whether they come from sparsely settled, rural culture communities. Such centers provide a means for the judicial and administrative agencies of state government to better plan, coordinate, and administer delinquency control programs. In addition, large capital as well as operational savings can result from the establishment of these centers. Lastly, they can prevent institutional recidivism and contribute new effectiveness to the more conventional institutional and community programs for

the care of delinquent children by accurately diagnosing and assigning them to programs which will meet their needs on an individualized basis.

Opposition to the state reception and diagnostic center concept is substantial. Many judges, criminologists, legislators, agency and institutional administrators do not favor their establishment for various reasons. They contend that it is inadvisable to construct separate state institutions for the reception and diagnosis of delinquent children since this can be better done at the city or county level, and by existing agencies at less expense. They argue that placing a child in a reception and diagnostic institution hundreds of miles away from his local community, after he has already been diagnosed by local clinicians, is most expensive because it duplicates both capital and operational expenses. Alternatives have been developed such as those in Maryland where the courts commit some delinquents who must be removed from the community directly to state institutions classified by the Welfare Department on the basis of sex, age, and type of program offered. The courts commit on the basis of written institutional classification criteria supplied by the Welfare Department. After initial commitment, the Department is empowered to transfer and release delinquents at its discretion. This raises the issue of court versus administrative agency in the planning and administration of services and facilities for delinquent children.

With the large increase in the numbers of delinquent children being arrested, appearing before the courts and institutionalized in America since 1945, a pronounced trend is evident in the direction of state governments establishing fuller programs for delinquency control services. For many years the role of the state governments in the field of delinquency control had been restricted to the supervision or administration of state institutions such as training schools, and subsidizing or licensing voluntary institutions. In recent years, many states have expanded their programs and now administer a variety of prevention, diagnostic, and treatment programs of both an institutional and community nature. This is a significant development in American juvenile corrections. The United States Children's Bureau, the National

Council on Crime and Delinquency, the National Association of Training Schools and Juvenile Agencies and other organizations advocate the creation of a single state agency for the administration of most services for the prevention, control, and treatment of juvenile delinquency. Detention, police services, aftercare, mental health, diagnostic, foster care, and welfare services are included. Probation is left, however, with the courts, even though the American Law Institutes Model Corrections Act placed probation in the state authority.

In some states, the factors of population, size, and the distribution of the population play roles in determining the extent to which the state rather than the local governments becomes involved in overall delinquency control programs. In states where the population is concentrated in urban areas and prevention and treatment programs have been highly developed, many times under the driving impetus of a juvenile court judge, the state government plays a different role. Some of these urban programs serve populations in excess of 3,000,000 people and an elaborate network of local level services for delinquents has been developed. In these instances, the state government plays a supporting role, makes available construction and operational subsidies, provides consultation, carries on research, licenses and sets standards for probation, police, detention, institutional, child welfare, educational and other services for delinquents. It also provides a coordinating function and is involved in the training of correctional workers.

The emergence in the last quarter century of state reception and diagnostic centers for delinquents in the United States resulted from a number of developments here and abroad. Long before many state governments were caring for delinquent children, the most significant legal event in the history of juvenile corrections took place in Cook County, Illinois, in 1899, when the first juvenile court was established. Roscoe Pound, the eminent jurist, referred to this as "the most important event in the administration of justice since Magna Carta."[3]

The legislation creating the Cook County Juvenile Court

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[3] Roscoe Pound: "The Juvenile Court and the Law," *Yearbook,* National Probation Association, 1944, p. 13.

introduced into our general state laws a special legal status for children charged with having committed delinquent and criminal acts. Juvenile courts were created as non-criminal and equity courts and given exclusive and original jursidiction in many delinquent cases. Any person who appeared before them and was found to be a delinquent child was granted a number of legal protections not applicable to adult offenders. The child became a ward of the state by order of the court which found him delinquent. The court, which was bound by law to proceed in a nonpunitive, protective manner, was obliged to seek an understanding of the causes of the delinquent behavior and to order such disposition of the case as to be in the best interests of the child as well as the society he had offended. Juvenile courts have subsequently focused more direct attention upon diagnosing the individual needs and problems of the child as well as in considering the offenses he committed. The juvenile court became a court of individualized and socialized justice.

Soon after establishment, the more progressive juvenile courts turned to the behavioral disciplines for assistance in achieving a better understanding of the children who appeared before them. Medicine, psychiatry, psychology, social work, education, and sociology were seen as essential supporting disciplines to the court in its legal, diagnostic, and treatment role. In keeping with developments in the field of mental health, "clinics" made their appearance.

Some clinics were established directly by the courts and located physically within the court or detention building or operated under voluntary or public auspices outside the administrative control of the court. Many courts continue to operate or use such clinics. The mental health team approach is generally utilized today. A "team" of clinicians representing the various disciplines conduct examination of a child and "work up" a full report on those medical, psychiatric, and family-community factors which provide a "profile" of the child and his needs. As courts became oriented towards the behavioral disciplines, they employed men and women generally called probation officers, who worked closely with the judge, the clinical team, and community agencies. Probation officers play key roles in

the diagnostic process in most jurisdictions. Professional training in social work is considered by most correctional experts as a minimum training requirement for probation and juvenile parole officers.

Another event of historic significance occurred in 1825, when the first House of Refuge was established in New York City.[4]

This enabled children charged with criminal acts to be separated from adult offenders. This was followed by the opening by municipal, county, state, and voluntary agencies of a number of institutions serving delinquent children exclusively. The larger of these institutions established procedures to properly receive, diagnose, and classify the children and to place them in cottages or living units. This process became known as *internal institutional classification.* Some training schools receiving hundreds of delinquent children each year developed this internal institutional classification system to a high degree. Since it was known that delinquent children vary considerably in their chronological, physical, social, psychological and educational characteristics, needs and problems, a study of each child was made after admission in order to roughly identify and classify the mentally ill, the retarded, those of normal intelligence and amenable to academic-vocational type programs found in community schools, and neglected children. Older "hard core" delinquents, most in the habitual recidivist category and sophisticated in their criminality, were also identified and classified. A special cottage, a reception-orientation building, or a unit in the institutional hospital was designated as the reception-orientation unit. Children spent up to 6 weeks in these special units. Today, however, superintendents disagree as to whether a separate building is required for the reception-diagnostic orientation program in a training school. Some of the large state juvenile institutions were constructed as decentralized, cottage plan facilities. This architecture made it possible to assign a special cottage the reception-study function. Children were then transferred after reception-diagnosis to regular cottages.

The employment of larger numbers of professional clinical

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[4] Paul W. Tappan: *Juvenile Delinquency.* New York, McGraw-Hill, 1949, p. 392.