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JUVENILE COURT IMPLEMENTATION OF CHILD GUIDANCE CLINIC RECOMMENDATIONS

A Study of Seventy-five Children Referred by the Calhoun County Juvenile Court to the Battle Creek Child Guidance Clinic for Diagnoses and Recommendations

by

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II

A PROJECT REPORT

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CHAPTER I

INTRODUCTION

The Problem and Its Selection

This study was made at the Battle Creek Child Guidance Clinic, Calhoun County, Michigan and the Juvenile Court, i.e., Juvenile Division of the Probate Court, of the same county. It was undertaken to determine the value of the diagnostic-consultative services of the Clinic to the Court, as measured by the frequency and under what circumstances the Court follows through on Clinic recommendations and to explore the factors entering into the Court's failure to carry out some of the recommendations made by the Clinic.

For some time the Clinic staff has been interested in ascertaining the helpfulness of its diagnostic-consultative services to the community agencies who request it. The Clinic felt that one way of measuring this helpfulness would be to ascertain to what extent the community agencies do carry out the recommendations suggested by the Clinic. Such an approach was regarded as particularly useful by the Clinic's director, Mr. Samuel Lerner, and was agreed upon as the method that was most feasible and practical. Due to the limited time, the writer was able to study only one of these other community agencies and chose the Juvenile Court because of her special interest in this area. The writer therefore

conferred with the probate judge and the juvenile court referree and obtained their permission to study the Court's records in the cases involved.

The cases studied were referred by the Juvenile Court to the Clinic during the period from June 1, 1956 through September 30, 1958. Generally, the Court's request fell into either of two of the following categories: (1) a request for diagnosis and recommendations, or (2) for support of the Court's own recommendations. It was first assumed that the Court would not be able to carry out all of the Clinic's recommendations. It was also assumed that through a study of cases in which the Clinic's recommendations were not carried out by the Court, reasons for the lack of their implementation of those recommendations could be identified. It was further assumed that there were some practical reasons for the Court's inability to follow through on some recommendations, and that if the reasons were made known to both agencies, measures could be taken to correct the situation. September 30, 1958 was selected as the ending date of the period of the study on the assumption that a period of at least six months would be necessary, in many cases, for the Court to implement the recommendations.

The purpose of this study was not to use the basis of the effectiveness of the child's adjustment subsequent to the Court following through with the Clinic's recommendations as a measure of the effectiveness of the Clinic's

service. This would have involved a follow-up study which time did not permit. However, it was decided that whenever Court records indicated the adjustment or whereabouts of the child following the final Court disposition, this information would be obtained since it would give some indication of the usefulness or validity of the recommendations which the Clinic made.

The following questions were considered in this study:

What were the age, sex and problem characteristics of the children who were referred to the Clinic by the Court? What types of services did the Court request for these children? How did the Clinic arrive at its recommendations? What was the relationship between the referral problem as stated by the Court and the diagnoses and recommendations made by the Clinic? Was the Court willing and able to carry out these recommendations? What were some of the reasons involved when the Court was unable to carry out the recommendations? Were factors such as race, sex, age or nature of diagnosis related to whether or not the Court was able to act in accordance with the recommendations made by the Clinic? Were other factors involved which were extrinsic to the children's characteristics and problems? What should the Clinic consider in making its recommendations that it is not now considering?

Setting

1. The Clinic. The Battle Creek Child Guidance Clinic is one of seventeen clinics in the state of Michigan under the Michigan Department of Mental Health which were established to offer "early preventive services and treatment to help disturbed children develop healthier and happier personalities."[1] This service includes diagnosis and treatment of children and their parents and "consultation to parents, schools, physicians and any person or agency who may work directly with children in relation to the emotional and personality problems of children."[2]

The Clinic was established in February, 1952 and serves Calhoun and Branch counties in Michigan. Prior to its establishment, these two counties were serviced, along with seven other counties, by Kalamazoo Child Guidance Clinic. Efforts to establish the Battle Creek Clinic began in the 1940's when it became apparent that much more clinical service was needed than the Kalamazoo Clinic was able to provide.

Calhoun and Branch Counties are primarily rural areas and have a combined estimated population of 163,000.[3] Battle

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[1] Battle Creek Child Guidance Clinic, a pamphlet sponsored by the Michigan Department of Mental Health and the Board of Directors of the Clinic. p. 2.

[2] Ibid.

[3] According to the Battle Creek Chamber of Commerce obtained April 10, 1959.

Creek (Calhoun County) is the largest city in the two counties and has a population in its metropolitan area of more than 100,000.[4] Other major cities are Marshall, the county seat of Calhoun County, which has a population of about 5,777;[5] Albion, a factory town, which also contains a small college; and Coldwater, the county seat of Branch County and the location of a state home and training school for the mentally retarded.

The present staff of the Clinic consists of the director who is a psychiatric social worker, a staff psychiatrist who comes to the Clinic on a four-day-a-week basis, two clinical psychologists, five psychiatric social workers, one of whom works part-time, a bookkeeper-receptionist, a secretary-dictaphone operator, and two other dictaphone operators. In December, 1958, the Clinic began using the services of a psychiatrist at Children's Psychiatric Hospital, Ann Arbor, for treatment consultation.[6]

Referral to the Clinic consists of a letter or telephone call. Following this, the Clinic makes an appointment for the screening interview with a psychiatric social worker or a psychologist. The screening interviewer then arranges

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[4] Ibid., Battle Creek Chamber of Commerce.

[5] Ibid., Battle Creek Chamber of Commerce.

[6] The Battle Creek Child Guidance Clinic Annual Report, 1959, p. 1.

for the child to have a psychological test and/or a psychiatric diagnostic examination, whichever is indicated.

Because the staff is larger than it has been at any other period of the Clinic's history, the waiting period for initial diagnostic study has been greatly reduced, although there is still a waiting period between the completion of the diagnostic study and the time that treatment can be initiated. Following the diagnostic study, the staff confers to decide whether the case will be placed on the treatment waiting list or referred to another agency, or whether recommendations for other types of treatment will be made to the appropriate referring sources.

Sources of referral of cases to the Clinic which were opened during 1957 and 1958, were as follows:[7]

Source	1957	1958
Parents	104	142
Schools	49	108
Courts and Police	39	50
Physicians and Health Department	31	68
Social Agencies	22	38
Self	--	3
Other	--	4

2. The Court. The Juvenile Court of Calhoun County is a division of the Probate Court which is located at Marshall, the county seat. Its establishment is based upon a

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[7] Ibid., p. 4.

statute of 1907 in which the probate court of each county in Michigan was given original jurisdiction of dependent, neglected, and delinquent children under the age of seventeen years.[8] By waiver from the Circuit Court, it was also given jurisdiction over wayward minors (children between seventeen and nineteen), but this provision has seldom been used in the last several years.[9]

The Juvenile Court classified the children whom they referred to the Clinic as either dependent and neglected or delinquent. The dependent and neglected children, according to the juvenile code are those children under seventeen years of age within the County:

> (a) whose parent or other person legally responsible for the care and maintenance of each child when able to do so, neglects or refuses to provide proper or necessary support, education as required by law, medical, surgical or other care necessary for his health, morals or well-being, or who is abandoned by his parents, guardian or other custodian or who is otherwise without proper custody or guardianship; or
>
> (b) Whose home or environment, by reason of neglect, cruelty, drunkenness, criminality, or depravity on the part of a parent, guardian or other custodian, is an unfit place for such child to live in, or whose mother is unmarried and without adequate provision for care and support.[10]

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[8] State of Michigan, The Probate Code, Juveniles and Juvenile Divison, Chapter 712-A, Compiled Laws of 1948, p. 55.

[9] "Jurisdiction of Juvenile Division of Probate Courts," Children in Michigan's Juvenile Courts, a Study by the Michigan Crime and Delinquency Council of the NPPA, December, 1957, p. 11.

[10] Ibid., p. 9.

The juvenile code specifies six kinds of delinquency which are under the jurisdiction of juvenile courts:

> Exclusive original jurisdiction superior to and regardless of the jurisdiction of any other court in proceedings concerning any child under seventeen years of age found within the county
>
> (a) Who has violated any municipal ordinance or law of the state or of the United States; or
>
> (b) Who has deserted his home without sufficient cause or who is repeatedly disobedient to the reasonable and lawful commands of his parents, guardian or other custodian; or
>
> (c) Who repeatedly associates with immoral persons, or who is leading an immoral life; or is found on premises occupied or used for illegal purposes; or
>
> (d) Who, being required by law to attend school, wilfully and repeatedly absents himself therefrom, or repeatedly violates rules and regulations thereof; or
>
> (e) Who habitually idles away his or her time; or
>
> (f) Who repeatedly patronizes or frequents any tavern or place where the principal purpose of the business conducted is the sale of alcoholic liquors.[11]

The present staff of the Juvenile Court consists of the probate judge, the juvenile court referee, the director or chief of children's services, five court workers (a county agent, assistant county agent, and three probation officers); the registrar, and the assistant registrar.

The probate judge has been in office since January 1, 1957. The juvenile court referee has been in office since

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[11] Ibid., pp. 8, 9.

January, 1958. Prior to the time that the referee was appointed, the probate judge heard all of the juvenile cases, however, his work schedule limited the amount of time available for hearing juvenile cases. Since the referee took office, the Court became more available to juvenile cases and as a result, there were twice as many new cases seen in Court from January, 1958 to January, 1959 as there were in any previous year. Court hearings for delinquent children were scheduled much earlier than before and as a result, there have been more successes in the outcome of the cases.[12]

The referee hears the majority of the cases involving juveniles who are delinquent or dependent and neglected. The judge hears those cases sometimes also. However, the judge for the most part, hears those juvenile cases involving circuit court waivers and those involving termination of parental rights. The referee's report of the hearing is sent along with recommendations to the judge for his approval. The judge has the right to turn down the recommendations, but when he accepts them, they become orders of the Court.[13]

Few of the children who come to the attention of the Court are referred to the Clinic. As an illustration of this, of the 581 children referred to the Court between July 1, 1957

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[12]From an interview with the Juvenile Court Referee, Mrs. Mary Coleman, on March 30, 1959.

[13]Ibid., Interview with Court Referee.

and June 30, 1958,[14] thirty-two children were referred to the Clinic.

According to the Court referee, the Court neither believes that all children who come to their attention are maladjusted nor that all of them need to be studied or treated at the Clinic.[15] A referral to the Clinic is initiated when the Court believes that the child is mentally retarded, mentally ill, or otherwise emotionally disturbed, or when it does not fully understand the child or his problem.

Referrals may be initiated by either the judge, the referee or by the Court workers. In some instances, the children are referred before the case has been brought to Court for a hearing. In other instances, the referral follows disposition of the case. In the latter type of case, the Court may require the child and his parents to go to the Clinic as a condition for placing the child on probation.

The Court very seldom refers the children directly for treatment because of the long treatment waiting list. Usually the request is for diagnostic evaluations and recommendations.[16]

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[14] Juvenile Court Report, July 1, 1957--June 30, 1958, p. 3.

[15] Interview with Court Referee, March 30, 1959.

[16] Ibid.

There is generally close communication between the Court and the Clinic on the cases which the Court refers. This is particularly true in cases involving delinquent children. As an example of this close communication, a Court worker is sometimes present at the time the Clinic staff formally diagnoses the child's behavior and makes recommendations for the type of treatment for the child.

CHAPTER II

REVIEW OF LITERATURE

History and Current Opinion

A review of the history of the child guidance clinic and the juvenile court shows that they have a common interest in offering children protection and treatment. Eleanor and Sheldon Glueck pointed out that:

> Juvenile courts are traditionally interested in the mental health of the children who appear before them. The very first child guidance clinics grew out of this interest. The Juvenile Psychopathic Institute established by Dr. William Healy and his associates in connection with the Juvenile Court of Chicago in 1909 was the first clinic for child guidance.[1]

The Gluecks further pointed out that the keynote of the juvenile court law is "protection based on understanding rather than punishedment based on the establishment of a technical status of guilt."[2]

Previous to the twentieth century, children in the United States over fourteen years of age, and some between seven and fourteen were punished and confined to jails with adult offenders. They were committed to jail on charges such as vagrancy when their only offense was being destitute

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[1]Sheldon and Eleanor Glueck. One Thousand Juvenile Delinquents, Harvard University Press, Cambridge, Massachusetts, 1939. p. 46.

[2]Ibid., p. 17.

and homeless. The common law was the law under which criminals were tried, and under it children over fourteen were considered as responsible as were adults in committing crime. The protective element of the law, the state as parent (parens patriae), stems from the law of equity as administered in the court of chancery in England.[3]

Various steps led to the creation of the juvenile court in America in early decades of the nineteenth century. One by one, statutes appeared containing certain specific features of a juvenile court such as that of separate confinement and separate hearings and probation. As a result of efforts of the Federation of Women's Clubs in Illinois, the legislature enacted a statute in April, 1899 for the establishment of the first juvenile court--"An Act To Regulate the Treatment and Control of Dependent, Neglected and Delinquent Children."[4]

Judge Harvey Humphrey Baker, the first judge of the Boston Juvenile Court, realized that he and his probation officers needed assistance in studying and diagnosing children brought before the court, before effective treatment could be planned for the children. He died in 1915, but a

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[3]Miriam Van Water, Youth in Conflict, Republic Publishing Co., 1926, pp. 159-160.

[4]Hazel Fredericksen, The Child and His Welfare, San Francisco, W. H. Freeman, c1948. p. 133.

memorial was established under the leadership of his successor, Judge Cabot, in the Judge Baker Foundation organized in April, 1917. Children who presented difficulties were referred to the Foundation, where they were studied medically, psychologically, and socially. Close collaboration was worked out between the foundation, the judge, the probation officers, and other agencies.[5]

Stevenson and Smith stated that the development of the child guidance clinics was advanced in the five year period between 1920 and 1925 when the Division on the Prevention of Delinquency, of the National Committee for Mental Hygiene established demonstration clinics.[6]

In these clinics, the court was at first regarded as a point of psychiatric attack on delinquency, but it was learned in the demonstration at St. Louis and later in other demonstrations, that the children who appeared before the courts are often beyond the stage of prevention, and that other social agencies afford a better medium of approach in preventing delinquency.[7] Stevenson and Smith stated the following:

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[5]Harvey Humphrey Baker, Unbuilder of the Juvenile Court. Published by the Judge Baker Foundation. Boston, Massachusetts, 1920. p. 9.

[6]George S. Stevenson and Geddes Smith, Child Guidance Clinics. The Commonwealth Fund, N. Y., 1934. p. 20.

[7]Ibid., p. 24.

> It was considered early in our experience that child guidance clinics would make possible a much hoped for redirection in juvenile delinquency, and furthermore, that children showing undesirable behavior and personality traits would be helped to achieve such a quality of mental health that they would be saved from serious mental disorder later in life.[8]

Helen Witmer, in discussing the same subject, noted that the original purpose of the demonstration clinics established in 1922, was as follows:

> ". . . showing the juvenile courts and child-caring agencies that psychiatry, psychology, and social work have to offer in connection with the treatment of the 'problem child'; and by properly directive and effective methods of treatment not only to help the individual delinquent to a more promising career but . . . to decrease the amount of delinquencies." It soon became apparent, however, that there were disadvantages to working wholly through the courts and that the most effective preventive work was to be done with children whose misconduct had not yet been accounted legal delinquency. The later clinics were therefore established in connection with hospitals or schools, and referrals were sought from parents, teachers, and social workers.[9]

Hunter, in discussing this subject, suggested two periods or trends of emphasis in the clinic program. The first was from 1909 to 1915 when the clinics were in their early development. Emphasis then was in connection with the Juvenile Court. From 1915 to 1921, he noticed a trend by the clinics to extend service to the entire community instead of only to the court.[10]

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[8] Ibid., p. 10.

[9] Helen Witmer, Psychiatric Clinics for Children. N. Y., The Commonwealth Fund, c1940. pp. 51, 52.

[10] Joel D. Hunter, The Child, The Clinic and The Court. N. Y., New Republic, Inc., 1925. p. 209.

> The best date to set for the change in emphasis for contact with the juvenile court to contact with the community is 1921, for during that year the Commonwealth Fund published its Program for the Prevention of Delinquency which gave national importance to the idea that behavior or conduct of every child was a matter which should be studied and directed.[11]

J. F. Robinson suggested that overwork and other problems were the reasons for the clinic's change of emphasis:

> The clinic became preoccupied with the work that was before them. Innumerable problems presented themselves that did not have a direct affiliation with delinquency or mental disease. Difficulties that appeared, perhaps of a minor nature, because they were much more promising for treatment, and because it was appreciated that they might be serious in their potentialities. The clinical nature of child psychiatry was reassessed. . . .[12]

Many courts had already been using facilities other than the clinic, and some had their own psychiatrists and clinics. This became increasingly more necessary, and today many courts have their own clinics.

Paul Holmer, director of the guidance clinic of Berks County, Reading Pennsylvania, wrote that since the child guidance clinics began working in other areas, they have begun to develop independently of juvenile court work, and many do not even mention delinquency or consider its study important as a part of their function. He felt this to be unfortunate.[13]

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[11] Hunter, op. cit., p. 210.

[12] Franklin Robinson, "Current Trends in Child Guidance Clinics," Mental Hygiene, Vol. 34, 1950. pp. 107-108.

[13] Paul Holmer, "Tying the Clinic with the Court," Probation and Parole Progress, Yearbook, 1941. pp. 167-168.

> It seems to me that the future of both the juvenile court and the child guidance clinic depends on the development of a liaison between the two. I doubt if either agency can function without the participation of the other. Any juvenile court which does not use or does not have available child guidance services most certainly fails to make use of modern techniques for the diagnosis and treatment of behavior disorders in children. The clinic which is uninterested in delinquent behavior arbitrarily deprives a large proportion of children of a service which it is peculiarly suited to provide. Furthermore it is undoubtedly true that many communities unable at present to finance a clinic could do so with additional support from tax funds which the participation of court agencies would insure. It is my conviction that the child guidance clinic and the juvenile court are mutually dependent. Instances frequently arise in dealing with children's cases where the clinic must enlist the aid of the court.[14]

William Kvaraceus also stated that the community that attempts to cope with the individual problems of the delinquent without having the resources of a child guidance clinic close at hand places severe limitations on its program. He felt that the work of the clinic is central to the task of study, diagnosis, and treatment of troubled children.[15] He further felt that there are a number of problems between court and clinic which will have to be resolved before there will be really effective cooperation between the two.

Some of the problems which affect the relations of the clinic and court were pointed out by Kvaraceus. He quoted Samuel Hartwell,[16] director of the Worcester,

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[14]Holmer, op. cit., p. 168.

[15]William C. Kvaraceus, The Community and the Delinquent. N.Y., World Book Co., c1954. p. 215.

[16]Quoted from Samuel W. Hartwell, "The Guidance Clinic and the Court," Federal Probation, XII. September, 1948. pp. 3-7.

Massachusetts Child Guidance Clinic, who said there are a number of criticisms which court officials have concerning the operation of the clinic and that clinics also have complaints concerning the court. Some of these criticisms and complaints were as follows. Court officers complain that the clinics are too slow and too cumbersome in their operations to be of much use; that psychiatrists are too hard to understand; the trouble with the mental hygiene point of view is that it leaves no place for punishment; that the clinical personnel frequently neglect to consider society's welfare; and finally, that the clinic staff by work, look, and deed are highly critical and rejecting as well as professionally snobbish, toward the run-of-the-mill probation officer and the judiciary.[17] The clinic staffs often complain that the probation officer expects too much in the way of fact and direct solutions and hopes to slough off some of his case load; that court personnel are actually untrained and unskilled workers operating in a highly technical field; and that many judges who sit in juvenile courts really do not believe in psychiatric study and treatment and are convinced that the clinical approach seldom does much to help delinquent children. Kvaraceus felt that criticisms on both sides have an element of truth.[18]

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[17] Kvaraceus, op. cit., p. 227.

[18] Ibid.

> Through cooperative effort and a program of inservice training, probation officers may be helped to understand the limitations of the clinical approach. Arrangements for intake particularly in urgent cases can be worked out more effectively so court staffs will not be unrealistic in requesting overnight diagnostic and therapeutic services. The clinic must also face the issue that it does not always concern itself in a realistic manner with achieving an effective balance between individual adjustment and treatment, and the legal framework in which the community operates and within which the delinquent must make an adjustment.[19]

He went on to say that the clinic cannot appoint either judges or probation officers and might therefore attempt to train by precept and example many of the court personnel with whom it comes in daily contact.[20] It is one of the purposes of this study to see if the Battle Creek Child Guidance Clinic is realistic in making its recommendations to the Calhoun County Juvenile Court.

As previously indicated, because some child guidance clinics limit the number of court cases which they will accept, or accept none at all, it is necessary for the court to make other provisions. They must use other resources or establish those of their own. Current literature indicates that many do make use of other facilities. Agnes Donnelly of the Domestic Relations Court at Queens, New York, stated:

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[19] Ibid.

[20] Ibid., p. 228.

> Currently we are not equipped to offer intensive casework, but probation is a clearly defined process based on the constructive use of authority that sets limits on specified kinds of behavior and offers individualized help in building controls to meet those limits. Psychiatric consultation is available in our clinic. . . .[21]

In Guides for Juvenile Court Judges, we find:

> Many of the problems which bring children to the courts attention have their roots in some form of illness, physical or mental--frequently both. Because of this many of the juvenile courts in large urban communities have psychiatrists and pediatricians on their staffs; and those which have none make frequent use of the psychiatric and medical clinics available.[22]

Michael Hakeem wrote that despite the fact that many clinics do not provide services primarily to the court as they used to, the psychiatric approach is still the popular approach to the problem of juvenile delinquency.[23]

It is hoped that the above discussion might prove helpful in encouraging the Clinic and the Court to determine what their mutual roles should be. Perhaps in future studies, the two agencies may want to consider such questions as whether the Court makes full use of the Clinic's services, and if so, whether the Clinic should provide even

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[21]Agnes Donnelly, "Helping the Children in our Courts," Child Welfare, February, 1958. p. 29.

[22]Guides for Juvenile Court Judges, N. Y., National Probation and Parole Association, c1957. p. 9.

[23]Michael Hakeem, "A Critique of the Psychiatric Approach," Juvenile Delinquency, edited by Joseph Roucek, N. Y., Philosophical Library, c1958. p. 80.

more services to the Court. They may also wish to consider whether the Court should refer other children which they have not been referring; whether Court referrals should be given priority in Clinic services; or whether the Court should have a clinic of its own.

Studies Related to the Present Investigation

As the child guidance clinics found difficulty in meeting the problem of delinquency, their diagnostic value to juvenile courts was sometimes questioned. From time to time, studies were made in an effort to find out just what the value of the child guidance clinic is to the juvenile court.

Few of these studies are directly related to the present study in that the present study did not seek to determine the effectiveness of the Clinic in dealing with delinquency. Rather the present study sought to determine the value of the Clinic's service to the Court as seen through the Court's actions with respect to recommendations made by the Clinic regarding the delinquent as well as non-delinquent children which the Court referred.

A portion of the Gluecks study is related to the present investigation. The Gluecks studied the outcome of one thousand juvenile delinquents who were referred to the Judge Baker Foundation for diagnosis and recommendations concerning treatment. Their study showed that the court

carried out vocational recommendations most frequently and those having to do with changing family and living conditions less frequently.[24] Non-compliance with recommendations was mainly due to situations beyond the control of both the court and the clinic. Among these reasons for non-compliance were legal technicalities, such as lack of the legal right of the court to force parents to pay for support of the child on placement; limited resources or skills of probation officers; lack of parental cooperation, non-cooperation or inability of other social agencies to aid the court; and lack of cooperation of the probationer.[25]

The Gluecks further found that 66% of the 1000 children were placed on probation after diagnosis by the Clinic and the others were committed to institutions or to other agencies, whereas the clinic recommended that 47.3% be placed on probation, 34.3% be placed in foster homes or with other relatives, 10.6% be placed in correctional institutions, 6.2% institutions for the feebleminded, and 1.1% in orphanages or non-correctional institutions.[26]

The Gluecks felt that the court-clinic treatment of the children was ineffective because 88.2% of the juvenile

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[24]Eleanor and Sheldon Glueck, op. cit., pp. 125, 126.

[25]Ibid., pp. 133-134.

[26]Ibid., pp. 132, 133.

delinquents continued in misconduct during a five year period after termination of their treatment by the Boston Juvenile Court.[27] The present study did not make a follow-up study of the children, but in view of the Gluecks findings, such a study of the children in this study might well be undertaken.

Healy and Bronner criticized the Glueck's study, pointing out that in most cases there was only one examination of the child by the clinic, that the court's treatment dealt with the symptoms only and that the clinic did not supervise the court's treatment of the delinquent after making the recommendations. To test further the value of a clinic in treating delinquency, they established three research clinics for services to children in Boston, New Haven and Detroit and studied 105 delinquent children and 105 non-delinquent children. The researchers found that if all the facilities for the treatment of the delinquents and their families were utilized, and the clinic did not limit its services to diagnosis and recommendations, but treated the child also, the results were better. It was found that after the clinic treatment, the child was less likely to return to his former delinquent behavior. Healy and Bronner brought out the importance of considering not only treatment

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[27] Ibid., p. 69.

of the delinquent child but also of his family.[28] This is significant in that the Battle Creek Child Guidance Clinic very seldom treated the children which were referred by the Calhoun County Probate Court as the presentation of the data will show.

Samuel W. Hartwell discussed how the Worcester Child Guidance Clinic attempted to help the court and the community with its problems of delinquency through direct treatment of the child and family, through helping the probation officer and teacher to give better help to the child, and so forth. He found that most of the clinic's time was spent in evaluating children and making recommendations to the court in cases referred by the court than in treating such children.[29] This was found to be the case in the present study also, as brought out in Chapter I.

In 1955, Josephine Turner Parker made a study of fifty-eight children referred by the Juvenile Court to the Worcester Child Guidance Clinic for treatment. In one section of her study, she reported on delinquent children who were referred to the clinic merely for recommendations rather than for treatment. Her findings were as follows:

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[28]William Healy and Augusta Bronner, New Lights on Delinquency and Its Treatment, New Haven, Yale University Press, 1936. p. 159.

[29]Samuel F. Hartwell, "The Worcester, Massachusetts Child Guidance Clinic," Preventing Crime, a symposium edited by Sheldon and Cleanor Glueck, N.Y., McGraw-Hill Co., 1936. p. 364.

> Except when the clinic recommended that the children return for further examination or treatment, it based its recommendations on the one interview with the child and parents. The clinic acting as a diagnostician who located the seat of the trouble prescribed medicine but was not responsible for giving doses or seeing that they were given. In some instances, the clinic realized that its prescription was the ideal and probably could not be used. . . . It is likely that in many cities throughout the state, the recommendations were not followed, but because of the close personal understanding between the judge, probation officers and clinic staff, the Worcester Juvenile Court in so far as it was able, enforced the recommendations.[30]
>
> . . . Out of the eighty-nine total recommendations made, in only eight instances did the court refuse to carry them out. Of the thirty-six not carried out, twenty-eight were followed in effect so it can be said that the court accepted seventy-six of the eighty-nine recommendations. Five were unknown.[31]
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> . . . . . .
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> The recommendations were not carried out for the following reasons: The child or parents refused to accept clinic treatment; suspended sentence in several instances seemed to the court a better plan than commitment; room was not available in institutions for the feebleminded; parents refused to transfer the child from a parochial to a public school; child placing agencies could not offer foster homes; or the probation officer's duties were too heavy to arrange for recreation or better ways for the child to secure happiness.[32]

Dorothy Dwyer made a study in 1939-40 of the use the community made of the Reading County, Pennsylvania, Guidance Institute. She, too, found that the legal and correctional

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[30] Josephine Turner Parks, "A Study of Children Referred by the Juvenile Court to the Worcester Child Guidance Clinic." Unpublished Master's Thesis, Smith College School for Social Work, 1935. p. 13.

[31] Ibid., p. 14.

[32] Ibid., p. 15.

institutions referred the largest groups of children to the clinic mainly for diagnosis and recommendations rather than for treatment. She did not report on how the court carried out the recommendations. However, she found that the children who were brought to the clinic at the suggestion of the court prior to court action were likely to be more successfully treated at the clinic than the cases referred by court order.[33] The Battle Creek Child Guidance Clinic treated few of the children in this study who were referred by the Court, and in some cases, the family did not cooperate. One of the reasons might be just what Dwyer pointed out above, and the Court might wish to consider this point in making referrals.

In 1947, Susan F. Bedal made a study of thirty-three children who were referred from the Juvenile Court to the Guidance Institute of Berks County, Pennsylvania.[34] Her study is not directly related to the present investigation, as her purpose was to work out a referral system for the court because it had not developed a plan of referring children. However, she did make mention of the fact that the

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[33]Dorothy Dwyer, "How the Community Uses the Guidance Institute," Smith College Studies in Social Work, Vol. II, 1940. p. 147.

[34]Susan F. Bedal, "Referrals from the Juvenile Court to the Child Guidance Clinic of Berks County," unpublished Master's thesis, Smith College School for Social Work, 1947. p. 40.

Court offered its diagnostic services to the clinic in cases where the judge felt the children were in need of treatment or if he needed assistance in making other plans for the child. She found that the clinic thought treatment was needed in seven cases and were able to carry this out. And she found that in only one case was the court really unable to carry out the recommendations of the clinic.[35]

Cornelia P. Hamilton made a study of court cases which were referred to the child guidance clinic and selected for treatment. In general, her study was not pertinent to this study; however, she had some interesting findings which might be related to it. Her control group consisted of cases which were not accepted for treatment at the clinic. She found that this group included more children who committed a number of serious acts and concluded that there may be some negative relationships between the extent of delinquency and the clinic's offering of treatment rather than making other recommendations: that is, the clinic was less likely to accept children for treatment if they had a long history of delinquency. Also, most of the children who were accepted for treatment were those who could form a relationship with people. Other recommendations were made for those who could not.[36]

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[35] Ibid.

[36] Cornelia Hamilton, "Court Referrals Selected for Treatment in a Child Guidance Clinic," unpublished Master's thesis, Smith College School for Social Work, 1953. p. 31.

Hamilton found that reasons for not offering treatment often involved the parents. Sometimes they were seen as too psychotic or neurotic and sometimes they rejected treatment. In such cases, a large proportion of the children were recommended for a change of environment, for example, to be placed either in an institution or a foster home. Continued court supervision was also recommended in many of these cases.[37]

Thus, we found that several studies were made which, though not directly pertinent to the present study, showed to some extent (1) how frequently the court followed through on clinic recommendation and (2) the reasons for their failure to carry out recommendations in cases where this applied. On the whole the courts followed the clinic's recommendations. The major reasons the courts had not followed the clinics' recommendations were related to the inability of the suggested resources to accept the child because of lack of space and because of the refusal of the child and/or his parents to cooperate with the recommended plan.

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[37] Ibid., p. 30.

CHAPTER III

METHODOLOGY

Seventy-five cases were used in the study. These cases represent all but two of the cases referred by the Juvenile Court to the Clinic between June 1, 1956 and October 1, 1958 for diagnosis and recommendations or for support of the Court's recommendations. The two excluded cases, mentioned above, were referred for testing for eligibility for adoption and were eliminated from the study because the records could not be located in the Clinic. Sixteen other cases were eliminated because fourteen were subsequently found to have been referred by the Branch County Probate Court and two were found to have been referred by other agencies than the Court. The names of the cases were obtained from the Battle Creek Child Guidance Clinic Case Register which lists all of the cases seen at the Clinic.

As mentioned in Chapter I, September 30, 1958 was selected as the ending date of the study because it was felt that at least six months would be necessary, in many cases, for the Court to carry out the recommendations. The twenty-seven month period was chosen arbitrarily to insure an adequate number of cases for the study. Some of the children were seen two or three times (as re-referrals)

during the twenty-seven month period, but they are counted only once in the total number of cases.

After permission to use the records was obtained from each agency, the next step was to determine the data needed and to devise a means of obtaining it. After an examination of some of the records, a schedule was devised for each agency. Two small cards, 4" x 6", were provided for each case studied, and the schedules were written on them. A pink card was used for the Court data and a white card for the Clinic data. As the data was obtained, the cards were attached to combine the information on each case.

The information obtained from the Clinic was as follows: (1) sex; (2) age; (3) date of referral; (4) referral problem; (5) by whom the referral was made, where indicated; (6) recommendations and (9) the date the Clinic sent the diagnosis and recommendation to the Court.

From the Court records the following information was obtained: (1) history of contacts with the Court; (2) reason for referral to the Clinic; (3) the Court's disposition of the case following receipt of the Clinic's recommendations; (4) the length of time required to carry out the recommendations; (5) any subsequent changes in the child's status and/or (6) last known status of the child.

The items on the schedules are self-explanatory with the possible exception of "classification of the referral problem" and the diagnoses. As soon as the Court refers

the child, the Clinic classified the problems which the Court presented in one of several ways described below. It should be emphasized that this classification is not a diagnosis which the Clinic staff makes only after studying the child. Rather, the classification is simply a way of categorizing the nature of the problem as described by the referral agency, and is done prior to the child having been seen.

Each child is classified into one of the several categories: (1) conduct disorder, (2) habit disorder, (3) personality disorder, and (4) learning and developmental problems.

These classifications are described as follows:

> Conduct disorder: Antisocial behavior including truancy, lying, stealing, defiance, running away, temper tantrums, cruelty, overaggression and/or sex offenses.
>
> Habit disorder: Enuresis, nailbiting, thumbsucking, masturbation and/or tics.
>
> Personality problem: Chronic unhappiness, prepsychotic symptoms including withdrawal, daydreaming, depression, fears, anxiety, and inferiority.
>
> Learning and Developmental Problem: Education disabilities (such as slowness in academic learning), or specific subject disabilities (also adoptions, placements, and commitments).[1]

Many of the children presented more than one problem at the time of referral, however, classification is made on the basis of the problem which the Court stressed in referring the child.

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[1] Department of Mental Health, Child Guidance Clinic Statistical Manual, p. 3.

The diagnostic classifications used in the study were those listed in the Department of Mental Health, Child Guidance Clinic Statistical Manual. The Manual states the following:

> DIAGNOSIS - The classification below is taken from the APA Diagnostic and Statistical Manual of 1952. Enter the appropriate code number for diagnostic or treatment cases.
>
> 1. Brain syndromes associated with convulsive disorder (ideopathic epilepsy).
> 2. All other brain syndromes.
> 3. Mental deficiency.
> 4. Psychotic disorders.
> 5. Psychophysiologic autonomic and visceral disorders (psychosomatic disorders, organ neuroses).
> 6. Psychoneurotic disorders.
> 7. Personality (character) disorders.
> 8. Situational personality disorders (adjustment reactions).
> 9. Essentially healthy (no psychiatric disorder found).
> 10. Undiagnosed.[2]

The children in this study were diagnosed in the following categories: mental deficiency, psychotic disorders, psychoneurotic disorders, personality (character) disorders, situational personality disorders, and essentially healthy. Two were undiagnosed and two were brain damaged. The two brain damaged children were classified as having organic brain damage in this study rather than brain syndromes as listed in the above classification, because the term organic brain damage was more descriptive of their disorders.

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[2] Ibid., p. 8.

Definitions of the diagnoses used in the study were obtained from the American Psychiatric Association's Diagnostic and Statistical Manual and are described in Appendix B. (See page 91).

In most cases the diagnoses of the children were obtained from the Mental Health Clinics Closed Case Statistical Reports, a formal statement of the diagnosis at the time the case is closed.[3] Where this was not available, they were obtained from the letter tc the Court or from the psychological or psychiatric reports. Where the psychological and psychiatric reports differed as to diagnosis, and there was no formal statement regarding the diagnosis, the diagnosis in the psychiatric report was used. However, this was necessary in only three or four cases.

In collecting the data, some of the face sheet data in both the Court and Clinic records was found to be inadequate and consequently, the entire records had to be read to find the data in many instances. Race was not considered in the study because it was not designated with any regularity.

In addition to studying the case records at the Clinic and at the Court, interviews were held with the juvenile court referee to determine why certain recommendations were not carried out and to obtain recent information

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[3]See Appendix A for a copy of this form.

which had not yet been recorded in the folders. Interviews were held with the chief of children's services to ascertain whether or not some of the children had been adopted since the record did not always indicate this. Other court workers provided information which had not yet been filed or recorded. Access to the identifying cards and the closed records was provided by the Registrar and the Assistant Registrar at the Court.

The information was not gathered in any particular order. Records that were located first were used first. Sometimes information that was to be obtained from one agency was available at the other. Data was obtained from copies of letters and reports, and this data was noted in the event the record could not be located at the other agency. In only two instances were records not found and these two cases were eliminated from the study because some of the information which was needed was not available.

The next step involved making master sheets for the data which had been collected, and the organizing the tabulations into meaningful tables. For these tables, the presentation and analysis of the data was made.

CHAPTER IV

PRESENTATION AND ANALYSIS OF THE DATA

During the twenty-seven month period from June 1, 1956 through September 30, 1958, seventy-seven children were referred to the Clinic by the Calhoun County Juvenile Court for diagnosis and recommendations or for support of the Court's own recommendations.[1] Two of these cases were eliminated from the study because the records were unavailable at the Clinic. Both of these were referred for psychological testing to determine eligibility for adoption. The remaining seventy-five children were used in the study.

Characteristics of the Children in the Study

There were forty-four boys and thirty-one girls in the study. As seen in Table 1, the Court classified these children in two ways: dependent and/or neglected and delinquent. These terms were defined in Chapter I. Forty-one of the children referred were dependent and neglected whereas thirty-four were delinquent. The delinquent boys out-numbered the delinquent girls more than two to one, whereas the ratio

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[1]The Branch County Juvenile Court referred fourteen children to the Clinic during the same period.

TABLE 1

COURT CLASSIFICATION AND SEX OF CHILDREN REFERRED TO THE CHILD GUIDANCE CLINIC

Classification	Total	Boys	Girls
Total	75	44	31
Dependent and Neglected	41	20	21
Delinquent	34	24	10

of dependent and neglected boys to girls was almost equal.

Table 2 shows the nature of the problems for which the children were referred. It should be kept in mind that in some cases, particularly where the child was delinquent that several problems were sometimes stated in the referral. The problems reported in this study were the ones considered to be the most serious by the Court. In twenty-nine cases, or in over one-third of the cases, the Court requested psychological evaluations to determine the child's fitness for adoption. In the remaining fifty-six cases, psychological and/or psychiatric examinations were desired along with recommendations as to suitable placement. In four instances, the Court had tentatively planned for institutional placements, but sought either support for their recommendations or alternative recommendations. In one case, the child had already been committed to an institution, but an intelligence rating was needed before that institution would accept him.

TABLE 2

COURT CLASSIFICATION OF PROBLEMS OF THE CHILDREN REFERRED TO THE CHILD GUIDANCE CLINIC

Referral Problem	Total	Male	Female
Total	75	44	31
Adoptive testing	29	11	18
Stealing	9	8	1
School behavior problem	9		
-only	(4)	3	1
-and slowness in school	(4)	2	2
-and seizures	(1)	1	-
Sex problems	6	2	4
Breaking and Entering	5	5	-
Leaves home	3	1	2
Fire setting	2	2	-
School truancy	2	-	2
Soiling, bed wetting	2	2	-
Assault	2	2	-
Window peeping	1	1	-
Incorrigible at home	1	1	-
Forging Checks	1	1	-
Anorexia	1	-	1
Neglected, eligible for special farm?	1	1	-
School planning, brain damage	1	1	-

Nine of the children were re-referred by the Court. They had been initially referred to the Clinic by the Court either during an early period in the study, or during a year previous to the period of the study. In seven of those cases, the Clinic had previously tested the children to determine their eligibility for adoption. The Court requested another test on these seven children a year later, presumably because the children had not yet been adopted

and the Court needed more recent tests in order to place them.

Another child that had been re-referred had been previously seen by the Clinic which had at that time recommended Clinic treatment for him. His name had been placed on the treatment waiting list and the Court had been notified that he would be treated as soon as possible. However, the Clinic failed to see the case because the parents did not keep in touch with the Clinic. Three years later, during the period of this study, the Court referred the child again because he had been in serious difficulty.

In the final case in which the child was re-referred, the child had been initially seen at the Clinic for stealing, and probation was recommended because the Clinic felt he was reacting to the death of his father. He was re-referred two years later (during the period of this study) because he had again been discovered stealing. Again the Clinic stated that the stealing was related to the death of his father, and again the Clinic recommended that he be placed on probation. Both times, the Clinic stated that the child should have close contact with a man with whom he could identify. It appears, from the Court records, that there was no one available to devote this much time to the child at the time the Clinic made the first recommendation. However, when the Clinic made the identical recommendation on the second referral from the Court, one of the probation officers planned

to see the child frequently in an effort to carry out the Clinic's recommendation.

Almost as many boys as girls were referred for adoptive testing, but the delinquent boys outnumbered the delinquent girls more than two to one. Stealing and Breaking and Entering (referred to by the Court as B & E) were engaged in by boys for the most part. This is to be expected in view of national statistics which indicate that boys come to the attention of the Courts most frequently for stealing.[2] The girls outnumbered the boys four to one in sex problems and also outnumbered them in leaving home. This also is to be expected since according to national statistics, girls come to the attention of the courts most frequently for those reasons.[3] To cite examples, in 1945, five times as many boys as girls were referred to the courts for stealing.[4] In the same year, 18% of the girls who were seen in courts were referred for sex offenses, 19% for running away and 13% for truancy, whereas the percentages for boys were 5%, 8%, and 8% respectively.[5]

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[2]Paul W. Tappan, Juvenile Delinquency, N.Y., McGraw-Hill Co., c1947. p. 29.

[3]Ibid.

[4]Social Statistics, U. S. Children's Bureau, 1945. p. 11.

[5]Ibid.

A review of the history of the children found in the Court records indicated that the majority of the delinquent children had no Court contact previous to the one for which they were referred to the Clinic. However, in some cases there were indications that the children had been in difficulty with the policy several times prior to contact with the Court. Two delinquent children had been known to the Court as neglected children five years prior to their contact because of delinquency. Two delinquent children had been previously treated at the Clinic and treatment had been discontinued in both cases because the children and their parents refused to continue.

As soon as the Court refers a child to the Clinic, the Clinic classified the major problem as seen by the Court into one of the following categories: learning and developmental problems, conduct disorders, personality problems, or habit disorders. These classifications were defined in Chapter III, page 31. Again it should be emphasized that these classifications are classifications of the symptoms or problems as seen by the Court rather than a diagnosis of the child after he is seen in the Clinic. Table 3 shows how these problems were classified.

Comparing Table 3 with Table 1, the children with conduct disorders were the same children which the Court classified as delinquent. There is a discrepancy in one case because one of the delinquent boys was classified in

TABLE 3

CLINIC CLASSIFICATION OF CHILDREN'S REFERRAL PROBLEM

Classification	Total	Boys	Girls
Total	75	44	31
Learning and Development	[37]	[17]	[20]
Adoptive Testing	29	11	18
Other	8	6	2
Conduct Disorders	33	23	10
Personality Problems	3	2	1
Habit Disorders	2	2	0

the learning and development category. He was classified as such because they only wanted his intelligence rating which was required for his entrance to one of the boys' farms to which he had been committed.

The children classified as having habit disorders, personality problems, and learning and developmental problems were those children which the Court referred because they were dependent and neglected and needed to be evaluated for future planning. In some cases a child who was classified as delinquent had been neglected by his family, but because the Court felt that the delinquency was the more serious problem, the child was classified as a delinquent. As a result, the Clinic classified him in the conduct disorder category on the basis of the problem referred by the court.

The age range of the children in the study was from three months to seventeen years. Age was calculated from the time that the case was opened at the Clinic. In the cases of children who were seen at the Clinic on more than one referral, age was calculated from the most recent referral, that is, as of the last date the case was opened in the Clinic.

Table 4 gives the age distribution of the children by various age groups and by the Clinic classification of the referral problem. Slightly more than one-third of the children were of preschool age and one-third were between fourteen and seventeen years of age. The remaining number, slightly less than one-third, were between six and thirteen years of age. All of the twenty-six children of preschool age were referred to the Clinic for learning and developmental problems. In each case, a psychological evaluation was requested to see if the child was eligible for adoption.

There were fewer children in the six to ten age range than in any other age range. Most of those children in this age range had learning and developmental problems. One child each was classified in each of the conduct disorder, personality problem and habit disorder categories. Of the five children in the six to ten year age range who had learning and developmental problems, adoptive testing was requested in three instances and evaluation for future planning, other than adoption, was requested in the other instances. Only

TABLE 4

AGE, SEX, AND CLINIC CLASSIFICATION OF CHILDREN IN THE STUDY

Classification	Total	Preschool			6 - 10			11 - 13			14 - 17		
		T	M	F	T	M	F	T	M	F	T	M	F
Total	75	26	9	17	8	7	1	16	12	4	25	6	9
Learning and Development	37	26	9	17	5	4	1	2	2	-	4	2	2
Conduct Disorder	33	-	-	-	1	1	-	11	8	3	21	14	7
Personality Problem	3	-	-	-	1	1	-	2	1	1	-	-	-
Habit Disorder	2	-	-	-	1	1	-	1	1	-	-	-	-

Key: T - Total
M - Male
F - Female

one child in this group was considered delinquent. He was eight years old.

In the eleven to thirteen age range and the fourteen to seventeen age range, the conduct disorders (delinquent children) predominated. Only one child considered delinquent was under eleven and, as mentioned above, he was eight years old. This child had been seriously neglected by his family; however, he was considered delinquent because he presented a serious behavior problem to the school. Incidentally, the Clinic recommended that he be sent to his mother in another state and this was carried out.

The boys outnumbered the girls in the eleven to thirteen year age group by three to one, but more than half of the children in the fourteen to seventeen age range were girls. Of the five children who had personality problems and habit disorders, none was under six and none was over thirteen.

In summarizing the characteristics of the children, the following was found: more boys were referred than girls; delinquent boys outnumbered delinquent girls more than two to one, but the ratio between neglected and dependent boys and girls was almost equal; over one-third of the children were referred for adoptive testing only; all of the children of preschool age were referred for adoptive testing, adoption had been previously recommended by the Clinic in seven cases, but the Court requested a new test a year later; delinquent

boys were more often referred for stealing, delinquent girls for sex problems and leaving home; only one delinquent child was under eleven and he was also seriously neglected; most delinquent children were between eleven and seventeen; and few children were referred because of habit disorders and personality problems.

The Clinic's Contact with the Children

Because of the large number of referrals to the Clinic and the relatively small staff, the opening of a case sometimes follows a waiting period. The length of the waiting period has been sharply reduced since 1957 when the Clinic instituted a screening process whereby the children were seen fairly soon for evaluation and their names were placed on a treatment waiting list where treatment seemed indicated.

In general, Court cases were considered emergencies and the children were seen for evaluations in relatively shorter periods of time. Table 5 showed that forty children were seen within a month of the date of the referral. More than one-half of the forty children were seen within two weeks. In many instances in which cases were not opened for more than three months after the referral date, the cases had been opened in 1956 or early 1957 prior to the time the screening process was initiated. In other instances where the cases were not opened at the Clinic for more than three months after the referral date, the children had been

TABLE 5

LENGTH OF TIME BETWEEN THE DATE THE COURT REFERRED CASES AND THE DATE CASES WERE OPENED AT THE CLINIC

Time Period	Number of Cases
Total	75
Under 1 month	40
1 - 2 months	15
2 - 3 months	7
3 - 4 months	2
4 - 5 months	5
5 - 6 months	1
6 - 7 months	1
7 - 8 months	1
8 - 9 months	1
Unknown	2

called in for appointments, but for one reason or another (for example, illness of the child), the dates were postponed.

On the whole, children with conduct disorders were seen more quickly than those who were seen for adoptive testing. On the other hand, reports to the Court on children seen for psychological testing only (usually the adoptive cases and those who were mentally retarded) were made more quickly than reports on the children in the conduct disorder category because the latter generally required more extensive evaluations.

Clinic Diagnoses.--Following the diagnostic studies of the children, the staff conferred to diagnose the children's behavior. In some instances in which only psychological tests were administered, formal staff diagnosis of the child's behavior was not considered necessary. In such instances, the findings of the psychological examination were frequently sent to the Court either the same day the child was tested or one or two days later.

The formal staff diagnosis of the child's behavior was based on the social history data obtained from the Court and from the screening interview conducted by the social worker or psychologist with the child's family, and on the psychological and/or psychiatric examination of the child.

As mentioned in Chapter III, the diagnostic staff meetings were frequently not recorded and the diagnoses had to be obtained from other sources. For example, they were obtained from the psychological examination, psychiatric examination, letters to the Court, or from the Closed Case Statistical Report which contained a formal statement of the diagnosis at the time the case was closed.[2]

Table 6 gives the diagnoses of the children in the study. Twenty-nine or 38.7% of the children were considered essentially healthy. This number was so large because

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[2]See Appendix for a copy of this form.

TABLE 6

DIAGNOSES OF THE CHILDREN IN THE STUDY

Diagnosis	Total	Male	Female
Total	75	44	31
Essentially Healthy	29	12	17
Psychoneurotic	10	8	2
Personality (Character) Disorders	10	6	4
Situational Personality Disorders	8	6	2
Mentally Deficient	7	4	3
Psychotic Disorders	5	3	2
Undiagnosed	4	3	1
Organic Brain Damage	2	2	-

twenty-seven of the children were only tested to determine eligibility for adoption. Ten children had personality (character) disorders; ten had psychoneurotic disorders; eight had situational personality disorders (adjustment reactions); seven were mentally deficient; five had psychotic disorders; four were undiagnosed; and two had organic brain damage, one of which was associated with a convulsive disorder (epilepsy).

Of the four children who were undiagnosed, one had been tested four times to determine his eligibility for adoption and was considered untestable each time. In two cases, no diagnoses were given in the records and there was no indication in either record that examinations had or had

not been administered. However, in one of those cases, a belated recommendation was sent to the Court when the Court requested the Clinic for the examination results. In this case, the Clinic supported the Court's judgment that the boy should be released from probation on the basis of his improved conduct.

Omitting those children who were considered essentially healthy, the largest number of boys (eight) were psychoneurotic and the largest number of girls (four) were diagnosed as personality (character) disorders. It can be speculated that such a large ratio of girls were found to be personality (character) disorders because girls are more frequently sent to the Court as a last resort, that is, when their problems have become very serious, and most generally when a sexual problem is involved.

Table 7 brings out clearly that planning for the child cannot be based on his symptomatic difficulties alone. For instance, the children who had come to the attention of the Court for stealing were diagnosed into five different major classifications: one was psychotic, two had personality (character) disorders, one was mentally deficient, and one was diagnosed as a situational personality disorder. The children with sexual problems were diagnosed into four different major categories, and those who committed B & E (the Court term for Breaking and Entering) were diagnosed in three different ways, as were those who truanted from

TABLE 7

COMPARISON BETWEEN THE COURT REFERRAL PROBLEMS AND THE CLINIC DIAGNOSES

Referral Problem as Stated by the Court	CLINIC DIAGNOSES								
	Total	Essentially Healthy	Psychoneurotic	Personality (Character) Disorder	Situational Personality Disorder	Mentally Deficient	Psychotic Disorders	Undiagnosed	Organic Brain Damage
Total	75	29	10	10	8	7	5	4	2
Adoptive testing	29	25	1	-	-	2	-	1	-
Stealing	9	-	3	2	1	1	2	-	-
School behavior problem	9								
-only	[4]	1	-	1	1	1	-	-	-
-w/slowness in school	[4]	-	-	1	-	3	-	-	-
-w/seizures	[1]	-	-	-	-	-	-	-	1
Sex problems	6	-	1	3	1	-	1	-	-
B & E	5	-	3	1	-	-	-	1	-
Leaves home	3	-	-	1	1	-	-	1	-
Fire setting	2	2	-	-	-	-	-	-	-
School truancy	2	-	-	-	1	-	-	1	-
Soil., bed wetting	2	-	-	-	2	-	-	-	-
Assault	2	-	-	-	1	-	1	-	-
Window peeping	1	-	1	-	-	-	-	-	-
Incorrigible at home	1	-	-	-	-	-	1	-	-
Forging Checks	1	-	-	1	-	-	-	-	-
Anorexia	1	-	1	-	-	-	-	-	-
Neglect, eligible for special farm?	1	1	-	-	-	-	-	-	-
School planning, brain damage?	1	-	-	-	-	-	-	-	1

Note: Figures in brackets are breakdown of the figure [9] above them.

home. It should be mentioned that the Court seemed well aware of this fact as indicated in the nature of the referral letters and referral telephone calls.

Clinic Recommendations.--As indicated in Table 8, the Clinic made recommendations for only seventy-four children. In the remaining case, the Clinic record indicated that the child was to be seen on a particular date, but there was no other information in the record. There was nothing to indicate that the child was or was not seen, nor that the Court was contacted. The Court record did not indicate whether or not a report was received from the Clinic, so it may be assumed that the child was not seen at the Clinic. This indicated inadequate recording on the part of the Clinic, and possibly a lack of follow-up on the part of the Court, unless of course, the plans were made verbally.

It should be pointed out that the Clinic gave alternative recommendations in seven case. For two psychotic boys, hospitalization was recommended as an alternative to probation if the boys did not get along satisfactorily at home. It might be mentioned that the alternative plan was not necessary in either case. Placement, type unspecified, was given as an alternative to probation for a child diagnosed as situational personality disorder but placement was not necessary since he made an adequate adjustment on probation. In the case of another boy who was diagnosed as a situational personality disorder, the Clinic recommended

TABLE 8

RELATIONSHIP BETWEEN CLINIC RECOMMENDATION AND CLINIC DIAGNOSES

Recommendations	Total	CLINIC DIAGNOSES: Essentially Healthy	Psychoneurotic	Personality (Character) Disorders	Situational Personality Disorders	Mental Deficiency	Psychotic Disorders	Undiagnosed	Organic Brain Damage
Total	75*	29	10	10	8	7	5	4	2
Eligible for adoption	27	25	1	-	-	-	-	1	-
Institutions	12	-	-	-	-	-	-	-	-
Mentally Def.	[6]	-	-	-	-	6	-	-	-
Correctional	[3]	-	-	3	-	-	-	-	-
Mentally Ill	[2]	-	-	-	-	-	2	-	-
Epileptic	[1]	-	-	-	-	-	-	-	1
Probation	8	2	2	1	2	-	1	-	-
Special farms and boarding schools	8	1	2	1	2	-	1	1	-
Residential Treatment	4	-	2	1	1	-	-	-	-
Foster home	3	-	-	1	2	-	-	-	-
Dismissal	2	1	1	-	-	-	-	-	-
Probation & clinic treatment	2	-	2	-	-	-	-	-	-
To relatives out of state	2	-	-	1	1	-	-	-	-
Special classes	2	-	-	1	-	-	-	-	1
Foster home & clinic treatment	1	-	-	1	-	-	-	-	-
Help child adjust in father's home	1	-	-	-	-	-	1	-	-
Do not adopt, further tests needed	1	-	-	-	-	1	-	-	-
Release from probation**	1	-	-	-	-	-	-	1	-
Not stated	1	-	-	-	-	-	-	1	-

*Including two cases in which a recommendation was not stated and a recommendation was delinquent and did not benefit the court.

**Made delinquently

placement out of state or the alternatives of placement in a foster home or encouraging the child's father to give him more attention. He was placed out of state with a relative. For a psychotic girl, the Clinic recommended placement in a state hospital, special boarding school or correctional institution and placement in the boarding school was carried out. In two cases, placement out of the home was recommended and several alternatives were made, none of which could be carried out in either case because of the refusal of the parents to cooperate.

More data will be brought out on the Court's action on the various recommendations in the section on The Court's Action which follows. The action of the Court on these seven cases was described here in order to shed light on whether or not more alternatives should be given the Court in other cases. These findings suggested that alternatives are not acted upon in most cases. However, since there were only seven cases in which alternatives were given, it was difficult to generalize whether or not it was necessary for the Clinic to have given the Court more alternatives.

Table 8 related the Clinic recommendations with the Clinic diagnoses. This comparison was made to determine what types of recommendations were made for the various diagnoses. This was an attempt to determine if there was any consistency between the nature of the clinical diagnoses and the recommendations offered by the Clinic.

Of the twenty-seven children considered eligible for adoption, twenty-five were essentially healthy, one was found to be psychoneurotic and one was undiagnosed. The Clinic felt that if the psychoneurotic child were placed with care, preferably in a home where she was the only child, adoption would be preferred to temporary boarding care. The child who was undiagnosed had been untestable on four different attempts to test him, but the Clinic felt it was unfair not to make permanent plans for the child since no signs of mental retardation or physical impairment were present.

Placement in an institution for the mentally deficient was recommended for six of the seven children who were diagnosed as mentally deficient. Since the recommendation for the one remaining child was to place him in a "special class" for retarded children, the recommendations in these cases may be said to have been consistent.

Placement in correctional institutions was recommended for two girls and one boy, all of whom had been diagnosed as personality (character) disorders. Seven other types of recommendations were made for the remaining seven children who were diagnosed as personality (character) disorders, but it is to be noted that psychiatric treatment was recommended in only two cases. The other recommendations usually consisted of some environmental manipulation. This indicates a high degree of consistency in the nature of the recommendations made for the children diagnosed as personality (charter)

disorders.

For each of the eight children who had situational personality disorders, a change of environment was recommended. This was logical since these children were reacting to their immediate environments. The need for intense treatment was thought to be necessary in only one case--and in that case, placement in a residential treatment center was recommended.

In only two cases did the Clinic recommend that the child return to the Clinic for treatment, and both children were diagnosed as psychoneurotic. In one of these cases, Clinic treatment was recommended on condition that the child be removed to a foster home because of the uncooperative attitude of his parents. An alternative of placing the child in a special boarding school or boy's farm was given. This child had been placed on the Clinic's treatment waiting list three years previously when he was referred by the Court, but he had not been treated because the parent's did not maintain their contact with the Clinic.

One other child had been treated at the Clinic three years prior to her contact with the Court; however, treatment was not recommended this time. She had been seen at the Clinic in forty-eight treatment sessions and was thought to have improved. Placement in a boarding school was recommended for her when she was seen during the period of this study and the Clinic stressed that she should not be placed

in a correctional institution. Although she was diagnosed as a personality (character) disorder, it was felt that such a placement would be more harmful than helpful to her.

Of the five children found to be psychotic, the Clinic felt two could remain with their families, however, removal from the father's home and placement with the mother was believed indicated in one of those cases. Two children were considered in serious enough condition to warrant placement in an institution for the mentally ill, and a special boarding school or farm was recommended for one child although the reason was not stated.

Placement in an institution for epileptics was recommended for one brain damaged child (the child with epilepsy) and special classes were recommended for the other brain damaged child.

In summary then, there was generally a consistent relationship between the Clinic's diagnoses and the Clinic's recommendations. Environmental changes were recommended for those children who had situational personality disorders and personality (character) disorders because the former were reacting to their immediate environment and the latter, for the most part, had personality disorders which were too fixed to respond to psychotherapy. A "limited" environment was recommended for those children who were mentally retarded and who had organic brain damage. The greatest variations were in the recommendations for the psychotic children and

it can be speculated that this was related to the degree of the mental illness.

In only seven cases were alternative recommendations given. Whether or not alternative recommendations should be given in more cases can be more fully weighed after viewing the action that the Court made in response to the Clinic's recommendations.

The Court's Action

Table 9 shows the relationship between the Clinic's recommendations and the action the Court took with regard to them. It should be remembered that in seven cases, alternative recommendations were given. In two of these cases, the Court was not able to carry out any of the alternatives. In the remaining five cases, the Court carried out the first choice in three cases, the second choice in one case, and the third choice in one case. Where alternatives were carried out, it was considered that the Court carried out the Clinic's recommendations.

Table 9 indicates that fifty-one recommendations were carried out. Excluding the case in which a recommendation was apparently not made (according to the records) and the case in which the recommendation was made belatedly and did not benefit the Court, 69.8% of the recommendations were carried out. In addition, four recommendations were in the process of being carried out. Three children were in the process of being adopted and one child was awaiting admission

TABLE 9

COURT IMPLEMENTATION OF CLINIC RECOMMENDATIONS

Recommendations	Total	Carried Out	Changed Later	In Process of Being Carried Out	Not Carried Out	Unknown or Dubious	Does not Apply
Total	75*	51	(5)	4	17	1	2
Eligible for adoption	27	15	-	3	9	-	-
Commit to institutions	12	12	-	-	-	-	-
Mentally deficient	(6)	(6)	-	-	-	-	-
Correctional	(3)	(3)	-	-	-	-	-
Mentally ill	(2)	(2)	-	-	-	-	-
Epileptic	(1)	(1)	-	-	-	-	-
Probation	8	6	(2)	-	2	-	-
Special farms and boarding schools	8	5	(2)	-	3	-	-
Residential treatment	4	2	(1)	1	1	-	-
Foster home	3	2	-	-	1	-	-
Dismissal	2	2	-	-	-	-	-
Probation and clinic treatment	2	2	-	-	-	-	-
Sent to relatives out of state	2	2	-	-	-	-	-
Special classes	2	2	-	-	-	-	-
Foster home and clinic treatment	1	-	-	-	1	-	-
Help child adjust at other parent's home	1	-	-	-	-	1	-
Do not adopt, further tests needed	1	1	-	-	-	-	-
Release from probation**	1	-	-	-	-	-	1
Not Stated	1	-	-	-	-	-	1

*Includes a case in which a recommendation was not stated and a case in which a recommendation was made delinquently and did not benefit the court. **made delinquently

to a residential treatment center where he had been committed. In effect then, fifty-five or 75.4% of the recommendations have in some way been carried out.

Seven of the nine children who were considered eligible for adoption, but who were not yet adopted, were made permanent wards of the Court in preparation for adoption. Two of those seven were committed to a placement agency for adoption and the other five were in Court boarding homes pending the location of adoptive homes for them. When, and if, these seven children are adopted, the Court will have carried out sixty-two or 84.9% of the Clinic's recommendations.

Recommendations for placement in institutions for the mentally deficient, the mentally ill, and epileptics and placement in correctional institutions were carried out in all twelve (100%) of the cases. Recommendations for dismissal, probation and clinic treatment, special classes, and placement with relatives out of state were also carried out in all of the cases.

Only six of the eight children for whom probation was recommended were placed on probation, and only two of the four children for whom residential treatment was recommended were placed in such centers. Of the eight children for whom placement in special boarding homes or farms was recommended, three could not be placed. Nor was foster home placement and clinic treatment carried out in the case in which it was recommended. The Court believed that the

child who was removed from his father's home and placed with his mother, as recommended by the Clinic, did not adjust there. Court records indicated that this child was periodically sent back to his father's home when the mother could not manage him. This boy was diagnosed as psychotic and it was the Court's position that the father was on the verge of psychosis himself.

Table 9 also indicates that after carrying out the Clinic's recommendations, the Court eventually had to make other arrangements for five of the children. In one case, residential treatment was recommended, and the treatment center accepted the child, but released him after diagnostic study, declining to treat him. Eventually a relative was located in another state and he was sent there. Two boys who were placed on probation on recommendation of the Clinic, violated probation by getting into serious trouble again, one within a month of the time probation began. Both boys were sent to a correctional institution. And in two cases, the Court committed the children to special boarding schools as recommended by the Clinic and they were admitted there. However, they were later discharged at the requests of the schools because of their disturbing influence on the other children. One of these children was diagnosed as psychoneurotic by the Clinic. In the other case, the boarding school felt the child was psychotic and recommended she be placed in an institution for the mentally ill. The Clinic

was consulted and disagreed with the boarding school's recommendation. Because of the disagreement between the Clinic and the boarding school, the Court believed it could not send the child to an institution for the mentally ill and instead committed her to a correctional institution on the basis of her incorrigible behavior. It might be added that she had been seen at the Clinic three years previous to her contact with the Court. She had been seen in forty-eight treatment sessions and was felt to have improved. She was diagnosed as having an incipient neurotic character disorder at that time. When seen at the Clinic on referral from the Court, she was diagnosed as a "character disorder", but it was felt that placement in a correctional institution would be more harmful than helpful to her.

As stated above, the Court implemented fifty-one of the recommendations made by the Clinic. Table 10 shows the amount of time it took for the Court to implement those recommendations. In three cases, the Clinic supported the plans which the Court had already made. Ine one of these cases, the Clinic supported the Court's decision to commit a boy to a special school for boys by advising that his intelligence rating indicated he was eligible for that placement. The other two children were already in special classes and the Clinic supported the Court's decision to place them there.

TABLE 10

LENGTH OF TIME BETWEEN CLINIC RECOMMENDATIONS AND COURT IMPLEMENTATION OF THE RECOMMENDATIONS

Length of Time	Number of Cases (Recommendations Carried Out)
Total	51
Carried out by court before clinic recommendation was given	3
Less than 1 month	10
1 to 2 months	5
2 to 3 months	7
3 to 4 months	2
4 to 5 months	3
5 to 6 months	6
6 to 7 months	2
7 to 8 months	4
8 to 9 months	0
9 to 10 months	0
10 to 11 months	0
11 to 12 months	1
12 months and over	1*
Unknown	7

*In four adoptive cases, the child was seen the year before and at that time adoption was recommended. However, the Court requested another test a year later. Technically, then, there were five cases in which recommendations were not carried out for more than one year.

In ten cases, recommendations were carried out in less than a month. These were frequently cases in which the Clinic recommended that the children remain in the community. More time was required for placement of children in institutions or boarding schools and farms than for making plans for those remaining in the community; however, some of the children were placed in institutions in relatively short period of time. One child was placed in a residential treatment center within a week. This was considered an emergency because she was refusing to eat and had lost an enormous amount of weight.

In summary, it would appear that it was easier for the Court to make plans for the children in the community and in institutions than in the special farms, boarding schools, and residential treatment centers.

In some of the cases in which several months were required to carry out the recommendations, part of the delay was due to postponement of Court action. By far the largest period of time was required to place a child for adoption, which was understandable in view of the great amount of preparation which was necessary. In seven cases, the date of the adoption was not available or was unknown by the Court. This was particularly true when another agency placed the child and Court had not yet received the final report.

In four cases in which the Clinic had recommended adoption, the child had been seen at the Clinic a previous year. However, the Court requested another test a year later, even though the Clinic had recommended adoption the first time. The Court presumably requested new tests because they had been unable to place the child at the time of the first test and needed more recent tests before placing the child for adoption. Technically, then, there were five known cases in which recommendations were not carried out for more than one year.

In nine cases, it took six months or more for the recommendations to be carried out. The number may be a little larger since in seven cases, the dates that the recommendations were carried out were unknown. This supports the assumption made in Chapter I that six months would be required to carry out some of the recommendations. However, the number of recommendations which were not carried out for more than six months was smaller than originally expected. In summary, more than half of the recommendations were carried out in four months and very few were not carried out six months from the time the recommendations were made.

The study sought to explore the factors which prevented the implementation of the recommendations. Table 11 shows the sex and the diagnoses of the children for whome recommendations were not carried out. Eleven of these children were diagnosed as essentially healthy, and none of those

TABLE 11

SEX AND DIAGNOSES OF CASES IN WHICH RECOMMENDATIONS WERE NOT CARRIED OUT

Recommendations Which Were Not Carried Out	Total	SEX		DIAGNOSES		
		Male	Female	Essentially Healthy	Situational Personality Disorder	Personality (Character) Disorder
Total	17	10	7	11	3	3
Eligible for adoption	9	4	5	9	-	-
Special farms or boarding schools	3	1	2	1	1	1
Probation	2	2	-	1	1	-
Residential treatment	1	1	-	-	-	1
Foster home and clinic treatment	1	1	-	-	-	1
Foster home	1	1	-	-	1	-

were thought to be eligible for adoption. Placement on a special farm was supported by the Clinic for one child who was exceptionally bright. He had been seriously neglected by his family and such a placement was originally suggested by the Court. Unfortunately, this could not be carried out because there was no room available there for him. In the final case in which the child was considered healthy, probation was recommended. Although the child remained at home, he was not on probation because the Court had not yet made a disposition of the case. In this case, the recommendation had been sent to the Court over a year ago at the time of the study, but the case remained on open adjournment because the boy's father could not be located. Thus, recommendations were not carried out for eleven of the twenty-six children who were considered healthy. Lack of facilities was responsible for this in ten of the cases and in the remaining case, the child's father was wanted by the Court before it made its final disposition of the case.

The ages of the five girls who were considered eligible for adoption, but who were not yet adopted, were five, three and one-half, three, twenty-three months and ten months, at the time the recommendations were made. At the time the data was collected for the study, they had been permanent wards of the Court (awaiting adoption) for the following periods: 1.4 years, 1.6 years, six months, eight months, and 1.3 years, respectively.

Of the four boys for whom the recommended adoption was not carried out, two were placed on the Court's adoptive waiting list. Their ages were 3.9 and seven years at the time the Clinic made the recommendations. At the time of the study, both had been permanent wards of the Court for 1.4 years. Other plans were made for the other two boys and this will be described in another section of this chapter.

Ages of the children who were adopted corresponded with the ages of those who were not. Factors other than age may play a part in the children not being adopted. Since more girls than boys were tested for eligibility, the fact that more girls than boys were waiting adoption does not seem to be significant.

Six of the seventeen children for whom the recommendations could not be carried out were diagnosed as having pathological disorders. They were evently divided between situational personality disorders and personality (character) disorders. Since there were eight children diagnosed as situational personality disorders and ten children diagnosed as personality (character) disorders, it cannot be said that failure to carry out the recommendations was based solely on the child's diagnosis. The ages of these children were twelve, thirteen, thirteen, thirtee, fourteen, fourteen and

sixteen respectively at the time the recommendations were made. Since this age distribution coincided with the age distribution of the children for whom the Clinic recommendations were carried out, age as a significant factor in whether or not the Court will implement the Clinic's recommendations does not appear to be a factor.

In considering whether or not sex was a significant factor in the Court's implementation of the Clinic's recommendations, inspection of the data revealed no significant difference between the number of recommendations carried out for boys and those carried out for girls. According to the data, there was a highly consistent relationship between the percentage of boys in the study (56.9%) and the percentage of the Clinic's recommendations which were not carried out by the Court for boys (58.7%). And there was a highly consistant relationship between the percent age of girls in the study (41.1%) and the percentage of recommendations which were not carried out in their behalf (41.3%). It thus appeared that on the basis of this investigation, sex did not appear as a factor in whether or not the Court will implement the Clinic's recommendations.

In conclusion, age, sex, and diagnoses, in themselves, had little, if anything to do with the recommendations not being carried out. Diagnosis, however, was related to some of the other factors, as shall be brought out later.

A review of the Court records revealed nine reasons why the seventeen recommendations were not carried out. Table 12 shows these reasons. The placement agency had not yet found adoptive homes for two children and the Court had not found adoptive homes for five children. In one case in which adoption was recommended by the Clinic, the Court returned the child to his parents at their request. In one case, the child had remained with his own family pending Court action which had been postponed for over a year. During that time, the parents treatment of the child had improved, and they had requested to keep the child instead of having him placed for adoption.

There were three instances in which the child was not placed in special farms or boarding schools as recommended by the Clinic. In two instances, the resources did not have room available for the children. In the third case, the Court did not accept the plan because it regarded the child's foster home as offering more warmth than the Clinic had judged. Persuading the Clinic worker that its plan in behalf of the child was a more optimum one, the Court placed the child in a foster home. Subsequently, however, the child truanted from home until she was referred to the Juvenile Home. At the time of the study, the Court was reconsidering the Clinic's original recommendation with a view of implementing it. The validity of the Clinic's original recommendation was thus supported.

TABLE 12

REASONS RECOMMENDATIONS WERE NOT CARRIED OUT BY THE COURT

Reasons	Recommendations Not Carried Out						
	Total	Adoption	Special Boarding S or F	Probation	Foster Home and Clinic Treatment	Residential Treatment	Foster Home
Total	17	9	3	2	1	1	1
Court had not found adoptive homes	5	5	-	-	-	-	-
Placement agency had not found adoptive homes	2	2	-	-	-	-	-
Final disposition hearing was not yet held	2	1	-	1	-	-	-
Recommended resources would not accept child	2	-	2	-	-	-	-
Parents and child refused recommended plan	2	-	-	-	1	-	1
Parents wanted child returned to them	1	1	-	-	-	-	-
Case dismissed--evidence of guilt was inconclusive	1	-	-	1	-	-	-
Court felt child's home offered the desired warmth (Clinic later approved)	1	-	1	-	-	-	-
Clinic recommendation received after child had shown symptomatic improvement (also, Clinic delinquent in replying)	1	-	-	-	-	1	-

In the case in which the Court did not agree with the Clinic's recommendation for residential treatment, the Clinic's recommendation was received by the Court after the child had shown symptomatic improvement. He was discharged from probation after a satisfactory adjustment, and Court records indicated that he later joined the navy.

In the case in which the alternative recommendation was made of foster home and clinical help on the one hand or placement on a farm or a boarding school on the other hand, the parents refused to cooperate. In another case, the child was too unhappy at being placed in a foster home and the parents refused to cooperate with the plan. Consequently, the Court felt it was better not to insist upon this plan. Inasmuch as the child's behavior improved, the Court closed the case.

In one case in which probation was not carried out as recommended, evidence of the child's guilt was not conclusive, so the Court dismissed the case. In the other case in which probation was not carried out as recommended, the Court had not yet made a disposition in the case.

Thus it was found that the Court was able to carry out the majority of the Clinic's recommendations and that it actually disagreed with only three of the recommendations. Table 13 was a comparison between the total number of recommendations made by the Clinic and the total number of dispositions made by the Court (excluding the five changes which

TABLE 13

COMPARISON BETWEEN THE TOTAL NUMBER OF RECOMMENDATIONS MADE BY THE CLINIC AND THE TOTAL NUMBER OF DISPOSITIONS MADE BY THE COURT

Types of Disposition	Number recommended by Clinic	Number made by the Court+
Total	74*	75
Adoption	27	18
Commitment to institutions	12	12
Mentally Deficient	[6]	[6]
Correctional	[3]	[3]
Mentally Ill	[2]	[2]
Epileptic	[1]	[1]
Probation	8	14
Special farms or boarding schools	8	5
Residential treatment	4	2
Foster home	3	11
Dismissal	2	3
Probation and clinic treatment	2	2
Sent to relatives out of state	2	4
Special classes	2	2
Foster home and clinic treatment	1	0
Help child adjust in other parent's home	1	0
Do not adopt, further tests needed	1	1
Release from probation	1**	1

*Clinic failed to make one recommendation.
**Does not apply since it was sent to the court belatedly after court plans had been completed.
+Excluding the five changes which the Court had to make later after it had carried out the recommendations.

the Court had to make later after carrying out the recommendations).

The outstanding differences between Clinic recommendations and Court dispositions were with regard to adoption, probation, foster home placements, placement in special farms and boarding schools, and placement in residential treatment centers.

Nine children were not adopted because adoptive homes were not found. The number of placements in foster homes was high largely because of the adoptions which were not carried out. In one case, the recommendation made by the Clinic for foster home placement was not carried out. The large difference between the number of children who were placed on probation in relation to the number recommended for probation was the result of retaining those children in their homes who were not accepted in the residential treatment centers and the special farms and boarding schools.

Four children were sent to relatives out of state, whereas this was only recommended for two children. This also was because of the Court's inability to carry out the Clinic's recommendations. Interestingly enough, in all cases where institutional placement was recommended, such placements were carried out with little or no difficulty and in relatively short periods of time.

Two of the Clinic's recommendations for placement in residential treatment centers were not carried out. Inasmuch

as there were only four recommendations for such placement, this meant that half of the recommendations for placement in residential centers were not carried out. There were eight recommendations made by the Clinic for placement in special farms and boarding schools but the Court implemented only five of them. It appeared then, that adoptive placements and placements in residential treatment centers and special boarding schools were the most difficult for the Court to carry out. The adoptions were not completed because of the lack of availability of adoptive homes. Placements in residential treatment centers and special farms and boarding schools were not made apparently because of lack of adequate facilities or because the children were considered by the facilities to be too much of a disturbing influence.

It appeared that a better understanding by the Clinic of the types of children who were acceptable in these facilities was needed. However, it should be pointed out again that the total number of children recommended for placement in such facilities was small so this may not be a valid point. It appeared that unless institutional placement was recommended, the Court was more likely to place the children on probation or to permit them to remain in foster homes.

CHAPTER V

SUMMARY AND CONCLUSIONS

Summary

This study was undertaken to determine the value of the diagnostic-consultative services of the Clinic to the Court by determining (1) how frequently the Court implemented the Clinic's recommendations and (2) the reasons for the Court's failure to implement some of the Clinic's recommendations.

In determining the answers to the above major questions, there were related questions which required investigation. Some of these were as follows: What were the characteristics of the children who were referred to the Clinic? Why were the children referred? What was the nature of the recommendations of the Clinic and on what bases were they made? Was the Court willing and able to implement these recommendations? What were the factors involved when the Court did not carry out the recommendations? Is there anything that the Clinic should consider in making its recommendations that it is not now considering? The study also sought to determine whether other studies were made in this area, and whether the findings of this study corroborated the findings of other studies.

In exploring these questions, seventy-five children who were referred to the Clinic by the Court for diagnoses and recommendations were studied. These children represented all but two of those children referred to the Clinic by the Court during the twenty-seven month period between June 1, 1956 and September 30, 1958.

Conclusions

The following areas were considered in drawing conclusions about the study: the nature of the referrals from the Court to the Clinic, the characteristics of the children who were referred; the nature of, and bases, for the Clinic's recommendations; the Court's action on the Clinic's recommendations; and the study related to this investigation.

The Nature of the Referrals.--More than one-third of the children were referred to the Clinic for adoptive testing only. The remaining children were referred for diagnoses and recommendations. Generally, the Court did not refer cases which were considered candidates for treatment at the Clinic. Only three of the children who were referred for diagnoses and recommendations were considered by the Clinic to be candidates for treatment at the Clinic, and in one of those cases, the condition was made that the child be placed in a foster home before treatment would be begun. Thus, it might be speculated that most of the children either did not require psychiatric treatment or they were referred too late for treatment to be considered beneficial.

The Characteristics of the Children.--More than twice as many delinquent boys as girls were referred. This is consistent with the fact that more boys than girls come to the attention of the courts.[1] The ratio between the number of neglected and dependent boys and girls (including the adoptive cases) was almost equal. It may be speculated that parents would neglect or be unable to support boys and girls alike. In that event, that finding would not be unexpected.

The ages of the delinquent children who were referred by the Court to the Clinic corresponded with the age range of such children who come to the attention of the courts. Most delinquent children are between the ages of thirteen and seventeen years of age. Most of the children who were considered candidates for adoption were of preschool age. This might be expected since couples generally prefer to adopt younger children.

Boys were most often referred because of stealing and girls because of sexual problems and running away. Few children were referred because of habit disorders or for personality problems such as withdrawing, chronic unhappiness and daydreaming. It may be speculated that such problems would most likely come to the attention of agencies other than the Court unless the children were also delinquent, dependent, or neglected.

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[1]Social Statistics, loc. cit.

Nature of and Basis for Recommendations.--The Clinic tended to view the Court referrals as emergencies and saw the children for diagnostic studies in relatively shorter periods, most of them within a month. The recommendations for the children were made on the basis of the results of these diagnostic studies.

Generally, the recommendations were consistent with the diagnoses. For example, environmental changes were generally recommended for those children with situational personality disorders (that is, adjustment reactions) and those with personality (character) disorders, the former because they were reacting to their immediate environments and the latter because they had disorders which were too fixed to respond to psychotherapy. A noncompetitive environment was recommended for those children who were mentally retarded or who had organic brain damage. The greatest variation in recommendations was in those for the psychotic children, and it can be speculated that this was related to the degree of illness. Some type of direct treatment was indicated in the majority of the cases in which psychoneuroses was diagnosed (residential treatment centers, clinic treatment, for example); however, only two of the ten who were psychoneurotic were considered for direct treatment at the Clinic. It may be speculated that the decision not to treat more psychoneurotic children at the Clinic was based on the severity of the child's problem, the neurosis or psychosis

of the parents, or the fact that only a change of environment was indicated. Most of the children were not candidates for Clinic treatment.

Most of the children were classified as essentially healthy. This was related to the large number of children who were seen for adoptive testing only. Only two of the children who were essentially healthy were seen for reasons other than adoptive testing.

The Clinic failed to be of service to the Court in two cases. In one case there apparently was neither a diagnosis nor a recommendation. In the second case, no diagnosis was given, and the recommendation was too late to be of benefit to the Court.

The Court's Action on the Recommendations.--The data revealed that, on the whole, the Court carried out the majority of the Clinic's recommendations. Of the seventy-three recommendations which were sent to the Court in time, the Court implemented fifty-one, were in the process of carrying out four, and planned to implement an additional seven. This would seem to indicate that the Clinic's service to the Court in most of these cases was beneficial.

The Court did not carry out seventeen of the recommendations, although in only three cases did the Court disagree with the recommendations. In fourteen cases, it was difficult or impossible to carry them out.

The Court was not able to carry out the recommendations because of the following reasons: (1) lack of a sufficient number of Court adoptive homes and placement agency adoptive homes; (2) the recommended resources would not accept the children, (3) one child and his parents would not accept treatment, (4) the parents of one child wanted him returned to them, (5) a case was dismissed because of inconclusive evidence that the child had been delinquent, (6) the Court felt that the child's home offered more warmth than the Clinic had believed, (7) the child's symptom had improved by the time the recommendations were received, and (8) in one case, the final disposition hearing had not yet been held.

In five cases, the Court had to make other plans for the children after having followed the Clinic's recommendations for them. Two children violated probation and were sent to correctional institutions and in three cases, the resources that accepted the child later requested that the child be removed. It would appear in the last two instances that the Clinic's recommendations were ideal. Either there was no room for the child or the agency felt it could not handle the child's problem.

Although in seven cases the Court was given alternative recommendations, in most instances, not even the alternative recommendations were carried out.

All of the recommendations for placement in institutions for the mentally retarded, the mentally ill, the epileptic and

in correctional institutions were carried out. Placements in boarding schools and residential treatment centers were less likely to be carried out because often there was not room available and sometimes the resource felt the child should not be there. It appeared that the Clinic may have needed to know more about the requirements for entrance into boarding schools and residential treatment centers. Or, perhaps the resources involved should have been more flexible in accepting agressive children who do not require placement in authoritative settings, since there were no other types of facilities for such children. Because facilities were frequently not available for those children, perhaps alternatives should be given the Court, if this is at all possible.

Eleven of the seventeen recommendations which were not carried out, involved children who had been classified as essentially healthy. The number of recommendations not carried out was large because nine of these children were tested for adoption and adoptive homes could not be found for them. In the other six cases, three of the children were diagnosed as situational personality disorders and three as personality (character) disorders. Even though there were only six children involved, there may have been a relationship between the diagnoses and the recommendations not being carried out. For instances for both groups, changes in environment were required, and frequently a non-authoritarian

institution was felt desirable but because of lack of facilities, this could not be carried out. Some of the children diagnosed as personality (character) disorders seemed to be too agressive for non-authoritarian facilities. Again the question arose as to where agressive children could have been placed when they were in need of controlled, non-authoritarian environments.

In conclusion, it would appear that in these cases, the Court benefited from the Clinic services, and that the Clinic's diagnostic-consultative services to the Court were generally adequate. However, one could not generalize that this meant that the Court made full use of the Clinic's services. In fact, the opposite seemed to be the case in view of the small number of children which the Court referred to the Clinic in comparison to the number of children which come to the attention of the Court. This may be an area which the two agencies may want to investigate further.

Related Studies.--As stated in Chapter II, no study was found which was specifically related to this investigation. However, this study did support some findings of other studies. This study supported the Gluecks finding that non-compliance with clinic recommendations by the court were mainly due to situations beyond the control of the court, with regard to the delinquent children.[2] In contrast to

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[2]Glueck and Glueck, loc. cit.

Healy and Bronner's findings, very few of the children in this study were treated by the Clinic or were regarded as being able to use direct treatment.[3]

This study corroborated Parks findings that most of the recommendations were followed and that in few instances did the Court refuse to carry them out.[4] This study corroborated Dwyer's findings that the court referred children mainly for diagnostics and recommendations rather than for treatment because of the clinic's long treatment waiting list.[5] Bedal's findings that the court was able to carry out most of the Clinic's recommendations[6] were also supported in this study. Finally, this study corroborated Hamilton's findings that "hard core" cases (those involving long histories of delinquency or parents that are too psychotic and neurotic) are not considered good treatment candidates.[7]

Recommendations

This study has attempted to place before the Court and the Clinic a reasonably accurate picture of the use the Court made of the Clinic and the services which the Clinic offered the Court.

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[3]Healy and Bronner, loc. cit.

[4]Parks, loc. cit.

[5]Dwyer, loc. cit.

[6]Bedal, loc. cit.

[7]Hamilton, loc. cit.

Although this study showed the Court received meaningful assistance from the Clinic in the cases studied, some suggestions from this investigation might point up areas for further study as well as point up certain desirable changes in the use the Court makes of the Clinic and the service the Clinic offers the Court.

1. A follow-up study of the children in this study might be considered to determine the present adjustment of the children. The adoptive cases could be excluded from such a study. Such a study would answer the question of whether the best interests of the children have been served, and it would further buttress the validity of the recommendations made by the Clinic.

2. Inasmuch as the Clinic was established to offer early preventative services and treatment to help disturbed children develop healthier personalities, it would appear that more of the less seriously delinquent children should be referred while they can still benefit from direct outpatient treatment. Although the Clinic did offer testing to determine eligibility for adoption, the proportion of such cases in relation to the number of other children who were referred seemed to be too high. The Court did not seem to have made use of the primary service which the Clinic offered.

Although the Clinic had a treatment waiting list, it might have placed some of the children on the treatment

waiting list if the Court had referred them or, barring that, if other treatment facilities had been recommended. In this way, repeated delinquent behavior might have been prevented.

3. Making more use of the Clinic for consultation in cases involving children would no doubt have meant more work for both agencies, but would doubtless have proven more beneficial to emotionally disturbed children. Follow-up studies of children who came to the attention of the Court should offer some enlightenment on this issue.

It would be necessary for the Clinic to increase its staff in order to provide the Court with additional services. If the Clinic is unable to provide the staff, perhaps the Court may need to provide a Clinic or a trained clinician of its own. In either case, more funds would be needed to provide the personnel to carry out the additional responsibilities.

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APPENDICES

APPENDIX A

MENTAL HEALTH CLINICS
CLOSED CASE STATISTICAL REPORT

CLINIC	CODE	CASE NO.	NAME OR INITIALS	DATE CLOSED

FINAL SERVICE CLASSIFICATION	30		1. DIAG. AND TREATMENT	2. DIAG. ONLY	3. PSYCHO TESTING ONLY			
PERSON INTERVIEWS								
WITH PATIENT	31							
WITH PARENT	34							
WITH SPOUSE (ADULT CLINICS ONLY)	37							
COLLATERAL TELEPHONE	62							
OTHER COLLATERAL	40							
TOTAL PERSON INTERVIEWS	43							
TOTAL INTERVIEWS	46							
INTERVIEW FREQUENCY PATTERN	49		1. SEMI-WEEKLY	2. WEEKLY	3. BI-WEEKLY	4. MONTHLY	5. SPORADIC	
DIAGNOSIS	50							
CONDITION ON TERMINATION	54		1. IMPROVED AFTER TREATMENT	2. UNIMPROVED AFTER TREATMENT	3. NOT TREATED			
DISPOSITION	55							
COLOR (OPTIONAL)	57		1. WHITE	2. NON-WHITE				

INSTRUCTIONS
REFER TO MANUAL FOR DEFINITIONS.
ENTER CODE NUMBER OF CORRECT
CATAGORY IN BOX FOLLOWING ITEM

CM-13 REV. 7-1-58

APPENDIX B

Definitions of the Diagnoses Used in the Study

The following definitions were obtained from the American Psychiatric Association's Diagnostic and Statistical Manual, c1952:

1. DISORDERS CAUSED BY OR ASSOCIATED WITH IMPAIRMENT OF BRAIN TISSUE FUNCTION

   These disorders are all characterized by a basic syndrome consisting of:
   1. Impairment of orientation
   2. Impairment of memory
   3. Impairment of all intellectual functions (comprehension, calculations, knowledge, learning, etc.)
   4. Impairment of judgment
   5. Inability and shallowness of affect

   This syndrome of organic brain disorder is a basic mental condition characteristic of diffuse impairment of brain tissue function from any cause may be mild, moderate, or severe. . . . [p. 14]

2. MENTAL DEFICIENCY

   Here will be classified those cases presenting primarily a defect of intelligence existing since birth, without demonstrated organic brain disease or known prenatal cause. This group will include only those cases formerly familial or "idiopathic" mental deficiencies. The degree of intelligence defect will be specified as mild, moderate, or severe, and the current I.Q. rating, with the name of the test used, will be added to the diagnosis. In general, mild refers to functional (vocational) impairment, as would be expected with I.Q.'s of approximately 70 to 85; moderate is used for functional impairment requiring special training and guidance, such as would be expected with I.Q.'s of about 50-70; severe refers to the functional impairment requiring custodial or complete protective care, as would be expected with I.Q.'s below 50. The degree of defect is estimated from other factors than merely psychological test scores, namely, consideration of cultural, physical and emotional determinants. . . . The diagnosis may be modified by the appropriate

qualifying phrase, when, in addition to the intellectual defects, there are significant psychotic, neurotic, or behavioral reactions. . . . [p. 23-24]

3. PSYCHOTIC DISORDERS

These disorders are characterized by a varying degree of personality disintegration and failure to test and evaluate correctly external reality in various spheres. In addition, individuals with such disorders fail in their ability to relate themselves effectively to other people or their own work. . . . [p. 24]

4. PSYCHONEUROTIC DISORDERS

The chief characteristic of these disorders is "anxiety" which may be directly felt and expressed or which may be unconsciously and automatically controlled by the utilization of various psychological defense mechanisms (depression, conversion, displacement, etc.). In contrast to those with psychoses, patients with psychoneurotic disorders do not exhibit gross distortion or falsification of external reality (delusions, hallucinations, illusions) and they do not present gross disorganization of the personality. . . . Special stress may bring about acute symptomatic expression of such disorders. . . . [p. 31]

5. PERSONALITY DISORDERS

These disorders are characterized by developmental defects or pathological trends in the personality structure, with minimal subjective anxiety, and little or no sense of distress. In most instances, the disorder is manifested by a lifelong pattern of action or behavior, rather than by mental or emotional symptoms. . . . [p. 34]

Personality pattern disturbances are considered deep seated disturbances with little room for regression. [p. 34]

6. TRANSIENT SITUATIONAL PERSONALITY DISORDERS

This general classification should be restricted to reactions which are more or less transient in character and which appear to be an acute symptom response to a situation without apparent underlying personality disturbance.

The symptoms are the immediate means used by the individual in his struggle to adjust to an overwhelming situation.

In the presence of good adaptive capacity, recession of symptoms generally occurs when the situational stress diminishes. Persistent failure to resolve will indicate a more severe underlying disturbance and will be classified elsewhere. . . . [p. 40]

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