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SOME ASPECTS OF THE C.Y.A. "SPECIAL TREATMENT PROGRAM"

HANS A. ILLING

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Although it is too early to assess some of the aspects of the over-all "Special Treatment Program" which the C.Y.A. (California Youth Authority) started at the beginning of this year, it is perhaps appropriate to mention some points of the program, with particular reference to the papers recently published by Dr. Mark L. Gerstle, Chief Psychiatrist, and Dr. Keith S. Griffiths, Chief Clinical Psychologist, in charge of the program.¹ The "reality," of which Gerstle speaks in his paper will be discussed here in terms of the existing program of the C.Y.A.,—namely, the diagnostic study, the selection for short term treatment, and the pre-parole release program.

THE DIAGNOSTIC STUDY

Both the C.Y.A. and the Adult Authority of the State Department of Corrections accept their committed charges from the various courts for, to begin with, a diagnostic study or classification.² One can fully agree with Gerstle who states that "we must try not to be coerced into accepting unsuitable wards into the C.Y.A." Among the unsuitable wards he includes the overtly psychotic, the feebleminded, and all those who are incapable of being helped or cared for satisfactorily in any of the C.Y.A. institutions.³ To this category should be added all those wards who are committed by some courts because of the prejudices and punitive attitudes towards them of certain judges. For

¹ *Reality, Hopes, and Dreams Concerning the Special Treatment Program of the California Youth Authority.* By MARK L. GERSTLE, M.D., YOUTH AUTHORITY QUARTERLY, & *New Youth Authority Research Program Reedited.* By KEITH S. GRIFFITHS, *Ibid.*, Spring, 1958.

² Memorandum of the Superintendent of the Southern Reception Center and Clinic, 1958.

³ *Short-term Contact Group Psychotherapy.* By HANS A. ILLING, *INTERNAT. J. GROUP PSYCHOTHERAPY*, Vol. II, 1952.

instance, one judge has a record of sending Negro children to the C.Y.A. on a first offense, and then often on a minor charge. As a matter of fact, these children are often paroled immediately from the diagnostic centers rather than sent to one of the C.Y.A. institutions. Their prejudiced treatment in the first instance creates poor public relations, community resentment, and results in inadequate planning for them. In other instances, judges commit children to the C.Y.A. on insufficient evidence (i.e., the children standing "trial" in Juvenile Court without the benefit of legal counsel). A number of cases are known in which children were exonerated after their admission to a reception center and clinic and, therefore, were immediately paroled, again resulting in poor public relations including the undermining of the court's authority and a shattering of the people's belief in the justice of the court.

On the other hand, there are judges known to be biased against the C.Y.A. and its facilities; they often make disparaging remarks about it to the public both in and outside of the courtroom. Those judges often will refrain from sending a child to the C.Y.A., even though this may be seen to be necessary.

Therefore, Gerstle's suggestion to establish a good relationship with the community appears to be mandatory. A good relationship with the community as well as other agencies, particularly the committing authority—the courts—is vital in order to serve the one party which is most often forgotten—the child. Therefore, the diagnostic study appears to be the necessary first step in caring for the disturbed child and in helping him. (This writer is avoiding here the term "delinquent," because he accepts this term in a clinical sense only.)

Almost every member of a diagnostic study-team in one of the two reception centers and clinics of the State of California will agree that he is overworked with an unrealistically high case-load as well as extraneous duties, which prevent him from doing one of the most responsible jobs of the C.Y.A. In many instances, because of the staff shortage and the meeting of deadlines for board hearings as well as the pressure to process children out of the centers and make room for new commitments, the child can be seen by a clinical team member but once. This is clearly inadequate. It will often bring about misjudgements, and it leads to a marked increase in recidivism. Another important aspect of the ideal diagnostic study is a direct contact with the home of the committed ward, by each team member (psychiatrist, clinical psychologist and psychiatric social worker). While it is true that the investigating parole officer makes a home visit prior to the ward's commitment, it is also a fact that often the parole officer is not well equipped to assess either the personalities of the parents or the atmosphere of the home properly because of lack of training. However, even if he were fully trained, such information reaches the clinic team of a diagnostic center and clinic as secondary information and, therefore, in most instances, is not coordinated with the over-all picture of the child's personality and such factors as environment, race, religion and culture. Since the clinic team member can see a child but once, he has usually no time to contact the home, even though doing this may fall within the province of his work.

Finally, the C.Y.A. Board making the final decision as to the ward's immediate future, rests its opinion on the diagnostic conclusions of the staff. While, as experience shows, most board members will go along with the staff's conclusions and recommendations, it also can happen that expediency dominates the decision rather than concern for the individual child. That is, the Board's calendar may contain too many cases and will exhaust the Board members before the day is over; or, children may be assigned to less crowded institutions for the sake of empty beds rather than for the sake of the children.

These conditions are a few that are observable in the everyday work of the Reception Centers and Clinics. They should be laid at the door of the community rather than of the C.Y.A. or any of its staff.

SELECTION FOR TREATMENT

At least in the Southern Reception Center and Clinic some small portion of the staff's activity is devoted to short-term treatment, which should not be confused with the new "Special Treatment Program" mentioned above. The short-term treatment is usually recommended by the staff and must be approved by the Board. At best, it consists of two periods "of continuances of stay," ruled by the Board, amounting to at most five months. If a continuance is approved, a ward may "stay over" for one or two periods up to five months (until his transfer to an institution or his discharge on parole), and during this time may undergo some treatment, either individual or group psychotherapy or both. In the Southern Reception Center and Clinic the Superintendent recently appointed a committee for further development of a therapeutic environment (3). Some of its members had many years of experience in the development of what has been termed a "therapeutic community." Therefore, the committee outlined the following functions in order to enhance a program leading to the therapeutic community: 1) to survey the field of juvenile correction with regard to development of a therapeutic environment, 2) to examine the procedures involved in the handling of the wards which could perfect the therapeutic environment, 3) to make recommendations to the Superintendent regarding further developments of the environment at the Clinic, 4) to suggest to the Superintendent the order of the steps which are to be taken, 5) to make recommendations to the Superintendent regarding implementations which can be approved by him, and 6) to evaluate current practices and the results achieved.

Some features of a therapeutic environment have been established for some time, particularly the formation of therapeutic groups. Wherever the staff's time permits it, held-over wards who are therapy-motivated join these groups. The experiences gained from group psychotherapy in a diagnostic center with short-term therapy have been invaluable and are probably a special treatment program in themselves; they certainly constitute a small, but hard, core of reality (4). It can be stated that a number of wards released on parole after they went through a continuance program of group psychotherapy pursued group psychotherapy while on parole at the private offices of psychiatrists or in out-patient clinics, particu-

larly those established by the California State Department of Mental Hygiene.

THE PRE-PAROLE RELEASE PROGRAM

This program is perhaps to date the least complete and satisfactory one. Again the investigating parole officer has to make a home visit to certify or verify that the home is adequate and satisfactory for the return of the child. Such a "certification" is often inconsistent with the same parole officer's previous home visit made for the purpose of acceptance by the C.Y.A. that the home was the major contributor to the child's delinquency. It is also inadequate inasmuch as the officer usually has no direct contact with the ward and, therefore, bases his information about the child on secondary sources. It is further inadequate inasmuch as the releasing authority (whether it be the diagnostic center team of the Reception Center and Clinic or a treatment team or the personnel outside of a treatment-team in one of the C.Y.A. institutions) has usually no direct contact with the home, or knowledge of it.

Perhaps most regrettable about the Pre-Parole Release Program is its inability vigorously to follow up the team-members' suggestions and recommendations for the wards while on parole. While such inability is still the rule among adult parolees, the lack of follow-up for children is actually both unpardonable on the part of the

community as well as costly. At the present rate it may threaten the whole program of the C.Y.A. Surely, an over-worked parole officer supervising a hundred or more parolees cannot be expected to do counseling, let alone intensive treatment. Yet the parole officer's "supervision" (which at best consists of one monthly report by the ward) is in most instances the only form of control and "treatment" which the child receives. This tends to make any benefits which a ward may have received while institutionalized by the C.Y.A. null and void. Therefore, it would appear that Gerstle's suggestion is sound: "money spent now will surely prove to be the most economical investment the taxpayer could make." Gerstle's statement that, from "a psychiatrist's orientation, all our wards are disturbed, emotionally unstable, usually infantile and/or immature, they are in this sense sick"—can be endorsed by the two allied professions, clinical psychology and social work. The criticism about the Pre-Parole Release Program is therefore obvious.

The realities and limitations concerning the "Special Treatment Program" are, therefore, in line with Griffiths' question: "What happens to a ward when he is committed to the Department of Youth Authority during his institutionalized period, during his post-institutional parole-period, and afterward?" Yes, what happens?