City of New Orleans

The Mayor's Criminal
Justice Coordinating Council

FINAL EVALUATION REPORT

YOUTH STUDY CENTER

Prepared by

Mayor's Criminal Justice Coordinating Council

March, 1978

Frank R. Serpas, Jr., Executive Director

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Submitted to the

Louisiana Commission on Law Enforcement
and Administration of Criminal Justice

Baton Rouge, Louisiana

Col. Wingate White, Executive Director

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CRIMINAL JUSTICE COORDINATING COUNCIL

FINAL EVALUATION REPORT

Project:	Youth Study Center
Project Number:	75-J9-9.1-0365
Funding Source:	Louisiana Commission of Law Enforcement and Administration of Criminal Justice
Subgrantee:	City of New Orleans
Operating Agency:	City Department of Welfare
Period of Report:	January, 1977 - January, 1978
Prepared by:	Robert Sternhell
Grant Award:	$34,000
Authorized Official:	Ernest N. Morial, Mayor

YOUTH STUDY CENTER

Introduction

In January, 1977, the Youth Study Center (YSC) was awarded a $34,000 grant by the Law Enforcement Assistance Administration and the New Orleans Criminal Justice Coordinating Council. The YSC is a subunit of the Department of Welfare of the City of New Orleans, which has been open since 1971. The facility was created originally through an earlier LEAA grant and has been designed to serve two functions. The first is the detention of youths charged with a criminal act (and prior to 1975, this included offenses now termed as "status") who are found by the Juvenile Court to require incarceration prior to the hearing. The second function is the clinical evaluation of the youth for evidence of either psychiatric disorder or mental retardation.

Historically, the clinical evaluations have been limited to those youths detained by the court. In those instances where the YSC has been asked to evaluate youths not detained by the court, irrespective of whether the person was charged with a crime, they have as a rule had to decline on the grounds of a limited budget.

The 1977 grant to the YSC was extended with the idea of providing monies from the clinical evaluation of "out-patient" youths. Although the primary referral source designated was the Juvenile Court, the YSC was given the flexibility to accept "drop-ins" and referrals from mental health centers. This

evaluation report reviews the development of the grant, the procedures used in the evaluations, and the effects of the diagnostic procedures on court actions.

The present evaluation was made possible by the full cooperation of the staff of the YSC, who spent many hours answering questions and assisting the evaluator in the examination of case files. Particular appreciation is extended to Ms. Lo Ann Ibele, the Director of Diagnostics.

PROGRAM LOGIC

Goals and Objectives

Inherent in the operation of the Diagnostic Unit of the Youth Study Center is the relationship among mental disorder, mental retardation, and criminal behavior by juveniles. This relationship is referred to throughout the grant application and is summarized in the brief abstract fronting the application.

> The project addresses two well-documented needs: (1) the need on the part of the Court for outpatient (e.g., non-detained children) diagnostic services tailored to its needs, and (2) addresses the need for improved treatment resources for local juvenile offenders. It is hoped that by improving court workers' skills and by demonstrating successful outcomes when needed treatment can be obtained, service will be improved to local offenders and then the juvenile delinquent problem can be somewhat eased.

Although goals and objectives were not listed in the application, two purposes were identified:

1. To provide diagnostic workups to the non-detained delinquent beyond what is presently available.

2. To provide treatment resources not currently available to the juvenile offender.

In order to accomplish these two "purposes", one of diagnosis, the other of treatment, the YSC proposed to hire a caseworker to manage the diagnostic workups and the treatment activities. Additionally, the grant proposed to extend the contacts of the consulting psychiatrist and psychologist and to provide a range of services that are available to youth that are detained (i.e., EEG's, EKG's, hearing and eye tests).

The basis for referral into the YSC diagnostic program was to be determined by the Juvenile Court, working within the following guidelines. Youths were to have had a charge placed against them, either criminal or status, were not to be incarcerated in the YSC, and were required to be between 7 and 17 years of age. It was estimated that the unit would process 16 referrals per month.

Although the evaluation may be specifically requested by a parent, the grant makes it clear that all evaluations require the approval of a parent or guardian.

Operational Procedures

The Diagnostic Unit is organized to complete the evaluation within 10 days. This schedule was developed, however, for incarcerated youths. The application makes note of this, and estimates the procedure may take as long as three weeks before a report is issued to the Juvenile Court. The key here, of course, is the cooperation and accessibility of the parent.

The key elements in the evaluation are:

1. The family interview
2. Psychological testing
3. Interview with the youth
4. Psychiatric evaluation, if indicated

The report that is sent to the court provides treatment recommendations and a presentation prepared by the caseworker. These recommendations may involve a broad range of service agencies, mental health centers, hospitals, and vocational programs.

RESEARCH DESIGN

Because the program is one that seeks to improve the procedures for dealing with youths charged with either criminal or status offenses, all the evaluative questions pertain to the manner in which the program operated. Unlike experimental or quasi-experimental programs, there are no impact goals established within the logic of the application.

Within the evaluation literature, an analysis of program operation is termed a process evaluation. Process evaluations are of particular value in two areas: (1) describing in some detail the activities and procedures used by programs, and (2) raising questions about the logic or interrelationship of program elements. The objective of a process evaluation is to first determine if a program established its routine operations as they were described in the grant application, and second, to discuss the observable consequences of these activities.

The easiest and most concise way to examine the YSC project is to follow the logical sequence of events that occur--beginning with the referral from Juvenile Court and ending with the report back to the court. The following questions are organized to reflect the project's sequential events.

1. What were referral sources?
2. What were the reasons for referral?
3. How many referrals were sent?

4. How many parents refused to cooperate?

5. How many youths were tested?

6. How many youths received a psychiatric diagnosis?

7. How many evaluations were completed?

8. What was the average time involved?

Of related interest is the substance of the evaluations. That is, what did the evaluations conclude in terms of mental retardation and mental disorder? What treatment recommendations were made to the court; what was the relationship between the recommendations and the psychiatric diagnosis? Much of this information should be helpful in understanding (1) the relationship between mental retardation, mental disorder, and criminal behavior by juveniles, and (2) the role of the YSC with respect to the juvenile justice system in Orleans Parish.

Data Collection

All information used in this report is taken either from the grant application and monthly narratives, or from case-files maintained by the Youth Study Center. The YSC creates a case folder for each youth referred for evaluation. A completed folder will include the referral form from Juvenile Court, correspondence from mental health centers, prior testing results performed elsewhere, copies of letters to parents and the probation officer assigned to the case, a signed approval (by the parent) for the evaluation, notes made by the case-worker from the personal and family interviews, the report of the psychological tests, the psychiatrist's diagnostic

impressions and recommendations, reports covering neurological or other medical examinations, and the formal report to the Juvenile Court.

Case folders for each youth were examined by the evaluator, and portions of many of the forms and documents were copied on a coding sheet. The code sheet was in turn used as the basis for the construction of tables, charts, and figures. During the course of the data collection, the evaluator asked questions regarding YSC procedures and in a few instances, pursued particular cases.

Formal data collection took place in December, 1977 through January, 1978. Earlier in 1977, the evaluator met with the Director of the YSC and the head of the Diagnostic Unit. The initial meeting took place in February, 1977, shortly after the program was funded. A research design was submitted to the YSC in February, and no objections were raised. In June, the evaluator met again with the Diagnostic Unit director and reviewed the logic of the program, the problem areas, and the research design. The inactivity between the initial meetings and the June discussions were due to delays in funding brought about by questions raised by the Louisiana State Planning Agency regarding the use of consultants. These issues were resolved in late March, 1977, and the program quickly became operational.

With the conclusion of the program six months later, the evaluator initiated formal data collection. It should be noted here that two other forms of regular contact with the project

were maintained. First, the YSC submitted detailed narrative reports. Second, and more important, the planner responsible for juvenile programs made regular monitoring visits to the YSC throughout the year.

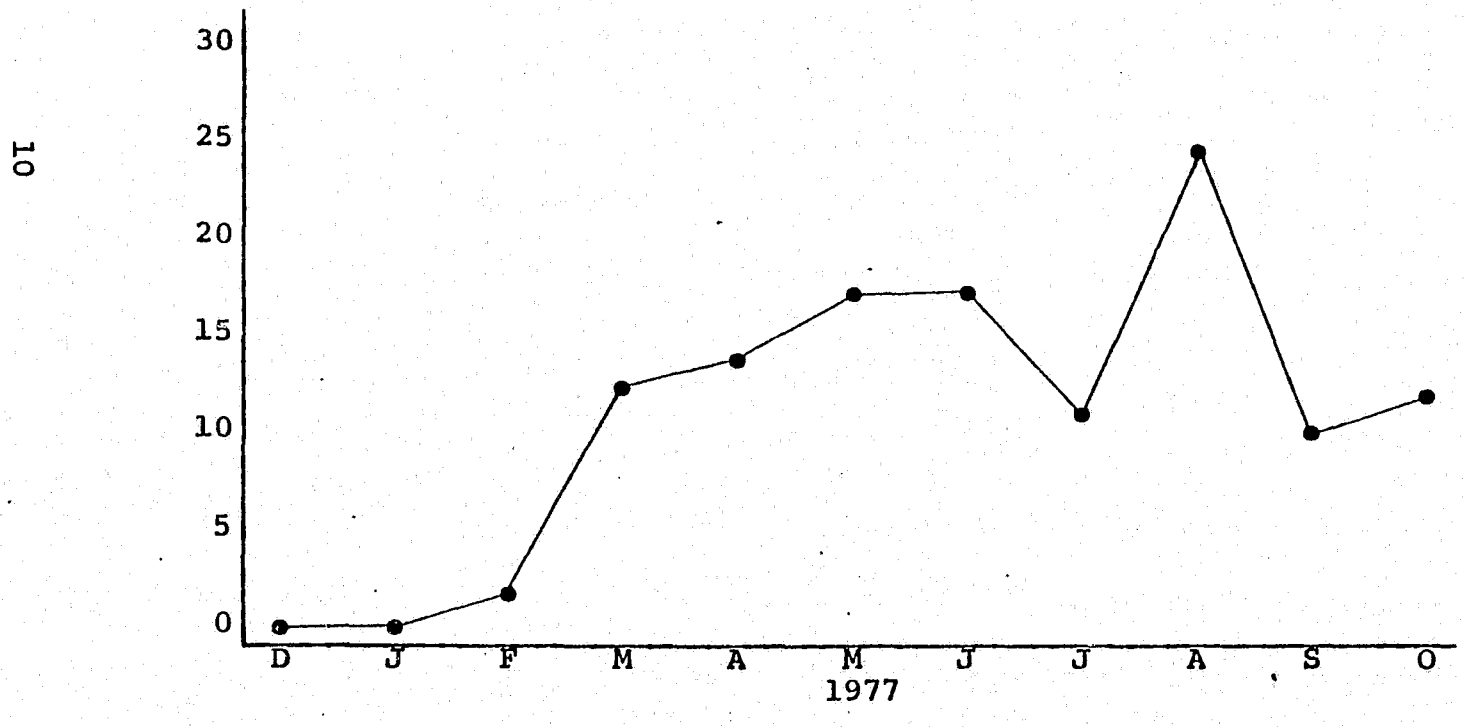
PROJECT DEVELOPMENT

Although the out patient diagnostic program was funded for December 1, 1976, it was March of 1977 before the contracts with the consultant psychiatrist, psychologist, and psychometrician were approved by the State Planning Agency. Additionally, it was in March that the caseworker was hired. As a consequence of these delays, the project developed slowly. The initial referral to the program was made on February 11, 1977, and only one other occurred during February. Active court referrals began in March and accelerated slightly through most of the remaining months (see Figure 1). Total referrals for the project reached 120. If we exclude months December through February, the Youth Study Center received an average of 15 referrals for the eight month period (March through November, 1977). This figure closely matches the expectations discussed in the grant. Of the 120 referrals, the YSC returned recommendations to the court on 103. In all instances in which an evaluation was not completed, it appears that the youth either failed to keep appointments or a parent refused to grant permission.

In a search of the program files, 99 of the case folders were found. Because cases may be in any one of several offices, it was presumed by the evaluator that an even more through review would locate the remaining files. Of the 99 cases, 87 were relatively complete, lacking no more than one element. Seventy-seven cases contained all the diagnostic elements.

Figure 1

PATTERN OF REFERRALS AT YOUTH STUDY CENTER
FOR OUT-PATIENT DIAGNOSES



Again, missing elements were due to failures to appear by the youths. These 99 cases will be used in the examination of referrals, diagnoses and recommendations, although statistics on the length of evaluation will use the YSC's summary file of all 120 cases.

All but five cases were referred by Juvenile Court or the Probation Office. In those five cases, referrals came from mental health centers. Because all referrals from the court are processed by the Juvenile Probation Office, it is difficult to tell whether a judge specifically ordered it--unless specific mention is made. Thus, although judges are listed as ordering the referral in 18 cases, this figure may radically undercount the role of the court. In 12 cases, the probation officer specifically asked for the psychiatric evaluation in order to place the youth in a residence outside the home. This explicit request may or may not reflect a larger incidence of requests intended to produce specific outcomes. In this respect, all 12 youths were recommended for placement in a group home. Two others were required to undergo an evaluation in order to return to school.

Thirty-four of the 95 youths referred by the Juvenile Court were charged with status offenses. Many of these cases were clearly the result of requests by parents to the court for some form of assistance, guidance, moral support, or legal action. The recurring theme in most requests was a child who refused to conform to the parents' instructions, one who was excessively truant from school, and one who was frequently

involved in family fights. (Of the 20 status offender cases in which psychiatric evaluations were completed and recommendations made, half were directed to placement outside the home.)

Those 60 youths referred by the court because of a criminal charge exhibited a broad range of offenses (see Table 1). For the most part, the present charge was nonviolent, and some of the charges are misleading. The aggravated arson charge is belied by a description of the offense. Only 12 cases involved the use or carrying of a gun, and a substantial number of cases involved minor acts of theft, possession, shoplifting and simple robbery. At the same time, notes made by the probation officers indicate that at least 50% have had prior charges placed against them.

The most confusing aspect of the referral process is the similarity in recorded behavior among youths charged with criminal offenses and those charged with a status offense. In making the referral to the YSC, the probation officer is provided with nearly one half a page to cite the reasons for the referral. In more than 50% of the criminal cases the probation officer has cited either problems at school, violent or outlandish behavior, runaways, or other forms of conflict with parents. These are, of course, the most frequent categories for status offenses. Because so many of the youths charged with crimes are in fact involved in theft-related offenses, social meaning of the distinction between status offenders

Table 1

REASONS FOR REFERRAL

Status Offenses	34
Mental Health Center Referrals	5
Criminal Charges	60

1.	Shoplifting	(4)
2.	Theft	(12)
3.	Possession of Marijuana	(2)
4.	Trespassing	(1)
5.	Simple Burglary	(12)
6.	Simple Battery	(3)
7.	Aggravated Battery	(6)
8.	Attempted Armed Robbery	(3)
9.	Weapons	(1)
10.	Possession of Stolen Goods	(6)
11.	Simple Robbery	(4)
12.	Fleeing Police	(1)
13.	Exposure	(1)
14.	False Fire Alarm	(1)
15.	Attempted Aggravated Arson	(1)
16.	Attempted Rape	(1)
17.	Unknown	(1)

and criminal offenders seems to be blurred.[1] By social meaning, we refer to the broader social implications of the acts, i.e., can we talk about the different "nature" of status offenders as opposed to criminals. The question of social meaning is important because one of the major functions of the YSC is the evaluation of youths in order to try to explain their behavior. A closely related objective is to make recommendations to the Juvenile Court as to disposition on the basis of these explanations (i.e., diagnoses). For these reasons, we will take a brief look at the diagnoses and the recommendations in the following section.

The YSC correctly assumed (in the grant) that the evaluation of nonincarcerated youths would take longer than for those kept at the institution. They underestimated, however, the actual difference. The standard procedure takes 10 days; the estimate was 21 days. The actual avarage was 33 days, with a median of 32. The review of the case folders suggests that the time lags were in nearly all cases the result of missed appointments.

Diagnoses and Recommendations

From available records, 78 psychiatric evaluations were done, including 20 on status offenders, 53 on youths charged

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[1]Obviously, the legal distinction is clear. A youth who is truant cannot be charged with theft, and the penalties for theft are quite different (at least in their uppor limits) from those for truancy. The attempt to provide social meaning for the concept of status offender has concentrated on distinguishing status offenders from those charged with criminal acts. An example of this approach is the "Symposium on Status Offenders" sponsored by the National Council of Jewish Women, May 17-19, 1976, in Washington, D.C.

with criminal offenses, and 5 on youths referred from mental health centers.

The term used by the psychiatrist to present the assessment is a diagnostic impression. The term diagnostic impression would appear to refer to a provisional assessment, normally used when the individual is first admitted to the facility.[2] The implication here is one of tentativeness, based presumably on a much shorter period of observation of the youth than might otherwise be the case. The use of this terminology is confusing, if not potentially misleading. First, the judgement of the psychiatrist is accepted by the court as a professional diagnosis. One source of evidence for this is the number of specific requests by probation officers for diagnosis as the basis for legal action (i.e., placement in a residential home, a return to school). The second problem is the congruence of the psychiatrist's recommendations to those recommendations issued by the YSC to the court. In almost all cases, the language is identical, leading to the conclusion that the judgement of the psychiatrist is the basis for the institutional recommendations. The difficulty we have with this procedure is that if the diagnosis is only an "impression", can its intellectual weight match its legal significance? Is a psychiatrist legally bound to an impression; that is, can he be held accountable in a court of law? If he cannot, and of course this is conjecture, how can the impression be used as the basis for legal action by the court? If he is legally responsible, does the nature of the diagnostic procedure meet professional standards?

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[2]Joint Commission on Accreditation of Hospitals, Hospital Accreditation References, 1964 Edition, P. 116.

The terminology used in the psychiatric diagnosis tends to reflect usage as found in the Diagnostic and Statistical Manual-II.[3] By listing the 77 diagnoses, eleven diagnostic categories were created. These categories are not mutually exclusive, in the sense that each describes a separate phenomenon. Instead, these categories tend to identify dominant themes or characteristics. Moreover, in many cases the notation of mental retardation in a youth is accompanied by another "impression". Thus, of the 26 cases in which retardation is identified, 24 include reference to a second behavorial problem. These categories and their definitions are shown in Chart No. 1.

The most salient finding is that each of the 77 youths evaluated were found to have an emotional disorder. If these findings are correct, then the relationship between criminal activity and mental disorder is 1:1, and the association of status offenses and mental disorder is also 1:1. This would seem to be a startling conclusion, and there is some confusion as to the meaning of these relationships. Does this mean, for example, that a "casual" relationship exists between mental disorder and criminal activity? Is mental disorder both a necessary and sufficient condition for criminal activity?

As table 2 indicates, the most frequent diagnosis was behavior disorders of childhood or adolescence. Included in this category are "an adjustment reaction of adolescence", and a "group delinquency reaction adolescence", often with neurotic features. Fully a third of all "impressions" fell in this category.

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[3]The DSM-II is a glossary of terms and procedures released by The American Psychiatric Association.

TABLE 2

DIAGNOSTIC ASSIGNMENTS
FOR OUT PATIENTS OF THE YOUTH
STUDY CENTER

		N	%
(1)	Mental Retardation (MR)	2	2
(2)	Organic Brain Syndromes	1	1.2
(3)	Psychoses (Schizophrenia)	10	12.6
(4)	Personality Disorders	12	15.1
(5)	Transient Situational Disturbance	1	1.2
(6)	Behavior Disorders of Childhood & Adolescence	27	34.1
(7)	MR plus Organic Brain Syndromes	2	2.5
(8)	MR plus Psychoses	3	3.7
(9)	MR plus Personality Disorders	8	10.1
(10)	MR plus Transient Situational Disturbances	0	-
(11)	MR plus Disorders of Childhood & Adolescence	13	16.4
		79	100%

The second most frequent diagnosis was the combination of mental retardation and disorders of childhood and adolescence. More than 50% of all diagnosis included a reference to a behavior disorder of adolescence.

Mental retardation was a diagnosis, (or in combination) in 28 cases, or 35% of the impressions. The phenomenon of retardation is potentially a major conceptual issue, since neurological examinations or electroencephalagrams were frequently not used for those youths diagnosed as retarded. Thus, while no physical damage was observed, either because a test wasn't given or because no evidence was found, test score results were used to designate retardation. (In seventy-five percent of retardation diagnoses, EEG's or neurological exams were neither performed or recommended.)

Are there any distinctions in diagnosis between youths referred for status offenders and those referred for criminal charges? The most obvious difference is the designation of mental retardation (see table 3). Whereas nearly one half of the youths sent because of charges were diagnosed as retarded. Only one status offender received such a designation.

What relationship was found between diagnosis and treatment recommendations? When we speak of treatment recommendations, the reference is to the YSC's report back to the Juvenile Court. In all cases however, these recommendations are a direct reflection of those made by the psychiatrist, so that in effect, the psychiatrist's recommendation is the institutional (YSC) recommendation.

In no instance is there a single recommendation. Usually three to five distinct notations are included, covering a range of the youths' life activities. Some of the recommendations are

TABLE 3

DIAGNOSTIC CATEGORIES BY
TYPE OF REFERRAL

DIAGNOSTIC CATEGORY	STATUS OFFENDER	CRIMINAL CHARGE	MHC
(1) Mental Retardation (MR)	-	2	
(2) Organic Brain Syndromes	1	-	
(3) Psychoses (Schizophrenia)	5	6	
(4) Personality Disorders	4	7	1
(5) Transient Situational Disturbance	-	1	
(6) Behavior Disorders of Childhood & Adolescence	9	15	3
(7) MR plus Organic Brain Syndromes	-	2	
(8) MR plus Psychoses	1	2	
(9) MR plus Personality Disorders	-	7	
(10) MR plus Transient Situational Disturbances	-	-	
(11) MR plus Disorders of Childhood & Adolescence	-	11	1
	20	53	

intended for the youth - others are directed at the family. These categories, along with brief explanations, are shown in Chart No. 2.

Because these recommendations cover a number of different dimensions, comparisons across youths are difficult. In order to simplify the comparative process, we have focused on one aspect, the extent to which the youth retains relative freedom or is confined. Table 4 presents the range of treatment recommendations made by the YSC, and categorizes them according to the psychiatric diagnostic impression. If a youth was not recommended for either hospitalization or confinement in a residential home, then other recommendations were examined. If either probation or simple release were recommended, these were recorded as primary. If none of these four categories were mentioned, an other recommendation was recorded. The effect of this arbitrary procedure is to radically undercount those recommendations that occur frequently, but that are defined as "secondary" to the research definition being used here. For example, medication is shown as a primary recommendation (in table 4) only three times, whereas it was part of the "recommendation package" for eleven youths. In these eight cases, some form of confinement or probation was also recommended, and they were recorded as primary.

When the data is reduced to the dimension of confinement, as is shown in table 5, we can see that 39, or 50% of the youths were recommended for either hospitalization or residential confinement. In all other cases, the youth was allowed to return home or to the home of a relative. Thus, in a substantial number

CHART No. 2

PROBATION: The youth is referred to the Juvenile Probation Office, where he/she is assigned an office and conditions of supervision. The youth is allowed to return to his/her home, or to that of a relative or guardian.

HOSPITALIZATION: It is thought that the severity of the mental disorder requires a minimum stay in a secure setting, as the basis for medication and/or therapy.

GROUP HOME: The institutional alternative to hospitalization. Some homes are fairly secure, others are relatively unconfining. The group home represents the more recent view that large scale institutional homes are inappropriate for youthful offenders.

MEDICATION: Rarely prescribed outside a group home or hospitalization setting.

INDIVIDUAL PSYCHO-THERAPY: Usually contingent upon the ability of the family to pay for the service for the youth.

FAMILY COUNSELING: The family (or members thereof) is directed to a mental health center, as a means of modifying existing family relationships.

GROUP THERAPY: An alternative to individual psychotherapy, and usually considerably less expensive.

NO ACTION: The youth is thought to be capable of behavioral change without the Court's intervention. In most cases, this recommendation is accompanied by a recommendation for family counseling.

SPECIAL SCHOOL: Usually directed toward youths designated as mentally retarded.

EEG: Sometimes recommended for youths scoring low on the test battery, that includes the PPV IQ, the DAP SS, and WRAT.

TABLE 4

PSYCHIATRIC DIAGNOSES AND TREATMENT RECOMMENDATIONS

	Probation	Hosp.	Group Home	Medication	Ind. Psycho-Therapy	Family Counsel.	Group Ther.	No Action To Be Taken	Spec. School	EEG	TOTALS
(1)								1	1		2
(2)			1								1
(3)	1	3	5	1							10
(4)	1		7		1	3					12
(5)								1			1
(6)	8	1	10			4	1	2	1		27
(7)	1									1	2
(8)		2					1				3
(9)	1		4			1				1	7
(10)											0
(11)	3		6	2					1		12
No Psych. Evaluation	1		2			3	1	2	1		10

TABLE 5

THE FREQUENCY OF CONFINEMENT

	Hospitalization	Residential Confinement	Relative Freedom
(1)			2
(2)		1	
(3)	3	5	2
(4)		7	5
(5)			1
(6)	1	10	16
(7)			2
(8)	2		1
(9)		4	3
(10)			
(11)		6	6
TOTAL	6	33	38
No Psych. Eval.		2	8

of instances, the YSC recommended some form of institutionalization. There is no readily observable pattern to these recommendations, insofar as diagnostic impressions are concerned, except that in the ten cases where appointments with the psychiatrist were missed, eight of the YSC recommendations excluded confinement. (These 10 were cases in which appointments had been set, but youths failed to appear.)

What relationship, if any, can be found between treatment recommendations and type of referral. Table 6 shows the same pattern to hold across the two most frequently used referral categories (the low number of mental health center referrals discourages any statistical analysis). Status offenders and those face criminal charges are recommended for some form of confinement in 39% and 52% of the cases respectively.

TABLE 6

TREATMENT RECOMMENDATIONS
and
REFERRAL TYPE

Recommendation	Status Offender	Criminal Changes	MHC
Hospitalization	2 (8)	4 (7)	0
Group Home	8 (31)	25 (45)	2 (40)
Other	16 (61)	27 (48)	3 (60)
Totals	26 (100)	56 (100)	5

Financial Records

The Youth Study Center chose to spend only 57% of the monies budgeted. The financial summary (Table No. 7) shows that $22,280 of the original total of $38,587 was requested prior to the end of the grant period. One of the contributing factors was the necessity to postpone the starting date while approval of the contracts with the psychiatrist and the neurologist was pending at the Louisiana Commission on Law Enforcement. As a result of the delay, the period in which the money could be spent was significantly shortened. Approval of a subsequent grant extension allowed some additional monies to be used, but as Table 7 indicates, $16,307 was the balance remaining the grant upon conclusion.

All narrative and fiscal reports were submitted in a timely fashion, and management of the monies was found to be appropriate.

CRIMINAL JUSTICE COORDINATING COUNCIL
1000 HOWARD AVENUE, SUITE 1200
NEW ORLEANS, LOUISIANA 70113

Table 7
FINANCIAL SUMMARY

Grant Title: YOUTH STUDY CENTER
Grant Number: 75-J9-9.1-0365
Period Covered: 12/1/76 to 11/5/77

Date Report Prepared: 2/22/78

Item	TOTAL GRANT FUNDS			LEAA CASH ONLY		
	Amount Budgeted	Total Expenditures	Balance	Amount Budgeted	Total Expenditures	Balance
Personnel	7,808.	8,389.	(581)	7,808.	8,389.	(581)
Fringe	1,511.	1,678.	(167)	936.	1,039.	(103)
Travel	200	14.	186.	100.	7.	93.
Equipment	-o-	-o-	- o-	-o-	-o-	-o-
Supplies	554.	110.	444.	354.	70.	284.
Contractual	26,722.	10,297.	16,425.	23,010.	8,867.	14,143.
Construction	-o-	-o-	-o-	-o-	-o-	-o-
Other Direct	-o-	-o-	-o-	-o-	-o-	-o-
Indirect	1,792.	1,792.	-o-	1,792.	1,792.	-o-
TOTAL	38,587.	22,280.	16,307.	34,000.	20,164.	13,836.

Note: Total grant funds includes both LEAA cash and City in-kind match
Expenditures include encumbrances.

PREPARED BY: Robert C. Rhoden, Jr., Grants Administrator

CONCLUSIONS

The Youth Study Center implemented the grant in a timely and efficient manner, once approval of the consultants was obtained. Those youths that appeared for scheduled interviews and tests received full clinical evaluation, including social histories, psychometric testing and a psychiatric diagnosis. Records and budget documents are in order.

Questions raised in the evaluation have tended to focus on organizational procedures used in the grant. For example, it is not clear why all youths referred receive a designation of mental disorder, mental retardation, or both. Another area of some confusion is why the evaluation precedes the hearing for the youth, particularly because many youths discuss "for the record" the offense they are charged with committing. A more disturbing trend is the use of the psychiatric evaluation as the basis for legal action by Juvenile Court (i.e., the probation department). Probation officers frequently state on the referral form they need a psychiatric evaluation in order to place a youth in a group home confinement. In every instance of such a request, the psychiatrist recommended a group home placement. This gives the impression that the evaluation performed by the psychiatrist has more of a bureaucratic and legal significance than a medical one.

Because the format used has been a clinical or case study approach, we have not sought to apply specific tests of hypotheses. Rather, the objective has been to examine the procedures used, as well as some of the substantive phenomena, as a means of understanding.

the role of the YSC in the juvenile justice system, and the function of pychiatric diagnosis in juvenile law. Obviously, we have raised many questions that we cannot answer. Perhaps future studies will address these concerns.

PRIDE BUILDS NEW ORLEANS

MOON LANDRIEU

MAYOR

CITY OF NEW ORLEANS

March 29, 1978

MAR 29 78

Mr. Frank Serpas, Director
Criminal Justice Coordinating Council
1000 Howard Avenue
Suite 1200
New Orleans, Louisiana

Dear Frank:

Attached are the concerns and critique of the Evaluation of the Youth Study Center Diagnostic Out-Patient Program. These comments are the result of a staff review of the draft that was submitted to this office. We will be prepared to discuss each in greater detail at the meeting.

This report as well as the research study done by Calhoun and Berry raises some fundamental questions about the appropriateness of the purpose, goals, methodology and recommendations that emanate from the Diagnostic Process. Some of the questions raised are valid as a means of perfecting the Diagnostic Process and may beg the question for a study, the scope of which supersedes the perimeter of the two aforementioned studies. It is certainly within the rights of the Criminal Justice Coordinating Council to initiate and facilitate such a study, if one is deemed necessary. Neither the Calhoun and Berry Report or the Sternhill Evaluation Report meet the requirements.

Certainly, the Diagnostic Unit is only one of several essential components in the Juvenile Justice Process. The questions that are raised impinge more upon the Juvenile Justice Process, as a whole, than does the singular Diagnostic Unit. The answers to these questions then should embrace assessments of each component in this linkage system. The City Welfare

Department is committed to validating and perfecting the Diagnostic Process but not condemning the process as explicated in the Calhoun and Berry Report and implied in the Sternhill Report. It is in this vein that we are open to discussion about the role that we play in the Juvenile Justice Process.

Very truly yours,

Morris F. X. Jeff, Jr.

MORRIS F. X. JEFF, JR.
DIRECTOR

MFXJjr:dh

REVIEW AND CRITIQUE
OF DIAGNOSTIC EVALUATION

1. The essence of the evaluation process should be centered upon those contractual items delineated in the grant application between C. J. C. C. and City Welfare Department. This is partially done.
2. Evaluation should record series of events that occurred that were tangential to the application but impinged upon the initiation and implementation of the program. This is partially done.
3. A priori questions related to purpose and objectives of the diagnostic process are inappropriate since these matters are implicit in the contract process. C. J. C. C. chose to buy a service. The City Welfare Department agreed to provide same with the understanding that the services purchased were appropriate to solve an agreed upon problem. Delete pages 6 - 28.
4. The report is replete with historical, factual and semantic mistakes. (See page one (1), page two (2) paragraph one (1), page 8, page 11)
5. No evaluation is given on the staff training, and treatment components.
6. The evaluator's background assumption and biases of the diagnostic process are projected and assigned to the contractee thus skewing the quality of the actual process. (For example, page 4, paragraphs 2 and 4, page 14, sentence one (1), page 18 paragraph 2.) More importantly, the diagnostic process as viewed by the evaluator is fragmentized and partialized only emphasizing the psychiatric component and disregarding the medical, sociological, economic, social

functioning and psychological components.

7. The diagnostic process is not fully comprehended by the evaluator. It is obvious that the Youth Study Center Diagnostic Unit Operations Handbook was not thoroughly digested before the study was initiated. (See page 4, paragraphs 2 & 4 match with Final Report Guide in Handbook)

END