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A SURVEY OF RECEPTION-DIAGNOSTIC CENTERS FOR ADULT OFFENDERS IN THE UNITED STATES

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CHAPTER I

INTRODUCTION

Background

Social control of mankind has universally presented a perplexing situation. There has always been a need for some method of imposing sanctions on those members of society who cannot, or will not, live within the laws of that society. Early in man's history, the prison, in one form or another, provided a solution to the problem of what was to be done with those who were judged to be unacceptable in the free society. Prisons, like all institutions, have been subjected to the great pressures of the forward push of civilization into the twentieth century. Change, however, has been a painful process and has required great skill and great patience for those who would seek to have these changes move along at a more rapid pace.

Early prisons in the United States were deplorable, and accomplished nothing except to isolate the inmate from society. It must be remembered, however, that isolation was the acceptable solution in the early nineteenth century and prevailed for many years as the basic justification for jails and prisons. There was little or no attempt to do anything with the "prisoners" except to keep them securely locked behind bars. In the latter part of the nineteenth century, a movement began to bring about some sort of reformation in the prisoners through education, productive labor, the mark system, the indeterminate sentence and parole. Elmira Reformatory in New York,

opened in 1877, was the first attempt at a program of this sort.[1]

The twentieth century brought a new idea of prison utilization. The prison now began to specialize. From the old Walnut Street Jail, through the Pennsylvania and Auburn systems to the reformatories and training schools, there has been a slow but steady trend toward an emphasis on classification and treatment and away from punitive forms of imprisonment. Separate institutions were built to house juvenile delinquents, insane criminals, young adults, women, defective delinquents, misdemeanants, the sick, and other special groups. The motives for the separation and specialization were the prevention of contamination of one type of offender by another, and the adaptation of methods of work and of facilities to the characteristics of the special groups of offenders. Considering what had preceded this idea, it was indeed a step forward in the treatment of the inmate.

Treatment, however, was only an idea at the turn of the century and had to fight a persistent battle with the prevailing orientation of custody. Today we still find that a paradox exists when society demands conflicting objectives for the prison system. Reformation, incapacitation, retribution, and deterrence are all demanded at the same time, for the same inmate, from the same institution and often using the same operational staff. As a result of this problem, attempts have been made to develop solutions within the existing framework of the correctional program.

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[1]Elmer H. Johnson, Crime, Correction, and Society (Illinois: Dorsey Press, 1964), p. 342.

The classification system stands out as one of the early methods of coping with this enigma.

> Some common-sense distinction between types of criminals existed, of course, from an early date. The canonical courts distinguished between clergy and laity. We have seen that separation by sex, age, and nature of offense was imperfectly carried out in some early European and American institutions. Baltimore segregated women in its prison system in the early nineteenth century. The three juvenile institutions built about 1825 dealt separately with children. The isolation of the insane seems first to have been proposed in 1844. Later a few states permitted the transfer of criminals to these asylums, and in 1859 New York opened the first hospital for the criminally insane. Early in the eighteenth century the development of American houses of correction separated misdemeanants from felons. The building of Indiana's separate prison for women in 1873 is usually regarded as the beginning of the women's reformatory movement. The pioneer men's reformatory at Elmira dates from 1876. Modern classification at the institutional level implies the organization of special centers for this purpose, and that movement is about 35 years old.[1]

The idea that newly admitted prisoners should be properly studied, classified, and assigned to housing and programs is not new, but it is only within the last generation that the American penal and correctional institutions have moved to implement, to some degree, the classification idea.

Initially, classification consisted of mere segregation of prisoners, for purposes of discipline and administrative control, according to such criteria as age, sex, race, and degree of hostility. Classification, as an idea, has now come to refer to the whole system of differentiation according to inmates' needs and individualized implementation

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[1]Donald R. Taft and Ralph W. England, Jr., Criminology (New York: The Macmillan Co., 1964), p. 433.

of treatment programs consistent with those needs. Although classification has contributed a great deal in bringing correctional programs closer to a true rehabilitative effort, it still lacks one major facet. The underlying need for the system to operate effectively is the ability to get to the real root of the individual inmate's problems and needs.

Recent progress in penology has produced the concept of the Reception-Diagnostic Center. Its purpose is to establish a guidance oriented facility where all sentenced inmates within a given state may be sent to determine their problems and institutional needs. The inmate is given a series of tests and examinations which are used as a basis for individual diagnosis and classification.

The objectives of imprisonment in contemporary society have been delineated as follows: reformation, incapacitation, retribution, and deterrence. In the reception-diagnostic center, only reformation and incapacitation are considered important. The idea of retribution and deterrence have been discarded.

Since reception-diagnosis is a relatively new concept, all states have not yet profited from its potential. Those states that do have reception-diagnostic centers developed them with a relatively small amount of background information or an equally small degree of comparison with what was being done in other states. Based upon this need for information relating to the function of reception-diagnostic centers in the United States, the purpose of this study is to investigate and analyze the present state of development and some of the major problems of the adult centers now functioning within some of the states.

Importance of the Problem

Historically, the reception-diagnostic center concept is comparatively new. Although it had its early formulation in the juvenile institutions, its use in adult facilities dates from about 1933 when Illinois opened its Diagnostic Depot at Joliet.[1] These early beginnings were an outward manifestation of an idea. Perhaps it would have been premature at the time to even call it an "idea," since it was more of a dream that someday, somehow, it would be possible to treat an inmate of a correctional institution more like a patient than a prisoner. Although this thought was far ahead of any practical application, the idea was, at least, being discussed.

In recent years many states have built new physical facilities to house their reception-diagnostic center operations, many utilizing new cities, while other have simply incorporated these operations into the existing structure. The basic concept remained the same, only the real estate was different.

> Gradually, specialized facilities are developing in a few scattered diagnostic and reception centers though which more relevant information is being secured concerning the individual offender. Somewhat detailed social and psychological data are useful in the making of wise decisions concerning treatment of the offender. Sound data should be the foundation both for the process of court dispositions and later for the classification of offenders into specialized institutions and into particular programs for treatment. The need today is great for the more widespread development of diagnostic centers such as those at

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[1]Edwin H. Sutherland and Donald R. Cressey, Principles of Criminology (New York: J. B. Lippincott Co., 1966), p. 528.

> Menlo Park, New Jersey and Elmira, New York, and for the recruitment of effective personnel to carry on the work in them if treatment decisions are to be more soundly guided.[1]

As each state instituted its program it became more apparent that there was no experience factor on which to base decisions pertaining to such things as staff, functions, physical plant, and similar problems. As a result, the centers were established and began operation using the juvenile programs as a pattern.

There were, of course, differences. Each of these states developed certain kinds of programs unique to their needs. This was done, however, with much experimentation and trial and error. There has not been a comprehensive survey made to determine the results of these early programs. The end product within each state has undoubtedly produced many ideas which would be of value to other states which are either not as well developed or are just starting a program of this type. The focus of the problem at the present time, therefore, is an evaluation of the adult reception-diagnostic centers at their present state of development.

Often we find that ideas, concepts, and plans evolve with little consideration or study of what problems have been encountered elsewhere in the same or parallel enterprises. It is important, then, to subject this reception-diagnostic concept to a degree of scrutiny which will bring into focus those areas which can be identified as common problems and to clarify the goals of these programs.

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[1]Paul W. Tappan, "Objectives and Methods in Correction," Contemporary Correction, ed. P. W. Tappan (New York: McGraw-Hill, 1951), p. 14.

> Our diagnostic and treatment methods should be analyzed and appraised continually to determine whether they are most produc- give. There must be continual search for new and better methods. It hardly need be said that current workloads in the diagnostic and treatment areas are too high to permit the intensive work efficient correctional treatment demands.[1]

Basic Assumptions

The very basis of this effort is predicated upon certain assumptions which lend themselves to ready acceptance. First, it is assumed that most states have or are planning to have, a functional program within, or directly related to, their Correctional Division which can be defined as being within the purview of the reception-diagnostic concept. The second assumption is that a survey questionnaire can be developed to elicit current, accurate, and sufficient data for a valid comparative study and analysis of the various programs now in existence.

Procedure

A survey was made of literature in the field from 1945 to 1967, inclusive, as found in the Florida State University Library. Information dealing specifically with the reception-diagnostic center was limited and it was, therefore, necessary to include the general area of classification to insure an adequate analysis.

A survey questionnaire was designed consisting of fifty items, so constructed as to probe the functions of ten specific areas within the reception-diagnostic center. The questionnaire was pre-tested by submitting

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[1]Frank Loveland, "The Classification Program in the Federal Prison System: 1934-1960," Federal Probation, Vol. 24 (June, 1960), p. 12.

it to administrative officials of the Florida Division of Corrections and selected graduate students in the field of Criminology and Corrections at Florida State University. Based on this pre-testing phase certain changes were instituted to insure proper wording clarity, accuracy, and uniformity of understanding.

The questionnaire was then mailed to the Division of Corrections, or its equivalent, in each state in the United States.[1] It was recognized that each state did not have a reception-diagnostic center, however, some states conduct a diagnostic program within their main correctional institution, therefore, to insure that these operations were included, each state was given the opportunity to participate. The Directory of Correctional Institutions and Agencies was used as a source list to insure mailing to the proper agency.[2] Enclosed with each questionnaire were two cover letters explaining the study and its significance. The first letter was from the Director of the Florida Division of Corrections and the second from the author of this study.[3] A self-addressed envelope and a post card were also enclosed. The post card was used as a means of identifying receipt by each state and to have on file an accurate address for each reception-diagnostic center. Twenty days after initial mailing, a follow-up

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[1]See Appendix C.

[2]American Correctional Association, Directory, Correctional Institutions and Agencies of the United States of American, Canada and Great Britain (Washington, D.C.: By the Association, 1966).

[3]See Appendix A and B.

letter was sent to those states which had not responded.[1] Fifteen days after the follow-up letter was mailed the survey was concluded, and the data from the completed questionnaires were analyzed.

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[1]See Appendix D.

CHAPTER II

SURVEY OF THE LITERATURE

Since the beginning of the reception-diagnostic center found its basis in the systems of classification being used throughout the various correctional institutions, much of the material which has been published deals with the general area of classifying the inmate upon his entry into the correctional program. Presently there is no single text or publication which deals exclusively with the subject, and studies which demonstrate any degree of depth are not available. Rarely does one find an author or researcher who has an insight into the importance of reception and diagnosis in the correctional process. A survey of a broad spectrum of the literature indicates several authors, who, at least, take cognizance of the fact that there is a movement under way in the area of classification which is highly specialized and which will have an infinitely greater impact on penology than anything prior to it.

The development of classification has not been a single, all encompassing procedure, but rather a combination of four distinct phases in the study of the inmate. Diagnosis makes up the first phase and consists of an analysis of the problems presented by the individual through medical, psychiatric, and psychological examinations; through educational and vocational studies, and through casework interviewing. The concentration of the present study is focused on this diagnostic phase. The

second phase consists of a program plan of treatment and training. If these two phases are to be of any value it is obviously necessary to implement the plan or program of treatment. Phase three consists of implementation of the plan. The fourth and final phase of classification is reclassification or modification, if necessary. This will require a monitoring of each individual program and a decision as to whether or not it should be modified.

To speak of the process of classification, then, is to speak of a system or method rather than a separate and distinct, self-sustaining, procedure. It is the broad scope of activities concerned with the study and assignment of the inmate, acting as the general framework, within which the process of reception and diagnosis will accomplish its job Loveland states the objectives of the classification system rather succinctly:

> The development of an integrated and realistic program for the individual, arrived at through the coordination of diagnostic, planning and treatment activities; and an informed continuity in these activities from the time of commitment until release.[1]

The process of classification is not, of course, an exclusive system of the United States. Many countries have used similar methods in their prison systems for many years. In some instances the United States is considered to be behind in its methods. As recently as 1963, Italian authors writing in the Federal Probation made the following comments:

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[1]Frank Loveland, "Classification in the Prison System," Contemporary Correction, ed. P. W. Tappan (New York: McGraw-Hill, 1951), p. 92.

> Classification in the United States, even in the better institutions, is not based upon the highly professional diagnosis found at Rebibbia. But even more important than this difference is the fact that in the United States classification boards generally make a decision only on the particular institutions to which the inmate will be sent. The type of custody and program of that institution is the determining factor, as the board tries to fit the individual to the institution. Although the principle of individualized treatment is virtually the same in both countires, the Rebibbia procedure again appears to be much more intensive, elaborate and precise. The Institute not only has the benefit of its detailed clinical observations on the inmate's etiologic factors, but then carefully uses these data for planning a treatment program geared closely to his needs and problems. Thus, not only the kind of institution but the type of training, therapy and custody, are presented to the instituion to which the inmate is sent, for guidance on how to train and rehabilitate the offender. This extension of diagnosis and prognosis into treatment is a full expression of individualization which is the rule rather than the exception at Rebibbia.[1]

It is important to note, however, that recently, progress has been made in many states, and these new systems of reception and diagnosis certainly are as competent, if not more so, than those of most other countries.

That part of classification, then, which is central to the system consists of diagnosis and the physical manifestation of this function is embodied in the reception-diagnostic center.

Ideally the process of diagnosis and treatment should be accomplished by the same clinical personnel. This would enable the clinician to develop the initial program for the inmate, based upon the information made available through the various tests and interviews, and then follow through with the program making whatever changes are deemed necessary as the inmate responds.

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[1]Franco Ferracuti, Mario Fentanesi, and Marvin E. Wolfgang, "The Diagnostic and Classification Center at Rebibbia, Rome," Federal Probation, Vol. 27 (September, 1963), p. 34.

This system would require a complete diagnostic and clinical staff at each institution with the capability of developing and maintaining a total treatment program.

> The diagnostic evaluation is based on the belief that rehabilitation assistance and proper release as soon as the public interest and that of the individual prisoner will allow are primary considerations. Prisons must protect society against those who commit crimes, especially the ruthless and violent criminals, but vigorous efforts can be made to diagnose and treat those disorders that lead to criminal behavior. The treatment approach is somewhat less primitive and more rehabilitative. The practice of separating prisoners on the basis of age and then locking up youthful offenders and hardened criminals and forgetting about both categories is far from satisfactory.[1]

The problem of economic support for this kind of program has necessitated a certain amount of compromise. Although the reception-diagnostic centers, as presently established, do not meet the ideal situation, they are a step toward that goal.

> The disadvantages of the diagnostic center is that it is not integrated with the total prison program. Diagnosis and therapy have to be done by the same individual in order to be effective to the optimum degree. They are inseparable, anyway, in the practical situation. The most fruitful approach to this problem would seem to be the establishment of the reception center as part of the major institution in the jurisdiction to receive all prisoners, to administer routine tests, and the persons obviously belonging to another facility in the system would be sent there within a few days for further study and programing by the professional people who will be responsible for their therapy. The majority of new prisoners would remain at the reception center for diagnosis, programing, and orientation.[2]

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[1]William H. Cape, "A Psychiatric Reception and Diagnostic Center for Prisoners," American Journal of Correction, Vol. 29 (January-February, 1967), p. 9.

[2]Vernon Fox, "Blueprint for the Progressive Prison," Federal Probation, Vol. 20 (June, 1956), p. 22.

Classification, as it is now understood, is generally accomplished in each institution within the correctional system of a given state. The process is often only a cursory examination of the inmate's records and quick assignment to the area which is shortest of manpower. An alternate method might be to base the decision entirely on the type of security required for the inmate, with little consideration for rehabilitative needs or potential abilities. Neither the state nor the inmate gain from this sort of superficial classification. The Manual of Correctional Standards indicates:

> Correctional institutions and agencies can best achieve their goal of rehabilitation by focusing their attention and resources on the complete study and evaluation of the individual offender and by following a program of individualized treatment.[1]

To be of any value whatsoever this process of individualized treatment must start as soon as possible after sentencing by the court. From a very practical standpoint, of course, the correctional institution must have the inmate in its control before its influence can be felt. Hopefully, the inmate will not be sent directly to a correctional institution upon sentencing, but rather to a reception-diagnostic center. Here, in the center, he will spend his first thirty or sixty days being analyzed and studied to determine which of the state correctional facilities has the kind of program which will be of most value in effecting his rehabilitation back to society as a useful citizen. This initial exposure to the correctional

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[1]American Correctional Association, Manual of Correctional Standards (Washington, D.C.: By the Association, 1966), p. xxi.

procedure is of vital importance and may be the deciding factor in determining whether there will be success or failure with this particular offender.

> The period immediately following the admission of an inmate is, therefore, one of great significance for the program of classification and treatment. It is during this period that the diagnostic procedures essential to the planning of the treatment program are placed in operation. It is a period of fundamental importance to the inmate since it is at this time that he receives his first impressions of institutional life, has his first experience with the personnel and begins to learn of the institutional facilities available for his training and treatment. It is during this early stage that attitudes are formed which will determine his future adjustment to the institution and his acceptance of the rehabilitative program.[1]

All of the skill and knowledge of a highly qualified and dedicated staff may be to no avail if the attitudes of the inmates are not intelligently and adequately developed during this initial contact.

> No time may be more important to the prisoner, in determining his later attitudes and patterns of behavior, than when he enters the institution. He may entertain the layman's concept of the prison as a place of punishment. He may be in the throes of emotions, such as guilt, anxiety, resentment, self-pity, depression, remorse, and hostility. Few prisoners bring with them any reality based understanding of the correctional program or any real hope of profiting from this experience. Most have erroneous preconceptions gained from other prisoners while in jail awaiting trial or commitment. The reception period immediately following admission to prison is, therefore, of great significance. Intimate and skilled counseling is especially necessary to help the inmate start his efforts to gain insight into his situation and to accept what he, himself, must do about it.[2]

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[1]American Prison Association, Handbook of Classification in Correctional Institutions (Philadelphia: The American Foundation Studies in Corrections, 1965), p. 38.

[2]Manual of Correctional Standards, p. 354.

It is this initial impact upon the inmate which must be so carefully controlled. At no other time do we have the psychological advantages that are present during those first few weeks in the institution. If this period is not wisely utilized, there will undoubtedly be a far greater investment in terms of time and personnel during the period that the inmate is serving his sentence.

> While not discounting the fact that we continue to learn about the individual after he has left the admission-orientation unit, experience over the years has demonstrated that intensive study during the first thirty days can accurately provide the information for planning sound programs in most cases. There is every reason to start the individual on a well-planned program with goals as specific as possible and as soon as possible after commitment. The alternative is time consuming drifting.[1]

There are two important considerations which are evident throughout the literature on reception-diagnosis procedures. First, the center should be a separate institution whose primary function is the study and analysis of all persons sentenced to the correctional system. Secondly, the institutions to which an inmate may be assigned to serve his sentence should be specialized in such a way as to be planned and staffed for the rehabilitation of a distinct type of offender. Even if a state were to have an outstanding diagnostic facility, it could not function adequately, nor successfully, if the results of the complex diagnostic process were simply filed, and the inmate assigned to an institution on the basis of security requirements.

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[1]Loveland, Federal Probation, Vol. 24, p. 9.

> The action of the Center would conform to the general purposes of institutional training, it would be the responsibility of the Center to transfer to a given institution only those offenders who are considered amenable to the program in operation at that institution. Thus, the admission summary, prepared by the professional staff during the initial quarantine period of each offender at the Center, when supplemented by data determined thereafter, would serve as the medium of interpretation and understanding of individual behavior and become a guide to intelligent treatment by an institutional administrative staff and other law enforcement and social agencies who may have later contact with the offender.[1]

The diagnosis itself is the culmination of the professional opinions of the clinical staff and is of value only when applied to a supporting treatment program. The treatment phase should be clinically oriented and have as its goal a change in the attitudes of the inmate. As an adjunct to the treatment of the inmate, part of the total program should be training in a skill which will be of value to him upon his release.

> The reform of the prisoner is sought through the care, training, and employment which he receives. The underlying philosophy of the Guidance Center is that a proper diagnosis of the factors which led to the crime will enable the experts to devise a program of activities for each prisoner which will facilitate his rehabilitation. Specifically, his work in the prison will help to reform him and will give him those skills which will enable him, after his release, to find his place in society.[2]

Even now, as the growth the expansion of the reception-diagnosis concept is being recognized throughout the United States, many people still ask, "Why do we need the reception-diagnostic center and how will it improve the correctional system?" The question has been anticipated and the answer lies in the following clear and concise statement of the center's function:

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[1]Edmund R. East, "Classification Reception Centers," Journal of Criminal Law and Criminology, Vol. 36 (1945), p. 245.

[2]Harvey Powelson and Reinhard Bendix, "Psychiatry in Prison," Psychiatry, Vol. 14 (February, 1951), p. 75.

> The importance of the functions performed by the Reception-Guidance Center becomes evident from the following considerations: 1) the Guidance Center may be the prisoner's first contact with State penal institutions, and the orientation adopted by him determines in a significant measure whether his participation in rehabilitative programs will be constructive or otherwise; 2) the classification by the Center on the basis of the Cumulative Case Summary initiated by its staff provides the principle source of information for the correctional program pursued by the Department of Corrections while the individual is within its jurisdiction; 3) court decisions as to the propriety of imprisonment or some other form of sentence in cases of convicted but unsentenced felons referred to the Guidance Center are significantly influenced by the Center's reports and recommendations.[1]

Perhaps the most complete and carefully constructed answer comes from Edmund R. East:

> The establishment of a Classification Reception Center would provide a more effective and flexible method of handling convicted juvenile and adult offenders than exists presently in the majority of states. Outstanding among the many advantages of this premise are the following:
>
> 1. There can be more adequate institutional classification placement of committed offenders to penal or correctional establishments designed in purpose, organization, training, facilities and personnel to cope with the special problem each offender presents.
> 2. In view of the altogether too frequently demonstrated misplacement of offenders by the Courts, occasioned by the lack of facilities for assembling of verified data concerning them and a lack of knowledge of the available institutional programs most appropriate to meet their needs, many custodial problems early recognized by professional staffs can be avoided through facilitation of transfer.
> 3. The same facilitation of transfer, promoted by the establishment of a Center, can be of great assistance to an institution in contending with the custodial problems which arise as a result of the mal-placement and mal-adjustment of the offender during the period of confinement, and thereby removing administratively a detriment to the well-ordered operation of an institutional program.

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[1]June W. Stahl, "Caged or Cured: Classification and Treatment of California Felons at the California Medical Facility," Journal of Criminal Law, Criminology and Police Science, Vol. 56 (June, 1965), p. 177.

4. There can be an improved and more productive coordination of the sentencing, institutional and parole functions in discharging their general purpose, i.e. the protection of society and the ultimate rehabilitation of the offender, through the resultant ability for constructive, cooperative, long-range program planning.

5. A recognized Center can serve as the main focal point for the reception, utilization, and distribution of material from community agencies concerned with the individual case.

6. Through the establishment of a Center, there would be a natural conformity on the part of the institutions concerned toward a more uniform practice for the assembling and presentation of material concerning each offender and a consequent standardization of procedure in the use of the material assembled, thereby initiating more consistent institutional standards of dealing with individuals.

7. It is evident that the addition of a Classification Reception Center at an institution where adequate facilities for classification already exist would be far more economical, in initial establishment and subsequent operation, than the erection of a structure specifically designed for this purpose.

8. At a Center, there can be more extensive concentration of professional staff concerned with the systematic study and treatment programming of each offender; thereby, fewer professional staff members would be required at each of the other receiving institutions presently needed to fulfill this same function.[1]

In surveying the background of correctional concepts, it is immediately apparent that reception-diagnosis, as a separate and distinct entity, is still comparatively new. It will require study, evaluation, and dedication to its purpose to bring it to the fulfillment of its total capabilities. Problems will arise, but their challenge and solution will bring us that much closer to the ultimate technique in total rehabilitation of the institutional offender. The President's Commission on Law Enforcement and Administration of Justice recognized the necessity for continued emphasis in this area when it included the following recommendation in its report:

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[1]East, Journal of Criminal Law and Criminology, Vol. 36, pp. 246-247.

> Screening and diagnostic resources should be strengthened, with Federal support, at every point of significant decision. Jurisdictions should classify and assign offenders according to their needs and problems, giving separate treatment to all special offender groups when this is desirable.[1]

The results indicated in the reception-diagnostic centers up to now have been positive, and it is imperative that correctional systems constantly utilize as many of these positive processes as possible in their search for the key to returning the inmate to the community as a useful and productive member of society.

> It is logical to conclude that a possible decrease in a delinquency within a state may result from the reduction of contact between more or less experienced offenders, the increased opportunity for the individual to benefit himself during his period of confinement through his contact with an institutional personnel able to devote more time to his problem, and his exposure to a highly intensified program designed to meet his particular needs. This should reduce the probability of his further participation in delinquent activities. When such individuals are released to the community, the cumulative influence of their behavior should be less hazardous to society as a result of the training initiated for them at a Classification Reception Center.[2]

The literature, then, reflects the acceptance of the reception-diagnostic center in principle and practice. There is recognition of the trend toward a treatment philosophy of the inmate through qualified diagnosis and adequate treatment programs designed to return him to society as a productive citizen. It is agreed that the present system is far from the ideal in diagnosis and treatment, but the present facilities demonstrate a progressive approach to the requirements of this phase of the total correctional program.

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[1]U.S., the President's Commission on Law Enforcement and Administration of Justice, The Challenge of Crime in a Free Society (Washington: Government Printing Office, 1967), p. 180.

[2]East, Journal of Criminal Law and Criminology, Vol. 36, p. 248.

CHAPTER III

RESULTS OF SURVEY

Survey Response

In examining the information which will be presented, there are two important considerations. First, the study is concerned only with adult reception-diagnostic centers, therefore, even though questionnaires were initially sent to every state in the United States, all were not expected to respond. Second, it was anticipated that not all questions could or would be answered by all respondents, since the questionnaire was detailed and covered every phase of the reception-diagnostic center operation. In many instances, as an example, the reception-diagnostic procedure is being accomplished within the physical plant and staff structure of the main prison of the state. Answers to certain questions would, under these circumstances, be at wide variance with those of the separate institution. Table 1 indicates the responses by type and the number of states in each response category.

Specific types of responses for each state are listed separately.[1] To amplify the categories in Table 1, a brief explanation of the breakdown will be helpful. Of the fourteen states in the "No response" category, it was found that none of them presently has an operational reception-diagnostic center of any type. The lack of these responses, then, had little effect upon the main purpose of the survey.

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[1]See Appendix E.

TABLE 1.--Number of states in each response category

Type of Response	Number
Completed questionnaire	24
Did not complete questionnaire	26
Letter response[a]	12
No response	14

[a]These states indicated in their letters that their diagnostic programs were either nonexistent or on such a limited scale that their answers to the questionnaire would be invalid.

Of the twelve states in the "Letter response" category, none of these presently has an operational center. The twenty-four states that returned completed questionnaires included all twelve fully operational reception-diagnostic centers for adults.

Based upon the fact that the survey was designed to determine the present status of general operations, functions, and procedures of adult reception-diagnostic centers, the twenty-four completed questionnaires were studied to determine whether their answers indicated an acceptance of the basic procedures generally associated with the reception-diagnostic center. The questionnaires from the twelve operating centers were immediately accepted. Four of the remaining questionnaires were considered to meet the needs of the survey; thus a total of sixteen questionnaires were acceptable for analytical purposes. An exception to this number was in the three opinion type questions at the end of the questionnaire; all twenty-four completed questionnaires were used to develop this analysis. It was considered appropriate to use all responses

because, even though the other sections of the questionnaire were not applicable, the respondents indicated a sincere interest in these opinion questions and answered them quite candidly. It should also be pointed out that all questionnaires were studied to develop the discussion of each of the areas of interest, but where numerical comparisons are indicated, they are based on the sixteen selected questionnaires.

Analysis of the Data

The study seeks to analyze ten specific areas or procedures which are basic to the functioning of the reception-diagnostic center. These areas are:

Personnel	Transfer Procedures
Administration	Reports
Reception Procedures	Follow-up Procedures
Program of Activities	Staff Conferences
Testing Program	Problem Areas

To facilitate clarity of presentation and ease of comparison, each of these areas will be discussed separately. It must be understood that in many instances there is some overlap of these procedures and often the results of one action are reflected in the results of another.

Throughout the discussion there will be statements concerning accepted standards within the correctional field. The general procedure will be to base the analysis on a comparison of the standards and the findings of the survey. All references to standards are based on two publications: (1) Handbook on Classification in Correctional Institutions, (2) Manual of Correctional Standards. Both publications were compiled by committees of leading authorities in the correctional field and are recognized as the best available guidelines for corrections.

Personnel

The first area of consideration in the survey was that of personnel. This area may be considered of primary importance and has an immediate and absolute effect on all other phases of the center's operations. Qualified personnel are absolutely essential for the center to accomplish the purpose for which it was designed. The fundamental objective of the correctional system should be the selection of qualified persons who are interested in correctional service as a career. Selection should not be based on political, racial, religious, or other nonprofessional influences. Standards have been established for the minimum staff requirements, however, they are not included here because excessive variance of responses to the survey precluded any comparative analysis.[1] The minimum educational standard of a high school education has been established for the correctional officer. Other staff positions do not have established standards, except those implied by the professions to which they belong. The staff of the reception center should be separate and independent and responsible only for the operation of the center.

The survey indicated that present staffing standards are as varied as the number of states. In many instances, dual utilization of staff is necessary. Under this system the reception-diagnostic center is usually located within the physical plant of another institution and the staff divides its time and talents between the two institutions. Although this

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[1]Handbook on Classification in Correctional Institutions, p. 26.

is not the recommended standard, it is being practiced in ninety per cent of the institutions with at least two members of the staff functioning in both institutions.

All institutions reported a continuous problem in recruiting qualified staff members. Although it is not the only reason, salary range was mentioned frequently as an area requiring immediate improvement. Assuming that salary requirements are brought to an adequate level, it is, then, the individual staff members personal association and involvement with his work which will bring the most satisfaction. Recruiting and retention must go beyond the discussion of adequate monetary return. The professional dedication to an idea is just as strong, if not stronger, an incentive to become a part of a progressive state correctional staff.

As previously indicated, standards for staff positions are lacking, except for those imposed by the specific professional field to which an individual member might belong. The information in Table 2 is an indication of the widely accepted educational level required for the specific staff positions. It does not imply standards, but does demonstrate that there has been an effort to maintain a high educational level.

TABLE 2.-- Educational requirements of specific positions within the reception-diagnostic center

Institutional Job Title[a]	Education Required		Level Required By Most Institutions
	Max.[b]	Min.	
Director	6	3	4
Assistant Director	6	4	5
Case Coordinator	6	3	5
Psychologist	6	5	6
Education Counselor	6	4	5
Academic Teacher	4	4	4
Vocational Counselor	6	4	4
Vocational Teacher	4	2	2
Recreation Director	6	2	4
Recreation Instructor	4	2	2
Social Worker (Sociologist)	6	4	5
Head Clerk	4	2	2
Clerk	2	2	2
Stenographer	3	2	2
Deputy Chief Cust. Officer	2	2	2
Custodial Officer	2	2	2

[a]Positions of psychiatrist, chaplain, physician, dentist, and registered nurse are not shown because educational requirements are generally established by the professions.

[b]Educational Requirements Number Code:

1 - Less than High School
2 - High School Graduation
3 - Some Undergraduate College
4 - Undergraduate Degree-Diploma
5 - Some Graduate College
6 - Master's/Doctor's Degree

Administration

This section was designed to gather information which was directly related to proper administrative procedures. Since physical location, in relation to other institutions, has an effect on administration, it was also considered. The standard, at the present time, is that reception centers will achieve their greatest usefulness and best efficiency if located outside of, and administratively separated from, any other institution. Clerical, custodial, and clinical personnel should be separate from, and independent of, any other institution. Inmates being processed through the center should be housed separately. Inmate employment within the center is not recommended, however, selected inmates may be assigned to the center, on a limited basis, to work at maintenance type jobs. As little restriction as possible should be placed on inmate correspondence, however, all mail should be censored.

The survey indicated that only twenty-five per cent (4) of the centers are located on separate real estate. Twenty-five per cent (4) are physically separated from, but on the same real estate as, another institution. Fifty per cent (8) are physically located within the buildings of another correctional institution.

Housing for inmates being processed through the center was closely related to physical plant: forty-four per cent (7) housed them in the same buildings as, but segregated from, inmates of another institution; thirty-one per cent (5) housed them in a separate building, but on the same real estate as another institution; and twenty-five per cent (4) housed them only at the center, which was a separate institution.

Average monthly prisoner input for the centers ranged from twelve to four hundred ninety. Thus it is immediately apparent that staffing requirements vary widely. Most centers indicated approximately one hundred fifty inmates as an average monthly input.

Average daily population varied with an equally wide spread from twenty-five to five hundred twenty-five; the median number was two hundred seventy.

In terms of daily per capita expenditure, there was an average cost of $4.82 per inmate. Range of costs was from $.35 to $8.78 per day.

All centers indicated that they are dependent upon other institutions for certain administrative support. In each of the three major administrative areas, the centers are either self-supporting or dependent upon another institution for assistance. Table 3 indicates the support requirements for each of the administrative areas. Inmates are utilized to assist in center operations in eighty-one per cent (13) of the centers and functioned as food service personnel, janitors, clerks, photographers, and barbers. It would appear that this is done in the interest of economy of operation and will always be found to a certain degree.

Careful check should be made of the inmate's correspondence, both incoming and outgoing, not only for security reasons, but to gain information in regard to his relationship with his family. A good censor of correspondence, working closely with the social workers, can materially assist in interpreting the family picture. Inmate incoming mail was

censored in eighty-one per cent (13) of the institutions and outgoing mail was censored in all of them. Weekly individual mail allowances ranged from one letter outgoing and two letters incoming, to seven letters outgoing and no limit on incoming. The rule here seems to depend upon the capacity of the censor to keep up with the volume permitted.

TABLE 3.--Self-support or dependency in administrative areas of the centers

Administrative Area	Institutions Self-supporting	Institutions Dependent
Clerical	56%	44%
Clinical	31%	69%
Custodial	31%	69%

Reception Procedures

Reception procedures represent a multitude of administrative details which must be accomplished rapidly. skillfully, and with a great deal of accuracy. They make up the inmate's initial exposure to the institutional program and will have an immeasurable influence on his attitude throughout his incarceration. The idea in this section of the questionnaire was to gather some general basic information about this reception period. The standards indicate that all inmates should initially be sent to the reception-diagnostic center. Upon arrival, a member of the clinical staff should meet the inmate. In-processing

should be accomplished as rapidly as possible to insure maximum time for clinical evaluation and a minimum time spent at the center prior to assignment to another institution. It has been found very helpful for new inmates to have their interview with the chaplain within two or three days after arrival. An official letter should be sent to the inmate's family immediately indicating his arrival at the center and enclosing such basic information as hours and rules for visiting.

Not all inmates are sent through the reception center, as was indicated by thirty-eight per cent (6) of the respondents. Those inmates who are sentenced to death are excluded. Females are also excluded and sent directly to the women's detention facility.

It is important that a member of the clinical staff be present to contact the inmate upon arrival. Most of the centers indicated that a member of the medical staff (physician, male nurse, medical technician) was the first clinical staff member to see the inmate. This was routinely done during the physical examination. It would be more appropriate to have a clinical staff member, other than the medical staff, make the initial contact with the inmate. This is a crucial time for him and usually requires a supportive relationship. The rapport developed at this time will often prove valuable during the testing and evaluation period.

In all institutions the entire in-processing procedure was accomplished by the end of the second day, at the very latest. In half the institutions these procedures were carried out on a twenty-four hour basis if necessary.

The question concerning whether or not an official letter was sent to the inmate's family indicated that fifty-six per cent (9) were sending one. In all institutions the letter was sent out on or before the third day after the inmate's arrival. Two items were most often enclosed, (1) the visiting rules, and (2) an inmate history questionnaire to be completed by the family and returned. Only one institution indicated that it had tried the letter without success and had therefore discontinued it.

Program of Activities

A regularly scheduled program should be established for the inmate which will be followed during his stay at the center. This program should include educational classes, vocational activities, and recreation. In the activities part of the questionnaire, information was requested about these three areas of interest. Thirty-eight per cent (6) of the centers said they are conducting education classes and each reported that these classes are considered to be a "testing situation" as opposed to a "teaching situation." This follows the procedure recommended by the standards, since all phases of reception-diagnostic center procedure should be, in some way, designed to test the inmate's response to given situations. Only one institution said they had a vocational training program, and once again it was considered a "testing situation."

Two of the sixteen institutions reported a physical training program, which was required in each instance. Eleven institutions were conducting a full scale recreation program, of which eight were voluntary and three were required.

Testing Program

One of the major reasons for the existence of the center is to administer tests and examinations to the inmates to assist in developing a proper diagnosis. It is desirable that this testing be completed as soon as possible after arrival of the inmate. Table 4 shows the number of the day on which the listed tests or examinations were completed. Day number one would be the day of arrival at the center and each succeeding day is numbered consecutively.

TABLE 4.--Day of completion of various examinations

Type of Examination	Earliest Day of Completion	Latest Day of Completion	Average Day of Completion
Medical Examination	1	4	3.4
Dental Examination	1	10	3.4
Educational Tests	2	10	5.2
Psychological Tests	2	15	11.3
Psychiatric Interview	5	20	6.6
Social History Interview	2	19	6.6
Chaplain Interview	2	22	7.7

The development of the background and history of the inmate constitutes an important segment of the total analysis. The sources of this information are relatively standard in each center. The majority of respondents listed the following, in order of frequency, as their primary sources:

1. Family
2. Employer
3. Interview with inmate
4. Military records
5. Court records
6. D. A. report
7. F.B.I.
8. Educational questionnaire
9. Pre-sentence investigation
10. Medical history
11. Arresting Officer's report
12. Delivering Officer's report

Half of the centers reported that an educational test was given to all inmates being processed. The other half indicated that there were exceptions such as elderly inmates and those who were illiterate.

Sixty-three per cent (10) indicated that psychological tests were administered to all inmates being processed. Thirty-eight per cent (6) reported there were exceptions who were not tested, with low I.Q. being given as the major reason.

Transfer Procedures

The problem of who assumes legal custody when the inmate is assigned to the center is solved in eighty-eight per cent (14) of the states by having the inmate committed to the Division of Corrections. This seems to be the best and most expeditious procedure and tends to eliminate many administrative problems when transfer takes place from the center to a specific institution.

Prior to transfer to another institution, the inmate must complete his evaluation at the center. The time spent at the center is generally dependent upon the depth of the testing and diagnostic procedure, and, in addition, any law which limits the amount of time. There was a law specifying maximum time in only four states. One state limited time to thirty days; another to sixty days; and two states to ninety days. Table 5 shows

the number of days an inmate spend at the center prior to being assigned to another institution. This time is required by the center to properly analyze the test results and prepare a complete diagnostic and treatment program.

TABLE 5.--Elapsed number of days at center before transfer

Range of Days	Maximum	Minimum	Average
Minimum number of days	60	5	23.3
Maximum number of days	120	27	43.9
Average number of days	64	10	28.6

Reports

The diagnostic evaluation is the most important single document developed by the center. Eighty-eight per cent (14) of the center indicated that they maintained a copy of each evaluation for an indefinite period, the other retaining a copy for a specific number of years, or not at all. The two major purposes reported for keeping copies were (1) for use with recidivists, and (2) for research purposes.

All institutions said that the evaluation report was a privileged document. It was, however, releasable to a court, a court representative, or a penal institution. Law enforcement agencies were granted access upon permission of an authorized court. Normally, records were not allowed to be taken from the center.

Follow-up Procedures

Unless the center has some method of determining whether its recommendations are being followed, it is extremely difficult to make necessary changes to facilitate improved diagnosis and assignment. All centers reported that, in their opinion, their recommendations were being followed fifty per cent of the time or better. Thirty-one per cent (5) of the centers reported that, in their opinion, their recommendations were followed in all cases.

Staff visits between the center and the various correctional institutions within the state are considered highly desirable and should be accomplished whenever possible. Not only does it give the staff member an appreciation for the other institutions, but also develops a much closer working relationship among members of the staffs. Some indication of the present staff visit program is shown in Table 6.

TABLE 6.--Number of institutions making inter-staff visits between receiving institutions and reception-diagnostic center during past two years

Type of Visit	All Staff Members	Half of Staff	Less Than Half
Visits to R-D centers by institutional staff	7	6	3
Visits to correctional institution by R-D staff	11	3	2

Staff Conferences

The staff conference is normally held for one of two purposes. First, there is the administrative conference, for the purpose of discussing operational and functional problems. All key personnel attend and the chairman is the director of the institution or his immediate assistant. This conference may also be utilized for training purposes, however, it should not be a substitute for regularly scheduled in-service training sessions.

The second purpose of the staff conference is for clinical discussion. This conference is normally attended by at least one member of each of the clinical sections and is less formal in its conduct of business. Its purpose is to discuss inmate case progress reports and arrive at a diagnosis and treatment plan. The chairman may be the institutional director, his immediate assistant, or the senior clinical staff member.

Standards for the staff conference have not been established, since the frequency of meeting and membership are dependent upon the specific institutional staffing and the demands of clinical and administrative caseload.

The survey indicated that all respondents held weekly staff conferences for both purposes. In two centers, special note was made of a monthly administrative staff conference where all available staff members attended. This was an opportunity for the Director to address the entire staff and enhanced communication at all staff levels.

Comments

The final section of the survey consisted of three open-end questions. These were designed to give the respondent the opportunity to reflect upon the knowledge and experience gained at his center. The questions contained no structured responses or any indication of positive or negative approach. The respondent was at liberty to comment freely.

The responses to these questions were quite candid and elicited firm opinions from the respondents. It is possible that the present job position of the respondent may have some influence on the kind of answer given. Information about the respondents indicates that the questionnaires were completed in four states by the Director of the reception-diagnostic center; in seven states by the Associate Director; and in five states by the Chief of Classification. It is surmized that the personnel filling these staff positions are representative of the opinions of the various staff members.

The first question asked for an opinion concerning the suggestion that the reception-diagnostic center also become the inmate medical treatment center for the state correctional system. The concept would be that all inmates who become seriously ill within state correctional institutions would be transferred to the diagnostic center for treatment. Upon complete recovery, they would then be returned to the institution to which they were assigned. The range of illness would include all physical disorders and the less serious mental problems. Serious mental illness problems would be under the care of the state mental hospital.

There are several advantages to such a proposal. The individual institutions would be relieved of the responsibility for the care of medical problems. The center would have a better medical staff and more extensive equipment with which to correct these problems. Budgetary allowances for medical support could be concentrated on the center and therefore effect certain economy of operation. In addition, it would give the center staff the opportunity to do more than just diagnosis. They would also be able to use their knowledge and skills for treatment, which is a major part of their training.

Respondents to the question were equally divided in their opinions. Seven of the answers were definitely in favor of the proposal; seven were definitely opposed to it; and two did not comment.

The following statement represents a composite view of those who were in favor of the proposal:

> The additional capability of the diagnostic center to function as a central medical facility would provide a better equipped and better staff center. It is more likely that professional consultant services would be available. Clinical staff would be more easily recruited and retained if able to engage in treatment in addition to diagnosis.

A composite statement of those opposed to the proposal is as follows:

> The function of the center is diagnosis, evaluation, and recommendation of a treatment program. Medical treatment is an entirely separate function and should be accomplished in a separate institution. The full time of the staff is required to meet the needs of adequate diagnosis and evaluation.

Question number two dealt with problems which were being encountered by the center at the present time. Respondents were asked to identify the two most important problems. Basic to the solution of these problems was

the lack of sufficient funds in the current budget. Because it is an ever present problem, funding has been eliminated from consideration.

Responses are shown below in descending order of important as indicated by the number of times each was mentioned in the comments.

1. Continued difficulty in recruitment of professional staff. (7)
2. The lack of space and facilities to accomplish the requirements of the center. (7)
3. The lack of quantity and quality in inter-departmental communications. (2)
4. The lack of quality in evaluation and diagnosis.
5. The excessive amount of time spent in administrative processing. (2)
6. The orientation for the staff is totally inadequate. (2)
7. The inadequacy of the custodial staff, both in quality and quantity. (1)
8. The poor location of the physical plant. (1)
9. The physical plant is poorly maintained. (1)

The final question in this section asked for the two problems which were most prevalent during the opening phase of the center. This question elicited the least comment, primarily because most of the centers had been operating for many years and therefore present staff members were not aware of the problems previously encountered. In the responses received, however, the problems indicated are the very same ones which are still having an adverse effect upon center operations.

Major responses were as follows:

1. The center should have been built as a separate institution. (4)

Present thinking and standards agree with this statement. States which replied that they were in the process of planning or building centers all indicated that the new structure would be a separate institution.

2. The initial staff was not large enough to accomplish the job. (2)

   The standards recommend: In planning a Reception Center the following steps should be taken in determining the number of personnel required: First, what will be the average intake per month and per week? This will determine the volume of clerical work and the rapidity with which it must be done. Second, housing capacity must be known accurately. Third, the length of stay of the inmate at the center must be determined by the policy with regard to the type of analysis of an inmate desired by the authorities.

3. The salary range was inadequate to attract qualified personnel. (2)

   Proper budget planning and careful fund allocation will help in solving this problem. It requires constant reevaluation.

4. The center should have been built as a new facility rather than to remodel an old one. (2)

   Prison architecture and the building industry are rapidly developing vastly improsed methods and material. It is often false economy to attempt to fit the requirements of the reception-diagnostic center into an outdated physical plant.

All other comments made in reply to this question were essential the same as, or are included in, those discussed above.

There will, of course, always be problems involved in operating an institution with the complexity and responsibility of a reception-diagnostic center. It becomes a matter for efficient management to concentrate their efforts and resources on those areas of greatest concern. The value of this series of questions lies in the focus of attention being placed on the specific areas which will require concerted effort as the center progresses from drawing board to full operational capability.

The ten areas surveyed here are representative of the structure and function of the diagnostic center and are indicative of the problem areas within the correctional system. The common observation throughout the survey was the variation that existed between the states in their reception-diagnostic procedures. There is general agreement on the requirements on the center operations, however, each state has developed its program within the special needs unique to that state. The future lies in a degree of standardization of the center functions through cooperative interstate programs.

CHAPTER IV

SUMMARY AND CONCLUSIONS

The study was basically designed to determine the status of the adult reception-diagnostic centers as they exist today in the United States. This determination was based on the information made available through a search of the literature and a survey of the states that have existing adult reception-diagnostic centers, or diagnostic units which very closely approximate such an operation.

As indicated previously, the ideal diagnostic concept would be to have the same clinical personnel work with the inmate from initial imprisonment, through treatment, including rehabilitation and release. It is unlikely that this concept will be adopted, since economic considerations preclude this type of program at the present time. The survey indicated that the center operations in all responding states was only for diagnostic use and inmates were assigned to other institutions to complete the treatment plan which had been developed at the center. Since the ideal correctional treatment cannot presently be achieved, the state correctional systems have accepted the compromise of separating diagnosis and treatment.

In addition to the survey itself, twelve states answered in letter form indicating plans for the future. Six of the twelve states answering by separate letter stated that the funds had been allocated and they were in the initial phases of planning or building new diagnostic centers. The

concept, then, of a diagnostic and treatment approach to the inmate's anti-social behavior has been accepted in its present form and will continue to expand on this basis.

The personnel problem, in terms of quality, quantity, and retention is evident throughout the nation. This situation, of course, is not peculiar to the reception-diagnostic center, but is a wide-spread problem in the correctional field in general. The diagnostic center, however, enjoys a singular reputation within the correctional system. The results of its work will have a direct effect upon each of the correctional institutions in the state. It is imperative, therefore, that personnel assigned to the center meet the most exacting qualifications. If less than these qualifications are accepted, this decision will permeate the entire correctional staff. A prime area of major consideration must be the recruitment and retention of the highest caliber of personnel available to make up the staff of the reception-diagnostic center.

Comparison of the several states responding to the survey indicates a wide degree of variance in all the areas of consideration. In some instances, the respondent was unable to equate his operation with any of the other methods being utilized. Respondents were, in those cases, reluctant to comment on their methods. It is apparent that there are gaps in the standardization of administrative and operational procedures in the operation of the centers. It is understood that there will always be some degree of individual approach because of the very nature of the state concepts of its correctional system. It would appear, however, that an expansion of inter-state communication between the staffs of the various

centers would do much to achieve a degree of standardization of diagnosis and treatment. This requirement is even more vividly amplified by the fact that inmates often serve sentences in more than one state and are therefore subjected to a variety of treatment programs.

Finally, it must be concluded that there is a certain lethargy existent within the entire field of corrections, a part of which is the adult reception-diagnostic center. In this survey alone the responses were only minimal and often inadequate. There were exceptions, of course, who returned complete and fully usable information. This trend of acceptance of status quo must be overcome before any real progress can be made. The correctional field is fortunate in having a few dedicated, highly skilled, professional leaders who strive to bring to corrections the drive and impetus it requires.

Limitations of the Study

This study is limited to the present status of the adult reception-diagnostic centers. It creates, in fact, only the framework for future study. It was conceived as a broad analysis of the diagnostic concept in the United States. The implications are that a greater depth of analysis is required in each of the ten areas of interest. It will be through this kind of analysis that specific criteria may be established as a guide for future operations. In this study the problem areas are clarified; resolving the differences must follow later.

Recommendations

Based upon the survey of the literature concerned with adult reception-diagnostic centers it is clear that there is a limited amount of published information, therefore a need exists for wider dissemination of material specifically discussing reception-diagnostic centers and their operations. It would appear relevant, at this time, to emphasize the specific operational experience of the centers now functioning.

There is no doubt that the reception-diagnostic concept and procedure is steadily changing as new ideas and better experience factors influence the programs. Since these changes will foster further research, it is recommended that this research be channeled into two areas. First, the clinical analysis of the inmate and the diagnostic process should be examined on a continuing basis to define the methods that have been demonstrated as successful. Second, the administrative and custodial systems of the centers should be analyzed in detail. These systems are often unique to the requirements of the center and should be studied separately from the general correctional institution.

Each of the ten areas of this survey might be subjected to a study in depth. An analysis of this sort would produce the details of the practices and procedures being used in the various states. Based upon such a study, it would then be possible to establish a model procedure.

The question of the use of the center as a medical treatment facility has neither been fully explored nor resolved. The reception-diagnostic center of the State of Florida will provide an ideal research facility to

develop a study of the feasibility of incorporating a medical facility into the full scale operation of the center.

The most far-reaching hope is that all correctional institutions may eventually develop the capability of receiving, diagnosing, treating, and releasing the inmate using the same clinical staff throughout. A pilot study is needed to develop an economically acceptable program of this type.

The concept of diagnosis and treatment has been established. It rests with the profession of corrections to develop it to its ultimate potential.

APPENDICES

APPENDIX A

COVER LETTER

Florida Division of Corrections
State Office Building
620 South Meridian Street
Tallahassee, Florida 32304

March 17, 1967

Dear Sir:

On July 1, 1967, we will be moving into one of the newest and most modern reception and diagnostic centers in the nation. Located in Northeast Florida on a 500-acre tract, the $7,000,000 Florida Reception and Medical Center will eventually consist of fourteen buildings and a hospital, in addition to laundry facilities and staff residences.

In order for us to formulate programs which are representative of current trends and practices, we solicit your cooperation in having the accompanying questionnaire completed by the administrative head of your state's adult reception and diagnostic unit.

Thank you for your assistance.

Sincerely,

s/ L. L. Wainwright

LOUIE L. WAINWRIGHT
Director

LLW/ces

APPENDIX B

EXPLANATORY LETTER

March 10, 1967

Gentlemen:

As a combined research project, the Florida Division of Corrections and the Department of Criminology and Corrections of Florida State University are conducting a nation-wide survey of reception and diagnostic procedures in the adult correctional system. The purpose of this study will be to analyze existing procedures being utilized in accomplishing the diagnostic task in the various states. A summary of the results will be published in a concise form which may be used as the basis for initiating or expanding the Reception-Diagnostic concept of your state.

You will find enclosed the questionnaire for the survey. We request that it be completed, if possible, by the Superintendent of your adult Reception-Diagnostic Center. If you do not presently have a separate Center, then it should be completed by the chief administrator of the unit which is now performing the job of reception and diagnosis in your adult correctional system. As an indication of your receipt of this questionnaire, please complete the attached postcard and return it to us as soon as possible.

This study is designed to be completed within a limited time frame, therefore, may we ask that the completed questionnaire be returned to us prior to April 10, 1967. A pre-addressed envelope is enclosed for your convenience.

In return for your assistance we assure you that a copy of the completed study will be forwarded to you upon publication. Please understand that the study can only be successful if your State is represented. We shall look forward to your early response and the inclusion of your data in the study.

Yours truly,

s/ Raymond R. Stommel

Raymond R. Stommel - Major, U.S. Army
Department of Criminology and Corrections
Florida State University