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Clinical supervision of court-referred juvenile offenders: Are juvenile referrals the least among equals?

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ABSTRACT

In the counseling field, clinical supervisors operate between the line-level counselor and the organizational administration. They are responsible for both the efficient operation of the therapeutic aspect of the organization, and the supervision, training, and management of the therapists. The quality of the treatment offered by an institution can be assessed by a number of measures, including the ratio of clinical supervisors to counselors, the training and experience of the clinical supervisor, and the number of different tasks the clinical supervisor is asked to perform. Through a survey of clinical supervisors in five western states we compared the differences among clinical supervisors who had large versus small numbers of court-referred juveniles in their programs. Data indicate that therapeutic programming and clinical supervision are different in programs with a high proportion of court ordered juvenile offenders relative to those with a high proportion of private referrals. This programming, however, may be superior to the programming and clinical supervision received in programs with fewer court-ordered juvenile offenders.

1. Introduction

Ben Lindsey, known as "the kid's judge" in Denver, Colorado in the early 1900s (Hiner & Hawes, 1985), once said that juveniles are neither moral nor immoral, but rather "unmoral" because they have yet to fully develop. They are, he said, "little savages, living in a society that has not yet civilized them" (Lindsey & O'Higgins, 1911:134–135). Judge Lindsey believed that the juvenile court had a duty to offer juveniles the opportunities necessary to make them fully functioning members of society. His point of view, while popular at the time, represented a perspective more enlightened and in many ways quite different than the beliefs that had preceded it.

1.1. History of the American juvenile justice system

The history of the juvenile justice system in America is in many ways similar to that of the adult system. Both have gone through significant changes, often brought about by public pressures and economic realities, and both have cycled between treatment and punishment as ways to control criminal behaviors. The juvenile system, however, is unique because it has always dealt with a relatively weak segment of the population, and many abuses within the system went undetected and uncorrected for years. Abuses also occurred within the adult justice system, but the victims were usually less likely to remain quiet, and therefore their experiences were more likely to come to the attention of the public. As a result, abusive treatment of adult offenders was typically less prolonged than that of the juvenile population.

During the earliest period of social development in Anglo-American culture, there was little legal differentiation between adults and juveniles. While placement in a workhouse was a common response to crime for both juveniles and adults in the 16th century, the response was aimed toward punishment, rather than reform. Both adults and juveniles arrived at the workhouse through the same legal process, and there were not separate courts for juvenile offenders. That began to change in the 19th century, and the belief that juveniles, because of their still "incomplete" status, deserved a justice system response that reflected that status (Binder, Geis, & Bruce, 2000). The New York House of Refuge opened in 1825 to address the needs of these juvenile offenders and to focus on their reform, rather than their punishment. Similar houses of refuge opened in Boston in 1826 and Philadelphia in 1828, indicating a growing interest in reforming wayward youth. The legal system soon followed with court cases, which strengthened the state's powers over these youths, allowing the state to act in the best interest of the child, even if this action was against the will of the parents (Ex Parte Crouse, 1839). Prior to this change, much of society had been operating under the ideals set forth by the church, known as Paterna Pietas. The principle of Paterna Pietas implied that God, as a heavenly father, treated his earthly children with care and concern, and parents were to act in the same way with

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their offspring. The shift away from Paterna Pietas and toward Parens Patriae, which placed the ultimate responsibility for the care of the child in the hands of the state, indicated that the state was going to take the care of children seriously, and that it would maintain the ultimate authority in the decision of what is right and necessary for the care of the child (Binder et al., 2000). While the doctrine of Parens Patriae has its roots in English common law and English history, the United States made these laws a greater part of their justice system, and initially worked to create a juvenile justice system that would change and nurture, rather than punish, the juvenile offender.

This new therapy-centered juvenile justice system would be focused on the goal of doing that which was in the best interests of the child (Mears, 2002). This benevolence implied three changes to the system of juvenile justice. First, there would need to be courts designed around the needs and the specific differences of juveniles; second, sentencing options beyond punishment were necessary for those who were processed through these new juvenile courts; and third, the system would need to change to allow juveniles to more rapidly and conveniently exit the court system and move directly into a therapeutic setting. All of these goals could be accomplished with the knowledge and technologies available at the time of the emergence of these juvenile courts. These changes, however, would prove to be rather expensive.

At this point in juvenile justice history, the public supported spending money on services and programs which could potentially prevent large numbers of juveniles from becoming adult offenders. These costs, however, could not be borne indefinitely, and as funding was reduced, services diminished, staffing declined, and populations within the juvenile institutions increased, along with the accompanying frustration and violence (Wooden, 1976).

The experiences of the American juvenile justice system of the 1930s are amazingly similar to the experiences of the 1990s (Marcotte, 1990). As Cannon and Beiser pointed out, juvenile facilities of the 21st century are "chronically short of money, which means fewer staff, more overcrowding — in short, more trouble" (2004:30). Furthermore, many detention facilities are holding juveniles with mental health issues. As many as 60 to 70% of the juveniles in detention facilities were evaluated as having psychiatric disorders, making their treatment and management more problematic, more expensive, and more difficult (Teplin, Abram, McClelland, Dulcan, & Meicle, 2002).

1.2. Budgetary effects on the operations of the American juvenile justice system

When faced with decreasing budgets and growing populations of increasingly difficult inmates, the adult prison system typically addressed the problem in a logical, albeit undesirable manner. Budgets could be trimmed minimally in the areas of food and clothing, leaving only programming and services for reductions. Service cutbacks were limited by federal guidelines and in some cases court orders, so these decreases could again only be minimal. Reductions in programming would eventually result in diminished numbers of inmates qualifying for parole, but in the short term these reductions were the most feasible way to balance a budget. This reduction would best be accomplished by hiring less qualified (and cheaper) persons to provide programs and services, and offering less individualized treatment plans, including self treatment-based 12-step programs (Prendergast & Wexler, 2004). Juvenile facilities, faced with similar budgetary reductions and similar restrictions were able to utilize many of these same options, although often to a lesser degree.

To decrease detained populations and costs while continuing to offer supervision and services to their clients, juvenile justice systems increased the number of juveniles on supervised release programs. Overall rates for juvenile probation referral increased from 56 to 62% between 1985 and 2002, with person and public order offenses increasing approximately 50%, and drug offenses nearly doubling in the same period (Livsey, 2006). Informal probation increased only 5% in the same period, indicating a trend toward "more formal processing of delinquency cases" (2006:1). Given the types of cases receiving probation at a greater rate, and the budgetary issues juvenile services routinely face, it is logical to assume that many of these juveniles placed on probation were also required to attend programming outside the confines of the institution. Indeed, in 2002 6.2% of the total juvenile arrests for drugs were disposed through court ordered counseling rather than traditional probation supervision (Snyder & Sickmund, 2006). Given the importance of counseling to the operations of the juvenile justice system, the quality of the counseling received by juveniles may be useful as an indicator of the overall health of the juvenile system and the likelihood of effective treatment and decreased potential for recidivism (Jones & Wyant, 2007).

1.3. Clinical supervision as an indicator of treatment quality

In research which was to mark the beginning of a new area of study, Biasco and Redfering (1976) noted that clinicians who received supervision from more experienced clinicians were likely to have clients who made more significant progress compared with clinicians who were unsupervised. From this empirical foundation the process of clinical supervision has continued to be studied, and the requirement of clinical supervision has become codified and mandatory in virtually all jurisdictions. Furthermore, Holloway (1995) notes that clinical supervision became recognized as a separate discipline in 1980. Clinical supervisors now serve as the interface between the administration, those who generate new ideas and practices within the field, and the practicing clinical counselor (Haynes, Corey, & Moulton, 2003). A good clinical supervisor stays informed through conference attendance and professional publications, and brings to the practitioners the newest and most successful clinical protocols (Amodeo, Ellis, & Samet, 2006). Clinical supervisors are also expected to certify that these practitioners are performing the operational duties required of them by the organizational administration, and to make sure the practitioners are following organizational policies. Many clinical supervisors are also asked to supervise clinical interns, evaluate their clinical sessions, and keep track of the hours required for full licensure. Often, clinical supervisors also maintain a treatment caseload along with the duties listed above. As expected, these multifaceted duties take a great deal of time, and clinical supervisors are therefore unlikely to provide quality supervision if they are asked to supervise a great number of clinicians (Milne & Weterman, 2001).

While the literature does not indicate a "proper" ratio of clinicians to clinical supervisors, lower numbers of supervisees has been shown to improve the effectiveness of the clinical supervisor as well as the therapeutic practices of the clinicians in the organization (Haynes et al., 2003, Herbert & Trusty, 2006). Milne and James (2002) noted that more clinical supervision improved overall clinical competency and likely the success of the therapeutic intervention, and van Ooijen (2000) noted that balance among the three areas of clinical supervision (administrative, educational, and supervisory support) benefited both the supervisor and the supervisee, likely resulting in enhanced institutional effectiveness.

As juvenile justice systems attempt to provide more services with less funding, and more juveniles are court-ordered into therapeutic settings to reduce correctional populations, the question which must be asked is "are these court ordered juveniles getting the same level of care as juveniles who are privately referred (not institutionally ordered or required) into treatment programming?" However, given the importance of the clinical supervisor to the overall quality of treatment received, the question may be more appropriately termed "are facilities with large proportions of court ordered juveniles offering quality clinical supervision to their therapists?" This is the research question we sought to answer.