



Visionary Leadership for Psychiatric-Mental Health Nurses around the World

INTERNATIONAL SOCIETY OF PSYCHIATRIC-MENTAL HEALTH NURSES

White Paper, June 2014

Meeting the Mental Health Needs of Youth In Juvenile Justice

1. Statement of Position

According to the U.S. Office of Juvenile Justice and Delinquency Prevention, the arrest rate for violent offenses among youth in 2010 was the lowest it has been in 30 years (Puzzanchera & Kang, 2013). One and one half million youth 18 years and under were brought before a juvenile court and 36% were placed on formal probation, a trend that has increased in the last two decades (Livsey, 2012). Most cases of probation were White youth who had committed property crimes. The caseload of Black youth increased 52% from 1985-2009 and the number of female probationers grew from 18% to 27% in the same period. On the annual 2010 census date there were more than 66,000 youth under 21 years of age held in juvenile detention facilities in the U.S. (Hockenberry, Sickmund, & Sladky, 2013). In 2011, one year later, there were just less than 42,000 detained youth (Sickmund, Sladky, Kang, & Puzzanchera, 2013).

2. Purpose

The purpose of this white paper is to update juvenile justice statistics, discuss the abiding mental health needs of youthful offenders, and delineate the role of the Advanced Practice Nurse in Psychiatric Nursing who may work in forensic and juvenile justice settings. The paper concludes with a Call to Action for ISPN to sponsor and promote reform areas.

3. Background

The obligation to provide health care for incarcerated youth falls upon the juvenile justice system as a matter of constitutional law (NCCHC, 2011). The provision of appropriate medical and psychiatric care is further mandated by The Juvenile Justice and Delinquency Prevention Act of 1974 (PL 93-415). The law, however, does not define appropriate care, determine accountability or fund care (Pajer et al, 2007). Juvenile detention and confinement facilities may rely on the standards of accreditation bodies such as the National Commission on Correctional Health Care (NCCHC) and the American Correctional Association (ACA) to guide them in establishing health care policy. Juvenile care and treatment encompasses

everything from receiving screening, health assessment, mental health screening and evaluation, and emergency and non-emergency care, to health promotion and care of juveniles with special needs, such as chronic illness, who require special services. The intent of the standards is to promote collaborative, integrated health and custodial care (NCCHC, 2011). Shelton (2005) found that only 23% of youth with mental disorders in a Maryland juvenile justice system sample received treatment. Disparities in who received treatment were found with older youth and African American youth least likely to receive services.

Family, peer, and community risk factors are similar for both males and females; however, females' risk differs because of early onset puberty, traumatic life events, association with criminal males, and the prevalence of sexual abuse (Mayworm & Sharkey, 2013). While the rate of criminal behavior by boys has decreased in the last decade, this is not the case for girls. Trending data suggest that over the last decade females are detained in increasing numbers. In addition, there appears to be a change in the way the legal system responds to female behavior by dispensation of more punitive court rulings for behavior considered of lesser criminality (Javdani, Sadeh, & Verona, 2011). A gender paradox identified by Walrath and associates (2003) suggests that because females report higher numbers of individual risk factors than males that program development and intervention in juvenile justice systems are gender tailored in order to elicit the desired outcomes.

Youth of color are overrepresented at every step in the juvenile justice system and in every state. The issue has been discussed for more than 25 years; change in the justice system remains slow as well as in education systems where minority youth are also overrepresented in the numbers of suspensions and expulsions. The connection to school is relevant because of the rates of crime that occur when students should be in school. Krisberg and associates (1986) reported that minority youth were incarcerated at three to four times the rate of whites and were detained in more secure facilities. Youth of color remain in the system longer and represent 37% of the detained population but account for 17% of the youth population (NCCD, 2007).

While the issue has been identified and reasons for it explained over the last 20 years, the fact remains that overrepresentation is more complex than initially thought (Kempf-Leonard, 2007). Some known factors of causes for disproportionate minority contact (DMC) include differential offending and opportunities for treatment, biased risk assessment instruments, selective enforcement of delinquent behavior, and institutional racism (The Sentencing Project, 2013). Indeed, Alexander (2010) posits that the incarceration rates of people of color in the United States is the criminal justice system's way of social control and racial injustice. Another troubling trend is the increasingly more punitive sanctions for youth of color with subsequent incarceration in adult jails and prisons. Peaking in the 1990s, the rate of youth incarceration in adult facilities where a rehabilitation model is not the norm continues to be high (The Sentencing Project, 2013). Additionally, while international rates of incarceration are decreasing, the number of people incarcerated in the U.S. only continues to increase with more than one million prisoners in 2012.

4. Mental Health Needs

Two large surveys of youth incarcerated in the U.S. demonstrate the high rates of trauma experience and posttraumatic stress disorder among the population. Abram and colleagues (2007) found that 92.5% of a sample of incarcerated youth reported at least one traumatic experience, the most common of which was

seeing or hearing about someone they knew who was badly hurt or killed. Ford, Hawke, and Chapman (2010) found that detained juvenile offenders were three times more likely than children and adolescents in the community to have experienced type II childhood trauma, or complex trauma. Complex trauma is defined as a traumatizing event of such magnitude that attaching to a primary caregiver and/or regulating emotions is seriously compromised. Experiences that contribute to complex trauma, such as on-going child abuse, victimization, or exposure to violence, are associated with mental health problems in children such as anxiety, affective disorders, eating disorders, psychosis, substance abuse, and disruptive behavior disorders. Incarcerated youth, when compared to youth who remain in the community, have been identified as having a greater risk (by 200%) of suicide (Gallagher & Dobrin, 2006).

A systematic review of 25 studies identified the prevalence of psychiatric disorders among youth in detention located in the United States, United Kingdom, Canada, Australia, Denmark, Spain, and Russia (Fazel, Doll, & Långström, 2008). Conduct disorder was the most prevalent diagnosis, identified in more than half of both incarcerated boys and girls. One in 10 boys and 1 in 5 girls were diagnosed with an attention deficit disorder, and 11% of boys and 29% of girls were diagnosed with a major depressive disorder. When compared to rates among youth in the community, psychotic and depressive illnesses and disruptive behavior disorders were much higher for youth in detention.

The lack of mental health care in juvenile detention and confinement facilities is frequently due to funding shortages. Medicaid does not pay for health care for incarcerated youth. Services are predominately paid for through state and local funding, and federal grants (Koppelman, 2005). States and localities must therefore determine how funding will be allocated to target those in greatest need of services. Because disparities exist, Migdole and Robbins (2007) suggest that juvenile justice and mental health professionals must collaborate in developing practical, well-integrated services and share these models across local, state, regional and national levels. Development involves creative coordination of services between child welfare agencies, mental health agencies, and the juvenile justice system. Care coordination of youth in juvenile justice is complex requiring that practitioners work interprofessionally (Bonham, 2011). Care is demonstrated through mental health and substance abuse screening and monitoring, suicide prevention, treatment planning that includes community re-entry, education services, violence prevention, early identification and community based intervention programs.

Mental Health and Substance Abuse Screening and Monitoring

All youth entering a juvenile detention or correctional facility should be screened for mental or substance use disorders, suicide risk factors, and other emotional, developmental or behavioral problems, such as their adjustment to the juvenile justice setting. Youth should undergo this screening within the first 24 hours of incarceration (Penn et al., 2005). The Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) is an evidence-based tool which is intended to be used immediately upon entry to the facility (Grisso et al., 2001). All screening tools utilized should have clearly established thresholds for referral for more comprehensive mental health assessment.

In addition to screening on intake, all youth should receive continued monitoring for mental or substance use disorders, suicide risk, and other emotional or behavioral problems, with awareness that not all problems will be recognized on intake and further assessment is needed. Additionally, clinicians and

custody staff should be cognizant of the stressful nature of incarceration, which may precipitate problems not present at intake (Penn et al., 2005).

Suicide Prevention

Suicide prevention programs are an essential service needed to identify and respond to those youth who may be potentially suicidal. Youth with recent or current suicidal ideation, attempts at self-harm, or symptoms of a mental or substance use disorder should be referred for more comprehensive evaluation by a mental health clinician. The evaluation should be biopsychosocial in nature, addressing adolescent developmental, peer, gender, cultural, religious and family issues. Collateral information from family, correctional staff, teachers, and previous providers should be obtained whenever possible. Special education placement, developmental delays or learning disorders must be identified so that youth with individualized education plans may have them implemented within the facility. Histories of trauma, including exposure to domestic violence, physical and sexual abuse, and family history of criminality and mental illness should be explored. Youth who are evaluated and found to have acute symptoms that cannot be managed within the facility must be transferred to an appropriate treatment setting (Penn et al., 2005).

Treatment Planning and Community Re-entry

Clinicians should be involved in the development, implementation and reassessment of treatment plans for incarcerated youth. Treatment modalities used in correctional settings may include individual, family and group therapy. Substance abuse education and prevention training should be provided due to the high prevalence of substance use disorders among juvenile offenders. Psychotropic medications may be part of a comprehensive treatment plan when indicated, but only after a thorough risk-benefit analysis. Many youth within the juvenile justice system demonstrate poor treatment adherence in the community. The clinician must be cognizant of the inherent risk in prescribing medication for youth who may not follow up with a community-based provider. Additionally, there is risk in prescribing medications such as stimulants that may be diverted or abused (Penn, et al., 2005).

Integral to the care and treatment of incarcerated youth is planning for release or re-entry planning. Youth who require mental health or substance abuse treatment after release must have a specific plan with identified community-based services. Continuity of care is essential and the clinician must be aware of the availability of services within the community (Penn et al., 2005). Short-term medication management clinics for youth released from correctional settings, such as Connecticut's HomeCare Program, have demonstrated effectiveness in providing a bridge back to the community and maintaining continuity of care until more long-term community-based services are secured (Pearson, McIntyre-Lahner, & Geib, 2005). Indeed, incarcerated youth describe a post detention life as a future full of possibilities (Bonham, 2007).

Education Planning

Educational services are, likewise mandated by law for all school-aged youth who are incarcerated and are part of the holistic care of the youth. Juvenile detention and confinement facilities face several challenges in providing academic services. Youth being served in the juvenile justice system frequently face significant academic problems even before they enter the juvenile justice system. Youth

with learning disabilities, mild to moderate retardation, and developmental delays are overrepresented in juvenile correctional settings. Additionally, many have experienced school behavior problems resulting in multiple suspensions and expulsions, disengagement, and low academic achievement. Appropriate educational interventions before, during and after incarceration are critical to future success.

Collaboration with the school attended prior to incarceration is integral to the accurate placement of the youth within the correctional educational system. The youth is best served when parental involvement in the development of individualized educational plans (IEP) is encouraged and supported, and when disruptions in educational services are kept to a minimum. Transition planning is necessary to assist youth to re-enter school and succeed academically, and should be a concerted effort between juvenile correctional educational staff, public schools, mental health and social service agencies (Closson & Rogers, 2007). Probation services may also be part of this effort if ordered by the court.

Violence Prevention

Gorman-Smith, Henry, & Tolan (2004) found that youth from struggling families reported significantly higher rates of violence exposure than youth from moderately functioning families regardless of overall community risk. Overall, the risk of violence is compounded by the number of risk factors involved. Evidence suggests that the larger the number of risk factors to which an individual is exposed, the greater the probability the individual will engage in violent behavior (Hawkins et al., 2000). It stands to reason that interventions that target multiple risk factors may be more effective in preventing violence than those that target single risk factors. As the family seems the logical place to begin, enhancing parental involvement on any level may mitigate other risk factors.

Early Identification and Community Based Intervention

Over the past decade an increase in the development of empirically supported treatment programs for justice-involved youth and their families occurred. Early intervention programs such as diversion and mentoring are utilized to identify at-risk youth prior to incarceration when negative influences might be countered (Trupin, 2007). Rigorously studied evidence-based programs such as Multisystemic Therapy (MST) and Family Functional Therapy (FFT) have been found to produce consistently better results than traditional juvenile justice interventions. These programs are likewise community-based and involve partnering with parents in the rehabilitation of youth (Models for Change, 2014; Trupin, 2007). Both MST and FFT employ techniques that foster parental involvement.

For any mental health practitioner, understanding the juvenile justice population necessitates knowing that the population tends to have high levels of psychopathology, high level of psychosocial need, and tends to be comprised of minority youth. Mental health services are often first accessed through involvement in juvenile justice (Chapman, Desai, & Falzer, 2006). The population requires family models of treatment, treatment of substance use disorders, and assessment and treatment of skill deficits around social skill acquisition and management of aggressive impulses. Chapman and others advocate for a multi-disciplinary team that coordinates and manages delivery of mental health care (2006). Nurses are a logical part of this team but are not identified in the literature as involved in these models of care. Successful community based programs are programs that prevent the delinquent behavior in the first place (Greenwood, 2008). Successful community based programs have been initiated by the John D. and Catherine T. MacArthur Foundation, sponsor of Models for Change (MacArthur Foundation, 2014); Annie E. Casey Foundation sponsors the Juvenile Detention Alternative Initiative

(Annie E. Casey Foundation, 2014); and the Robert Wood Johnson Foundation supports Reclaiming Futures (Buck-Willison, et al, 2010).

5. Psychiatric Mental Health Advanced Practice Nurse Role

Specifically for juvenile justice populations, the Psychiatric Mental Health Advanced Practice Nurse (PMH -APN) must be educated about the unique interplay between psychosocial dysfunction and psychiatric illness, the role of the family with juvenile justice involved youth, and the legal implications of having juvenile justice involvement. Advanced practice nurses (APN) who work with this population need to understand the nuances of the nurse-patient relationship, the use of evidence based techniques such as motivational interviewing, the high rate of substance abuse, and the high risk of physical comorbidities and re-incarceration.

When the first juvenile justice position paper was published by ISPN (2008), it noted that there was support for the juvenile justice screening and assessment guidelines put forth by the Office of Juvenile Justice and Delinquency Prevention (2004) and the American Academy of Child Psychiatry (2005). At that time the document recognized the need for data on program effectiveness for mental health interventions for juvenile justice youth, bridging programs from detention into the community, and a continuum of mental health care for these youth. At that time large numbers of APNs were not working with this population. Thomas and colleagues (2005) stated that most juvenile justice systems do not have budgeted positions for advanced practice nurses even while it made good fiscal sense to have APNs work with this population given the multiple roles nurses can seamlessly take with the population. Key to her comments was the observation that leaders in juvenile justice do not seem to oppose APNs working with this population of youth. Rather there is a lack of awareness of the services that can be provided with the role (Delaney, 2008). Thomas, et al (2005) advocated for education of juvenile justice leaders about the benefits of the APN role. These comments have applicability to the APN role with this population six years later.

The differences inherent in working within the nonmedical structure of the juvenile justice system provide a basis for claiming forensic psychiatric nursing has a specialized knowledge and skill base for meeting the needs of this population (Shelton, 2003). Due to a complex variety of factors that include the high rate of mental disorders among youth in detention (Teplin, et al 2006) and the evolution of the juvenile justice system as the *de facto* provider of mental health services (Delaney, 2008), the most difficult to manage and resource-costly youth frequently end up in the juvenile justice system. Therefore, Cashin (2006) refers to psychiatric nursing in juvenile justice as “extreme nursing”.

Nurses are, of course, accustomed to working in systems and within teams, thus the PMH-APN is especially well-equipped for this role (Drew & Delaney, 2009; Delaney, 2008). Clinically prepared PMH-APNs have a skill set which aligns with the needs of a wide range of mental health consumers and allows them to work in integrated care systems (Hanrahan, Delaney, & Merwin, 2010). The educational preparation of the PMH-APN in science, neurobiology of psychiatric disorders, psychopharmacology, systems theory, assessment and treatment methods and relationship science makes them uniquely suited to provide psychiatric-mental health services in juvenile justice settings (American Nurses Association, 2007). Thomas (as cited in Delaney, 2008) comments on the breadth of skills the PMH-APN has to offer in terms of assessment, diagnosis, and treatment of psychiatric disorders. By virtue of their education they have expertise in counseling, psychoeducation, and planning for re-entry to the community. In short, the

PMH-APN is prepared with skills commensurate with those of the psychiatrist, psychologist, social worker, and professional counselor and must play a key role in the reintegration of youth involved with the juvenile justice system.

The education of the APN issue dovetails with the complex and multi-dimensional workforce issues which have hampered the advancement of an APN role in specific settings with particular populations, such as juvenile justice youth (Bonham & Delaney, 2010). Hanrahan (2009) noted that there were not enough adequately trained APNs for the inpatient and community health care needs of individuals with psychiatric illness. There is no formally identified training program for advanced practice nurses aimed at care provision to a juvenile justice population identified in the literature. Yet, APNs encounter these vulnerable youth in a variety of settings, predominantly in the community, and their psychiatric care needs are both similar and different from peers without juvenile justice involvement.

6. Recommendations/Call to Action

Therefore, the position of ISPN is to sponsor and promote reform areas that include:

1. **Evidence-based practices.** Models for Change promotes the use of evidence-based practices such as Multisystemic Therapy (MST) and Family Functional Therapy (FFT) which have been found to produce consistently better results than traditional juvenile justice interventions.
2. **Aftercare.** Through the development of effective models for aftercare, or post-release supervision, services and supports, youth are able to make successful transitions back to their communities.
3. **Disproportionate minority contact.** States are working to better understand the nature of the problem through data collection and analysis with the goal of designing appropriate interventions to promote objective decision-making, improved language and cultural competency, education and workforce development, and detention alternative and nontraditional services to reduce racial and ethnic disparities.
4. **Juvenile indigent defense.** Through assessments, training and technical support, Models for Change promotes meaningful access to legal counsel for all youth.
5. **Mental health.** Models for Change promotes collaborative work to meet the mental health needs of youth without unnecessary juvenile justice system involvement.
6. **Community-based alternatives.** Work is underway to strengthen and expand the network of community-based alternative services and programs, and to reserve formal detainment and commitment for only the most serious cases (Models for Change, 2014).
7. **Advanced practice nurse education.** Academic programs can offer specific preparation and clinical site placement in juvenile justice.

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