Juvenile Mental Health Courts for Adjudicated Youth: Role Implications for Child and Adolescent Psychiatric Mental Health Nurses

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Abstract

TOPIC—Juvenile mental health courts for adjudicated youth.

PURPOSE—To describe the role of psychiatric nurses in reducing mental health disparities for adjudicated youth via juvenile mental health courts.

SOURCES—ISI Web of Knowledge; Sage Journals Online; HighWire; PubMed; Google Scholar and Wiley Online Library and websites for psychiatric nursing organizations. Years included: 2000–2010.

CONCLUSIONS—Juvenile mental health courts may provide a positive and effective alternative to incarceration for youth with mental health problems with psychiatric nurses playing a key role in program implementation.

Search terms
Adjudicated youth; adolescent mental health; child and adolescent psychiatric nursing; juvenile delinquency; juvenile justice system; juvenile mental health courts; psychiatric nurse practitioner

Introduction

Utilizing online databases, including research published between 2000 and 2010, we identified data to demonstrate the increasing rates of adolescent delinquency and involvement with the juvenile justice system. Adjudicated youth (i.e., those who have been found to be guilty of committing a delinquent act) represent a growing segment of the child and adolescent population. These youth often exhibit difficulty in managing negative
externalizing behaviors (including violent crimes, property crimes, and weapons-related crimes) that are likely precipitated by undiagnosed and untreated mental health concerns, and that are associated with any number of critical social, physical, and economic problems (Tarolla, Wagner, Rabinowitz, & Tubman, 2002). Studies have consistently demonstrated that 65–70% of all youth with juvenile justice system involvement (including youth of color and white youth) have a diagnosable mental health disorder, with the most prevalent diagnoses including psychotic disorders, mood disorders, ADHD, and conduct disorder (Bonham, 2006; Fazel, Doll, & Langstrom, 2008).

In recent years, researchers have examined disparities in incarceration rates among youth, and in the diagnosis and treatment of mental health disorders among adjudicated youth. Generally speaking, African American and Latino youth are significantly more likely to be adjudicated than their White peers and are significantly more likely to receive harsher penalties once they enter the juvenile justice system (Bell & Ridolfi, 2008). Given the greater likelihood of African American and Latino youth involvement with the juvenile justice system, coupled with the overall high levels of unmet mental health need among all adjudicated youth, it is not surprising that undiagnosed and/or untreated mental health problems constitute a significant health disparity (both regarding race and the population of youth currently involved with the juvenile justice system). Treatment of the mental illnesses reported by adjudicated youth in general, and youth of color in particular, varies from moderate to nonexistent, with significant racial disparities in both access to and quality of care. Ostensibly, improvement in the areas of identification and treatment of mental health concerns for diverse, adjudicated youth is necessary. In response, we present our ideas regarding the utility of a recently established institution, the Juvenile Mental Health Court, as a viable and feasible approach to reducing mental health disparities and creating multiple positive impacts on adjudicated youth. In describing this new approach to serving the mental health needs of youth, we also describe the key role of the psychiatric child and adolescent nurse practitioner.

**Background**

Most scientists would likely concede that youths’ emotions mature prior to their abilities to self-regulate those emotions. In other words, as psychiatrist Dr. Carl Bell states, “youth are neurodevelopmentally predisposed to being “all gasoline, no brakes, and no steering wheel” (Bell & McBride, 2010, p. 565). Additionally, some have argued that problems in the primary family, including parental discord, parental mental illness, family violence, and abuse contribute significantly to youths’ inability to self-regulate and self-monitor their emotions and behaviors. It is possible that youth who have yet to develop and master age-appropriate self-discipline, emotion regulation, and goal-directed behaviors may lack some of the necessary skills essential for controlling negative “acting out.” Management of such acting out in settings like schools, however, have yielded mixed results. In recent years, the concern has grown regarding the utility of new and poorly evaluated approaches to youth discipline and behavior management. These approaches include school policies like “zero tolerance,” ad hoc searches of individual property, and metal detectors. Theoretically, such policies were designed to assist youth in self-monitoring of poor behaviors, but many would argue that instead these policies encourage a “school to prison” or “cradle to prison” pipeline (Children’s Defense Fund U.S., 2007). More importantly, it appears that often these well-intentioned policies (designed in part to create safe environments for youth) are more directed toward removing youth from the settings in which they commit their offenses than assisting youth in obtaining appropriate services to support them in creating positive behavior change. As a result, youth are directed toward punitive types of reform for their poor behaviors rather than more constructive, positively focused types of mental health treatment (Breland, 2000; Breland-Noble, 2004). In summary, the absence of appropriate
access to mental health diagnosis and treatment for adjudicated youth serves as a significant barrier to reducing recidivism among our most vulnerable (Behnken, Arredondo, & Packman, 2009).

According to the Justice Policy Institute, approximately 93,000 youth reside in juvenile justice facilities in the United States. Of that number, almost 70% are postadjudicated youth for whom the average cost of residence is approximately $241.00 per day per youth (Bell, Ridolfi, Finley, & Lacey, 2009; Justice Policy Institute, 2009). It is unsurprising that youth in such facilities exhibit a wide range of emotional and behavioral problems. For example, one study of detained youth found that 60% of boys and 70% of girls had a diagnosable mental disorder, while other research indicates that of youth in detention, including postadjudicated residential placements, up to 64% meet criteria for at least one mental illness (Abram, Teplin, McClelland, & Dulcan, 2003; Barnes et al., 2005).

In 2007, the state of California published data regarding the costs of providing mental health care to adjudicated youth. For youth in California housed in juvenile detention facilities, the data suggest that the average cost of providing psychotropic medications is $4,387 per youth per stay in a facility (Justice Policy Institute, 2009). Conversely, significant cost savings (including costs associated with the provision of mental healthcare youth living in other types of residential out of home placements) are reported for youth placed in alternative forms of residential care, including those which focus on multisystemic therapy (MST) and functional family therapy (FFT). For example, the study authors note that alternative placements (like MST and FFT) generate $10.69–$13.36 in benefits for each dollar of cost to communities compared with the costs associated with incarceration and postadjudication managed facilities (Justice Policy Institute, 2009). These statistics illuminate the significant costs associated with the diagnosis and treatment of adjudicated youth in traditional detention, and managed facilities compared with the reduced costs associated with evidence-based alternative treatments that in many cases allow post-adjudicated youth to reside with family members (MST Services, 2010).

For some, findings like those mentioned previously beg the question of whether profits belie the goal of rehabilitation for juvenile offenders. Essentially, concerns have been raised that significantly more private, for-profit facilities exist to “warehouse” youth than less expensive and more effective alternative types of placements (Vaughn, Wallace, Davis, Fernandes, & Howard, 2008). Investigations by the U.S. Department of Justice support this idea by raising questions about the ability of many juvenile facilities to adequately respond to the mental health needs of youth in their care (Cocozza & Shufelt, 2006). In fact, individual states within the United States spend approximately $5.7 billion each year on the imprisonment of youth, for which most are held for nonviolent offenses (Bell et al., 2009; Justice Policy Institute, 2009). For most juvenile offenders, contact with the juvenile justice system is often their initial and primary opportunity for obtaining mental health assistance (Skowyra & Cocozza, 2007). Given this knowledge, we believe that one key to ensuring a solid balance between juvenile offender accountability and community safety is the provision of appropriate, accessible, and consistent mental health treatment.

Thus far, we have presented research and findings from the perspective of researchers and community groups who share concerns about the plight of mentally ill youth relegated to juvenile justice involvement instead of mental health treatment. A different perspective from that of researchers and community advocates is that of judicial representatives. Judge J.L. Webster, an administrative law judge for the state of North Carolina, provides that perspective for our research team. Judge Webster was eager to share his concerns about youth in the juvenile justice system, based on his 30 years in practice as an attorney, and, more recently, as a judge. His expertise is derived from firsthand experience with our
judicial system’s inadequate means for addressing the emotional and behavioral problems that lead many juvenile offenders into the judicial system. In his opinion, the judicial system in America is still struggling with recognition that many of the youth that interface with our courts are in need of mental health treatment far more than they need punishment. The court system, like society in general, continues to ignore the fact that many of our juveniles come from broken homes, broken dreams, and broken minds brought on by mental illnesses that they cannot control. Society, including the judicial system, has done far too little to rid society of the stigma that goes along with mental illness. Too often juvenile “justice” is defined only as punishment, and so the real underlying problem goes untreated. Much attention needs to be given not only to the juvenile courts, where criminal offenses are addressed, but in our administrative courts as well, where decisions are made about what plan of care is adequate to address juveniles need for services, such as “habilitative” and “rehabilitative” services. Because of budget constraints, cuts are being made in our legislative chambers across the country that will further curtail mental health treatment for our youth. The budgets for training of our law enforcement also need to be increased to enhance awareness of juvenile mental health issues and to educate law enforcers on the best practices of working with the youth in their care. The predictable outcomes of these legislative decisions to cut or not to fund programs will be revealed in the years to come as our prison populations will likely increase with adults who were once untreated juveniles. Unfortunately, much of this increase will likely come from minority and other underserved communities, which will only add to the well-documented disparities which are the focus of this article.

In response to the aforementioned concerns, we believe that one potentially effective solution for mentally ill adjudicated youth is the inclusion of courts in mental health service coordination. This approach to mental health service coordination for adjudicated youth has been demonstrated in the drug court model to be an effective, community engaged alternative to strict incarceration (Griffin, Steadman, & Petrila, 2002; Grudzinskas & Clayfield, 2004). The community-based service model (i.e., a model wherein mental health and other social services are provided for individuals by smaller, local providers instead of by large, state-run facilities) employs a collaborative approach to integrating the community with the courts in supporting youth entry into mental health treatment. Rendered under court supervision, this approach allows for the provision of structured support to assist youth in building the emotional and psychological stability necessary for juvenile offenders to assist in their own recovery. Overall, strong evidence supports the idea that adjudicated youth diverted from institutional placements and provided with community mental health services suffer less recidivism than untreated youth (Cuellar, McReynolds, & Wasserman, 2006; Grisso, 2008).

One community-engaged service model that integrates the judicial and mental health service systems and which has yielded positive results is the juvenile mental health court (JMHC). Juvenile mental health courts utilize a multidisciplinary team approach, with teams comprised of representatives from mental health, probation services, prosecutors’ offices, and defense counsel. This approach began formally in Santa Clara, CA, and has since expanded into a number of states throughout the United States (Loftus & Arredondo, 2007). In the next section, we provide an overview of the JMHC approach, its utility for addressing mental health disparities among adjudicated youth, and we describe the critical role that psychiatric nurses can play in supporting its growth, systematic implementation, and success.
JMHC

The original philosophy guiding the JMHC approach to addressing the needs of juvenile offenders was that “The juvenile justice system is not a mental health service delivery system for kids with severe mental illness. Its charge is to provide swift and sure consequences to young people who have broken the law and to help them turn away from delinquent behaviors by holding them accountable for their actions and helping them develop the skills and strategies necessary to become productive citizens” (Arredondo et al., 2001, p. 3). The rationale of the mental health court approach, per Arredondo and colleagues, is that a system designed primarily to reform poor behaviors and assign accountability cannot do so effectively in the absence of addressing the root causes of the problematic behaviors. Hence, one of the primary purposes of the JMHC system is to, “[hold] adolescent offenders strictly accountable for their behavior while matching them to appropriate diagnostic, therapeutic, and aftercare interventions” (Arredondo et al., 2001, p. 3).

As stated earlier, JMHCs utilize a multidisciplinary team approach, with teams comprised of representatives from the mental health, probation, prosecutorial, and defense sectors—all entities that eventually benefit from youth placement in appropriate, community-based, family-supportive treatment services instead of expensive “warehousing” detention facilities. Beginning with the implementation of the Court for the Individualized Treatment of Adolescents (CITA) in Santa Clara, CA, in 2001, there are approximately 20 JMHCs in various stages of implementation and operation in the United States today (Cocozza & Shufelt, 2006).

Eligibility criteria for youth in mental health courts generally include being between the ages of 12 and 17 and demonstrating mental health need as evidenced by meeting criteria for significant or serious mental illness. Typically, mental health screenings for these youth are conducted by Juvenile Hall mental health clinicians, while more comprehensive psychological evaluations are conducted by psychologists and psychiatrists (Arredondo et al., 2001). It has been reported, however, that most JMHCs trend toward not including youth with gang involvement and/or those who commit serious, violent offenses (Cocozza & Shufelt, 2006). We note the following description of eligibility criteria from the original CITA court in Santa Clara, CA. “Potential candidates must have been diagnosed with a biologically based and serious mental illness, be developmentally disabled (i.e., pervasive developmental disorders, mental retardation, and autism), or have an organic brain injury or head trauma (i.e., severe cognitive deficit and degenerative diseases of the brain). A primary mental health diagnosis includes major depression; bipolar disorders, schizophrenia, mood or anxiety disorders, and certain impulse control disorders such as severe ADHD” (Arredondo et al., 2001, p. 11).

Formal referral to participation in JMHCs can occur at various stages of the youth’s involvement with the juvenile justice system, including (a) “at the preadjudication stage” and (b) after adjudication and before disposition and as an aftercare “add-on” for youth released from detention or residential facilities (Cocozza & Shufelt, 2006, p. 3). Through specialized screening and assessments, often provided by psychologists, youth are offered the opportunity to voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals (Council of State Governments, 2005).

For the majority of JMHCs, the point prevalence of cases ranges from 10 to 75 youth. The list of pending cases in the court is determined by a variety of factors, including the size of the community it serves, the amount of resources available to it, and whether the court
provides the services directly or relies on existing community providers to provide treatment and primary monitoring (Cocozza & Shufelt, 2006).

Established in February of 2001, the Court for Individualized Treatment of Adolescents (CITA) in Santa Clara County, CA, was the first juvenile mental health court in the United States (Skowyra & Cocozza, 2007). This collaborative approach to supporting adjudicated youth with mental health problems was developed and initially guided by a multidisciplinary group of concerned professionals, and included strong judicial (i.e., judges in the state of California) guidance. Once a youth has been screened and identified as having an “accepted” mental health problem, he/she is referred for a full battery of tests to assess familial, behavioral, educational, and social factors. Often, this assessment includes measures like the Diagnostic Interview Schedule for Children (DISC) or similar standardized assessments. Subsequently, each youth who remains eligible for CITA postassessment is also assigned a multidisciplinary treatment team (MDT) coordinator, who is responsible for organizing the youth’s treatment plan and monitoring the mental health interventions provided for the youth. The final step includes the youth’s placement with a JMHC probation officer and acceptance by CITA. Successful progress in the program requires that family members of the adjudicated youth are aware of and understand the treatment plan, and that the youth adheres to the plan by making regular appointments for therapy, adhering to his/her medication regimen, and by consistently attending school and/or work (Loftus & Arredondo, 2007).

Programmatic success was indicated by reports on the statistics of youth 1 year postprogram initiation. Specifically, in the first year after the program began, “none of the forty-three participating youth committed new law violations and only 7% committed probation violations” (Kadandale, 2008, p. 15). In addition, during the first 6 years of program implementation, CITA received over 700 referrals, from which 200 youth were accepted into the program, 101 graduated, and 93 remained crime free 1 year postgraduation (Loftus & Arredondo, 2007).

Many juvenile mental health courts hold cultural competence as a primary component of the successful implementation of the approach, particularly since it is well established that African American and Latino youth enter into the adjudication process at rates far outpacing their prevalence in the U.S. population. As an example of how juvenile mental health courts function, particularly with regard to diverse youth, we present the following case description excerpts reprinted with permission (Arredondo et al., 2001).

### Case Study

Pablo, 16, is the perfect example of a young man with mental health issues who becomes mired in the juvenile justice system. Initially arrested for misdemeanor assault, vandalism, and brandishing a deadly weapon, Pablo was sentenced to 3 months in juvenile hall and sent home on electronic monitoring after 30 days. Pablo failed to show up for reviews, tested positive for drugs, and was not following the electronic monitoring conditions. He was arrested again for assault and sent to the county rehabilitation facility (The Ranch).

Pablo spent more than 8 months trying to complete a 4-month program. (At one point) Pablo was kicked out of the program for making suicidal statements. After being cleared by mental health workers, Pablo was returned to The Ranch and promptly escaped again.

This scenario continued for months, and Pablo seemed to be failing dismally. He escaped from placement numerous times. He assaulted another ward when he was mocked for being “psycho.” Each time, Pablo would go back to court, and judges would keep sending him back to The Ranch.
Nearly a year after his initial arrest, Pablo’s case was screened for mental health court eligibility. He was found to be suffering from bipolar disorder (manic depression—a biological condition). With this information from the multidisciplinary team, the judge could be sure that more detention would not work. Bipolar disorder is a condition which gets progressively worse if left untreated. The juvenile mental health court judge placed Pablo on an electronic monitoring program for 90 days and sent him home.

After returning home, and with clear directives from the judge, Pablo made great strides in complying with the conditions of his probation and psychiatric treatment. He began to see a therapist to work on managing his rollercoaster emotions and a psychiatrist for medication. He began taking responsibility for his illness and accepting consequences for his behaviors. He enrolled in his local high school and went out for the football team. When he started to lag behind in school, Pablo approached his probation officer and asked for help. Together, Pablo, his probation officer, and a school counselor created an education plan.

His relationships with his family, teachers, judge, and his probation officer continue to improve. Had this change in approach not occurred, Pablo would be worse, not better. In fact, instead of helping him, the system could have harmed him. Pablo’s case demonstrates that adding the mental health perspective provided critical information for devising an individualized plan that worked. Without this information from the multidisciplinary team, there is little doubt that Pablo would have remained in detention until he aged out or the system gave up (p. 7).

As demonstrated by the aforementioned case summary, JMHCs offer numerous benefits to youth, including reduced recidivism rates, the provision of effective treatments, decreases in overcrowding of detention facilities, the facilitation of involvement in community mental health services, increased safety for detained youth, and the potential for improvement in working relationships across system groups within systems of care. Additional reported benefits of JMHCs include the expedition of court processing of youth into services, and the encouragement of family participation in treatment (Behnken et al., 2009; Skowyra & Cocozza, 2007). For adjudicated youth with behavioral problems and mental health concerns, interaction with juvenile mental health courts can provide psychological, behavioral, educational, social, and familial clinical assessments for use in determining best approaches to treating the underlying causes of many youths’ delinquent behaviors.

**Role of Psychiatric Nurses in JMHCs**

Overall, JMHCs offer many great benefits to youth, and support the reduction of health disparities by addressing the needs of a highly underserved population, adjudicated youth. Though unmet mental health need for the general population of U.S. youth is high (reported at upwards of 70% for the 13–20% of U.S. youth estimated to have a diagnosable mental illness), unmet mental health need of adjudicated youth is even higher when one considers that the rates of mental illness in this population are estimated to be as high as 70% (Kataoka, Zhang, & Wells, 2002; National Research Council and Institute of Medicine, 2009; Skowyra & Cocozza, 2007). Therefore, JMHCs are poised to help reduce the disparity in unmet mental health need between adjudicated and non-adjudicated youth. In this regard, psychiatric nurses stand to play a critical role in all aspects of JMHCs from design and implementation to program evaluation and advising on future directions. Child and adolescent psychiatric nursing is a profession focused on working with youth, families, and communities to support the proper assessment, diagnosis, treatment, and nursing care that youth and families need. According to the American Psychiatric Nurses Association, psychiatric nurses, at both the basic and advanced levels, provide a continuum of care for individuals and families with mental health concerns (American Psychiatric Nurses...
As there are multiple points of contact for youth referred to JMHCs (including Juvenile Hall admissions, acceptance into the mental health court, and community aftercare), child and adolescent psychiatric nurses can play a critical role in unique and diverse areas (International Society of Psychiatric-Mental Health Nurses, 2000). Below, we provide a detailed description of the multiple roles that psychiatric nurses can play in reducing health disparities for adjudicated youth as they progress through the CITA (or similar) JMHC.

The entry point for youth served by the Santa Clara County, CA (where CITA is based) juvenile justice system is typically Juvenile Hall. At this critical entry point, most youth receive a well-studied and validated instrument, the Massachusetts Youth Screening Instrument (MAYSI-2), a brief screening tool used in juvenile justice settings to screen youth for mental health concerns (Grisso, personal communication, January 23, 2001; Grisso & Barnum, 2000, p. 2). We believe that this is one of the first critical entry points where psychiatric nurses should be included to assist in the proper assessment of youth with mental health concerns brought to the attention of juvenile justice. Though the literature is limited regarding an operationalized approach to instrument-based, structured nursing assessments of children and adolescents involved with juvenile justice, an emerging body of literature indicates that psychiatric nurses, and, in particular, forensic psychiatric nurses play a critical role in the expeditious and accurate assessment of offenders for potential to inflict harm and the early development of treatment plans (Ford, Chapman, Pearson, Borum, & Wolpaw, 2008; Lyons, 2009). Additionally, psychiatric nurses’ long-standing experiences in emergency room settings, where they must quickly assess and stabilize patients with mental health concerns, make them particularly poised to provide support and leadership to mental health assessment teams in the early stages of youths’ entry into the system (F. Burriss, personal communication, August 30, 2010).

In the Santa Clara Juvenile Mental Health Court system, as youth move from the initial screening stage to the disposition of their cases, those meeting screening criteria for JMHC-recognized mental health diagnoses are often provided with a more comprehensive battery of psychological assessments. At this stage, psychiatric nurses might work in conjunction with child and adolescent, forensic, or court psychologists to support a more comprehensive review of the full body of psychosocial, familial, and neurological concerns presented by youth referred to JMHCs. For youth who are subsequently referred to and accepted into JMHCs, like CITA, the court is charged with ensuring that a comprehensive team of professionals is available to work closely with the youth and families in ensuring appropriate mental health care. As indicated in the case of Pablo, and as reported in the literature on JMHCs, a youth mental health service team typically consists of a multidisciplinary team charged with connecting youth to community-based counseling and therapy while monitoring the youths’ school attendance, medication management/compliance, and overall adherence to their stated treatment program (Loftus & Arredondo, 2007). Advanced practice psychiatric nurses, with prescriptive authority, are a crucial addition to such multidisciplinary teams, which often lack dedicated child and adolescent psychiatrists, who are in short supply nationwide (Shelton & Pearson, 2005).

Once youth have successfully fulfilled their agreed upon obligations to the JMHC, they may have their cases disposed to community aftercare, including wraparound treatment, residential facilities, and traditional outpatient services. These community-based resources are designed to provide counseling and therapy; evidence-based approaches to care and behavioral modifications to help strengthen family bonds; retrain youth in making sound choices and resolving emotional and behavioral trauma. In each of these settings, psychiatric nurses can support service integrity in a child-centered, family focused, culturally competent, and unrestrictive treatment format.
Preparing Psychiatric Nurse Practitioners to Work in JMHCs

As we have described, there is an important role for psychiatric nurses throughout the continuum of care that exists within the JMHC system. We therefore offer the following ideas regarding how the field of psychiatric nursing can best prepare practitioners to assume the roles described, and the areas of research necessary to support the greater inclusion of psychiatric nurse practitioners in JMHCs.

First, given psychiatric nurse practitioners’ training in the administration of psychotropic medications, more training in the specific uses of psychotropics with youth in forensic settings might be warranted (Shelton & Pearson, 2005). Delaney (2008) outlined the five educational trajectories for nurse practitioners who wish to provide clinical care to children and adolescents, and further describes the evolution of these programs over the years. In particular, she notes the recent rise of programs specifically designed to train nurse practitioners in the use of pharmacotherapies. Delaney’s description of newer child and adolescent psychiatric mental health clinical nurse specialist and psychiatric nurse practitioner programs provides an indication of the potential utility of training nurse practitioners not only as prescribers, but as researchers who can provide new insights to combined behavioral and pharmacologic therapies, which are increasingly being recognized as the favored approaches to treating child and adolescent mental health problems (The TADS Team, 2007). In addition, the training of advanced practice nurses would also potentially support the development of a cadre of investigators with the expertise to direct combined therapy clinical trials for youth given the paucity of research regarding the risks and benefits associated with specific psychotropic medication use in children and adolescents (Breland-Noble et al., 2004).

Conclusion

The 2003 President’s New Freedom Commission Report urged the implementation of diversion programs for juvenile offenders with mental illnesses. Our assessment of the benefits and costs associated with diversion interventions for adjudicated youth supports this idea. We believe that psychiatric nurse practitioners can play an essential role in reducing mental health disparities for adjudicated youth via the mental health court system. Their knowledge of the psychological problems faced by youth in general, coupled with their ability to quickly assess, stabilize, and develop treatment plans for acutely ill youth, make them well equipped for the fast-paced juvenile justice environment. Psychiatric nurse practitioners’ training in the coordination and implementation of clinical care services (particularly within residential and community-based settings) places them in an ideal position to collaborate with psychologists, key advocates, families, policy makers, judicial officials, and the youth themselves. The inclusion of psychiatric nurse practitioners in the JMHC system will provide much needed support to youth and family needs for mental health care.

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