The Clinical Practice of Juvenile
There is no clear concept of the forensic psychiatric nursing role in a juvenile justice setting. Most of the work that has been done in examining the professional role of forensic nursing in the United States has focused on victim services (International Association of Forensic Nurses [IAFN] & American Nurses Association [ANA], 1997). In the United Kingdom and Canada, the
role of forensic nurses has developed around the assessment, treatment, and management of adult offenders with mental disorders in a variety of secure environments (Chaloner, 2000; Peterenji-Taylor & Hufft, 1997; United Kingdom Central Council [UKCC] & University of Central Lancashire [UCL], 1999).

Sometimes referred to as "correctional nursing," forensic psychiatric nurses' practice has been identified as the care of individuals who have violated criminal law and have been committed for therapy to hospitals or specialty units within prisons (Sekula, Holmes, Zouche, Desantis, & Olshansky, 2001). With modification, this description can be applied to the nursing role within juvenile settings. This article addresses the gap in knowledge regarding the clinical practice of forensic psychiatric nurses who care for youth in secure institutional environments.

BACKGROUND

A failure of child mental health policy in the United States has resulted in the incarceration of children with mental health problems (Shelton, 2002), and child-serving agencies, adopting a "hot potato" approach for a variety of reasons, shift both the responsibility and cost of care for these difficult-to-serve youth from system to system. The resulting disparities in treatment for children and adolescents are most likely to occur for those with substance abuse and mental health problems and adjudicated as delinquent (Kenney, Haley, & Ullman, 1997). Caught in a vicious cycle where untreated behavioral symptoms sooner or later come to the attention of the police, these children deteriorate even further in juvenile justice facilities, at which point they are released and abandoned, destined to commit more serious offenses (Grinfeld, 2000).

Like adult offender populations, these youth appear non-compliant, generally lack structure in their lives, and have little or no support from their families or communities. They differ from adult populations in that fewer than 5% of youth commit violent crimes, and they present developmental challenges different from those observed in adult offender populations.

The intersection of the juvenile justice and mental health systems occurs around comorbid psychiatric conditions involving substance use (an illegal behavior) and around the issue of involuntary treatment. Where these systems differ is in assessment, approach to treatment, and restrictiveness of service setting. For example, the mental health approach to substance abuse is that it is a disorder, a lifelong disease that can be halted and treated, and from which recovery is possible, whereas the justice approach focuses on the illegality of the behavior and halting the harm caused to the public.

It has only been in the past few years that juvenile justice systems have been recognized as a component of the multiagency treatment system for children, and this perception provides opportunities for forensic psychiatric nursing involvement in ways that do not yet exist in adult offender care.

PURPOSE

This article describes the educational, occupational, and professional practice expectations placed on nurses working with young offenders in secure environments. For the purpose of this article, the term "secure environments" refers to treatment units within juvenile justice and psychiatric hospital settings where young clients, due to their offending behaviors and psychiatric symptomatology, are kept under secure conditions and behind locked doors.

METHOD

Eight focus groups were conducted with RNs (N = 67) who work in specialized (i.e., forensic) child and adolescent units within juvenile justice (n = 5), in an adult prison (n = 1), and psychiatric facilities (n = 2) in the Baltimore-Washington, DC, metropolitan area. All units were designed to handle youth who are involved in the legal system and who exhibit psychiatric symptoms. The number of focus groups conducted coincided with the number of specialty units available in this geographic region.

Although human subjects review and consent forms were obtained, access to the units was challenging and time consuming because various approvals at the state and facility levels were required. Persistent and numerous telephone calls and personal visits were also necessary to explain the purpose of the focus groups and to demonstrate that offender protection regulations (Office for Human Research Protections, U.S. Department of Health and Human Services, 2003) would not be violated. Eventual success can be attributed to the author's making contact with one managerial nurse in each setting who embraced the idea of the study and its implications for forensic nursing education.
Data collection occurred during a 5-month period. Each focus group met once, followed by a tour of the facilities and units. A semistructured interview format adapted from the work completed in the United Kingdom (UKCC & UCL, 1999) guided the groups. The interview guide included seven probes:

- Needs of the client group, key clinical skills, and demands of the job.
- Presence of evidence-based nursing interventions used in practice.
- Development and use of practice standards.
- Effectiveness of one’s preparation to work in secure environments.
- Clinical issues faced in working with clients who compromise therapeutic relationships.
- Challenges related to ethical dilemmas encountered in practice settings.
- Needs of special populations.

No formal structure for the groups was planned, allowing nurses to respond as needed. The seven probes covered within the interview guide were used as a probe to ensure all the topics of interest were covered. These groups were audio-taped, led by the author, and observed by two graduate nursing students who wrote field notes. Investigational Review Board approval was obtained, and consent procedures were explained prior to beginning each focus group. Each participant signed a consent form indicating they understood the procedure and their rights to confidentiality, and received a signed copy. Participation by the nurses was voluntary, and the provision of refreshments took on importance because many nurses were able to participate in the group only if they used their meal breaks. Reflecting on the experience, this provision of refreshments may have been symbolic—fulfilling a need for nurturing that was clearly evidenced in the groups. Once involved in the group, many nurses negotiated coverage of their units so they could remain for the entire group session. No time frame was placed on the groups, and their length (3 hours, on average), came as a surprise.

Little guidance by the faculty facilitator was needed after the group members got past their initial shyness. The participants made the group their own by responding spontaneously to each other, which may have been because the faculty facilitator and student observers were also nurses, permitting a “membership” or level of acceptance within their group, even if only for a brief time. At the close of each session, the opportunity to include any other issues or topics was offered, and themes were summarized by the faculty facilitator, then validated and prioritized by participants. Recorded responses were transcribed and analyzed using qualitative software (Scolari-Sage Publications Software, 2002), then compared and discussed, along with observational field notes, by the faculty facilitator and student observers. The individual com-

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juvenile justice settings were "contractual" (i.e., agency nurses who were not full-time employees), whereas those in the psychiatric settings were employed through the state mental health system. No nurses were new graduates, and most (88%) had 15 or more years clinical experience. Participants frequently commented that they had come to work in these settings because "they needed a new challenge in nursing."

**Description of the Environment**

All of the facilities in which these nurses worked were part of the public or state service system, crowded, and in poor repair. The child unit in the adult prison was the least conducive to a youthful population and had the poorest conditions, being dark and very noisy. Nurses reported:

- The wards have a horrible odor. Bedwetting is a problem. The officers deal with this. You don’t even have a chance to address this problem. It’s all you can do to deal with the problems referred in here.
- Toileting and hygiene are not maintained, in part due to the numbers of kids and the inadequacies of the facilities...there aren’t even doors to toilet stalls, just shower curtains. Some of the problem is because of the rigid schedules.

On the other hand, the psychiatric hospitals, although clearly in dated buildings, were better maintained and showed some effort to reflect the needs of the youthful population they served. In the juvenile justice settings and the adult prison, the "specialty units," which were the domains of the nurses, were noticeably cleaner, more orderly, and painted more brightly than the rest of the institution. Nurses reported that the tone of these specialty units was noticeably different, too, more calm and quiet, similar to what would be found in a psychiatric hospital. Nurses noted:

- This unit is much more comfortable; kids get more attention and get to watch TV. They want to be here because they fear some of their peers...the predators. We have less violence because we have higher staffing ratios and lower census.

- Residents have a lot to gain in coming to this unit. These units are run more like psych units than a prison. Residents get a lot more attention; there is greater attention to assuring personal safety...we utilize milieu management too. All this makes us more attractive to those who are in the general population. There’s also a secondary gain——there are lots of females in here as opposed to what’s out there among the officers.

It was interesting to note that all of the nurses in the juvenile justice and adult prison wore nursing uniforms and referred to their specialty units as "infirmaries." When asked about this observation, nurses responded by saying:

- Uniforms help the administrators, security, and residents understand that you are a nurse. I know this sort of makes us look like we work in a hospital, but we don’t just do medical care...there is a high demand for mental health care, too.
- People understand hospital nursing, uniforms, medical tests, and administration of medication. Even though nurses value the skills, there isn’t a strong presence of specialized psychiatric nurses because they increase cost. When you put a contract together for health services, you are really stretching to cover all the necessary services. You can’t hire specialty nurses...besides, primary care nurses are more readily available, psychiatric nurses are far and few between.

**FOCUS GROUP RESPONSES**

The results across all focus groups are classified under
the seven probes addressed in the interview guide. Excerpts representing the primary themes extracted from all groups are presented.

**Needs of the Client Group**

In addressing the needs of the client group and key skills necessary to provide care, the nurses unanimously agreed both physical and psychiatric nursing skills are needed to work within these facilities. Participants comments included:

- You need both a psych and medical background because there is a relationship between the two. Separation of one from the other makes no sense.... Even though separation of medical and criminal records is necessary for legal reasons, it does not help in treating the whole person when you don’t have all the information.
- The nurse’s role here has a lot to do with administering and monitoring medications. You have to keep kids healthy and safe, so you have to be up on your medical and psychiatric drugs.
- These roles really come together for me when major violence breaks out. We have had kids from two gangs in here at the same time. Everyone escalates, and people get hurt really bad. I had to talk some kids down while checking to see if another kid had a broken arm...and keep an eye on the security officers too!

Participants also noted the high rates of asthma and skin infections in this population:

- Respiratory problems are common. Lots of residents are treated for asthma. It’s hard because the kids cannot have their inhalers. Residents are not encouraged toward self-care. There is too much fear on the part of administration that the inhalers will be misused. The infirmary, where most of us are located, is not easily accessible to kids because they cannot just leave their group. Security is not interested in taking the time to walk the kids over here, or if they are short staffed, they simply can’t risk it.
- The number of skin problems is remarkable. Some of that is related to poor hygiene, some related to the industrial cleaners used to wash the kids jumpers. Everyone’s stuff, including underwear, goes into the same laundry, and they don’t necessarily get their own underwear back. We also have kids who chronically pick at themselves...their toenails get really infected.

Although the nurses seemed most comfortable with the primary care skills, the need for psychiatric expertise was identified as the greatest priority, demonstrated by the frequency and consistency with which it was mentioned across all groups. Management of suicidal behavior, aggression, and manipulative behaviors were three areas repeatedly mentioned.

Participants’ comments included:

- If I were to list the skills you’d need, I’d say risk assessment skills. You have to have the ability to therapeutically relate to residents and be effective in working with suicidal youth. You have to be able to separate out those kids who are gesturing because they have just been placed in the facility from those who have serious suicidal tendencies. Across our system, kids are successful in their attempts every year. We get really bad press when that happens.
- I find that many of these kids are diagnosed with borderline personalities. These [children] are particularly difficult to manage because they are so manipulative. They absorb so much time...if you don’t give it to them; they set it up so they get it anyway. It would be better to have the time, staff, and skill to deal with them head on.
- You had better know how to manage violence, and it's the primary task around here.

Other recurrent themes included differences in working with adolescents versus adult populations and the importance of milieu management:

- Adolescents think they are invincible; they are high risk takers...they lack insight to consequences. These risky behaviors are normal for them; they’re working through issues—it’s a different process than in adult life. Look at when they get incarcerated. Adults sort of have an idea of what to expect and why it happened. Not these kids; they’re all over the place.
- These kids are more violent and unpredictable than adults. They go from zero to overdrive in a blink. They come after you and act out their anger. You can reason more with adults. But not with these kids, they say stuff like “You’re not my dad.” It’s really not about you; they just react to you.
- That’s why it’s so important that you have knowledge of age differences when it comes to cognitive development and behavior. This impacts your method of teaching and their ability to comprehend and implement changes. Here’s a good example: most of these kids are doing poorly in school with reading and writing, and using journaling as an intervention would be inappropriate.
- You had better be ready for the noise level...it is something you have to tolerate. These kids
are raised different, their mannerisms differ; you need tolerance.

**Evidence-Based Nursing Interventions**

The nurses combined probes for evidence-based nursing interventions used in practice and discussed standards development in their responses. Management of aggressive behavior and use of restraints were two areas identified as having an evidence base:

- Management of aggressive behavior is probably the most refined practice that is based upon careful research and trials. As an example, we have learned to intervene in the early stages of escalation, but it is hard to implement when we are not always out in the general population.
- We have learned, and it has been well documented, that you test the child’s readiness to come out of restraints by talking them through it, releasing limb by limb.

A need for clinical protocols was also frequently voiced:

What we really need is a detox protocol. Most of the kids have some substance and alcohol abuse going on. Screening for this should be part of the normal routine, but screening instruments don’t always pick stuff up.

**Practice Standards**

In the discussion of standards, licensure and institutional policy were the themes noted in participants’ responses:

- We meet many standards, undergo Joint Commission [on Accreditation of Healthcare Organizations] surveys much the way hospitals do. We have to be sure that everyone is oriented to policies, trained in infection control, and stuff like that. The company that has our contract is responsible for making sure these requirements are met.
- Most of the time they just come in and tell us what they want done. No one asks what needs to be done, or if it can be done—it’s sort of a knee-jerk reaction.
- We do have some committees, but there are very few RNs to go around, so the task usually falls to the supervisor.

**Preparation to Work in Secure Environments**

Notable was how ineffective these nurses felt regarding their preparation to work in secure environments. Most felt that basic academic preparation was not adequate:

- Your basic RN degree gives you a generalist overview, to get you through the licensure exam. Then you get into the real world to get experience. After all that, when you come to a place like this, you realize that you have developed skills in either medical or psychiatric nursing, but you can’t really cross the lines easily.
- It’s hard for someone coming into this environment because the individual skills differ between RNs. Everyone gets an extensive orientation, but it doesn’t address individual needs. We have nurses who work with adults come, but they don’t know about how to work with kids. We have general medical nurses come, but they don’t know psych.
- There is no way a new graduate would be able to come into an environment like this. You have to have some experience under your belt. You might be able to attract new graduates if there was an extensive mentoring system for them. You can’t leave them out there alone, they’d get eaten up.
- Even for the seasoned nurses, if they haven’t worked in these systems before, they need help adjusting to the environment. We are able to attract many nurses. The salaries are good, and many things about the role, such as level of independence in your practice, are great. It falls apart because people in here are harsh, and the system is not really set up for nurses.

Knowledge of the criminal justice system and the priority of security in the workplace were also identified as areas of weakness in nursing preparation by participants:

- I was challenged by the difference in the work culture. Issues for me were how the justice system impacts what happens here. People don’t understand how much we are influenced by decisions made in court. The judge says he wants a certain thing to happen with an individual kid, and we scurry around to try to do it without the tools and resources to do it. Sometimes it is unrealistic.
- Even for those of us who are psychiatric nurses, your knowledge of offending behaviors is weak. There are dynamics that you have never considered before. Also, if you don’t know how the criminal system works, know the terminology and approach to management of the inmates, you’re lost. It takes a lot of energy transferring between health care and criminal care.

Nurses also spoke of security as an issue:

- You can be in the middle of doing clinic [sic] and there is a lock-down. Everything stops, stuff gets shoved in drawers and locked; kids have to get to their units...it’s chaos.
- Nurses have to learn. You are not conscious of security issues. Little things, like leaving pens out, are dangerous. You can’t even have a hole puncher...
because it may become a weapon. Sloppiness puts us all at risk. Nurses get blamed along with everyone else if stuff is not picked up on.

- [The worst experience I ever had was] when I was out in the general population and a fire was started. Things went out of control, kids screaming, a lot of people running, so much going on that no one really knew what was going on. The officers move really fast to lock everyone down. I had to stay where I was. I became acutely aware of my own personal safety. You simply cannot forget this. I never will. Everything happens so fast, and you have to act on it immediately, and you better know what the policies are, or you're left high and dry.

**Therapeutic Relationship Issues**

When exploring clinical issues faced in working with clients whom compromise therapeutic relationships, comments about boundaries, transference, splitting behaviors, and strained relationships between nurses and security officers were made:

- The big problem is when patients get attached to staff. For some kids, this is as good as it gets. In many ways, you're the parent this kid wished he had. But it goes the other way too. We have staff that gravitate toward certain clients. They give them gifts, don't pass consequences fairly, and stuff like that. We had a kid go AWOL [absent without leave], the staff went to pick them up— that's against our policy.

- As the RN you need to be consistent in the way you relate, behave, and where you hold your own boundaries. Once the residents learn where you are at, they get off your back. They know what to expect, and work with it or around it, as they need at that moment.

- See? There's that psychiatric skill coming into play again. You have to know who's faking and who isn't. Some kids take advantage when things on the ward get stirred up. When staff's attention is divided, things seem to break loose. Behavior escalates at a very fast rate around here.

- Nurses need to deal with their own issues. If you're caught in the middle of fighting, or you are assaulted, you have to handle how it makes you feel as a nurse...how it makes you feel as a human being. You also have to ask, what part you had in it all.

- One of the biggest differences is working through the correctional officers...they're the filter. What the outcome is depends on how good that officer is. You have to have a lot of skill to develop relationships with the corrections staff. But it takes time. This is not the norm of these institutions. There is a lot of mistrust. It's not all their fault, though. They are not asked for their opinion on how to manage a situation.

- Frontline staff could use additional training, but the system is not focused in that way. This is not about rehabilitation; it's about keeping kids off the street so that the people out there aren't screaming at public officials. It shows that the public lacks an understanding of how juvenile systems work. Whether they know it or not, these kids get out.

- I really think nurses are ill prepared to manage people and systems like this. It would be better if it were organized so that nurses would supervise officers like direct line staff. Right now we function as two separate, parallel systems. This doesn't help teamwork, especially when it is not encouraged at the top.

**Ethical Dilemmas**

The ethical dilemmas encountered in these practice settings...
were related to the influence of individual biases, the lack of resources, and the failure of the child service system in general. Individual biases were reflected in participant comments such as:

- Knowing a lot about residents can set off alarms and raise prejudices in you that impede the work you can do with the resident. An example of this is in the case of the adolescent pedophile. He knew the nurses didn’t like him. It set him up for poor management. It was too bad. I think he was looking for counseling; he wanted answers too.
- I’m not sure I want to know more about the inmates. I health and threatens your license if something happens.
- Everything we do is in response to a crisis, and it’s usually because we don’t have enough manpower. You can’t train people to do a better job because they can’t get released from their job, or they can’t pay for overtime because they’re over contract. There is no awareness of how all these things tie together. We’d have fewer crises if we went about things proactively. It saves money in the long run.

The nurses were particularly vocal regarding the status of the children for whom they provide care:

- Don’t really know how it feels to be so unwanted by all of society.
- ...and so how did this all happen? These kids didn’t wake up one day and say, “Hey, I’m gonna destroy myself and everyone around me ’cause I got nothing else to do.” These kids get this way over time, because of the numerous abuses imposed upon them. These kids are destroyed by those who are supposed to love and care for them.

When the nurses described needs of special populations, culturally sensitive care, attention to language barriers, and handling pregnant girls were issues identified:

"I’m here because they’re here. Despite the setting, they make you step back and reevaluate your own priorities in life.”

think it can cripple your work. You might be inhibited in getting to know them if you knew the horrible thing they did that got them there. So much of what goes on in here is based on fear. I [would] rather deal with the inmate as I find him [sic].

Needs of Special Populations

Limitations in resources, budget, and contracts were often voiced as concerns:

- There is a lack of understanding that such limited resources impact your work, like not even being able to do finger sticks on a diabetic. If you don’t have the tools, it threatens their treatment.
- These kids get dumped here. They have many issues that could be handled better somewhere else. We have kids who are disabled, mentally and physically. What are we supposed to do with someone with difficult behavior who has brain damage because the kid was beaten? I think the wrong person is incarcerated!
- You’d think these kids were garbage. No one stops to think why they’re not cooperative. They’ve been rejected by every child agency that exists to serve them. No one wants them. Their families have given up on them and discarded them. They have no place else to go. We just
- We have a growing number of residents who have limited language or communication capability. The Hispanic population is growing faster than any other cultural group. We don’t have translators. You have to take even more time to be sure they understand. Sometimes I just don’t have the time to do this.
- I thought I had this figured out. There are translators available through the telephone company... I thought [this was] great! We can use them to help us. Well, wouldn’t you know it, we had problems with access to phones, then we had kids manipulating so they could use
the phones. It got all blown out of proportion. But I haven’t given up...I’m determined to get this to work...we really need to address this issue.

- Girls who are pregnant further tax the system. We have limited resources, and there is a lot of concern for their safety. We move them out quickly. It seems strange that no one ever worries about how she got to this point.

- There is a lot of teaching that needs to be done. These girls have not been taking care of themselves, and they have no idea of the impact the baby will have on them. Sometimes, to make it more complicated, parents are demanding that the girl get an abortion. They want us to do something about it. That’s just not our role. But there you are, somehow in the middle of it...dealing with the parents, taking their calls, dealing with the impact on the girl. It’s not usually good.

ADDITIONAL FINDINGS

Hearing the nurses’ challenges, and viewing the often bleak and unfriendly environments in which they work, one may wonder why they do it. Participants’ responses reflected a sense of spirituality, hope for these children and belief in their ability to affect the life of a child:

- It's because of my spiritual belief that we are here to care for others who are less fortunate than we are. I don't think about being afraid, I feel good about making some small change. You have to believe; you just have to.

- I'm here because they're here. Despite the setting, they make you step back and reevaluate your own priorities in life. It's disappointing when they come to know you by name because they come back so much. I try to remember that they want acceptance, they want to be different, they want to have different lives.

- When I first came to the 3 to 11 o'clock shift, I was devastated. I went out to my car. I had to ask myself why I was here. I couldn't take watching these kids, locked up like this. When I graduated from nursing school, I never knew there were places like this; I never knew. As I processed how I felt, I said to myself, you love kids...there is something you can do here. I knew I had to stay. I have developed relationships with them, I have shared words of hope, I have given them skills.

- I followed the patients, and this is where they are.

- ...and this is where I can really make a difference.

DISCUSSION

The findings of this qualitative study of forensic nurses in secure juvenile settings portray issues similar to those noted elsewhere in the literature on forensic or correctional nursing with adult populations. The competing demands of custody and caring (Peterenel-Taylor, 1999) were evident as these nurses presented many examples of their work with young offenders. The differences in working with an adolescent population and the parallel systems (i.e., justice and mental health) provide a basis for claiming forensic psychiatric nursing has a specialized knowledge and skill base for meeting the needs of this juvenile population. Issues of control, trust building, and negotiation are involved in not only therapeutic intervention (Dhondea, 1995), but every interaction.

Generally, the nurses in this study felt their nursing educa-

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provided by substandard nurses. Nothing could be further from the truth. We’re leaders in the development of this kind of psychiatric nursing, forensic nursing that is.

IMPLICATIONS
The results of this study clearly identify a need for highly targeted academic and professional development programs for forensic psychiatric nurses. Flexible academic program models for advanced practice and post-degree certificate options at the BSN and graduate levels are called for. The lack of time within first-degree academic programs, combined with the growing demand to produce nurses in shorter lengths of time, limits the ability to adequately provide specialized training at the entry level. A post-BSN certificate would function as a stopgap measure for nurses who are already working in these settings. The focus at this level would be to develop knowledge and skills to intervene with the more complex clinical needs of youth with multiple problems.

Similarly, psychiatric clinical nurse specialist (CNS) programs also take a generalist approach, covering the wide range of adult, and to a lesser degree child, disorders and their treatments, including pharmacological interventions. The limited number of child and adolescent psychiatric CNS programs in the United States makes it even more difficult to build on an established knowledge base. A post-master’s certificate may help both child and adolescent CNSs and psychiatric nurse practitioners improve their knowledge and skills specific to the most difficult-to-treat youth, including those with coexisting disorders, severe and persistent disorders, sexual arousal disorders, and highly disruptive and self-harming behaviors. To be truly effective in these specialized settings, advanced clinical knowledge and expertise are needed, along with a well-developed knowledge base in legal and criminal systems. With this knowledge, juvenile forensic psychiatric nurses will be able to draw on theoretical and expert knowledge as they maneuver through these uncharted waters.

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