

Rehabilitating Youth in Juvenile Corrections

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Juvenile correctional programs that focus solely on safety, education, and structure yield suboptimal outcomes. Youth in these facilities often have learning disorders, and adaptive challenges, have been exposed to severe trauma, and have mental disorders, including autism spectrum disorder. Consequently, rehabilitation programs must be comprehensive, individualized, developmentally informed, and trauma-informed to achieve better outcomes. It is imperative that staff receive training to identify, intervene in, and report specific behaviors. This approach broadens staff skill sets, addresses the rehabilitation needs of a larger group of youth, generates data that facilitate accurate diagnoses and treatment planning, and enhances the likelihood of equitable rehabilitation for all youth.

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Meeting the needs of youth who have autism spectrum disorder in juvenile corrections facilities is essential for developmental, rehabilitative, and health equity. Too often, however, their needs are not met. Fodstad and colleagues¹ offer a framework that addresses many of the rehabilitation challenges autistic youth may encounter while confined. Interestingly, youth who do not have autism have many of the same concerns and needs. Examining the evolution of the juvenile corrections system can yield insight into the nature of the problem and, perhaps, identify mitigating interventions that are conducive to meeting the rehabilitation needs of both groups of youth.

Hon. Julian Mack was one of the founders of the *Harvard Law Review* and a juvenile court judge.² In 1909, the *Review* published “The Juvenile Court,” in which Judge Mack described his philosophy of rehabilitating juveniles.³ His position was informed by a review of how juvenile accountability is managed in the United States and abroad. He posited that punishment served as a deterrent for youth offenders and their peers, but it was not conducive to their becoming responsible members of society. Equitable rehabilitation was essential.

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Judge Mack said the goal of juvenile court hearings was to understand the biological, psychological, and social factors that affected the youth’s developmental trajectory and to determine what could be done to right that path. This is akin to using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) cultural formulation interview to identify social determinants of mental health, assess the impact of a youth’s environment and experiences on their future direction, and develop an individualized treatment or rehabilitation plan.⁴

Judge Mack did not support sending youth to adult prisons, which he said, “permitted them to become the outlaws and outcasts of society” (Ref. 3, p 107). Instead, they should be remanded to youth reformatories (also known as training schools or juvenile corrections facilities), where they would be held accountable while receiving support, training, and education so that they “could go out into the world capable at least of earning an honest living” (Ref. 3, p 106).

Additionally, Judge Mack believed the adjudication process in juvenile courts should not be informed by class. He opined that the parent “cannot keep his child and allow him to continue to violate the law of the state without successful check or barrier thereon, just because he has a comfortable and moral home” (Ref. 3, p 113).

Innovative programs require long-term governmental funding when implemented nationally. But

Judge Mack noted that “[p]rivate philanthropy has supplemented, and doubtless in the future will supplement, the work of the state in providing for the delinquents” (Ref. 3, p 111). This proved untrue. The juvenile reformatory program failed because of inadequate funding, standards, oversight, and accountability.

More than one century later, juvenile corrections facilities persist, although the census has declined 75 percent since the beginning of the 21st century from about 108,800 annual admissions in 2000 to about 27,600 in 2022.⁵ Research has shown that, even when offenders were matched on legal offense records, demographics, and 64 other factors, those who were legally confined did not have better outcomes four years after they were released than those who were not.⁶

Diversion programs for youth also offer an alternative to residential rehabilitation for some youths, including those who have neurodevelopmental or other disabilities. Fodstad *et al.* cite one such program, Nevada’s Detention Alternative for Autistic Youth (DAAY), which has successfully rehabilitated many youths with autism spectrum disorder.¹ Ideally, evidence-informed rehabilitation programs would exist for youth with autism and other neurodevelopmental challenges throughout the nation; however, this would not eliminate the problem of rehabilitating autistic youth in juvenile corrections facilities.

Individuals with autism have a range of intellectual, adaptive, language, and physical abilities. Each youth’s family may require different resources to maintain the youth at home or in a court-ordered residential placement. Therefore, one community-based program will not meet the needs of all delinquent youth who have autism.

The authors aptly express concern for autistic youth being exploited or victimized in juvenile corrections facilities. Unfortunately, these youth can also be exploited in the community if they are not closely monitored. For example, they may submit to gang members who are involved in violent activities that undermine community safety or they may have failed to adapt to less restrictive placements because of emotional dysregulation, adaptive challenges, being targeted by other youths, etc. Thus, there may always be some minors with autism in juvenile corrections facilities. This underscores the importance of rehabilitation programming for them.

Juvenile corrections facilities should provide an individualized rehabilitation plan for each youth that

is subject to periodic review. The individualized plan is the key to providing equitable rehabilitation for all youths, including those who have autism. Unfortunately, some facilities do not individualize youth rehabilitation because of resource deficits.⁷ Staff may lack proper training, support, supervision, and accountability. Also, the outcomes for youth in these facilities are likely to be worse, because they are being warehoused rather than rehabilitated.

This can affect youth with autism spectrum disorder as well as other youth in the facility, including those who have been exposed to trauma. Perhaps an equitable way to meet the needs of both groups of youths is to establish basic standards for rehabilitation, then enhance each rehabilitation program by addressing maladaptive behavior with interventions tailored to each youth.

Implementing a minimal evidence-informed standard for therapeutic skills training is the first step for providing competent youth rehabilitation.⁸ The institution should have acceptable staffing ratios, a youth rehabilitation program curriculum, staff training guidelines, and a procedure for program implementation that is conducive to maintaining a culturally safe environment for youth. Additionally, a continuous quality improvement program should be introduced, which includes incorporating supervision, accountability, and support for staff education and retraining as needed.

Training should include basic information on safety, suicide prevention, normative youth development, youth engagement, crisis intervention, behavior management skills, communication skills, documentation, stress management, and accountability, among other relevant topics. Maintaining a safe environment is essential, as is employing a team-based approach to rehabilitation that focuses on the unique needs of each youth. The rehabilitation program should be strengths-based and incorporate the principles of trauma-informed care, which has been shown to reduce behavioral infractions and violence in confined youth.⁹

Staff should have a fundamental skillset that includes identifying and managing early indicators of emotional and behavioral dysregulation, suicide spectrum behavior, self-injurious behavior, predatory activities, aggression, and other forms of violence and disruptive behavior. This can reduce the perceived need for seclusion and restraint.

Some youths, including some who have neurodevelopmental disorders, histories of trauma, and

obsessive-compulsive disorder, can be overly sensitive to touch, altered routines, or certain textures. They may also be sensitive to environmental annoyances, such as bright lights, slammed doors, enclosed spaces, arguments, loud noises, or other neurosensory challenges. These findings and ways to alleviate the youth's discomfort can be reviewed in treatment team meetings and added to the youth's individualized rehabilitation program.

Family engagement can be overlooked in juvenile corrections rehabilitation programs. The family network is an integral part of the youth's life; they are familiar with the youth's history, and can provide the psychiatrist and other team members with a description of the family dynamics. A caretaker who participates in developing the youth's aftercare plan (which includes linkages to school, medical, mental health, recreational, and other community resources) with the treatment team may be more likely to follow it, which can reduce the risk of recidivism.

Psychologists or social workers typically lead juvenile corrections treatment team meetings, which review a youth's behavioral, educational, and legal status. Sometimes health matters are discussed. The psychiatrist's participation is essential when the youth is receiving or being considered for medication management services. Additionally, treatment team members are not supervised by medical professionals and may not be covered entities under the Health Insurance Portability and Accountability Act (HIPAA).^{10,11} Staff may unintentionally use the youth's medical information in a manner that differs from its intended medical purpose.

Case Examples

Disclosing psychiatric diagnoses to juvenile corrections staff requires careful consideration and discretion. The diagnosis can be stigmatizing and derail youth rehabilitation, especially if staff shift from using evidence-informed methods to methods derived from their lived experiences and lay knowledge of mental disorders. The following case examples are composites of events that occurred in juvenile corrections facilities.

Youth "A," who had mild intellectual disability, reportedly had unprovoked episodes of assaulting staff "R" without cause. The assaults occurred once or twice per month before school. The youth said during the interview that she hit staff "R" when she would not serve syrup with pancakes or French toast. Staff

"R" explained to the psychiatrist that women should not eat syrup during their menstrual cycle. The nursing supervisor educated staff "R," assigned a different team member to work with Youth "A," and the problem ceased.

Youth "B" was defiant, walked out of group therapy every session, and cut herself at least weekly. Data showed that the cutting episodes occurred on the same night each week. Staff "E" asked, "What do you expect from a girl with borderline personality disorder? She's just like my niece." The youth informed the psychiatrist that she was being forced to attend a group therapy program for survivors of trauma. She walked out of the group whenever she began to relive the sexual trauma. She cut herself to block the memories and thoughts of suicide. The psychiatrist treated the youth for posttraumatic stress disorder. Also, the group therapy program was canceled pending a review of the curriculum and participant selection protocol.

Staff said Youth "C" was a friendly, pleasant, and likeable "nonadjudicated serial sex offender," whose brief court-ordered juvenile corrections commitment had been extended repeatedly "because he masturbates in class all the time." He said he takes trazodone in the morning because, "I'm never going to get out of here, so I may as well sleep my time away." Trazodone was discontinued, "Youth "C" became more alert and engaged in class, and he stopped masturbating in class.

Staff said Youth "D" used to be "a problem, but we handled that and have got him under good control. He has conduct disorder and antisocial personality disorder. Sometimes he refuses to eat. He's just trying to get attention, so we ignore him." The youth's room was dirty, malodorous, and located far away from his peers and staff. He sat in the corner of the room, rocked back and forth, mumbled unintelligibly, and did not make eye contact with the psychiatrist. The plate of food was untouched. Staff did not appreciate the need for the youth to receive emergent inpatient psychiatric care "because hospitals don't want these kids."

Conclusion

These examples illustrate the importance of having standards, training, and accountability for rehabilitating youth in juvenile corrections facilities. The skills staff develop will help build on a youth's strengths

while addressing concerning behaviors in a timely manner.

The individualized treatment plans allow the treatment team to provide focused rehabilitation to youths who have mental disorders, including autism spectrum disorder, even if they have not been diagnosed. The program should offer all youth the opportunity to be rehabilitated.

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