The psychological context of deprivation of liberty of children[1]

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While a varying yet rather frequent outcome for children in conflict with the law in member states of the Council of Europe, depriving a child of his/her liberty should not be a casual decision. In fact, law enforcement personnel and judicial authorities would be surprised to discover the degree to which putting a child[2] behind bars raises the possibility of significant collateral damage that runs contrary to the original intention. Also, it is useful to ponder what a child experiences when he or she is detained? What are the psychological reactions to detention and what factors into these reactions? What is the influence of the type of detention environment? In what way does deprivation of liberty have a negative impact on children and adolescents? Do prior life experiences also shape the child's reactions? What about the effect of the quality of the peer group with whom the adolescent shares the period of detention? Or the level of staff training? While many other questions came to mind, the present contribution touches on a selection of psychological issues related to children's deprivation of liberty. But before delving into these issues, we believe it is necessary to propose a simple framework (quelques constats) that lends some coherence to our analysis and to our proposals.

The action of depriving a child of his or her liberty should always be the result of a law enforcement or judicial decision that is carried out with necessary due process safeguards and clear rehabilitative and educational goals. Numerous anecdotal reports as well as reported on systemic weaknesses in some Council of Europe member states suggests that this is not always the case. This situation only reinforces the notion that the juvenile justice system as a whole represents an incredibly complex adaptive system that cannot reasonably be analyzed without keeping in mind the theory of complexity (Mitchell M. Waldrop (1993). *Complexity: The Emerging Science at the Edge of Order and Chaos*. Simon & Schuster) and that our contribution simply scratches at its surface. Even so, we believe that we can make a significant contribution by adopting an overarching perspective rooted in the interdisciplinary field of children's rights.

Another element that is of paramount importance to our perspective is that we reject the notion that detention be viewed as a discrete time-limited period of a child's life. In other words, from a psychological perspective it makes little sense to examine issues relative to the deprivation of liberty as a discrete space and time that begins when a child enters a "detention system". Is deprivation of liberty a reality when a child enters an institution akin to a prison environment when his or her freedom of movement is impeded or is s/he already in detention from the moment the police stops him or her for questioning, and even more so when s/he is brought in or called in to the police station and booked? Our sense is that, in particular for children and adolescents, one cannot adopt a restrictive perspective. For children and

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adolescents, what happened in their life before any type of deprivation of liberty is probably as important, and perhaps, even more so than what takes place during a detention period behind bars (i.e., deprived of liberty). In other words, just like the Council of Europe's guidelines on child friendly justice, we should be considering the event of confined detention as one in a series of events in a given child's life that begin long before any contact occurs with the judicial system. The deprivation of liberty may be the end result that followed a pathway of unsuccessful interventions by the child protection system, the educational system, combined with the failing of the family or caretaker system.

In line with the theory of complexity, we recognize that children are a heterogeneous group and that therefore no child should be mistaken for another. They differ in every aspect from their genetic material to the familial and social circumstances in which they are brought up in. Each child is exposed from birth onwards to a unique array of stimuli and will meet a set of people that differs from the one any other child encounters. We are suggesting that, while it is necessary to address and discuss categories of children for programmatic purposes or transnational comparisons, we should never lose sight of the fact that each child deprived of liberty is a different story, represents a different history and a different developmental trajectory.

The general consensus in the scientific literature is that "detention has a profoundly negative impact on young people's mental and physical well-being, their education, and their employment" (Holman and Ziedenberg, 2006, p. 2)

Considerable research over a very long period strongly suggests that incarceration has a profound negative effect on detainees. In his seminal book, *The society of captives*, Sykes focused on the "Pains of imprisonment" which relate to the deprivations and frustrations of prison life. This led to the so-called deprivation theory which states that a person's psychological condition suffers from the loss of liberty, the loss of autonomy, the loss of material goods, the loss of heterosexual relationships and the loss of security. Simply put, taking a lot away from a person will make him or her very unhappy and produce pathological reactions ranging from mental illness such as depression, to self-directed violence such as suicide, and to violence towards others. Even more simply stated, according to this theory, prison is bad!

But deprivation theory must be completed by what is referred to as importation theory. This is also rather uncomplicated: the culture, beliefs, and characteristics of a detained person are imported into prison and will mostly be exacerbated. What you were before incarceration, what you were on the streets or in your family comes along with you when you are incarcerated and unless dysfunctional facers are forcefully addressed by treatment and rehabilitation programs, it stays the same or even more frequently gets worse. This is not exactly good news when one surveys the degree to which serious evidence-based treatment and rehabilitation programs are underfunded and understaffed, if they exist at all, in institutions of detention both for adults and for children across many Council of Europe member states.

It is also bad news because of a mental illness prevalence problem. Children in detention facilities are a high-risk population, who often have unmet physical, developmental, and especially mental health needs. Serious research points to alarming rates of prevalence for

mental disorders in the juvenile justice population. Saxena (2013), a well-respected researcher affiliated with the World Health Organization, cites a basket of studies that shows that the prevalence of mental disorders in juvenile justice populations is above 50% of adolescents compared to 10-20% among the general youth population. For example, Shelton (2001) conducted a well-regarded research, administering a validated, structured diagnostic interview to a random, representative sample from all 15 of the State of Maryland's juvenile facilities (n=312). She identified 53% of the youth (ages 12–20) as exhibiting diagnostic criteria for a psychiatric disorder. Notably, many of these children had not been previously identified as having a psychiatric disability.

The top researcher on the question of mental health prevalence in detention facilities, Linda Teplin, has studied very large samples of incarcerated juveniles in the United States. With her colleagues (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002), she has found by testing them at intake, that is shortly after they enter a detaining facility, that huge percentages of children and adolescents present easily verifiable mental problems. To be very specific this is the case even if you exclude conduct disorder which is very common condition among detained youth. In one of her latest samples, 60% of males and more than two thirds of females met diagnostic criteria and had diagnosis-specific impairment for one or more psychiatric disorders. Half the males and almost half the females had a substance use disorder, and more than 40% of males and females met criteria for disruptive behavior disorders. Affective disorders were also prevalent, especially among females. More than 20% of females met criteria for major depressive episode. It is estimated that the prevalence of serious psychiatric disorders in the general pediatric and adolescent population (in this case in the USA) is estimated to be between 7% and 12%. By comparison research points to rates of 60% upwards for incarcerated youth. When conduct disorders are not included and rigorous methodology is applied, 60% of juveniles in detention show either a psychiatric or substance use disorder and 45% a mental health diagnosis.

In the past few years, with a different methodological approach, very significant research has been carried by various sub-teams under Tom Grisso's influential guidance using the Massachusetts Youth Screening Instrument - Second Version or MAYSI-2. This instrument has six clinical scales identifying thoughts, feelings or behaviors (experienced in the past few months) that often are signs of a youth's mental or emotional distress. They include: alcohol/drug use (frequency and extent of use), angry-irritable (feelings of anger and resentment), depressed-anxious (feelings of depression or anxiety), somatic complaints (bodily sensations often associated with anxiety), suicide ideation (thoughts of self-harm) and thought disturbance (unusual ideas and visual/auditory experiences). A seventh scale, traumatic experiences, provides information about a youth's exposure to potentially traumatizing and stressful experiences. The MAYSI-2 does not provide psychiatric diagnoses. The primary purpose of the test is to screen in a pool of youths whose self-reported mental or emotional conditions require further attention (e.g., a clinical assessment). And because it is administered with the help of front line staff it is a very powerful tool for staff members to be sensitized to the issues that each adolescent carries into the facility.

For the majority of children and adolescents, detention makes things worse. If you were depressed before you came to prison, chances are your depression will be imported and, because you suffer from deprivation, your depression will intensify. This is why suicidal ideation and behavior are so frequent within youth prison populations. Suicide rates are four times higher than in the general population and significantly more violent. Why is this? Many juvenile facilities are overcrowded, they breed violence and chaos for children and

adolescents, and because in many instances the young detainees do not receive effective treatment.

Then again detention makes things worse because it interferes with a natural "aging out" process. As many as a third of young people will engage in delinquent behavior before they grow up but will naturally "age out" of the delinquent behavior of their younger years. While this rate of delinquency among young males may seem high, the rate at which they end their criminal behavior, (called the "desistance rate") is equally high. Most youth will desist from delinquency on their own. For those who have more trouble, it has been shown that establishing a relationship with a significant other (a partner or mentor) as well as education opportunities employment correlates with youthful offenders "aging out" of delinquent behavior as they reach young adulthood.

Youth who have experienced trauma may be more likely to be involved in illegal behavior for a variety of reasons, including the neurological, psychological and social effects of trauma. A growing body of research in developmental neuroscience has begun to uncover the pervasive detrimental effects of traumatic stress on the developing brain. The majority of brain development is completed during the first five years of life, with the most critical development occurring within the first two years. Considering that it is reported that the average first trauma exposure in children who experience trauma occurs at five years old, the experience of trauma in childhood is likely to impact some critical aspect of this brain development. Indeed, brain structures responsible for regulating emotion, memory and behavior develop rapidly in the first few years of life and are very sensitive to damage from the effects of emotional or physical stress, including neglect. Some of these structures are measurably smaller in abuse survivors, and irregular brain activity in these areas among abuse survivors is correlated with an increased frequency of violence. Without adequate emotional control, particularly in aggression centers of the brain, people may fail to develop empathy and are more prone to aggressive, violent and sociopathic behavior.

People who have experienced trauma often have abnormal blood levels of stress hormones, and the parts of the brain responsible for managing stress may not function as well as in people who have not been exposed to trauma. Also, a decreased integration of the left and right sides of the brain following prolonged stress exposure can affect the ability to use logic and reason and can result in children in poor problem solving skills to the same extent as adults. People who experienced trauma as children are also more likely to develop life-long psychiatric conditions, including personality disorders, conduct disorder, ADHD, depression, anxiety, substance abuse disorders and posttraumatic stress disorder (PTSD). Developmental delays, decreased cognitive abilities, learning disabilities and even lower IQ levels have been observed among those who experienced trauma at a young age. Research shows that a majority of people with these histories experience school problems; school dropout and expulsion rates are as high as three times those of peers who had not experienced trauma.

Although not every child in conflict with the law has experienced traumatic victimization, clinical and epidemiological studies indicate that at least three in four youth in the juvenile justice system have been exposed to severe victimization.

When exposed to trauma or mistreatment, a child may cope by resorting to indifference, defiance, or aggression as self-protective reactions. In these cases, risk taking, breaking rules, fighting back, and hurting others who are perceived to be powerful or vulnerable may become

a way to survive emotionally or literally. It is often these behaviors that bring youth into the juvenile justice system.

It seems that traumatic stress symptoms worsen as a result of juvenile justice system involvement. For youth who have experienced trauma who are entering the justice system, the process of arrest and incarceration can itself represent a traumatic event. Court hearings, detention, and incarceration are inherently stressful, and stressful experiences that are not traumatic per se can exacerbate trauma symptoms. Girls in particular may be susceptible to trauma after incarceration due to their high rates of exposure to traumatic stress and the possibility of retraumatization. Seclusion and restraint in psychiatric units is cited as an example of a practice that can be retraumatizing. Interventions at times of crisis include the presence of male security personnel, being strapped to beds, forced medication, seclusion, precautions which force disrobing, forced physical exams, and invasive body searches. No wonder that self harm frequently occurs during these crisis moments.

Last but not least, staff insensitivity or loss of privacy, can exacerbate negative feelings created by previous victimization, especially among PTSD sufferers and girls. Young people in correctional facilities are frequently exposed to verbal and physical aggression, which can intensify fear or traumatic symptoms.

In conclusion, two key words. The first is Training, training, training, holistic interdisciplinary training in children's rights, mental health issues, child and adolescent interviewing techniques. This should be standard for all those who are in contact with children passing through the judicial system, law enforcement staff, lawyers, judges, social workers, prison staff, teachers, monitoring bodies, everyone. The second word is diversion diversion… get as many children and adolescents in restaurative programs with a big emphasis on education and reinforcing their social net.

Saxena, S. (7 mars 2013). ***Mental health of children in detention***.. Side event to the Human Rights Council, Mental and physical health in juvenile detention. Palais des Nations, Nations-Unies, Genève.

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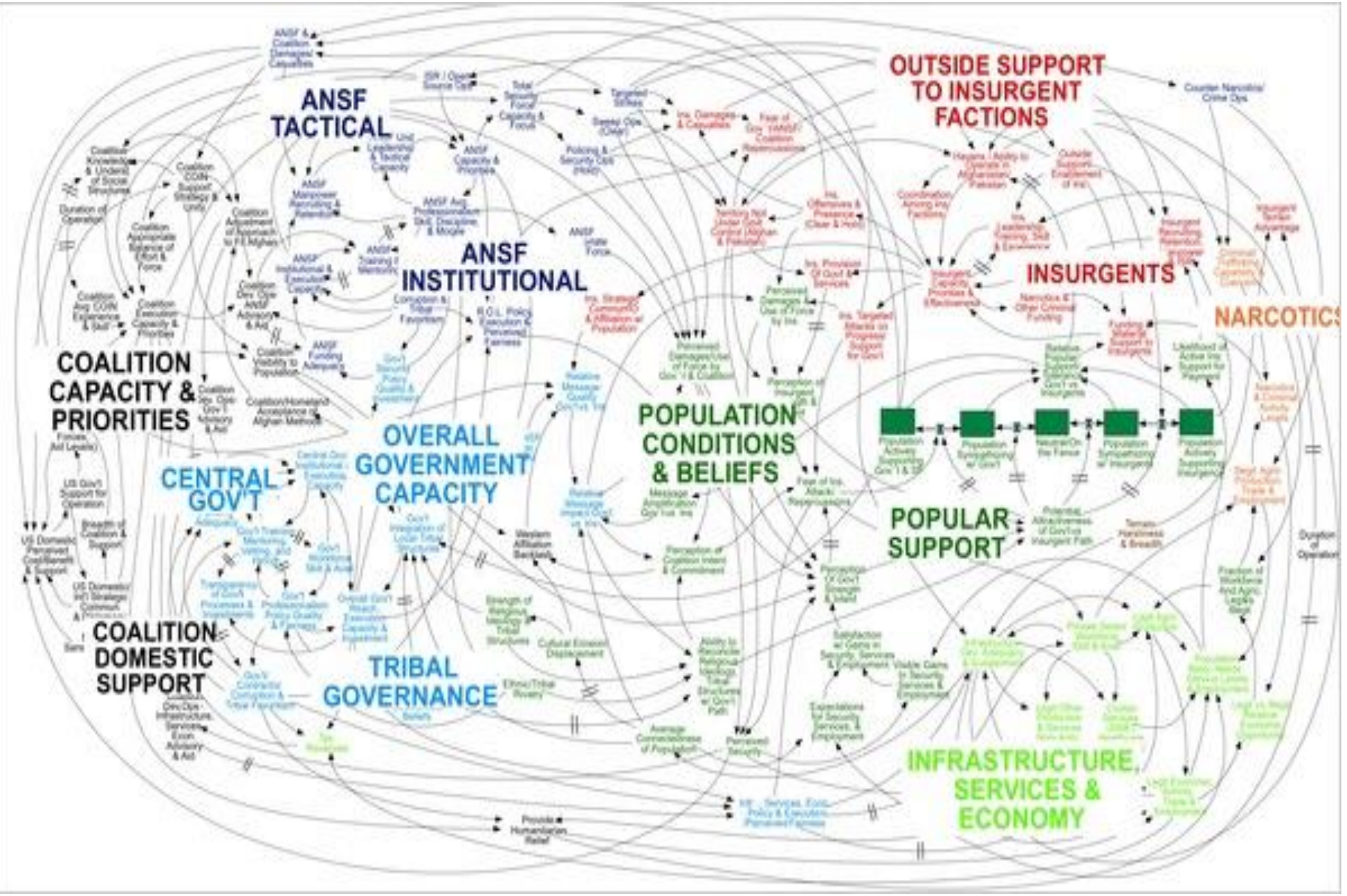
ANSF TACTICAL
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OVERALL GOVERNMENT CAPACITY
CENTRAL GOV'T
POPULAR SUPPORT
COALITION DOMESTIC SUPPORT
TRIBAL GOVERNANCE
INFRASTRUCTURE, SERVICES & ECONOMY

The general consensus in the scientific literature is that “detention has a profoundly negative impact on young people’s mental and physical well-being, their education, and their employment” (Holman and Ziedenberg, 2006, p. 2)

Gresham M. Sykes (1958)
The Society of Captives:
A Study of a Maximum Security Prison
Princeton University Press

The “Pains of imprisonment”

Deprivation theory states that a person's psychological condition suffers from the loss of liberty, the loss of autonomy, the loss of material goods, the loss of heterosexual relationships and the loss of security.

Importation theory:

The culture, beliefs, and characteristics of a detained person are imported into prison and will mostly be exacerbated.

Table 1. Psychiatric Disorders of Diagnostically Classified Youth in the Maryland Juvenile Justice System

Diagnostic classifications	*n*	percent[a]
Anxiety disorders	155	57.6
Disruptive behavior disorders	107	39.8
Schizophrenia or psychoses	86	32.0
Misc. disorders (tics, eating)	47	17.5
Affective disorders	45	16.7
Substance abuse disorders	100	37.2

Note: total sample *N*=312, total sample classified *N*=165.
[a]overlapping categories

Shelton (2001)

Prevalence

- Testing youth at intake, shortly after they enter a detaining facility, huge percentages of children and adolescents present easily verifiable mental problems. (Teplin et al, 2002)

- 60% of males and more than two thirds of females met diagnostic criteria and had diagnosis-specific impairment for one or more psychiatric disorders.

- Half the males and almost half the females had a substance use disorder.

- More than 40% of males and females met criteria for disruptive behavior disorders. Affective disorders were also prevalent, especially among females.

- More than 20% of females met criteria for major depressive episode.

- Prevalence of serious psychiatric disorders in the general pediatric and adolescent population is estimated to be between 7% and 12%.

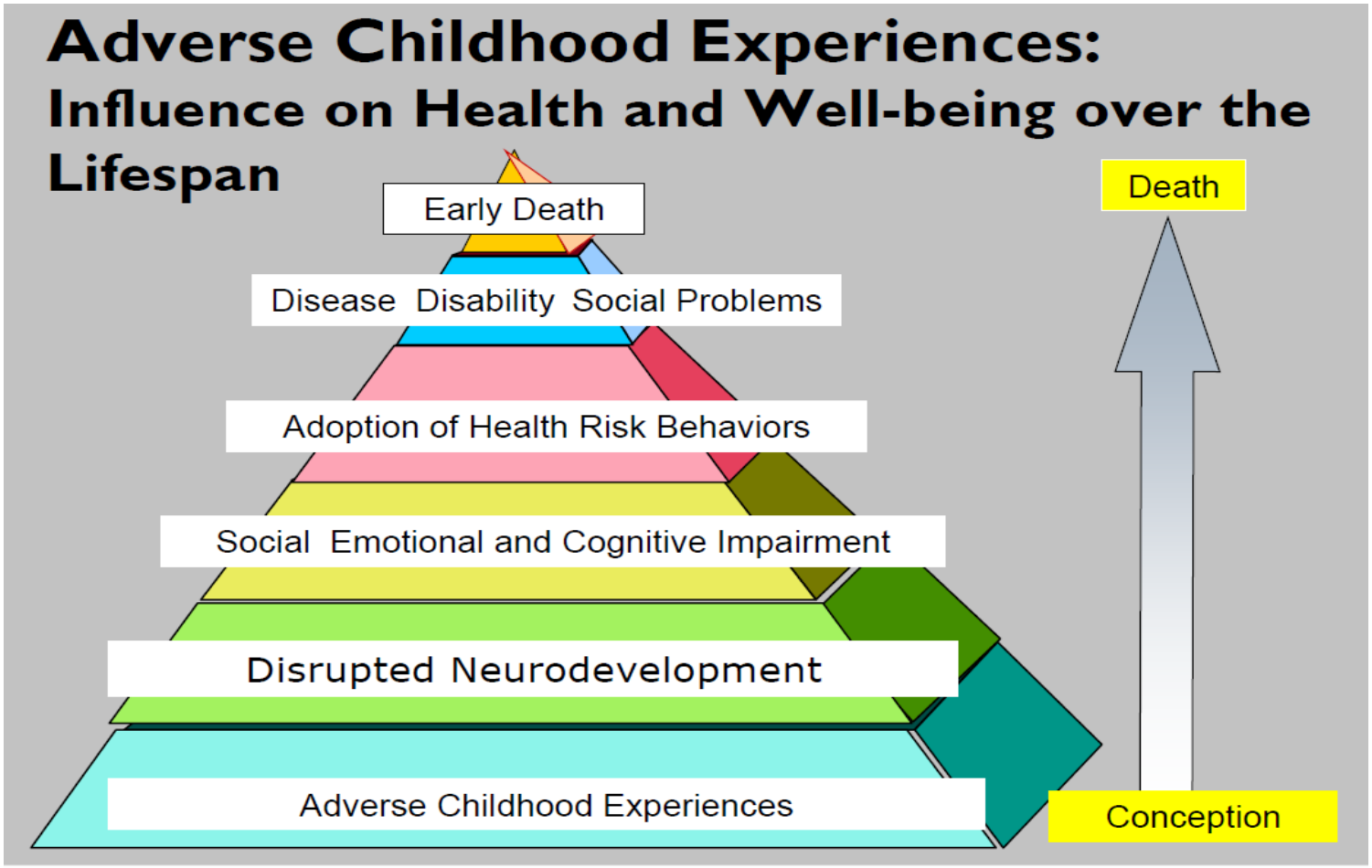
- When conduct disorders are not included and rigorous methodology is applied, 60% of juveniles in detention show either a psychiatric or substance use disorder and 45% a mental health diagnosis. (Teplin, et al, 2006)

MAYSI-2

Massachusetts Youth Screening Instrument - Second Version or MAYSI-2

= six clinical scales identifying thoughts, feelings or behaviors (experienced in the past few months) that often are signs of a youth's mental or emotional distress.

A seventh scale, traumatic experiences, provides information about a youth's exposure to potentially traumatizing and stressful experiences.



G. Griffin (2010).

An adolescent who does not break the Law is a statistical aberration.

Aging out

MANY THANKS FOR YOUR ATTENTION

Type of Trauma[2]	
Ever been in a situation where you thought you/ someone close to you was going to be hurt very badly or die? (*n* = 439)	53.2
Ever been attacked physically, or beaten badly? (*n* = 332)	35.3
Ever been threatened with a weapon? (*n* = 490)	58.4
Ever been forced to do something sexual that you did not want to do? (*n* = 130)	4.4

Karen M. Abram, Linda A. Teplin, et al (June 2013). PTSD, Trauma, and Comorbid Psychiatric Disorders in Detained Youth. Juvenile Justice Bulletin. www.ojjdp.gov

Ever been in a bad accident, like a car accident? (*n* = 234)	33.1
Ever been in a fire, flood, tornado, earthquake, or other natural disaster where you thought you were going to die or be seriously injured? (*n* = 93)	10.5
Other than on TV/movies, ever seen/heard someone get hurt very badly or be killed? (*n* = 595)	74.1
Ever been very upset by seeing a dead body/ pictures of a dead body of someone you knew well? (*n* = 224)	23.5

Karen M. Abram, Linda A. Teplin, et al (June 2013). PTSD, Trauma, and Comorbid Psychiatric Disorders in Detained Youth. Juvenile Justice Bulletin. www.ojjdp.gov

	Total (n = 898)
Ever Traumatized	
Ever experienced any trauma listed	92.5
Mean number of traumas	14.6

Karen M. Abram, Linda A. Teplin, et al (June 2013). PTSD, Trauma, and Comorbid Psychiatric Disorders in Detained Youth. Juvenile Justice Bulletin. www.ojjdp.gov