Research Paper Medical Science

Assessment of Delinquent Behavior Among Adolescents And Role of Pediatrician in Its Window Zone

Dr. Abhay Kumar Choudhary Associate Professor, Dept. Of Pediatrics, Laxmi Narayan Medical College, Bhopal, Madhya Pradesh

Dr. Pritesh Goutam Assistant Professor, Dept. Of Psychiatry, Laxmi Narayan Medical College, Bhopal, Madhya Pradesh (Corresponding Author)

Dr. Rituja Kaushal Assistant Professor, Dept. Of Community Medicine, Laxmi Narayan Medical College, Bhopal, Madhya Pradesh

ABSTRACT

Juvenile Delinquency and its increased prevalence is an alarming situation for current India as it is engulfing a proportion of its future citizens in their early teens. Objectives: This is high time to analyze magnitude & evaluate various risk factors and deep rooted social determinants causing it. Also there is a great need to find out medical methods for age assessment & cognitive maturity of delinquent children to help juvenile justice court. Study design, setting & participants: A cross sectional analytical study was planned in government schools located near our health facility- to find out prevalence and risk factors linked with this problem. A self-reported delinquency scale with attached proforma for risk factors was provided to 200 students (all males) of 12-20 years in different government schools. Outcomes: Results were analyzed in terms of prevalence (10.5%) & distribution of various risk factors for delinquency (0.5%-2%) in the study population. Conclusion: Due to many limitations it was concluded that more & more such multi centric studies should be undertaken in different parts of the country in order to get the real picture of the problem & to implement corrective measures to overcome it.

KEYWORDS : Juvenile Delinquency, Risk factors, Juvenile Justice Act, Delinquency Scales and Pediatrician

INTRODUCTION

Juvenile Justice (Care and Protection of Children) Act, 2014

In many ways, the Juvenile Justice (Care& Protection of Children) bill, 2015, passed by Lok Sabha, is a forward looking and comprehensive enactment that provides for dealing with children in conflict with the law and those require care & protection. However its laudable features have been overshadowed by one provision that states that children in the 16-18 age group will henceforth be tried as adult if they are accused of committing heinous offences.

The government believes that the provision will help address public disquiet over the perception that young offenders are getting away with light punishment after committing crimes such as murder and rape. But in 2006 in United States of America it was found that an adult prison sentence will not likely help juvenile offenders. As per the studies published in the journal "crime & delinquency" it has been illustrated that approximately 33% of juveniles attending adult prison system are more likely to continue committing crime than those who have gone through the juvenile system. Their cases have to be dealt at their individuality level. They should not be judged or compared on the same scales or standards as the most hardened criminals. Circumstances surrounding their alleged crime are different. So in spite of planning harsher prison sentences for serious crimes in later stages it would be judicial as well as beneficial that something must be done to stop children from getting to the point where they feel the need to start committing offences or go on violent crime sprees. Later on due to criticism in India also, government has dropped clause 7 in the bill but has tweaked the wording involved, saying that what the Juvenile Justice Board will hold is a preliminary assessment rather than a preliminary enquiry into the mental and physical capacity of the child to commit such an offence.

Juvenile Delinquency Scenario in India:

There has been 97.9% increase in crimes committed by children between 2003 and 2004, with more children being appeared for arson, theft and cheating. Over 33,000 juveniles, mostly between the age group of 16 to 18, have been arrested for crimes like rape and murder across Indian states in 2011, the highest in last decade[1].

Figure 1: Distribution of Population of Juveniles Arrested In Various States of India in 2011

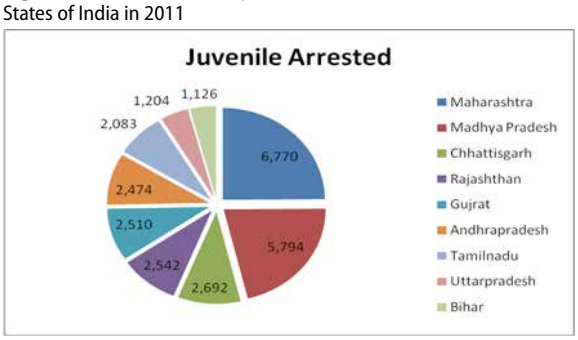
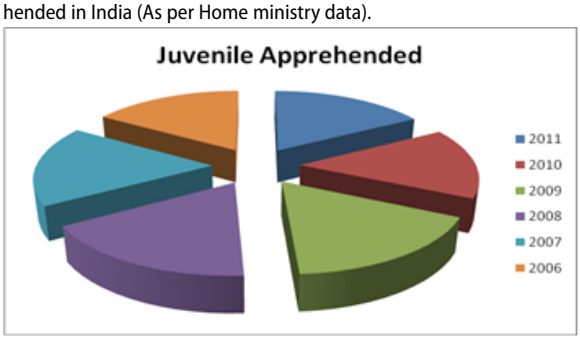


Figure 1: Year wise Distribution of Population of Juveniles Apprehended in India (As per Home ministry data).



MATERIAL AND METHOD

Design wise it is a cross sectional analytical study. Study was conducted over a period of 2 months in Bhopal city which is a part of central India. Inclusion criteria for study population included 200 students of age group between12-20 years belonging to 7 to 12 standard. Predesigned & pre tested semi structured very basic type of simple questionnaire was used as probe to reveal relevant information regarding

variables under study. Risk factors were recorded, pooled, tabulated and subjected to statistical analysis. Quantitative data in terms of number & percentages was assessed & prevalence was calculated. Study was conducted after taking clearance from institutional ethical committee. Verbal consent was taken from participants & confidentiality of data was maintained.

Result and Observation

Prevalence of delinquent behavior in students was calculated to be 10.5%

Table 1: Distribution of population as per various risk factors for Delinquent behavior in terms of numbers & percentages.

Risk factors for Delinquency	PRESENT (Out of 200)	ABSENT (Out of 200)
Suspension from school	2 (1%)	198 (99%)
Stolen things	2 (1%)	198 (99%)
Skipped school	4 (2%)	196 (98%)
Cheated	2 (1%)	198 (99%)
Shop lifted	2 (1%)	198 (99%)
Written things & damaged public property	3 (1.5%)	197 (98.5%)
Violence	3(1.5%)	197(98.5%)
Sexual relations	1 (0.5%)	199 (99.5%)

Discussion

United States department of justice has recognised such risk factors & categorised them as follows: Individual level factors like prenatal & perinatal factors plus psychological, behavioral & mental characteristics. Secondly social factors which include family structures & peer influences, thirdly community factors which includes neighbourhood & school policies.[2-21]

Pediatricians should employ their skills and influence mainly in four arenas against this menace:

Clinical Practice: use of an integrated plus comprehensive approach for anticipatory guidance/councelling, screening of children and families during the course of routine health maintenance.

Advocacy & Community Mobilization:

Pediatricians should advocate for: adequate publicly supported community- based behavioral health services; protection of children from exposure to drugs & firearms; bullying awareness by teachers, educational administrators, parents, and children coupled with adoption of evidence-based prevention programs; responsible programming on television, video, cable, the internet, and video game formats that minimizes youth exposure to violent images, messages, and themes etc. He should also advocate for adequate availability of community recreational centers for engaging youth's mind & brain in healthier aspects of life.

Information, Education & Communication (IEC) plus Behavior Change Communication (BCC) strategies:

Pediatricians should avail every available opportunity to learn more about violence prevention through adoption of interventional framework based on life skills education approach for youth.

Evidence based Research:

Pediatricians can contribute to needed research by: participating in practice-based research in the area of youth violence prevention; contributing data to existing intentional injury surveillance systems; and advocating for municipally supported, legislatively mandated active local injury surveillance systems. Through routine school/community surveys, they must screen out such juveniles for early prevention & control.

Evidence based research in this regard certainly has a very important role of a pediatrician in age as well as cognitive assessment methods for juvenile justice court' proceedings.

Age assessment methodologies: Crawley in 2007 described that the methods include a range of medical, physical, and psycho-social assessments, as well as approaches to assess age that make use of existing local knowledge. Evidence shows that most experts agree that age assessment is not a determination of chronological age but an educated guess, and can only ever provide an indication of skeletal or developmental maturity from which conclusions about chronological age may be inferred.[22]

Medical age assessment: Bone age assessment, Dental age assessment, (However, as with bone age assessments, medical opinion is that there are discrepancies between chronological and dental ages (Affidavit of Dr Herbert F. Frommer, January 28, 2002 in Physicians for Human Rights, 2003:132).[22]

Physical assessments: In practical terms, anthropometric values are compared across individuals or populations in relation to an acceptable set of reference values (de Onis et al, 1996a:650). There are clearly defined methods for rating puberty as described by Tanner in 1962. These give the ages of various stages of attainment of pubertal appearances, starting on average at 11 years in both males and females and going through to the final stages 21 acquired two or three years later.[22]

Psycho-social and developmental assessments: It clear that age assessments, need to be part of a comprehensive assessment that takes into account both the physical appearance and the psychological maturity of the individual and that there may be exceptional cases for when the guidelines they developed are relevant even if the applicant is older than 18, emphasizing the psychological and developmental maturity are as important as chronological age.[22]

Cognitive & neuropsychological predictors of juvenile adjucative competency: As in our country we are not having any clear cut policy or reliable data over this problem yet, we have to rely on research work of other nations in similar scenarios. Current laws in many countries are based on English common law, which required that defendants facing criminal charges must be able to understand the charges against them, appreciate the consequences of legal proceedings, and communicate with their lawyers (Zapf & Roesch, 2006). This requirement is designed to protect vulnerable individuals as well as to maintain the integrity and fairness of the justice system (Bonnie, 1992). Recent concerns over the increasing frequency and severity of youth violence has forced the juvenile justice system to undergo a shift in its focus from the protection of juveniles to the protection of the public (Burnett, Nobler, & Prosser, 2004). Similarly, transfer of juveniles to adult court has increased in recent years in the U.S (Grisso, 1998). It is important to note that these legal changes have been highly controversial, with many scholars arguing that they are not supported by research on youth violence. Further, subsequent harsher responses to youth crime have generally not impacted recidivism rates in the expected direction. In states that have reduced the maximum age of juvenile court jurisdiction and moved 16- and/or 17-year-old defendants to adult criminal court, no evidence of a general deterrent effect has been shown (Jensen & Metzger, 1994; Zimring, Fagan, & Kupchik, 2001). In fact, such transfer laws perhaps make it more likely that youth raised to adult court will recidivate (Bishop, Frazier, Lanza-Kaduce, & Winner, 1996; Fagan, 1995, 1996; Myers, 2001). This may be particularly true for transferred violent offenders (Lanza-Kaduce, 2005).[23]

Age consistently emerges as an important predictor in the juvenile competency literature. In a study comparing 108 juveniles to 145 adult trial defendants undergoing competency to stand trial (CST) evaluations, juveniles performed at an equal level to adults on simple competency abilities (e.g., knowledge of detention as a possible consequence, the importance of proper conduct in court, and their wish for positive outcomes for their cases) (McKee, 1998). However, many juveniles were less competent than adults when faced with more complex decisions that only an accused can decide (e.g., whether to testify, what plea to enter, whether to accept a plea bargain). On the basis of these findings, McKee (1995) concluded that "preteens' extensive deficits clearly challenge the law's presumption of competence to stand trial in person's facing criminal charges".[23]

Conclusion:

If any juvenile possesses certain risk factors, research indicates that it will increase his or her chance of becoming a delinquent. A risk assessment may aid in determining the type of intervention that will

best suit the juvenile's needs and decrease his or her risk of offending.

In recent years, the juvenile justice field has adopted an approach from the public health domain in an attempt to understand the causes of delinquency and work toward its prevention. Farrington (2000) calls this recent movement toward the public health model the "risk factor paradigm," the basic idea of which is to "identify the key risk factors for offending and tool prevention methods designed to counteract them"[20]

Based on all this & it's resemblance in Indian context also – India drastically needs a well defined juvenile policy in order to sort out this burgeoning problem.

s Pediatrician works on interface between community & legal system of any country in such problems, they should exploit the opportunity to screen for Juvenile Delinquency in children of these age group by doing regular camps and surveys. Other than radiological evidences, they should also utilise certain risk factors based scales as tool to get a grip over the problem. Examples are Massachusetts Youth Screening Instrument–Second Version (MAYSI-2), Inventory of Callous–Unemotional Traits (ICU), The Antisocial Process Screening Device (APSD), Peer Conflict Scale (PCS) etc. in early stages.

Other tools used in Juvenile Justice Facilities and Community-based Services are - SIQ; Reynolds, 1988, GAIN-SS; Dennis, Scott, Funk, & Foss, 2005, Voice-DISC; Wasserman, McReynolds, Fisher, & Lucas, 2005, CAFAS; Hodges, 2000, CANS-C; Lyons, Griffin, Fazio, & Lyons, 1999, ASEBA; Achenbach & Rescorla, 2001, BASC-2; Reynolds & Kamphaus, 2004, PADDI; Estroff & Hoffmann, 2001, WSJCA; Barnowski, 2004, YLS/CMI; Hoge & Andrews, 2006, SAVRY; Borum, Bartel, & Forth, 2006, RRC; Justice System Assessment and Training [J-SAT], 1998.

After screening & sorting them- appropriate corrective steps should be adopted to reform them.

[24, 25, 26, 27].

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