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# The pathogenic illusion of youth incarceration: a call for abolition medicine in Europe

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Across Europe, a regressive wave of punitive justice is replacing developmental protection with structural harm. Driven by political populism, several European states are systematically lowering the age of criminal responsibility and expanding youth incarceration. In May, 2026, Sweden legislated to transfer minors as young as 15 years to adult-managed prisons. France is actively debating lowering the age of criminal adulthood from 18 years to 16 years.[1] In 2023, Italy introduced the Caivano Decree, a punitive legislation that responds to youth social hardship by lowering thresholds for police custody, expanding pre-trial detention criteria and harsher sentencing rather than strengthening community-based social and health-care services, and dramatically streamlining pre-trial detention for minors.[2] Concurrently, new provisions under Italy's Security Bill introduce administrative preventive detention (*fermo preventivo*) on minors, alongside legislative proposals imposing an automatic presumption of criminal maturity for adolescents aged 14–17 years. The epidemiological consequence is evident: between 2023 and 2024, the number of individuals detained in juvenile correctional facilities surged by 50% in Germany, nearly 20% in France, and 80% in Italy.[3] Furthermore, the Council of Europe's Anti-Torture Committee has urgently called for eliminating mechanical restraint (the physical fixation of individuals to beds or structures using straps or ties) on detained youths in Spain,[4] exposing widespread human rights violations across European facilities.

This punitive turn ignores a fundamental public health reality: carceral environments are inherently pathogenic and structurally incompatible with positive adolescent neurodevelopment.[5] Rather than addressing upstream social determinants of youth crime (eg, poverty, educational disruption, and social exclusion), the carceral apparatus functions as a mechanism of social abandonment, replacing welfare and health-care interventions with punitive confinement. It concentrates vulnerable youth with high baseline rates of preexisting neurodevelopmental and psychiatric conditions (including attention-deficit hyperactivity disorder, depression, and substance use disorders) and trauma,[6] as well as unaccompanied and separated children (UASC). These UASC, bearing deep psychological scars from traumatic migratory pathways, are disproportionately incarcerated due to systemic shortages of community placement structures.[7] Furthermore, entry points into detention are compromised by flawed age-assessment procedures reliant on biometric and wrist x-ray data, which carry high error margins and subvert holistic, psychosocial evaluations.

Once detained, minors encounter European prison environments characterised by severe overcrowding, institutional neglect, and exposure to violence. The institutional scandal at the Cesare Beccaria juvenile prison in Milan, Italy, where 13 officers were arrested for systematic abuse, exemplifies how youth facilities might become sites of state-sanctioned trauma. Beyond direct physical abuse, constant exposure to vicarious trauma (ie, witnessing peer self-harm, interpersonal violence, altercations with staff, and physical restraint) destabilises developing adolescent psyches.[8] The improper use of disciplinary isolation irrespective of the location (ie, adjacent to health-care facilities) further compounds acute psychological distress. The resulting systemic lack of an environment of care within the custodial frame fosters a vicious cycle of

institutionalisation and adult recidivism (ie, persistent reincarceration and cycle of detention stemming from unresolved social disadvantage rather than intrinsic criminal behaviour).[9]
The somatic and psychological toll of this carceral crisis is devastating. Rather than providing evidence-based therapeutic care, juvenile facilities increasingly rely on chemical restraint to manage institutional tension. Across major Italian youth penal institutes, the administration of psychotropic drugs (primarily benzodiazepines, antipsychotics, and hypnotics) surged by a mean of 41% in 2024 (measured in defined daily doses).[2] Crucially, a sharp clinical distinction should be drawn between legitimate psychopharmacological care and the systemic use of sedatives to enforce compliance. In overcrowded facilities, psychotropic overprescription pathologises the situational distress of incarcerated youth while fostering iatrogenic addictions. When distress becomes intolerable, the system yields its most tragic metrics: self-harm and suicides, epitomised by the death of 17-year-old Danilo Rihai in Treviso juvenile prison in Italy.[2]
From a life-course perspective, adolescent detention severely disrupts neurodevelopmental and social transitions to adulthood, increasing long-term risks of severe depression, post-traumatic stress disorder, and substance use disorders.[10] Far from serving as a deterrent, carceral containment acts as a major vector for adult criminal justice involvement, yielding higher recidivism rates compared with community-based diversion programmes.[5]
For health-care professionals, this crisis induces an unsustainable dual loyalty conflict, in which ethical obligations to patient autonomy and wellbeing are subordinated to security mandates.[5] In carceral settings, clinicians are routinely pressured to prioritise institutional order over clinical needs—for instance, when expected to prescribe sedatives for behavioural management rather than therapeutic care, or when security protocols override medical confidentiality and clinical independence. This ethical tension forces health professionals to navigate contradictory roles as both caregivers and agents of state control, driving widespread clinician burnout, moral injury, and the erosion of professional standards.[5] As health professionals, we should refuse to let medicine be weaponised as a passive tool to contain regressive social policies.
Health professionals should embrace the framework of abolition medicine, a health-care practice rooted in the understanding that public safety and child health cannot be reached through cages but require the optimisation of social and health-care infrastructures.[5] Abolition medicine aligns directly with established European frameworks. Both the WHO Regional Office for Europe and the European Union Agency for Fundamental Rights have long established that custodial detention is inherently detrimental to child development and should strictly remain a measure of last resort.
The international medical community should urgently advocate for complete divestment from juvenile carceral structures. Public capital should be redirected away from prison expansions and towards community-based mental health services, paediatric advocacy, and non-custodial programmes led by multidisciplinary teams (physicians, nurses, psychologists, social workers, and educators) focused on education and recovery. Incarcerating children is not an antidote to social ills; it is its ultimate, most pathogenic manifestation. Public health professionals should lead the charge to close youth prisons across Europe, reclaiming a society in which all children have the resources to flourish rather than flounder.

# Competing Interests

We declare no competing interests.

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