ISBN 81-86431-00-4

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2011

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Published by:

National Institute of Mental Health and Neuro Sciences
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First printing 2011

This publication is part of a project titled **"Mental Health and Substance Use: Assessment and Approach in Prisons" sponsored by the Karnataka State Legal Services Authority, Bangalore**

Typeset and printed by WQ Judge Press
Residency Road, Bangalore - 560025

ISBN- 81-86431-00-4 **NIMHANS publication no-79**

This publication is supported by the

Karnataka State Legal Services Authority, Bangalore.

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10 January 2011

Foreword

Mental illnesses, including substance use disorders pose major challenges in prisons all over the world. Prevalence of mental ill health is disproportionately high among prison inmates. Mental disorders could be present before admission to prison, which might get exacerbated after admission into prison, or can manifest for the first time after incarceration. Factors such as violence, lack of privacy, lack of social networks, lack of meaningful relationships, poor health services etc adversely affect mental health.

Added to these, people with preexisting mental disorders are subject to more discrimination and isolation after incarceration. This is particularly true of women prisoners who more often develop symptoms of anxiety and depression following separation from their family, particularly their children.

Even prison staff has high levels of mental morbidity including stress related disorders. Unfortunately, even in developed countries with well developed prison organisational services, mental health needs of prison staff are rarely addressed.

Effective treatments are available for mental disorders including substance use disorders which can be delivered through cost-effective means. As a bare minimum, such treatments should be available to all prisoners. Positive mental health of prison inmates improves their quality of life and may help for better adjustment to the community outside the prison.While there is a substantial amount of literature on health problems among prisoners in western settings, the scientific information regarding prisoners' health issues is meager in Indian setting. This is worse where mental health issues are concerned.

While there is a substantial amount of literature on health problems among prisoners in western settings, the scientific information regarding prisoners' health issues is meager in Indian setting. This is worse where mental health issues are concerned.

In this context, I am extremely delighted to present this academic review which has been undertaken by Dr Suresh Bada Math, Professor Pratima Murthy, Dr Naveen Kumar C, Dr RajaniParthasarathy and Dr Madhusudhan S. This review summarizes both the available literature in the field and also provides an insight to the local situation. This book provides a wealth of information to planners and policy makers, students of mental health, law and related disciplines. I hope it can also act as a resource material for policy makers who can base decisions on the sound scientific information that is available in this book.

I sincerely hope that this work, which probably is the first in its kind in the country, will pave way for further scientific endeavors examining mental health and substance use in prison settings and lead to effective prevention and intervention for mental ill health.

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1. INTRODUCTION

Mental health is an integral part of our well-being, yet mental health issues have been woefully neglected in our country. Even worse is the fact that serious mental illnesses are not treated early and the treatment gap even for such disorders is very large. It is well known that people in disadvantaged situations have high levels of mental morbidity and poor access to treatment. Prisons and other custodial institutions are locations which see high levels of mental distress and morbidity.

Mental distress may occur in otherwise normal individuals in response to the stress of imprisonment. They may occur in vulnerable individuals who have pre-existing illness that gets exacerbated in prisons, or develops anew in prisons as a result of stress or other factors. Persons with certain types of personality disorders are also more likely to enter prisons. Given that many of these vulnerabilities are associated with the use of both licit and illicit drugs, it would be expected that these pre-dispositions would also enter the prison along with the prisoner. This adds to the already high burden of substance use (tobacco, alcohol and other drugs) encountered in prison.

In India, we do not have a clear understanding of the extent and patterns of mental health problems in prisons. Apart from instances of non-criminal mentally ill in prisons which captured the attention of the judiciary, and occasional reports of prison suicides, which attract the attention of the media, relatively little is known about the mental health needs and extent of mental illness in the prison population.

It is in this context that an evaluation of mental health problems in the Central Prison, Bangalore, was undertaken. This initiative was the result of a joint collaboration between the National Institute of Mental Health and Neuro Sciences, Bangalore, the Karnataka State Legal Services Authority and the Department of Prisons, Government of Karnataka. The results of this study have been published in Mental Health and Substance Use Problems in Prison: Local Lessons for National Action.

As part of this initiative, we also undertook a review of the prevalence of mental illness and substance use in prisons all over the world. In this publication, we discuss the prevalence of a range of mental illnesses including psychotic disorders, mood disorders, other common mental disorders and substance use in prisons from different countries. We

also discuss the range of high risk behaviours commonly encountered in prisons, from violence to self-harm and suicide. The review of literature on these issues, while not exhaustive, attempts to illustrate the kinds of mental disorders and behaviours that are over-represented in prison settings, and what intervention approaches have been found useful. The guidelines developed for mental disorder management in many countries may serve as a template for the development of mental health services in developing countries, with the necessary modifications relevant to local issues and needs.

The findings of mental health morbidity from prisons in other countries are compared against the findings of the Mental Health and Substance Use Problems in Prisons: Local Lessons for National Action. In this study, 5024 prisoners from the Central Prison, Bangalore, India were evaluated for psychiatric morbidity. The objectives of this study were to estimate the prevalence and patterns of major and minor psychiatric morbidity and substance use in the Central Prison Bangalore; assess their mental health needs and to develop guidelines for mental health care in prison settings. The prisoners were interviewed confidentially on a semi-structured questionnaire, a lifestyle questionnaire and a needs questionnaire, all specially developed for the study. The MINI Plus interview schedule was used to assess mental health morbidity. A random sample of resident prisoners and new entrants underwent physical evaluation and urine testing for sugar and protein, as well as testing for drugs of abuse. Prison staff (201) was also evaluated for mental health morbidity and their needs were assessed. A series of recommendations were developed based on the findings.

In this review, in the comparison of mental health morbidity between other countries and India, Indian comparisons are mostly drawn from the above study referred to variously as the Central Prison Mental Health Study, the Bangalore Prison Mental Health and Substance Use study or simply, the Bangalore Prison Study.

2. PRISON AND HEALTH

Health is one of the key indicators of wellbeing of a society and prisons serve as mirrors of society. Understanding health conditions in prisons would help us to improve our public health system. The World Health Organization's definition of health (as adopted by the International Health Conference in 1946) encompasses physical, mental and social dimensions. *"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"* (World Health Organization 1946). This definition clearly emphasises two commonly neglected aspects namely a) mental and b) social well-being, apart from physical health as being integral components of health.

Prison and jail environments are increasingly being recognised as settings in which society's diseases are concentrated (Fazel and Danesh, 2002). At any given time, over 3.5 lakh people are imprisoned in correctional institutions in India (NHRC 2008). Prisoners, who enter prison with history of drug use (such as alcohol, nicotine, cannabis, cocaine, opiates, volatile substances and so forth) or other health-related problem often leave without having received proper medical attention. In fact, their problems may often escalate in prison. Prisoners who are healthy on entry have a considerable risk of leaving prison with HIV, tuberculosis, skin diseases, drug problems or poor mental health. Many of the prisoners also have a history of high risk behaviour such as unprotected sex, violence, aggression, theft, or domestic violence. A single drug user upon entry into prison may become a multiple drug user; a person with HIV may contract TB. Thus, prisoners may be in a worse state of health upon exiting the prison than they were upon entry, and may carry the health problems back into the community. While in prison, they are completely at the mercy of the state for their basic needs and medical care. All health and behavioural problems need to be assessed and intervened before discharge from the prison, so that they do not recur in the community. Rehabilitation and reformation of the prisoners should occur at multi-dimensional levels, from physical, mental, spiritual, vocational and social perspectives.

Dual challenges

Developing countries like India face challenges of both communicable diseases (especially Tuberculosis, HIV, Malaria, Dengue, Diarrhoea, Amoebiasis, Cholera, Hepatitis and Sexually Transmitted Diseases), as well as non-communicable diseases

(commonly hypertension, diabetes, obesity, cancer, substance use and mental disorders) (Boutayeb, 2006; World Health Organization, 2002). Both communicable and non-communicable diseases add not only to mortality but also morbidity in society. These issues are more prevalent in the prison population than in the general population (Taylor, 2010). The most commonly occurring and most widely studied communicable diseases inside correctional settings are tuberculosis and HIV. These two conditions have received so much attention because they are the most challenging in terms of prevention, treatment, control and social stigma. At the same time, research and prevention in correctional settings with regard to non-communicable diseases is meagre when compared to communicable diseases.

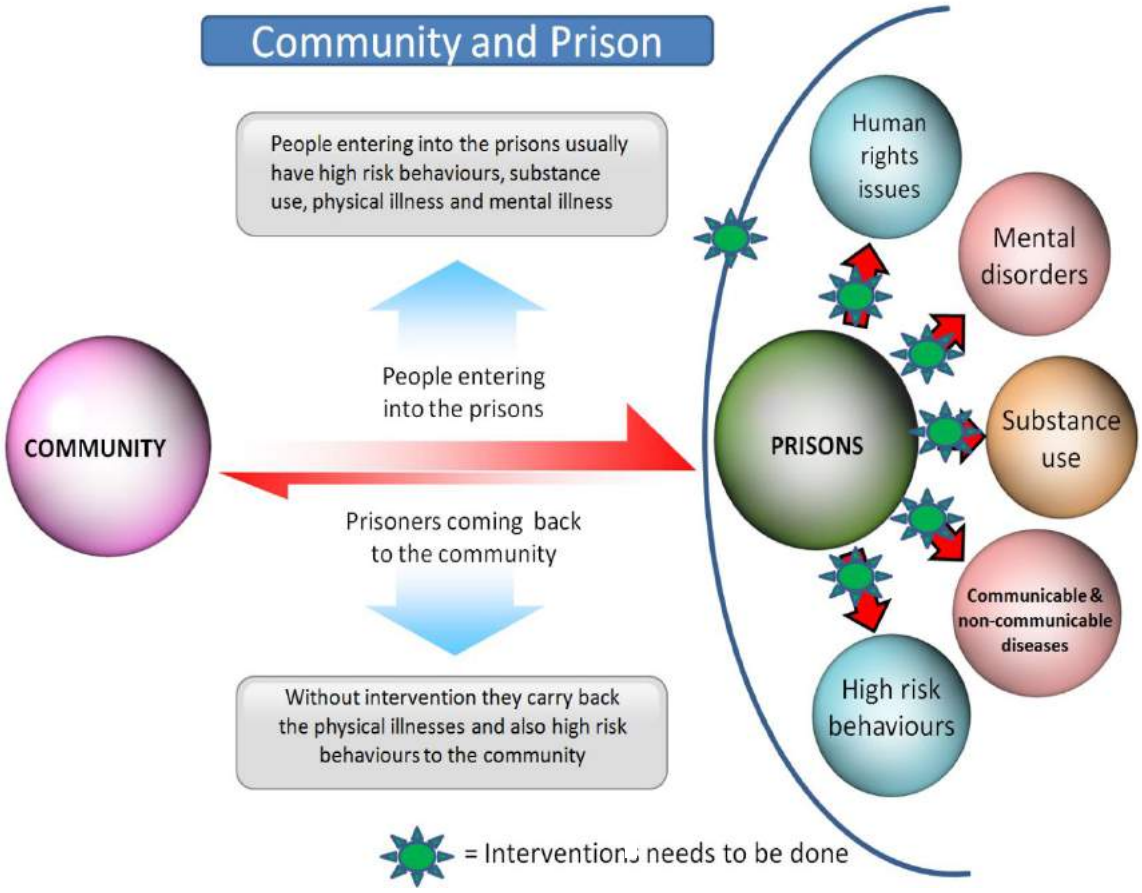
COMMUNICABLE DISEASES IN PRISONS

Tuberculosis

Correctional facilities have often been cited as reservoirs for tuberculosis (TB), presenting a potential threat to the general population, and to public health. World Health Organization (WHO) estimates that tuberculosis (TB), a contagious airborne disease caused by *Mycobacterium tuberculosis*, infects one third of the world's population. In the European Region alone, TB causes 49 new cases and kills 7 people every hour. A survey was done to collect data on TB in prisons of the WHO European Region during 2002. Only twenty-two (42.3%) countries completed the questionnaire. Survey results reported that prisoners had up to 83.6 times more TB than civilians (Aerts et al., 2006).

In a study to estimate the prevalence of tuberculosis in Zambian prisons, a total of 1080 prisoners were recruited. Sputum from 245 (22.7%) prisoners yielded M. Tuberculosis. Resistance to at least one anti-tuberculosis drug was detected for 40 (23.8%) isolates, while MDR-TB was identified for 16 (9.5%) isolates (Habeenzu et al., 2007). A study among prisoners of central jail, Hindalga, Belgaum, Karnataka, India, reported 2% prevalence of TB (Bellad et al., 2007). A Karachi central prison study from Pakistan reported that pulmonary tuberculosis was 3.75 times more common among prisoners than in the general population (Rao, 2004). Lower rates from developing countries can be attributed to the sampling procedure, case detection methods employed and high rates of tuberculosis in the general population. Although correctional facilities are recognised as ideal settings for interventions, little is known about the TB epidemiology within prison settings of India.

Figure 1: The continuum between the community and prison



Prisoners come from the community and they return to the community. People entering prisons are at high risk for mental health problems and vulnerable to human rights violations. They may develop mental illnesses secondary to stress. They may come with or initiate drugs/substance use in prison. They may suffer from physical illnesses or have high risk behaviours such as unprotected sex, aggression/violence, low frustration tolerance and contact with anti-social groups. If appropriate interventions are not provided, they carry these problems back into the community upon release. This scenario is particularly relevant in the current prison system in India.

Various factors play a crucial role in leading to high prevalence of TB in prisons. These include overcrowding, illiteracy, poor knowledge, stigma, fear of isolation, drug non-compliance, and non-availability of screening as well as inadequate health services inside

the prisons (Coninx et al., 2000). The problem is particularly acute for tuberculosis (TB) and is exacerbated by crowding and HIV infection (The Lancet Infectious, 2007). Infections and stress related disorders contribute majorly towards morbidity in prisons (Massoglia, 2008).

Human Immune-deficiency Virus

Rates of Human Immunodeficiency Virus (HIV) are five times and Hepatitis C virus infection (HCV) 17-28-times higher in prisons than in the general population (Flanigan et al., 2009). People in prison are at risk of contracting HIV through injecting drugs, unprotected sex and tattooing (Polonsky et al., 1994; Strike and Sutherland, 1994). Non-availability of conjugal rights and long stay in prison increases homosexual activities. However, there are studies that argue that most inmates with HIV infection acquire it from the outside community; prisons do not seem to be an amplifying reservoir (Spaulding et al., 2002). A majority of persons, who enter a correctional facility today will return home in the near future. Hence, the present challenge is how correctional health services deal with the HIV-infected person and this has important implications on the overall care of HIV-infected people in the community.

A systematic review of published and grey literature of Nepal was carried out by the National HIV Strategy of Nepal. Results of the study reported that prison conditions are poor and there is no accurate information regarding HIV prevalence or risk behaviours among prisoners. HIV prevention interventions have largely been limited to ad hoc training workshops. Antiretroviral treatment is not available to HIV infected prisoners. HIV prevention and care remains largely non-existent in Nepal's prisons (Dolan and Larney, 2009).

A qualitative exploration of the state of health care services with regard to inmates with HIV/AIDS was prepared from narratives obtained through face-to-face, in-depth, unstructured interviews, in three correctional facilities in the state of Maharashtra. Results of the study highlighted that high-risk behaviour among prisoners, inadequate access to health care services for HIV-positive inmates, and lack of HIV/AIDS prevention programmes are some of the major areas of concern. The study emphasised the urgent need for active collaboration with the National Aids Control Programme (Guin, 2009). Anonymous unlinked volunteer testing was offered to 15000 jail inmates across nine jails in six cities of Sindh in Pakistan. Only 4987 (33%) agreed to be tested, using a rapid

testing kit for HIV. The overall HIV prevalence was 1% (n = 49) in the study sample (Safdar et al., 2009).

Challenges in implementing HIV prevention programmes in prisons

Whether:

a) HIV and STI testing should be mandatory or voluntary in prisons,
b) urine drug screening of the new entrants should be made mandatory,
c) prisoners must be integrated or segregated by HIV serostatus,
d) condom promotion programmes need to be implemented in prisons,
e) needle exchange programme/availability of clean needles should be ensured,
f) conjugal rights needs to be granted to the prisoners and
g) opioid replacement therapy must be provided in prisons

These issues often have conflicting responses from the judiciary, prison officials and public health officials.

A screening of incarcerated populations of the Los Angeles County Men's Jail, particularly men who have sex with men (MSM), for the identification, treatment, and prevention of sexually transmitted infections (STI) and HIV was carried out recently. A total of 7004 inmates participated in the screening programme. The overall positivity rate for chlamydia was 3.1% (127 of 4157) and 1.7% (69 of 4106) for gonorrhea. In addition, early syphilis was identified in 1.6% of inmates (95 of 6008) and the overall prevalence of HIV was 13.4% (625 of 4658). This Los Angeles study revealed a high prevalence of STI and HIV infection in prisons (Javanbakht et al., 2009). Another group of incarcerated people who are at high risk of developing HIV are drugs users (Strike and Sutherland, 1994). Injection drug users (IDU), crack smokers, and commercial sex workers engage in illegal activities that place them at risk for HIV infection and also getting arrested (Carpenter et al., 1999). The potential for HIV transmission by contaminated equipment (needle and syringes) still exists in prison, where IDUs do not have access to new needles and syringes (Davies et al., 1995). Though needles and syringes are not available easily, the availability of drugs inside prisons is common world over. The correctional setting provides an excellent opportunity to screen for and treat sexually transmitted infections (STIs) and HIV. Along with the opportunity, there are certain obstacles that correctional institutions are faced with such as legal, ethical and moral issues. Though there are many unanswered questions regarding HIV prevention programmes, at least education and risk-

reduction counselling are the least controversial modes of prevention. These modes must necessarily be implemented by the government without fail. Another prevention programme which can be considered for implementation is opioid substitution treatment. A recent systematic review of the evidence on opioid substitution treatment (OST) in prisons reported that OST should be implemented in prisons as part of comprehensive HIV prevention programmes. Opioid substitution treatment has played a significant role in decreasing sharing of needles and syringes by intravenous drug users. This helped in keeping some control over HIV incidence in prisons (Larney, 2010). Drug substitution treatment and needle exchange programmes in German and European countries have been found to be effective (Stoever, 2002).

There is an urgent need to address the issues of HIV in prisons. A link between area HIV specialists and correctional health care providers is an important partnership for ensuring that HIV-infected patients have optimal care both inside prison and after release. However, most countries have largely neglected HIV prevention and care in prisons.

Other Communicable Diseases

Prisons in India are plagued with various communicable diseases as shown in the accompanying box.

Overcrowding, unhygienic environment, malnutrition and non-availability of health facilities play a crucial role in the health of prisoners. Hence, prisons are known for frequent out-breaks of illness (Wolfe et al., 2001). Unfortunately, none of them come to the notice of the civil society or the concerned health authorities.

Communicable diseases can be intervened against easily and effectively, if we understand the modes of transmission. Figure 2 depicts the modes of transmission of communicable diseases in prisons. Though sexually transmitted diseases are a known phenomenon in prison population, minimal efforts are taken to address them. Simple measures such as health education and counselling on healthy behaviour can curtail and prevent many communicable diseases (Bick, 2007). Modes of transmission of communicable diseases are similar to those in the community, but are amplified several times in prisons because of overcrowding and unhealthy environments. Unfortunately, non-availability of timely medical interventions contributes to both morbidity and mortality.

COMMUNICABLE DISEASES IN PRISONS

Food or Waterborne Diseases:

Typhoid fever -In this bacterial disease the patient usually exhibit sustained high fevers; left untreated, mortality rates can reach 20%.

Food poisoning -This may be either bacterial or viral and patients exhibit abdominal pain, vomiting, diarrhoea and sometimes fever.

Cholera -Bacterial disease presenting as painless diarrhoea in patients

Amoebiasis -Occurs because of entamoeba histolytica parasites and causes abdominal pain, diarrhoea and loss of appetite

Hepatitis A & **E** - In these viral diseases, the patient usually exhibits fever, jaundice and diarrhoea.

Blood borne diseases:

Hepatitis C & B -Typically present with jaundice, tiredness, upset stomach, fever, loss of appetite, diarrhoea, light-coloured stools and dark yellow urine.

HIV -Immunodeficiency virus disables the immune system and affected persons contract infections easily.

Vectorborne diseases:

Malaria - Caused by single-cell parasitic protozoa *Plasmodium*; transmitted to humans via the bite of the female Anopheles mosquito; patients exhibit in cycles of fever, chills, and sweats.

Dengue fever - Mosquito-borne (*Aedes aegypti*) viral disease; manifests as sudden onset of fever and severe headache; occasionally produces shock and hemorrhage leading to death in 5% of cases.

Chikungunya - Mosquito-borne (*Aedes aegypti*) viral disease, similar to Dengue Fever; characterised by sudden onset of fever, rash, and severe joint pain usually lasting 3-7 days, some cases result in persistent arthritis.

Japanese Encephalitis -Mosquito-borne (*Culex tritaeniorhynchus*) viral disease can progress to paralysis, coma, and death; fatality rates 30%.

Airborne diseases:

Upper respiratory tract infection - Bacterial or viral diseases characterised by cough, fever, sneezing, sore throat, fatigue and nasal discharge.

Lower respiratory tract infection - Bacterial or viral diseases characterised by shortness of breath, weakness, high fever, coughing and fatigue

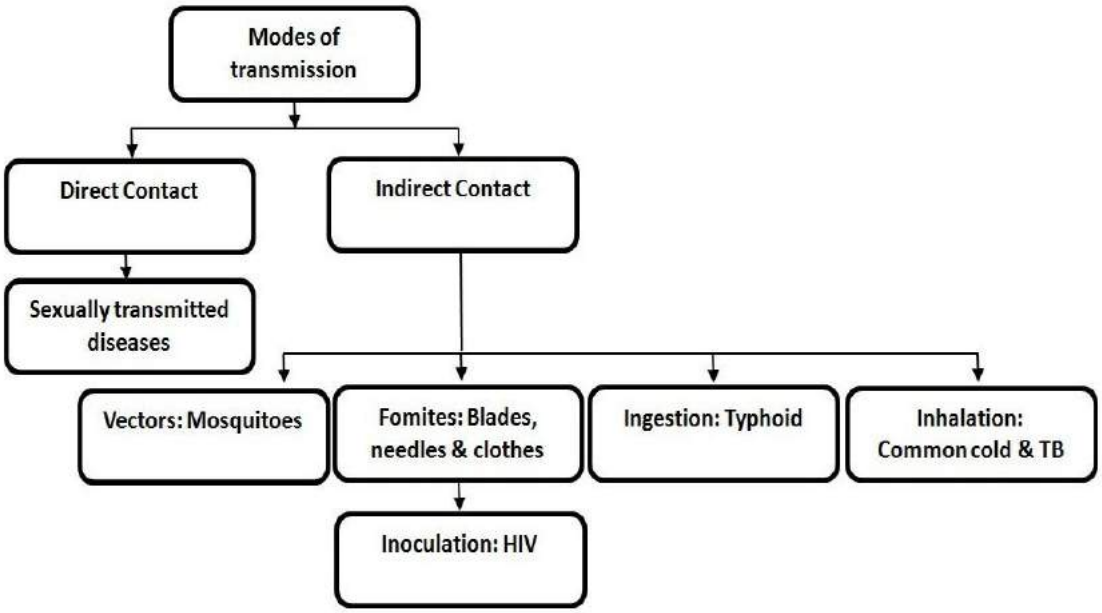
Meningococcal meningitis - Bacterial disease transmitted from person to person by respiratory droplets causing stiff neck, high fever, headaches, and vomiting; facilitated by close and prolonged contact resulting from crowded living conditions; death occurs in 5-15% of cases.

Sexually Transmitted Diseases:

HIV, Hepatitis A & B, Syphilis, Gonorrhoea, Chlamydia and Genital Herpes.

There are horrifying incidents of deaths in closed care settings. A retrospective study was conducted in Nagpur to investigate the cause of deaths of people in custody from the year 2000 to 2004 (Rajesh et al., 2005). Findings of the study clearly indicated that 43% (n=30) of the deaths occurred because of infections. Tuberculosis contributed to 30% (21) of the total deaths followed by ischaemic heart disease 17% (n=12). Furthermore, 7.14% of inmates had anaemia and 5.71% had hypertension (Rajesh et al., 2005). Another similar study from Maharashtra prisons reported that tuberculosis related deaths were maximum at 52% (n=34), followed by coronary artery disease 34% (n=22) (Sonar, 2010).

Figure 2: Common modes of transmission of communicable diseases in prisons



The Central Prison Mental Health study of Bangalore (Math et al., 2011) clearly depicted the morbidity and mortality because of communicable diseases. There are 4500 to 7000 consultations each month, and the most common consultations are for skin disease (40%), and gastrointestinal problems (20%). HIV seropositivity in 2008 was 3% which is much higher than seroprevalence figures for Karnataka at 0.69% (figure from NFHS 3 2005-2006). Deaths due to HIV related infections are also on the rise in many other Indian prisons.

NON-COMMUNICABLE DISEASES (NCD)

Non-communicable diseases (NCD) are those disorders which do not spread from one person to another. NCDs are now recognised as a major cause for mortality (Murray and Lopez, 1997b) (death), and morbidity (burden, dysfunction, or impairment in the quality of life) (Boutayeb and Boutayeb, 2005; Lopez et al., 2006; Murray et al., 1996). Though these disorders are recognised worldwide, they continue to be ignored by the policy makers investing in health. Most common NCDs are depicted in the accompanying box.

Non-communicable diseases:

- ✓ **Cardiovascular Diseases** – Hypertension, Coronary vascular disease
- ✓ **Mental disorders**- Depression, Obsessive compulsive disorders, Psychosis and Mental retardation
- ✓ **Substance use disorders** – Alcohol, Nicotine, Cannabis, Opioids, Cocaine Inhalants and Amphetamine. Intoxication, harmful use or dependence syndrome.
- ✓ **Neurological disorders** – Epilepsy, Stroke
- ✓ **Injuries** -Road Traffic Accidents, Fights/wars, Disasters
- ✓ **Endocrinological Disorders**- Diabetes Mellitus
- ✓ **Cancers** - Oral, Lung and Cervical,
- ✓ **Respiratory Diseases** – Chronic obstructive pulmonary diseases, Asthma

World Health Report 2001 has indicated that non-communicable diseases accounted for nearly 60% of deaths and 46% of the global burden of diseases (Murray et al., 1996). Risk factors such as a person's lifestyle, high blood pressure and high blood cholesterol, tobacco and excessive alcohol consumption, overweight, obesity and physical inactivity, genetics and environment are known to increase the likelihood of certain non-communicable diseases (Ezzati et al., 2002; Murray and Lopez, 1997a). These risk factors raise the risks of coronary heart disease, stroke, diabetes mellitus and many forms of cancer (Daar et al., 2007).

Along with the challenges of contagious diseases, India is also facing the challenges of NCDs (World Health Organisation, 2002). Prison health system also faces similar challenges but in an accentuated manner. The factors contributing to NCDS in prisons are summarised in the accompanying box.

Among the non-communicable diseases, coronary artery diseases contribute to 17-34% of the total deaths in the Indian prison population (Rajesh et al., 2005; Sonar, 2010). Percentage of deaths due to suicide was 5-8% in prison (Sonar, 2010). Custodial deaths in India awaken the judiciary and attract media attention. Unfortunately, many a time, deaths due to inadequate medical facilities or medical attention in prisons rarely reaches the media. Available data suggests that deaths due to medical illness account for 80-90% of all deaths (Rajesh et al., 2005; Sonar, 2010).

Factors contributing to the development of NCDs in prison

- Physical inactivity, idleness, boredom and poor motivation to do work
- Being overweight and obese
- Unstructured daily activity
- Stressful environment
- Unhealthy food
- Physical violence, intimidation and bullying
- Sexual violence
- Mental health problems such as depression, anxiety, adjustment problems and psychosis
- Tobacco, cannabis, opioid, cocaine and other use
- Deliberate self harm and suicide

Mental disorders and substance use problems in prison

Mental disorders are major public health problems. They are present in all cultures and societies. The prevalence of mental disorders in the Indian population is found to be 8-12% (Math et al., 2007). It is a sad reality, that at any point in time, a high proportion of those with mental health problems are incarcerated in the prisons of each country (Møller et al., 2007). Prisoners have greater physical and mental health needs compared to the general population (Hammett et al., 2001). The prevalence of mental disorders in prisons is high, but access to services to treat them is often very low (Fazel and Danesh, 2002; Steadman et al., 2009; Taylor, 2010).

The National Commission on Correctional Health Care in the US found that on any given day, between 2% and 4% of inmates in state prisons were estimated to have schizophrenia or a psychotic disorder and between 2% and 4% were estimated to have a manic episode. Between 13% and 18% of prisoners were estimated to have experienced a

major depressive episode during their life time (Veysey and Bichler-Robertson 2002). Similarly, prison rates of mental illness were higher than the rates reported in a nationally representative population used in the National Comorbidity Survey (Kessler et al., 1994).

A systematic review by Fazel and Danesh of 62 studies from 12 countries, in 2002, included 22790 prisoners. The overall prevalence of psychiatric disorders in prison populations was as follows: 3.7% of men had psychotic illnesses, 10% major depression, and 65% a personality disorder; 4.0% of women had psychotic illnesses, 12% major depression, and 42% a personality disorder (Fazel and Danesh, 2002). The rate of current serious mental illness for male inmates was 14% and for female inmates it was 31% (Steadman et al., 2009).

In an Australian study, the 12-month prevalence of any psychiatric illness in the previous year was 80% in prisoners and 31% in the community. Substantially more psychiatric morbidity was detected among prisoners than in the community group after accounting for demographic differences, particularly, symptoms of psychosis, substance use disorders and personality disorders (Butler et al., 2006). Drugs are related to crime in multiple ways. Most directly, it is a crime to use, possess, manufacture, or distribute drugs classified as having a potential for abuse (such as cocaine, heroin, marijuana, and amphetamines). Drugs are also related to crime through the effects they have on the user's behaviour and by generating violence and perpetuating illegal activity. Hence, it is said that violence, crime and drug use go hand-in-hand (US Drug Enforcement Adminstration). Use of substances such as alcohol, nicotine, cannabis, cocaine, opioid and amphetamines are very common among prisoners (Fazel and Danesh, 2002).

Available data indicates that a) the prevalence of mental illness in prison settings is significantly higher than the prevalence in the general population and it is approximately 3-6 times higher than the general population (Andersen, 2004; Fazel and Danesh, 2002; Lamb and Weinberger, 1998; Taylor, 2010; Wilper et al., 2009); b) substance use disorders (alcohol, nicotine, cannabis, opioid, cocaine, benzodiazepines and other drugs) are the most frequently diagnosed condition (Wilper et al., 2009); c) other commonly occurring mental disorders are Depression, Anxiety disorders, Personality disorders and Psychosis (Andersen, 2004; Fazel and Danesh, 2002; Lamb and Weinberger, 1998). However, there is paucity of data regarding the mental morbidity in prisons from the Indian subcontinent. To explore the mental health morbidity in Indian prisons, a study was undertaken by the National Institute of Mental Health Neuro Sciences, Bangalore in

the Central Prison, Bangalore in Collaboration with Prison Department, Karnataka. This study was funded by Karnataka State Legal Service Authority, Bangalore (Math et al., 2011).

The Central Prison, Bangalore Study

Data from the Central Prison, Bangalore (Math et al., 2011), reported 17 deaths in 2006, 22 deaths in 2007, 38 deaths in 2008, and 29 deaths in 2009 (until November). During this period, there were 9 deaths from suicide, mainly hanging. Analysis of the 38 deaths in 2008 indicates HIV as the cause in 26%, cardiac causes in 23%, cancer in 17%, TB in 9%. Four deaths were from suicide (11%) and in one case, use of ganja (cannabis) was recorded. All the patients who had died in 2008 had died following transfer to general or specialised hospitals. This study also indicates that 55% of deaths are due to NCD and 35% of the deaths were due to infections.

About 5% of the resident prisoners and 4.5% of new entrants tested randomly had positive urine sugar. On interview, only 3% had reported having diabetes, but urine screening helped to double the diabetes detection rate in prison. Nearly one in three prisoners was underweight with a BMI below 18.5 and one in 10 resident prisoners could be classified as being overweight or obese. According to the MINI psychiatric diagnosis, 79.6% (n=4002) individuals could be diagnosed as having a diagnosis of either mental illness or substance use. Recent studies suggest similar rates of mental morbidity in diverse countries such as Australia (80%) and Iran (88%).

A large part of the mental morbidity is contributed by substance abuse and its related consequences. 67.3% of the prison population reported ever using (lifetime) tobacco in some form in their lives and 43.5% of resident prisoners fulfilled diagnostic criteria for lifetime alcohol dependence and 14% for current alcohol dependence (year prior to prison entry). After excluding substance abuse, 1389 (27.6%) prisoners still had a diagnosable mental disorder. 2.2% of the prison population had a diagnosis of psychosis, primarily schizophrenia (Severe mental disorder). This is twice that of the general population. Considering that only 2% of the prison population self-reported any mental illness, it can be understood that a systematic assessment improves identification of diagnosable mental disorder by fourteen times.

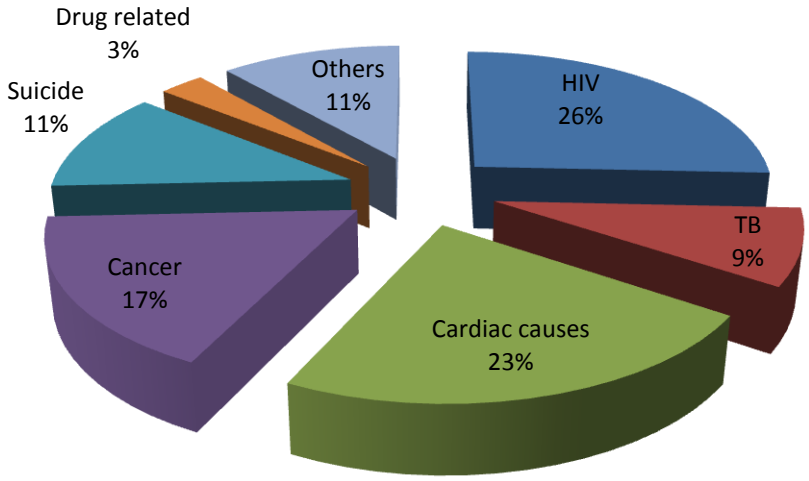


Figure 3: Causes of deaths in Prison

Despite increasing evidence that addiction/substance use is a treatable disease of the brain, most individuals do not receive treatment. Involvement in the criminal justice system often results from illegal drug-seeking behaviour, intoxication related violence, and participation in illegal activities. Treating these substance using offenders provides a unique opportunity to decrease substance abuse and reduce associated criminal behaviour.

Factors in prison that adversely affect mental health

Factors in prisons that may adversely affect mental health include overcrowding, dirty and depressing environments, poor food, inadequate health care, physical or verbal aggression. Lack of purposeful activity, lack of privacy, lack of opportunities for quiet relaxation and reflection aggravate mental distress. The availability of illicit drugs can compound emotional and behavioural problems in prison. Reactions of guilt or shame, anxiety of being separated from family and friends and worries about the future also compound such mental distress. Timely identification, treatment and rehabilitation are almost non-existent in many prisons, particularly in the developing countries. In some countries, mentally ill people are inappropriately locked up in jails because of inadequate mental health services. In many others, people with substance abuse problems are often

sent to prison rather than for treatment. In developed countries where institutional care for the mentally ill has declined and community care is not optimal, prisons have become custodians of persons with mental illness, which is also called as 'transinstitutionalisation' (Priebe et al., 2005). In such countries, is well known that persons with mental illness languish in prisons for several years as they are unfit to stand trial. Prisons in the developing world, in addition to having many of the problems faced in prisons of the developed countries, have special challenges. These include inadequate penal and judicial systems and prison resources, with resultant delays in access to justice and speedy trial. Inadequate attention to the human rights of persons in prison, including the right to decent living, clean and congenial existence, speedy trial, information and communication and right to health care, particularly mental health care, further aggravates the situation.

High-Risk behaviours

High-risk behaviours such as violence towards self (suicide and deliberate self-harm) and others (homicidal behaviour), sexual violence, substance use, bullying, intimidation and gang fights within the prison are also well known. Physical and sexual assault are part of the prison experience. Approximately 21% of male inmates are physically assaulted during a 6-month period. Sexual assault is estimated at between 2% and 5%. The high prevalence of sexual activity in prisons not been fully acknowledged (The Lancet Infectious, 2007). Although evidence of the prevalence is growing, less is known about the circumstances surrounding and resulting from these incidents (Lopez et al., 2006).

Suicide, deliberate self-harm and violence towards others are difficult behaviours to handle in the prison settings. These behaviours need to be addressed by various behavioural techniques such as counselling, anger management techniques, family therapy, de-addiction counselling, therapeutic community and life skills training (Day and Doyle, 2010). The World Health Organization has advocated life skills training programme for offenders so that possibility of reoffending (Greenwood, 2008; Krug et al., 2002; MacKenzie, 2006; World Health Organization., 1997), as also substance use decreases (Botvin and Kantor, 2000). Lifeskills are abilities for adaptive and positive behaviours that enable individuals to deal effectively with the demands and challenges of everyday life (World Health Organization., 1997). A list of 10 lifeskills, described as generic lifeskills for psychosocial competence, was identified by WHO as core lifeskills and these skills have been successfully implemented to curtail sexually transmitted

diseases, HIV prevention programmes, rehabilitate sexual offenders, prevent mental illness, in the management of substance use, school mental health programme and anger management. Integrated rehabilitation from both a physical and mental health perspective is a distant dream in developing countries.

Health Research in Prisons

In India, attempts to identify priority diseases in prisons and manage them effectively are very few. There have been no systematic studies examining these issues. Health related interventions in prisons have not been scrutinised or evaluated. Challenges like prison security, ethical and legal considerations in studying prison populations, non-availability of trained man power and lack of funding, are critical challenges in conducting research in prisons. Another important issue is that the public health system accords a low priority for prisons and prison policies have focused little on improving health services within the prison. Rapid turnover and frequent movement of undertrials in Indian prisons makes them difficult settings in which to quantify the prevalence of various diseases. Intervention based studies are minimal. Research on efficacy and cost effectiveness of rehabilitation programmes is hardly possibly in the absence of any worthwhile rehabilitation programmes in prison settings.

In the proposed model (see in figure no-1) the following interventions are required: creation of awareness, education and protection of human rights in prisons. Prison health needs to be considered as a public health priority and implementation of all the national health programmes inside the prison must be mandatory. Identifying and treating mental illnesses must be a priority. Availability of de-addiction treatment inside will provide an opportunity to the prisoners to recover from addiction. Identifying and treating contagious illnesses will improve health within the prison and prevent the prison from being a reservoir of infection for the community. Creating self-help groups within the prisons can help in creating awareness about AIDS, HIV, domestic violence and human rights. Availability of counsellors will help in training in life skills, anger management, family counselling and modifying high risk behaviours through various behaviour therapies.

In conclusion, prison health is often neglected and continues to be ignored despite accumulating objective evidence supporting the need for rational health policies in prisons. Politicians, policy makers, bureaucrats and community leaders have ignored this area, citing various reasons such as 'prisoners need not be treated', 'let them suffer', insufficient funds, non-availability of trained manpower, the presence of other pressing needs, and that the law does not permit such interventions. Many prisoners with serious physical and mental disorders fail to receive care while incarcerated. Furthermore, public-health strategies adopted in the community are ignored in the prison setting (The Lancet Infectious, 2007) Despite the high prevalence of tuberculosis, drugs use and HIV in prisons, screening for such diseases is rarely available on entry into prison. There is no access to health promotion and comprehensive treatment. In India, there has been little systematic assessment of the prevalence and patterns of mental morbidity among prisoners. Research in prison is a need to be encouraged so that effective interventions can be planned. Examples include systematic collection of data and evaluation of HIV prevention strategies in prisons (Kate et al., 2007).

Unfortunately mental health needs of prisoners are completely unrecognised. Even in situations where they might be recognised, the responses are largely individualised and systemic response to the problem is absent. Providing treatment for substance use, mental illness and high risk behaviours benefits both prisoners and the wider community. Improvements are needed both in correctional health care and in community mental health services in order to prevent crime and incarceration.

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3. SUBSTANCE USE PROBLEMS IN PRISONS

World over, it has been established that prisons have a high prevalence of mental health and substance use problems. Substance use related disorders have serious consequences on self and others. Although they are considered under the broad rubric of mental disorders, here they are considered separately because of their magnitude, severity and implications, particularly in prison settings.

As in the case of mental illnesses, substance abuse (that is, the abuse of tobacco, alcohol or other drugs) may be present either prior to prison entry, develop or get exacerbated in prison and persist after release from prison. Prison administrators have a responsibility to guard both against (a) new problems emerging from drug use in prisons and (b) exacerbating problems that existed at the time of prison entry.

There is abundant literature on drug use in prison settings from several countries across the world. However, such data is often complex and difficult to interpret. The situation in developing countries is very different. There is hardly any published literature on drug use in prison settings. In this chapter, a summary of selected literature from different countries is presented to give an idea about the extent and patterns of drug use in prison. The findings of the Bangalore Prison Mental Health Study (Math et al., 2011) findings with respect to substance use are summarised and compared to findings from other parts of the world. Successful prison programmes and guidelines formulated to prevent and address substance use problems in prison are also discussed.

Problems associated with substance use

Substance uses, particularly the use of illicit drugs, injecting drug use or alcohol bingeing are associated with high rates of mortality and morbidity. Injecting drug users carry the risk of overdose leading to respiratory depression, seizures and death. There is a heightened risk of infection from both injecting drug use and unprotected sexual contact to HIV, Hepatitis B & C and other conditions. Alcohol intoxication is associated with violence. Acute intoxication with cannabis can produce altered sensorium, disinhibition, paranoid ideation, mood changes and hallucinatory experiences. Cocaine and stimulants like amphetamines can also produce acute behavioural changes. Inhalants cause severe organ damage and can seriously affect the brain.

Diagnosis of Substance Dependence

Dependence has been defined in ICD10 as "*A cluster of physiological, behavioural and cognitive phenomena in which use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviors that once had greater value*"

The criteria for substance dependence syndrome has been influenced by the criteria laid down by Edwards and Gross (1976) for the diagnosis of Alcohol dependence syndrome. Though Edwards and Gross laid down the criteria particularly for alcohol dependence, this has been used uniformly to diagnose all classes of substance dependence.

The ICD 10 criteria specifies dependence as three or more experiences exhibited at some time during a one year period

1. ***Tolerance***: there is a need for significantly increased amounts of the substance to achieve intoxication or the desired effect. For e.g., an individual would have started with 60 ml of whisky to obtain pleasure, however with continuous use, he has to consume 180 ml of the same to obtain the same amount of high.
2. ***Physiological withdrawal state***: characteristic symptoms experienced on stoppage/reduction of a substance after prolonged use. The patient uses the same (or closely related) substance to relieve or avoid withdrawal symptoms (every class of substance produces its own set of signs/ symptoms of withdrawal. For e.g. alcohol withdrawal would produce tremors, sweating, nausea/ retching/ vomiting, insomnia, palpitations with tachycardia, hypertension, headache, psychomotor agitation and in severe cases, hallucinations, disorientation and grand mal seizures).
3. ***Impaired capacity to control substance use behaviour in terms of its onset, termination or level of use as evidenced by the substance being often taken in larger amounts or over a longer period than intended; or by a persistent desire or unsuccessful efforts to reduce or control substance use***. Some researchers are of the view that loss of control is the most important criterion determining substance use.
4. ***Preoccupation with substance use, as manifested by important alternative pleasures or interests being given up or reduced because of substance use***; or a great deal of time spent in activities necessary to obtain, take or recover from the effects of the substance.
5. ***Continued use in spite of clear evidence of harmful consequences***, as evidenced by continued use when the individual is actually aware, or may be expected to be aware, of the nature and extent of harm.
6. ***Strong desire to use substance (craving).***This craving may occur spontaneously or induced by the presence of particular stimuli.

Criteria (1) and (4) are physiological, while criteria (3), (4) and (6) are psychological in nature. Thus, not one domain is sufficient to diagnose dependence. For e.g. cancer patients who are given opioids as analgesics may have tolerance and withdrawal. However they may not be diagnosed as having a dependence syndrome unless they fulfill other criteria. The dependence syndrome criteria are not an all or none state, rather they exist in degrees of severity.

While many substance users begin use on an experimental or recreational basis, many users progress to regular use and dependence. There are different patterns of problematic use of substances (tobacco, alcohol and other drugs). This includes use to intoxication, harmful use and dependence. The features of dependence are summarised in the accompanying box.

Factors that mediate substance use initiation and progression to dependence

The dangers from substance use emerge from the unpredictable effects on the user, poor control on the amount used, mode of use (inhaling, injecting etc), the pharmacological properties of the substance or drug, and the biological and psychological makeup of the user. The interactive risk and protective factors that encourage or discourage problem substance use and dependence are summarised in Figure 1. While the initial decision to take drugs is mostly voluntary, once drug abuse and dependence takes over, a person's ability to exert self-control can become seriously impaired. Withdrawal, craving and loss of control are important triggers for continuing substance use.

Community prevalence of drug use

India has a huge burden of both licit or legal substance use (tobacco and alcohol) as well as illicit substances (Murthy et al., 2010). The National Household Survey of Drug Use in the country (NHSDA, Ray et al., 2004) was the first systematic effort to document the nation-wide prevalence of drug use. Alcohol (21.4%) was the primary substance used (apart from tobacco) followed by cannabis (3.0%) and opioids (0.7%) among men. Rapid assessment surveys are making it evident that pharmaceutical medications like buprenorphine and benzodiazepines are increasingly being abused among both men and women (Murthy, 2008).

Drug use in prisons

In the European Union (European Monitoring Centre for Drugs and Drug Addiction 2004 or EMCDDA, 2004), 22% to 86% of prison populations in EU countries reported ever having used an illicit drug. In this region, 16-54% of inmates used drugs in prisons and 5-36% used them regularly (EMCDDA, 2004). Several studies in Europe also suggest that between 3 to 26% of drug users report their first use of drugs while in prison and between

0.4 and 21% on injecting drug users (IDUs) started injecting in prison (National Report 2001).

Figure 1: Mediators of substance abuse and dependence

Fazel et al's (2006) review of 13 studies of 7563 prisoners estimates prevalence for alcohol abuse and dependence in male prisoners to range from 18 to 30% and drug abuse and dependence to vary from 10 to 48% for male prisoners and 30% to 60% for female prisoners at the point of incarceration. In a Nigerian prison, according to Williams et al (2005), lifetime use of any substance among the prison population was 85.5%. 27.7% of prisoners reported current drug use, and dependent use was estimated to be 12.5%. In the

United States, the number of people incarcerated annually for drug-related offences in the past 20 years has grown from 40,000 to 450,000, leading to prison populations with high rates of drug use (Stover and Michels, 2010). Another study in Lithuanian prisons (Narkauskaitė et al., 2007) showed that 48.7% of prisoners had ever used drugs. The experience from Tihar Jail shows that about 8% of new entrants come with drug addiction problems (Tihar Jail, 2009; UNODC, 2007).

Findings from the Bangalore Prison Mental Health and Substance Use study (BPMHSU study)

In this study (Math et al., 2011) of 5024 prisoners, 79.6% of individuals could be diagnosed as having a diagnosis of either mental illness or substance use, and a large part of the mental morbidity is contributed by substance abuse and its related consequences. Recent studies suggest similar rates of mental morbidity in diverse countries such as Australia (80%) and Iran (88%).

During their lifetime, 45% of the prison population reported using some substance or other in a dependent fashion. A majority of this is attributable to tobacco and alcohol dependence. Lifetime dependence on all substances was significantly higher among UT prisoners than convicted prisoners. During the last year, 15.7% of UT prisoners met criteria for alcohol dependence. This is more than 3 times the prevalence of dependence in the general population (Ray, 2004).

The problem of tobacco

Tobacco is a highly addictive substance. Worldwide, it is estimated that 1.9 billion people currently smoke. The greatest proportion of people affected can be found in the developed world, where smokeless forms of tobacco are also rampant. According to the WHO, tobacco is the second leading cause of death in developed and developing countries. Tobacco will eventually kill one in two users; it is responsible for the death of one in ten adults' worldwide, with 4.9 million deaths occurring worldwide each year. It is estimated that it will cause some 10 million deaths each year by 2020, assuming the current smoking patterns continue (WHO, 2007).

Tobacco use in India: According to the National Family Household Survey 3 (2005-2006), 57% of men and 10.8% of women use tobacco in some form or the other (Murthy and Saddichha, 2010) and tobacco use is a major cause of preventable death and disease. The recently published Global Adult Tobacco Survey (GATS, 2009-10) reports that 47.9% of men and 20.3% of women use tobacco in India. However, these figures are lower for men and higher for women in Karnataka. An ICMR study carried out in 2001, where the prevalence of current use of tobacco in any form in Karnataka was 32.7% among urban men and 42.9% among rural men, 8.5% among urban women; and 16.4% among rural women.

Tobacco use in prisons: Although few studies have been carried out on the prevalence of tobacco use in penal facilities, American scientists admit that, according to the available data, the majority of inmates smoke (Bobak et al., 2000). In the Nigerian prison study, among drugs being currently used, nicotine is the most frequently (22.9%) reported (Williams et al., 2005). In the study in Lithuanian prisons (Narkauskaitė et al., 2007) 85.3% *currently* smoked tobacco.

In the Bangalore Prison study (Math et al., 2011), 67.3% of the prison population reported ever using (lifetime) tobacco in some form in their lives. This is more than double the tobacco use prevalence in Karnataka (29.6%-figure for 2001). 60.2% reported ever smoking tobacco and 14% ever chewing tobacco. 97% of those who smoked or chewed tobacco had been using tobacco in the year prior to prison entry. Undertrial prisoners were significantly more likely to have ever smoked or chewed tobacco compared to convict prisoners. Among new male entrants into the prison, 74.3% reported using tobacco and 71.9% reported using tobacco during the month prior to prison entry.

Tobacco use pattern after entry into prison: Undertrials had increased their smoking from an average of 9.2 sticks per day before prison entry to 34.3 sticks per day in the last week in prison. Convict prisoners had increased their smoking from 11.4 sticks to 44.9 sticks. Among those who chewed tobacco, UTPs had increased their use from 8.3 sachets prior to prison entry to 20.9 sachets in the last week in prison, and CTPs had increased consumption from 8.7 sachets to 10.8 sachets. Thus, smoking among UTPs and CTPs increased about four times after coming into prison. Chewing tobacco increased marginally among CTPs after prison entry and about two and half times among UTPs.

The problem of alcohol

Worldwide, alcohol and illicit drug use account for 5.4% of the world's annual disease burden, with tobacco responsible for 3.7% (WHO, 2010). Alcohol consumption is the leading risk factor for disease (WHO, 2004). Apart from the direct effects of intoxication and dependence resulting from alcohol use disorders, alcohol is estimated to cause about 20–30% of each of the following worldwide due to: oesophageal cancer, liver cancer, cirrhosis of the liver, homicide, epilepsy and motor vehicle accidents. In the late 1990s it was estimated that 4.2% of the global population aged 15 and over used illicit drugs, causing 0.8% of the total burden of disability. While research has shown that it is difficult to demonstrate a clear causal relationship between alcohol and violent crime, the British Medical Association has estimated that either the offender or victim has consumed alcohol in 65% of homicides, 75% of stabbings, 70% of assaults and half of all domestic assaults. In the UK it has been estimated that 78% of assaults are committed under the influence of alcohol (Prime Minister's strategy, 2003).

Alcohol use in India: Nearly one third of adult men and approximately 5% of adult women use alcohol in India. Per capital alcohol consumption in India is steadily increasing. Alcohol carries a huge health burden as well as serious social and psychological consequences (Benegal et al., 2005; Gururaj et al., 2006; Gururaj et al., 2011). Alcohol carries with it a high societal burden.

Alcohol use in prisons: Williams et al., (2005), in their study in a Nigerian prison found that in terms of lifetime use of any substance, alcohol use was reportedly the highest (77.5%) among prisoners. In France, in 2003, just over 30% reported alcohol abuse and a third regular drug use in the past 12 months (Mouquet et al., 2005). In the Lithuanian prison study (Narkauskaitė et al., 2007), 92.1% of prisoners reported having used alcohol at least once in their lives.

Few studies have focused on standardised diagnoses of alcohol or drug abuse/dependence (AAD and DAD) among prisoners, and most have been limited to incoming or remanded prisoners: estimates ranging from 25% to 74% for DAD and from 21% to 50% for AAD have been reported (Peters et al., 1998, Lo et al., 2000). A New Zealand study revealed that 81% of the prisoners had a lifetime alcohol disorder, and 39% of them had symptoms in the 6 months prior to incarceration. Half of the prisoners had met criteria for an

alcohol-dependence syndrome. Thirty percent had a lifetime drug use disorder with 14% showing symptoms in the last 6 months prior to incarceration. One-quarter had been drug dependent. Alcohol disorder was more than twice as common among prisoners as in the general population (Bushnell et al., 1997).

In the developed world, while correctional systems have been conscious of the relationship between alcohol use disorders and crime (Graham et al., 2001) they have traditionally focused on providing treatment intervention for prisoners whose crimes are drug related. While both the United States (US) and the United Kingdom (UK) have developed National Strategies supported by significant levels of funding to address the problems of illicit drug use, there remains a conspicuous absence of priorities in addressing the social and economic consequences of licit substances like alcohol.

In the Bangalore study (Math et al., 2011), more than one in two prisoners (51.5%) reported lifetime alcohol use. This is more than double the national prevalence of alcohol use (21%). Of those who reported ever drinking, 86% had AUDIT scores above 8 indicating harmful drinking patterns. Mean AUDIT score was 17 and was comparable between UTPs and CTPs. UTPs had started drinking alcohol at a mean age of 19.4 years and CTPs at a mean age of 21.4 years. Among new entrants, 58% reported ever use of alcohol and 51.9% reported use in the last month.

With regard to lifetime dependence, 43.5% of resident prisoners fulfilled diagnostic criteria for lifetime alcohol dependence and 14% for current alcohol dependence (a year prior to prison entry). Current alcohol dependence rates in the prison population are nearly three times more than in the general population. UTPs were significantly more likely to have a lifetime ($p=0.006$) diagnosis of alcohol dependence compared to convicts. They were nearly twice as likely to have a diagnosis of alcohol dependence in the previous year compared to convicts (16% and 9% respectively). With respect to alcohol use in prison, 3.7% of the resident prisoners reported alcohol use in the last week. However, on breath analysis of 169 male prisoners selected randomly, none was positive for breath alcohol. This needs to be interpreted carefully because results of the alcohol breath analysis depends upon timing of the test after last consumption and availability of alcohol inside the prison.

The problem of cannabis

Cannabis is the most widely used illegal drug in the world. Cannabis is said to be firmly established in the youth culture, particularly in developed countries. Large illicit markets have emerged to fill the markets. Cannabis can cause behavioural problems with excessive use and precipitate psychosis in vulnerable individuals. Cannabis intoxication mimics a psychotic disorder with predominant changes in emotion, excitement and hallucinatory experiences. Long-term cannabis use associated with amotivational states.

Cannabis use in India: According to the NHSDA data (Ray et al., 2004), 3% of adult males reported lifetime cannabis use. Literature from India has shown the occurrence of cannabis related psychotic episodes. Although cannabis use has been culturally sanctioned during religious festivals in India, currently, much of the cannabis use occurs on account of its mind altering properties. Various forms of cannabis are commonly used in India and common names include bhang, hashish, ganja, grass and marihuana.

Cannabis use in prisons: Cannabis was the most frequently reported illicit drug, with lifetime prevalence rates among inmates of 11–86% in prisons in the EU countries (EMCDDA, 2004). Marijuana or hashish was the most common drug inmates said they had used in the month before the offence. Among inmates who had a mental health problem, more than two fifths of those in State prisons (46%), Federal prisons (41%), or local jails (43%) reported they had used marijuana or hashish in the month before the offence (James et al., 2006).

In a prison study on drug use, Lukasiewicz et al, (2007) reported that cannabis use had overtaken opiate use as the most frequent drug used, in little over one in four prisoners, five times more than opiate use. More than one third (35.2%) of prisoners presented either alcohol or drug abuse or dependence (AAD or DAD) in the last 12 months. 18.4% had presented AAD and 27.9% DAD in the last 12 months. 11.2% (N = 111) had both diagnoses in the previous 12 months. Cannabis was the most frequently used drug in the previous 12 months (26.7%), others drug use being marginal (2.7% for opiate to 5.4% for cocaine/crack) (Lukasiewicz et al., 2007). The use of cannabis in the Bangalore prison (Math et al., 2011) is discussed along with other drugs in the subsequent section.

The problem of other drugs

Use of other drugs in India: According to the World Health Organization (2010), at least 15.3 million persons across the world have drug use disorders. The World Drug Report (UNODC, 2010) suggests that drug use is shifting towards new drugs and new markets. While drug use has stabilised in the developed world, there are signs of an increase in drug use in developing countries and growing abuse of amphetamine-type stimulants and prescription drugs around the world.

Use of other drugs in India: Among other drugs of abuse, opioids continue to be the most common after cannabis. Rapid assessment surveys indicate the increase of abuse of drugs meant as prescription drugs (UNODC, 2006). Use of drugs among women has definitely been a source of concern in the last decade (Murthy, 2002) and is growing (Murthy, 2008).

Use of other drugs in prison: Drug use disorder was eight times as common in prisons compared to the general population (Bushnell et al., 1997). A UNODC drug report of 4343 million persons aged 15-64 years across the world in 2007 shows that, 172- 250 million had used drugs at least once in the past year; 18-38 million were 'problem drug users' and 11-21 million persons were injecting drugs of abuse (UNODC, Drug Report 2009). Prisoners' lifetime prevalence of cocaine (and crack) use was 5–57% and heroin 5–66%. In EU prisons (EMCDDA, 2004).

Fazel et al's (2006) review of 13 studies of 7563 prisoners estimates prevalence for alcohol abuse and dependence in male prisoners to range from 18 to 30% and drug abuse and dependence to vary from 10 to 48%. A British survey found that 60% of heroin users reported use in prison and more than 25% initiated use in prison (Boys et al., 2002).

In UK prisons, cannabis and opioids are the commonest drug of abuse. Andersen's review Danish prisoners on remand, shows opioid dependence is the most frequent drug disorder with subjects using injection representing a more dysfunctional group than subjects using smoke administration (Andersen et al., 2004). In the Lithuanian prison study (Narkauskaitė et al., 2007), 13.8% currently used narcotic drugs and 39.8% had first used illicit drugs in prison.

The problem of injecting drug use

Injecting drug use was reported in 136 of 147 countries, of which 93 reported HIV infection among this population (WHO, 2010). Injecting drug use is also a well recognised problem in India, with major concerns being very unsafe injecting practices like needle sharing, inadequate cleaning and poor hygienic practices (Ray, 2003, Murthy, 2008). Mortality in injecting drug users is very high in India (Solomon et al., 2009).

A lifetime history of incarceration is common among injecting drug users (IDUs); 56% to 90% of IDUs have been imprisoned previously. Drug-using prisoners may be continuing a habit acquired before incarceration or may acquire the habit in prison. In Europe, 16% to 60% of prisoners who injected outside prison continued to inject while incarcerated, whereas 7% to 24% of prisoners who injected said they started in prison. In another study, one-fifth of prisoners injected drugs for the first time in prison (Stover and Michels, 2010).

Patterns of drug use in the Bangalore Prison (BPMHSU) study: Six hundred and fifty two (13%) of prisoners self-reported ever use of any other drug apart from alcohol and tobacco. This group primarily reported use of cannabis (94%). Nine males (0.2%) reported injecting drugs and 6 (0.1%) reported the use of inhalants. Thus lifetime prevalence of cannabis use was 11.8%, opioids 0.6%, sleeping pills 0.6%, injecting use 0.2%, inhalants 0.1% and other ways of getting a high 0.2%. Self-reported prevalence of drug abuse was greater among the UTPs compared to convict prisoners (Math et al., 2011).

Urine testing improved detection: As part of the prison study, a random urine drug screening was carried out on 721 resident prisoners in an anonymous manner. 31% tested positive for cannabis use, 3% tested positive for opioids, 15% tested positive for cocaine, 9% tested positive for barbiturates, 43% tested positive for benzodiazepines and 6% tested positive for amphetamines.

There were no significant differences in the urine screening results for UTPs and CTPs with respect to detection of cannabis, opioids and cocaine. However, UTPs were significantly more likely to test positive for barbiturates, benzodiazepines and amphetamines. According to the prison psychiatrist at the time of conducting the urinalysis, of the entire prison population, 40-50 persons were likely to have been

prescribed benzodiazepines. On testing, nearly six times that number tested positive suggesting self-administration of these medications. Nearly a third of positive urine sample were positive for two or more drugs.

Table 1. Detection on random urine drug screening among UTP/CTP population (N= 721) in the BMHSU study

Sl.no	Drugs use	UTP (n=406)	CTP (n=315)	X^2	P
1	Cannabis	130 (32%)	92 (29.2%)	0.659	0.464
2	Opioids	12 (3%)	12 (3.8%)	0.402	0.537
3	Cocaine	68 (16.7%)	42 (13.3%)	1.600	0.212
4	Barbiturates	61 (15.0%)	4 (1.3%)	40.913	0.000
5	Benzodiazepines	233 (57.4%)	77 (24.4%)	78.549	0.000
6	Amphetamines	40 (9.9%)	4 (6.1%)	22.801	0.000

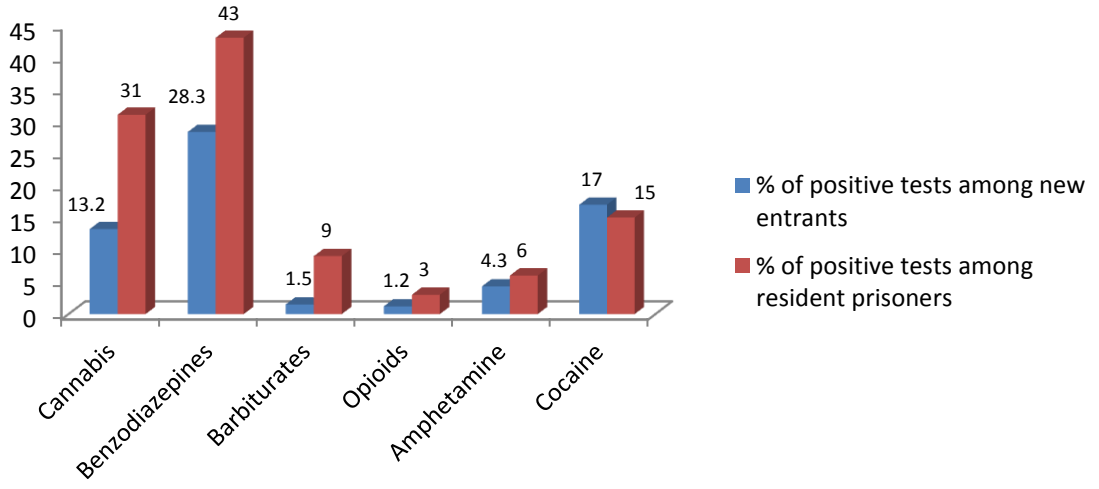
Source: Math et al., 2011

Among new entrants, 28.3% tested positive for benzodiazepines, 17% for cocaine, 13.2% for cannabis, 4.3 % for amphetamines, 1.5% for barbiturates and 1.2% for opioids. Generalising the findings among resident prisoners, urine testing was six times more likely to pick up drug use (8.8%) compared to self-report (1.5%). On comparison of percentages of positive urine drug tests between resident prisoners and new entrants (Figure 2), the use of most drugs had actually increased after entry into prison. Thus use of cannabis after prison entry had increased 2.3 times compared to use at the point of entry into prison, use of benzodiazepines 1.5 times, barbiturates 6 times, opioids 2.5 times, amphetamines 1.4 times. Cocaine shows a similar pattern both inside and outside prisons, with a slight decline of use, which can be attributed to its cost.

Co-morbid substance use and mental health problems in prisons

Prisoners with mental health problems have high rates of substance dependence or abuse in developed countries. Among those who had a mental health problem, local jail inmates had the highest rate of dependence or abuse of alcohol or drugs (76%), followed by State prisoners (74%), and Federal prisoners (64%) in the United States (James et al., 2006).

Figure 2: Comparison of positive urine drug screens between resident prisoners and new entrants in the Bangalore study



Source: Math et al., 2011

Anna Kokkevi and Costas Stefanis in 1995 studied opioid-dependent men recruited from prison and treatment services, using the Diagnostic Interview Schedule (DIS). Lifetime and current prevalence of any mental disorder, excluding substance use disorders, reached 90.3% and 66.1%, respectively. The most prominent lifetime DSM-III axis I disorders were anxiety (31.8% lifetime and 16.5% last month) and affective (25% lifetime and 19.9% last month) disorders. Antisocial personality disorder (ASP) had a lifetime prevalence of 69.3%. Psychiatric disorders seem to precede drug dependence in the majority of cases.

Some personality features have been commonly linked to patients with SUDs, the most salient variables being novelty-seeking, impulsivity, and low harm avoidance. Few studies have tried to differentiate between drug preferences and none have studied this among jailed substance users (Lukasiewicz et al., 2007).

Special prison populations

Women and juveniles comprise two very important subgroups in custodial or correctional settings where there are serious substance use concerns.

Table 2: Drug use in the month before the offence among convicted prison and jail inmates by mental status in the United States (James et al., 2006)

Types of drug used in the month before offence	State prison		Federal prison		Local jail	
	With mental health problem %	With out %	With mental health problem %	With out %	With mental health problem %	With out %
Any drug	62.8	49.1	57.1	45.2	62.1	41.7
Marihuana/hashish	45.7	33.3	41.2	32.0	43.4	27.1
Cocaine/crack	24.4	17.9	21.1	15.5	24.2	14.7
Heroin/opiates	8.9	7.2	7.2	4.7	9.6	4.6
Depressants	7.3	3.0	6.7	2.7	8.5	2.0
Methamphetamines	12.6	8.8	10.9	9.6	11.7	6.2
Other stimulants	5.8	2.8	4.5	2.5	5.2	2.4
Hallucinogens	8.0	3.4	9.3	3.0	7.5	2.9

Women and substance use in prison: Female offenders have a particularly high rate of substance use problems, and substance use in women offenders is generally regarded as one amongst multiple criminogenic needs (i.e., associates, attitudes, employment, marital/family, personal/emotional; as assessed by the Case Needs Identification and Analysis assessment system used in Canadian corrections). Female substance using offenders tend to have higher overall need level ratings, and also higher risk ratings, than non-substance using female offenders (Dowden and Blanchette, 2002). Statistics from DPFC (Victoria's female prison), suggest that women prisoners had the highest use of both licit and illicit substances for all Victorian prisons during 1999-2000 (Armytage et al., 2000, as cited in Sorbello, Eccleston, Ward and Jones, 2002).

A report on women in prison by H.M. Chief Inspector of Prisons, (1997) argues that substance use has different antecedents for women than men and serves different functions (Byrne and Howells, 2002). Primarily, drugs and alcohol are argued to serve the function of 'numbing' emotion for women (Murthy et al., 2008). Given this, it has been argued that traditional drug treatment programmes are inadequate in addressing the multitude of gender-specific physical, psychological, social and welfare needs found among female substance misusing offenders (Sorbello et al., 2002). The combination of a

range of traumas (i.e., physical and/or sexual abuse, psychological/psychiatric issues) is thought to trigger maladaptive coping strategies, (including substance use) to reduce subjective distress. Langan and Pelissier, (2001) argue that these differences suggest that treatment programs designed for men may be inappropriate for women.

In the Bangalore Prison Study (Math et al., 2011), 17.9% of women prisoners reported use of tobacco in some form. This is marginally more than the prevalence of tobacco use among women in Karnataka (15.2%-figures for 2001). Chewing tobacco was more common among women (12.7%) compared to smoking (5.1%). Among women resident prisoners, 3% reported ever using alcohol. This is lower than the prevalence of alcohol use among women in Karnataka, which has been estimated at 5.8% (Benegal et al., 2005).

Only one woman prisoner reported drug use in order to get a high. None self-reported use of any opioids, benzodiazepines or any other drugs. However, on carrying out anonymous drug testing among 60 women resident prisoners, 18 (30%) tested positive for one or more drug. Thirteen samples (21.7%) tested positive for benzodiazepines, 3 (5%) for cocaine, 2 (3.3%) for opioids and amphetamines respectively and one (1.7%) for cannabis. One person each tested positive for two drugs and three drugs respectively.

Juvenile offenders: Very high levels substance use disorders (SUDs), particularly alcohol and cannabis have been reported among juvenile offenders from several countries (Zilbert et al., 1994; Putnins, 2001; Teplin et al., 2002; McCleelland et al., 2004). Several other drugs are also abused by juvenile offenders, including inhalant use. There is a close association between substance use, severity of the committed offence and antisocial behaviour. Further, the earlier the age of onset of substance use, the greater is the likelihood of severe and chronic offending. Delfabbro and Day (2003) suggest that by far the most significant area of interest in Australia has been the problem of petrol-sniffing, "a form of addiction that has crippled many outback communities", causing significant brain damage, social alienation and isolation, and ultimately death for many hundreds of young indigenous offenders (MacLean and D'Abbs, 2000).

Gambling: A behavioural addiction

There are many non-substance use addictions that can cause problems to the individual or to others. These include gambling, sex, eating disorder and many others. A brief

discussion is provided here on gambling, as this addiction often goes in hand with substance use disorders. Gambling as a leisure activity is known to run rampant in prisons. However, it is recognised that this behaviour may often be picked up in prisons and carry on post release. Addiction to gambling can cause problems before entering prison, during imprisonment (debts, fights and clashes over settlement) or continue post release.

Recently sentenced inmates in four New Zealand male prisons ($N = 357$) were interviewed to assess their gambling involvement, problem gambling and criminal offending. Frequent participation in and high expenditure on continuous forms of gambling prior to imprisonment were reported. Nineteen percent said they had been in prison for a gambling-related offence and most of this offending was property-related and non-violent (Abbott et al., 2005).

In the Bangalore Prison Study (Math et al., 2011), about one in 10 prisoners (11%) self-reported having indulged in some form of gambling during their lifetime. The most common form was playing cards for stakes. There were no significant differences between UTP and CTPs with regard to lifetime gambling. Among women, a very small number reported any form of gambling.

Risks of substance use in prison

Large numbers of entrants to the prison come with a history of drug use. If these inmates are not recognised and treated when they enter the prison, they may develop severe withdrawal symptoms which may be life-threatening. Violence, illegal activities and substance use are closely related. Persons using drugs may also become violent during this period and may also become dangerous to others in prison.

Other consequences of drug use in prison include drug-related deaths, suicide attempts and self-harm. Drug use tends to be more dangerous inside than outside prisons because of the scarcity of drugs and sterile injecting equipment. In a study of 492 IDUs, 70.5% reported sharing needles while in prison compared with 45.7% who shared needles in the month before imprisonment ($P < 0.0001$). Of particular concern is that sharing injecting equipment inside prisons is a primary risk factor for human immunodeficiency virus transmission. Additionally, hepatitis C virus infection through shared injecting equipment in prison has been reported in studies undertaken in Australia and Germany. Drug use in

prison is also associated with the risk for involvement in violence. Inmates who incur disciplinary action related to possession or use of a controlled substance or contraband were 4.9 times more likely to display violent or disruptive behaviour than those who did not incur such disciplinary action. Prisoners using drugs are also at risk for engaging in further illicit activity. If discovered using illegal drugs, inmates risk prolonged incarceration for breaking security rules and eliciting hostility among prison staff (Stover and Michels, 2010). In the week after release, prisoners are approximately 40 times more likely to die than are members of the general population; in this immediate post-release period, more than 90% of deaths are drug related (Stover and Michels, 2010).

Need for treatment and its advantages

Substance dependence is now understood as a bio-psycho-social condition. Dependence occurs because of the effects of substances on the reward pathways in the brain, through the release of some pleasure producing, discomfort reducing neurochemicals. It also results from repeated conditioning to drug using cues, and the association between drug use, pleasure and relief of tension. Treatment approaches include counselling, medication, support and follow-up.

Substance dependence is a chronically relapsing disease and only coercive abstinence in prison may be followed by relapse immediately after release, often resulting in overdose, drug emergencies and death. Prisoners need to be educated on the benefits of treatment of drug dependence, which include reduction in use both in prison and following release, less risk taking behaviour, decrease in criminal activity, less risk of death and infection and reduced re-incarceration. In developing countries, abusing drugs has particularly high health, social and economic costs, which must be communicated to the prisoners, to motivate theme for change.

In a Canadian study, female substance-misusing offenders who successfully completed a planned treatment programme were found to be significantly less likely to re-offend than their untreated counterparts (Dowden and Blanchette, 1999 and 2002).

The United Nations General Assembly Special Session on the World Drug Problem in 1998 explicitly identified prisoners as an important group for activities to reduce demand for drugs (United Nations, 1998). In 1999, the European Union endorsed an action plan to combat drugs for 2000–2004 (European Commission, 1999, 2001 and 2002). Among the

targets set were those aiming to substantially reduce, over five years, the incidence of drug-related health damage (such as HIV, Hepatitis C and Tuberculosis) and the number of drug-related deaths. The WHO Regional Office for Europe (1999) issued, with UNAIDS, guidelines on HIV infection and AIDS in prisons. WHO Health in Prisons Project (2002) issued a consensus statement on the considerable role of prisons in contributing to a public health strategy for dealing with the harmful effects of drugs to public health, to the users, to staff and to the management of prisons. The principles, policies and practices outlined in that statement remain valid and considered along with this report.

In the United Kingdom, the prison programme (Integrated Drug Treatment System or IDTS) is funded to provide opioid substitution treatment (OST) in every adult prison, within an integrated clinical and psychosocial treatment approach, uniting prisons' psychosocial drug treatment services (counselling, assessment, referral, advice and through-care services) and clinical substance misuse management (incorporating the option of Methadone or detoxification) services. The design of the programme took into account the vulnerability of drug-using prisoners to suicide and self-harm in prison and to death upon release from prison because of accidental opioid overdose, prison regimen services that correspond to national and international good practice and the need to provide clinical interventions that harmonise with practice in the community and other criminal justice settings.

Treatment gap for substance use treatments in prisons

The World Drug Report, 2010 exposes a serious lack of drug treatment facilities around the world. "While rich people in rich countries can afford treatment, poor people and/or poor countries are facing the greatest health consequences", it warns. The Report estimates that, in 2008, only around one fifth of problem drug users worldwide had received treatment in the previous year, which means that around 20 million drug dependent people did not receive treatment. ‘It is time for universal access to drug treatment’. The other themes in this report are that ‘Drug addiction is a treatable health condition, not a life sentence’, ‘Drug addicts should be sent to treatment, not to jail’, ‘Drug treatment should be part of mainstream health care’ and ‘Just because people take drugs, or are behind bars, this doesn't abolish their rights’

The report cautions that countries are not in a position to absorb the consequences of increased drug use. The developing world faces a looming crisis that would enslave millions to the misery of drug dependence (UNODC, 2010). The WHO (2010) highlights the cost effectiveness of treatments of substance use. For every dollar invested in drug treatment, 7 dollars are saved in health and social costs. It is unfortunate that though many prisoners would like treatment for substance use, such treatments are not available. Brooke et al., (1998), in their study of remand prisoners, found that 23% of drug users requested treatment - a figure far higher than might be expected prior to imprisonment. In the Bangalore Prison study (Math et al., 2011), 85% of smokers, 73% of tobacco chewers, 99% of alcohol users and 71% of drug users expressed the need for help in being able to give up using these substances.

Barriers to treatment: These barriers may be classified as Prisoner related barriers (ignorance, lack of motivation, myths and misconceptions regarding treatment), Prison staff and other stakeholder barriers (negative attitudes, lack of understanding about the chronic relapsing nature of drug use and the positive impact of harm reduction measures) and Policy and Programmatic barriers (focus only on abstention without providing services for treatment and proper support to address factors maintaining the drug habit).

Indian experience

The UNODC has recommended that the Government of India initiate a process of inquiry in major prisons in India, and where necessary, set up the required facilities for the treatment of drug users. The major experience from India comes from the Tihar jail, where the oldest programme in an Indian prison for substance use was initiated. Drug offenders received at Tihar Jail are admitted to a "de-addiction" centre for detoxification and treatment of withdrawal symptoms. To address drug abuse, a Drug De-Addiction Centre (DAC) with a capacity of 120 beds was established in 2007 taking into account that six to eight per cent of the prison inmates are drug dependent at the time of admission, out of which some were injecting drug users. After detoxification, drug offenders are segregated from the other prisoners and placed in therapeutic communities run by NGOs including the Association for Scientific Research on Addictions (AASRA) and the AIDS Awareness Group.

In collaboration with the All India Institute of Medical Sciences (AIIMS), UNODC and Non-Governmental organisations, the Tihar jail administration initiated a pilot and the

first-ever Oral Substitution Treatment (OST) Centre in a prison in South Asia. The Civil Rights Initiative–Arthur Road Jail Project was started in January 2005 in partnership with and on request from the Sankalp Rehabilitation Trust. Sankalp is given a separate barrack for drug users who opt to undergo a rehabilitation programme. Sankalp provides users with counselling, medicines, treatment (Tihar Jail, 2009).

The UNODC, in its regional prisons project initiated in 2005, has been working with prison departments and civil society agencies to enhance institutional and technical capacities of relevant ministries and civil society partners to mount effective intervention programmes to prevent the transmission of HIV in prison settings, within a continuum of care of evidence-based drug dependence treatment and rehabilitation programmes. Presently this programme is underway in 21 prison sites in the South Asian region including the prisons in Delhi, Aizawl central prison, Mizoram and the Sajjawa central prison in Manipur. The main components of the programme include a comprehensive HIV prevention service, capacity building to meet the needs of drug users including opioid substitution treatment, support for the NGOs to provide linkages between prison and community programmes, including psychosocially assisted programmes and HIV prevention programmes.

It is a real challenge to be able to draw on some of these experiences and at the national level, be able to set up comprehensive substance use prevention and treatment services.

Measures to address substance abuse in prisons

1. Identification of substance use problems through questionnaires, behavioural observation and urine drug screening both at the point of entry and during imprisonment.

    a) Detoxification services and making suitable pharmacotherapy available for detoxification.

    b) For persons with dependence, making available long-term medication as well as motivational and relapse prevention counselling.

    c) Specific interventions to be made available include the following:

- Tobacco cessation services (behavioural counselling, nicotine replacement therapy, other long-term tobacco cessation pharmacotherapy.

- Alcohol–benzodiazepines for detoxification, vitamin supplementation for associated nutritional problems, counseling and long-term medication like acamprosate, topiramate, disulfiram, naltrexone and others.

- For Opiates – buprenorphine or clonidine detoxification, long-term medication including opioid substitution(methadone/ buprenorphine; opioid antagonists like naltrexone).

- All drug users need to be evaluated for injecting use, for HIV/STI (including Hepatitis B and C screening) and appropriately treated.

2. Prisoner education to inform about the health and other adverse effects of substance use, the benefits and support available for quitting, training of prison staff in motivating prisoners' desire for change, psychosocial counselling in individual and group settings, involvement of family members of prisoners.

3. Ensure availability of personnel and services to the extent possible within the prison, network with the community to establish linkages for effective counselling and aftercare. NGO's and self-help groups can be a valuable part of this network.

4. Sensitise and train all stake holders regarding the problem of substance abuse in prisons, helpful responses and barriers to effective care. Stakeholders include prison officials, state health departments, judiciary, police, and service providers for other health programmes (like HIV, tuberculosis etc).

5. Identification of vulnerability factors is an important part of substance abuse prevention, particularly important to prevent recidivism. A life skills approach to address these vulnerabilities, linked with other psychosocial approaches seems to be the most pragmatic approach.

6. In addition to reducing HIV transmission among intravenous drug users (IDUs), opioid substitution therapy (OST) reduces criminal activity among heroin users. Providing OST in the community is a crime control measure that can lead to reduction in the prison population (UNODC, 2006).

7. Engagement of family members to provide support for abstinence during incarceration and after release.

In conclusion, in India, we are gradually becoming aware of the magnitude of substance use and its impact on prisons. From the global experience, it is very clear that much has to be done, and that a lot of time and opportunity has already been lost. The prison system must take up this issue very seriously, and provide integrated services for the prevention and treatment of substance use in prison settings.

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4. SEVERE MENTAL DISORDERS: IMPLICATIONS IN PRISON SETTINGS

Psychotic disorders are mental illnesses that cause impairments in a person's judgement and ability to carry on with the tasks of day to day life. Schizophrenia and bipolar disorders are some of the most common types of psychotic disorders. Schizophrenia generally affects individuals in their early adulthood, thereby in their most productive phase of life. Typically, this disorder affects the individual's thought processes, perceptions, emotions and behaviours. Bipolar disorders (or affective psychoses) are characterised by periods of, elated mood, expansive ideation and over activity (mania), alternating with sadness and being withdrawn (depression). It is not uncommon to find prisoners with these disorders, which may develop before entry into prison or during imprisonment. In this chapter, the prevalence of psychotic disorders in prisons globally is reviewed, and the findings of the Bangalore Prison mental health study are discussed in this context. For the purpose of this review, both schizophrenia as well as bipolar disorders are included. Both have been subsumed under the category of 'severe mental disorders'.

Prevalence of schizophrenia and bipolar mood disorders

A study by Birmingham et al, (1996) defined the prevalence of mental disorders and the need for psychiatric treatment in new remand prisoners (akin to under trial prisoners) in a Durham prison for men. A semi-structured interview schedule (incorporating well validated psychiatric instruments) was designed specifically for the study. Schizophrenia and other psychotic disorders were present in 20 (4%) prisoners and affective psychosis was present in 4 (1%) of them.

The Bureau of Justice Statistics conducted three studies in the US (James et al., 2006). In 2002, inmates from all the local jails were interviewed and in 2004, inmates from all the State and Federal correctional facilities were interviewed. A history of mental health problems that had occurred in the 12 months prior to the interview or any history that included a clinical diagnosis or treatment by a mental health professional was considered for the definition of mental disorder. This study included a modified structured clinical interview for the DSM-IV. According to the above definition, 56% of the State prison inmates had some mental problem, while 45% of the federal prison inmates and 64% of the local jail inmates had symptoms of a mental problem. Symptoms of psychotic disorders were present among 20% of the state prisoners, 12.6% of the federal prisoners

and 31.2% of the local jail inmates during the past one year or since admission. Life time prevalence of manic symptoms were: 21.5%, 23.3% and 17% among state prisoners, federal prisoners and local jails respectively.

Herrman et al, (1991) estimated the prevalence of severe mental disorders in a representative sample of sentenced prisoners in Melbourne prisons. 189 inmates were interviewed for this purpose using the Structured Clinical Interview for DSM-III-R. 3% (n=6) received current diagnosis of psychotic disorder while 6% (n=11) had a lifetime diagnosis of psychotic disorder. A lifetime diagnosis of at least one mental disorder each was made for 82% of the respondents.

White et al, (2006) screened 621 men from the main remand and reception centre for males for the southern region of the state of Queensland, Australia. Of the 621 screened, 65 answered yes to at least one question in the Diagnostic Interview for Psychosis (DP). These patients were interviewed using the DP [DP is a composite semi-structured standardized interview schedule that combines social and demographic descriptors with measures of functioning adapted from the World Health Organisation Diasability assessment Schedule (DAS)]. 35% were homeless for an average of 32 weeks during the precedent year. Most of them had minimal contact with family members. 78% were unemployed and 80% were dependent on alcohol, cannabis or amphetamines. These rates were significantly high when compared to those of psychotic men who resided in the community.

Way et al, (2008) studied the characteristics of inmates who received a diagnosis of serious mental illness upon entry to a New York State prison. A chart review was performed for prisoners who entered prison between May 2007 and June 2007 and received a diagnosis of serious mental illness. Initial diagnosis was made by a psychologist or a social worker within a few days of arrival in the prison. Few days later, a psychiatrist reviewed the chart material, conducted a second interview and confirmed or modified the diagnosis. 6% (172 of 2,918 inmates) received a diagnosis of serious mental disorder. The mean (SD) age of these 172 patients was 36(9.6) years. A total of 167 (97%) had been hospitalised once earlier for psychiatric treatment and 48 (28%) had been hospitalised four or more times. Seventy nine (46%) had their first episode of hospitalisation ten or more years ago. A total of 107 (62%) had history of a serious suicidal attempt, 101 (59%) had history of inpatient treatment for substance abuse, and79 (46%) had been incarcerated earlier in the state prison.

Table: 1- Prevalence studies of Schizophrenia /other non-affective psychoses / Bipolar Affective disorders in Prisons/Jails

Authors (year), country in which study was conducted	Venue	Sample size	Sampling method	Diagnostic instruments	Prevalence rates
Bolton (1976), USA	Jail	1084 inmates	Not available (N/A)	N/A	Psychosis-7%
Petrich (1976), USA	Jail	122 jail inmates referred for psychiatric evaluation (84% males)	N/A	Psychiatric evaluation	Schizophrenia - 31% males and 25% females
Petrich (1976), USA	Jail	529 referred for evaluation; 80% males, 42% females	N/A	N/A	Psychosis-49%
Schuckit et al., (1977), USA	Jail,	199 males	N/A	Clinical interview	Affective disorder-5%
Piotrowski et al., (1976)	Jail	50 pretrial detainees referred for evaluation (88% males)	N/A	Psychiatric evaluation & chart review when possible	Schizophrenia -22% Bipolar Affective Disorder - 10%
Nielson (1979)	Jail	Unknown	N/A	Clinical	Psychosis - 24%

				evaluation	
Monahan and McDonough (1980)	County jail	632 referred for evaluation; 82% male,	N/A	N/A	Schizophrenia-32%
James et al., (1980)	Prison	409 inmates referred for medical evaluation	N/A	Clinical evaluation	Schizophrenia – 5%
Lamb and Grant (1982), USA	County jail	102 males referred for evaluation	Random sampling	Clinical evaluation	Schizophrenia-75% Affective disorder-22%
Lamb and Grant (1983), USA	Jail	101 female inmates referred for evaluation	N/A	Psychiatric evaluation	Severe overt psychopathology- 59%
Ninzy (1984), USA	Jail	50 volunteers, 74% males	N/A	N/A	Psychosis-26%
Virginia DMH, USA	Jail	171 mentally ill as identified by staff	N/A	N/A	Schizophrenia-40% Mania-21%
Glaser (1985), Australia	Jail	50 inmates referred for evaluation	N/A	N/A	Schizophrenia-48% Mania-16%
Guy et al., (1985)	Jail	486 inmates	N/A	Structured Clinical	Schizophrenia- 11.5% Bipolar affective disorder-

				Interview for DSM (SCID)	3.1%
Valdiserri et al., (1986)	County jail	769 inmates referred for evaluation;86% males	N/A	N/A	Psychosis-17%
Daniel et al., (1988), USA	Prison	100 female inmates	N/A	Diagnostic Interview Schedule-III	Schizophrenia – 7%
Teplin (1990), USA	Prison	728 male detainees	N/A	Diagnostic Interview Schedule-III	Schizophrenia- 2.7%
Maden et al., (1994), USA	Prison	301 inmates	N/A	Clinical interview schedule	Psychosis-2%
Roesch (1995)	N/A	790	N/A	N/A	Psychosis-5%
Bean et al., (1988), USA	Prison	464 inmates	Two-stage random sample stratified by facility.	Initial screening by PERI, later on used SCID	Schizophrenia-1.5% Bipolar disorders-2.8%
California department of	Prison	413	Two stage samples; general	DIS-III	Schizophrenia- 3.4%

corrections (1989), USA			population sample stratified on institutional security level (n=362); random psychiatric sample(n=51)		Bipolar disorders-2.9%	
Neighbors et al., (1987), USA	Prison	1240	Two stage random sample stratified by institution type	DIS administered to sample and SCID to screened sample	Schizophrenia-2.8%	
					Bipolar disorder-2.8%	
Motiuk and Porporino (1991), Canada	Male inmates	2185	Random sample stratified by region	DIS: wide criteria	Schizophrenia-4.9%	
					Bipolar disorder-4.9%	
				DIS: stringent criteria	Schizophrenia-4.9%	
					Bipolar disorder-4.4%	
Teplin (1994), USA	Male detainees	728	Stratified random sampling	National Institute of Mental Health Diagnostic Interview Schedule, Version III	schizophrenia	Life-time: 4%
						Current-3%
					Mania	Life-time: 2%
						Current:1%

Davidson et al., (1995), Scotland	Male prisoners	389	N/A	Clinical interview schedule	Psychosis-1%	
Birmingham et al., (1996), UK	Male remand prisoners	549	N/A	Semi-structured pro-forma that included well validated psychiatric scales	Schizophrenia & other psychotic disorder-4%	
					Affective psychoses-1%	
Brooke et al., (1996), UK	Male unconvicted prisoners	750	Randomly selected sample across young offenders and 13 adults prisons	Semi-structured interview and case note review	Psychosis-5%	
Powell et al., (1997), USA	male prison and jail inmates	213	Randomization	Diagnostic interview schedule-III	Psychosis-2%	
Singleton et al., (1998) [Office for National Statistics-Prison survey-1997], UK	Both remand and sentenced inmates	N/A	N/A	N/A	Psychotic disorder	7% (sentenced men)
						10% (remand men)
Simpson et al., (1999), New Zealand	Male inmates	441	N/A	N/A	Psychosis-4%	

James et al., (2006) [Bureau of Justice Statistics in the US]	State prison, Federal prison & local jails	State prisons-14,449	Stratified two stage sampling. Facilities were selected in the first stage. In the second stage, samples were systematically selected.	SCID	Psychotic disorder (life time prevalence)	State prisons-11.1%
		Federal prisons-3686				Federal prisons-7.8%
		Local jails-3365				Local jails-16.8%
Teplin (1990), USA	Male prisoners	728	Stratified random sampling	DIS	Current schizophrenia-2.94%	
					Current mania-1.36%	
White et al., (2006), Queensland, Australia	Male remandees	621	All remandees who entered the remand centre during the study period	Diagnostic interview for Psychosis (DP)	Psychotic disorders-9.5%	
Way et al., (2008), USA	State prison	172	N/A	Clinical interview	Schizophrenia-14%	
					Bipolar I disorder-13%	
					Unspecified bipolar disorder-19%	
Andersen et al., (1996) + Schuckit et al., (1997) + Panhuis	Male prisoners	1038	Fazel and Danesh (2002) have commented that	N/A	Psychosis-6%	

et al., (1997) + Smith et al., (1996) + Swank and Winer (1996) + Guy et al., (1985) + Barthalomew et al., (1967) + Brinded et al., (1999) + Shoemaker et al., (1997) + Watt et al., (1993)			the results of these five studies have been clubbed because of the smaller sample sizes		

Out of the 172 patients, 14 (8%) received a diagnosis of schizophrenia; 22 (13%), major depressive disorder; 21 (12%), bipolar I disorder; 33 (19%), bipolar disorder not otherwise specified; and 33 (19%), mood disorder not otherwise specified.

In correctional settings, schizophrenia and bipolar disorders (severe mental disorders or psychotic disorders) are generally found in a higher proportion of the inmates, when compared to that in the general population. Prevalence rate is highest in the age group of 25-44 years followed by the age group of 18-25 years. Some studies show that males have higher rates when compared to females. Rates vary between two and four percent. A large review (Fazel and Danesh, 2002) of 62 prison surveys also showed that 3.7% of males and 4% of female prisoners had psychotic disorder at the time of assessment. These disorders are found both among remand as well as sentenced prisoners. The phenomena of trans-institutionalization, re-institutionalization and substance abuse among inmates may have contributed to these high rates.

Findings from the Bangalore Prison Study

The Bangalore prison mental health study (Math et al., 2011) examined mental health morbidity in 5204 prisoners. According to the responses on the Mini International Neuropsychiatric Interview (MINI), there was very low reporting of symptoms for lifetime or current psychotic illness. Only 15 prisoners (0.4%) reported a lifetime history of psychotic disorder. Seven patients reported symptoms satisfying criteria for schizophrenia (0.1%). A more reliable indicator of the prevalence of psychosis was the record maintained by the prison psychiatrist. This indicated that a total of 112 cases (2.2%) had a diagnosis of psychosis, primarily schizophrenia. Table 2 depicts the frequency of schizophrenia and related disorders. The prevalence of bipolar episodes (including hypomania and mania) is depicted in Table 3.

The Bangalore Prison study (Math et al., 2011) showed the current prevalence rate of schizophrenia to be 1.1%. When all disorders with psychotic manifestations had considered, the prevalence rate increased to 2.3%. Almost all patients with psychotic manifestations will come in contact with not only the prison psychiatrist but also psychiatrists at the National Institute of Mental Health and Neurosciences, which is the tertiary centre for referral care for the Bangalore prison. Hence these figures are more reliable and valid than the figure (0.1%) obtained from the interview schedule. Though, world over schizophrenia and related psychotic disorders are found in higher proportion in correctional institutions, the same was not replicated in this study.

Table 2. Types of psychotic disorders

Sl No	Type of Psychosis	Number (%)
1.	Schizophrenia and related disorders	57 (1.1)
2.	Mood disorder with psychotic features	30 (0.6)
3.	Substance induced psychosis	19 (0.4)
4.	Organic psychosis	6 (0.1)
	Total	**112(2.2)**

Source: Math et al., 2011

Table 3. Prevalence of bipolar episodes

		UTP [n(%)]	CTP [n(%)]	Total	Chi-square	P-value
Hypomania /mania	Lifetime	4(0.1)	2(0.2)	6(0.1)	0.30	0.58
	current	1(0.02)	0	1(0.01)	0.31	0.57
Mania	Lifetime	3(0.1)	0	3(0.1)	0.94	0.33
	current	3(0.1)	0	3(0.1)	0.94	0.33

Source: Math et al., 2011

As presented earlier, global rates vary over a high range of between two to thirty percent across various countries. UK based studies are more towards the lower end with a rate of less than 4 percent (Birmingham et al., 1996; Gunn et al., 1991 and Fazel and Danesh 2002). Study by Herrman et al, (1991) in Australia indicate a prevalence of 6% for a lifetime diagnosis. Higher rates have been found in the United States according to the US BJS survey (James et al., 2006) which reached a maximum of 31.2% in one of their settings. The 1.1% prevalence for schizophrenia is just slightly higher than that of the general population (Isaac and Gururaj, 2004). This variation from global rates can be attributed to the facts that the prevalence of schizophrenia in general population itself is much lower in India when compared to the western countries (Kessler eta l., 1994; Isaac and Gururj, 2004); the phenomenon of reinstitutionalisation is not yet documented in our country. Moreover, majority of schizophrenia patients live with their families, which may protect them from both becoming homeless and getting involved in crimes. Substance abuse comorbidity is also very low in India when compared to the western countries.

In the Bangalore Prison Study (Math et al., 2011), the prevalence of life-time manic episodes was very low which makes it impossible to statistically compare this with any other study. Moreover, there are no reliable epidemiological studies of manic episodes in India. Nonetheless, we would like to state that issues that are discussed in the above sections can apply to patients with affective psychosis as well.

Other important issues with patients with psychotic disorders are related to their fitness to stand trial and the phenomena of transinstitutionalisation. Not only do these patients need to be treated adequately, proper mechanisms should also be put in place for their effective rehabilitation. In this context, the recent Supreme Court's judgment on the plight of such patients and gross violations of their human rights is an eye opener [Supreme Court, Writ Petition (CRL.) No(s). 296 of 2005] which needs to be followed up with the appropriate actions.

In conclusion, although the comparatively low rate of prisoners with severe mental disorders in Bangalore prison is somewhat reassuring, we cannot afford to be complacent and need to take appropriate actions. With globalization, fast and stressful lifestyles; traditional value systems being replaced by short term relationships, there has been a rapid breakdown in the culture of families acting as a protective mechanism for those suffering from schizophrenia and other psychotic disorders. We need to be better prepared to identify and provide appropriate facilities for the treatment of such people when they land up in prisons. Being a small number, they could very well be ignored and go unnoticed.

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5. THE FETTERS OF DEPRESSION

Deprivation of liberty invariably results in deprivation of choices usually taken for granted in the outside community. Once incarcerated, prisoners are no longer free to decide where to live, with whom to associate and how to spend their time. Communication with families and friends is limited and often without privacy (Blaauw and Van Marle, 2007). Petersilia, (2003) has estimated that one in six prison inmates has a mental illness. Depression is the most prominent among them. This chapter examines the details and extent of this problem in prisons and compares the results of the Bangalore mental health study in prisons with studies conducted both at the international and national level. For the purpose of this review, the terms jails and prisons are used interchangeably.

Prison factors that aggravate mental morbidity

There are external and internal factors that aggravate mental morbidity in prisons. The external factors, are more to do with the environment in prisons such as overcrowding, dirty and unhygienic living conditions, poor quality of food, inadequate health care, physical or verbal aggression by inmates, lack of purposeful activity, availability of illicit drugs and either enforced solitude or lack of privacy and time for quiet relaxation and reflection. Internal factors that play a contributory role are mostly emotional in nature, where prisoners may have feelings of guilt or shame about the offences they have committed, experience stigma of being been imprisoned, worry about the impact of their behavior on other people, including their families and friends, coupled with anxiety about how much of their former lives will remain intact after release. The cumulative effect of all these factors, left unchecked, tends to worsen their mental health and increases the likelihood of damage to the wellbeing of prisoners and staff (Blaauw and Van Marle 2007).

Depression

While it is understandable that anybody in a prison would be generally depressed, it is important to understand depression from the perspective of a mental illness. Depression is one of the most common mental disorder that generally occurs as an episode or series of episodes. People suffering from this disorder may not only exhibit depressed mood but may also lose interest in life's activities and easily become lethargic. They may have

difficulty concentrating or making simple decisions. They may develop ideas of hopelessness, worthlessness or helplessness. Severe depression may be accompanied by psychotic symptoms such as delusions. Persons suffering from major depression are at increased risk for suicide and may be preoccupied with thoughts of death (Hill et al., 2004). The fundamental disturbance in depression is the change in mood or affect to feelings of sadness. This is usually accompanied by a change in the overall activity. Other symptoms are either secondary to these fundamental disturbances or can be easily understood in the context of changes in mood and activity. Most of the depressive episodes tend to be recurrent and are often related to stressful events or situations. In typical depressive episodes, the patient usually suffers from *depressed mood, loss of interest and enjoyment, and reduced energy, leading to increased fatigability and diminished activity*. Marked tiredness after only slight effort is common. Other common symptoms are:

(a) Reduced concentration
(b) Reduced self-esteem and self-confidence
(c) Ideas of guilt and unworthiness
(d) Bleak and pessimistic views of the future
(e) Ideas or acts of self-harm or suicide
(f) Disturbed sleep appetite and sexual functioning
(g) Death wishes, suicidal ideas or attempts

Depressive disorders affect around 5% of the adult population at any given point of time. Patients with a 'mild depressive episode' are usually distressed by the symptoms and have some difficulty in continuing with ordinary work and social activities, but will usually not cease functioning completely. Patients with 'severe depressive episodes' have disturbed biological functioning and exhibit considerable distress. The lowered mood varies little from day to day, and is often unresponsive to circumstances (WHO 1992, Murthy et al., 2005).

Prevalence of depression in prisons

Independent surveys by Gunn et al, (1990; including sentenced prisoners) and Maden et al, (1994; including remanded prisoners) conducted in the UK in the early nineties showed a very high prevalence rate (27% and 91% respectively) of neurotic problems in the form of disturbed sleep, depression, worry, fatigue and irritability. Co morbidity was

present in 25% of the men and in about a third of the women in remand prisons. Both surveys were point prevalence studies conducted on samples of prison inmates (Birmingham, 2003).

A study by Birmingham et al, (1996) defined the prevalence of mental disorders and the need for psychiatric treatment in new remand prisoners (akin to under trial prisoners) in a Durham prison for men. A semi-structured interview schedule (incorporating well validated psychiatric instruments) was designed specifically for the study. Mental disorders (including substance misuse) were present in 148 (26%) of the 569 inmates at the time of reception into the prison. Major mood disorders were present in 13 (2%) and dysthymic disorder was present in 14 (2%) of the inmates.

The office for National Statistics-Prison Survey in the United Kingdom (UK; Singleton et al., 1998) conducted a survey that included prisoners from all over the UK. It found that the prevalence of all types of psychiatric disorders was considerably higher than that of the general population. Prevalence of neurotic disorders (in the form of worry, irritability, depression, disturbed sleep or fatigue) was as follows: 40% of sentenced men, 78% of remand men, 63% of sentenced women and 76% of remand women were affected. As is evident, more women had these neurotic symptoms and more remand prisoners had neurotic symptoms than their sentenced counterparts (Birmingham, 2003).

The Bureau of Justice Statistics in the United States (James et al., 2006) conducted three surveys. In 2002, inmates from all the local jails were interviewed and in 2004, inmates from all of the State and Federal correctional facilities were interviewed. A recent history of mental health problems that had occurred in the 12 months prior to the interview or any history that included a clinical diagnosis or treatment by a mental health professional was considered for the definition of mental disorder. This survey included a modified structured clinical interview for the DSM-IV. According to the above definition, 56% of the State prison inmates had any mental problem, while 45% of the Federal prison inmates and 64% of the local jail inmates had symptoms of any mental problem. Major Depressive disorder was present among 24% of State prison inmates, 16% Federal prison inmates and among 30% local jail inmates during the past one year since admission.

In a study by Assadi et al, (2006) in Iran, 351 inmates from one of the largest prisons in the country were interviewed using stratified random sampling. They used the Structured Clinical Interview for DSM-IV Axis I Disorders and the Psychopathy Checklist. 88% of the prisoners met DSM –IV criteria for life time diagnosis of at least one Axis I disorder,

while 29% met criteria for current diagnosis of major depressive disorder and 1.5% met criteria for dysthymic disorder. Depressive disorders were highly co morbid along with anxiety disorders (26%), substance use disorders (83%) and psychopathy (23%). Depressive disorders were more prevalent in the youngest age group. When compared to the Iranian general population, rates of psychiatric morbidity were around three times higher. Moreover, the prisoners were not a homogeneous group. Financial offenders had lower rates of psychiatric morbidity than other offenders.

Teplin, (1990) reported on the prevalence rates of schizophrenia and major affective disorders by age among a random sample of male prisoners. National Institute of Mental Health Diagnostic Interview Schedule was used. The prevalence rates in the prison were later compared with the general population data from the Epidemiologic Catchment Area study. After controlling for demographic differences between prison and city samples, the prevalence rates of current psychiatric morbidity in the prison were two to three times higher than those in the general population (Major Depression - 3.94% Vs 1.07%; Mania – 1.36% vs 0.12%; Schizophrenia – 2.94 vs 0.91%). The same held true even for life time psychiatric morbidity (Major depression- 5.75% vs 3.15%; Mania-2.5% versus 0.32; schizophrenia-3.71% versus 1.70%).

In a retrospective cohort study by Baillargeon et al, (2009), medical case records of 2,34,041 prison inmates were reviewed. Diagnosis was made according to the DSM-IV criteria. Major depressive disorder was present in 4.2% of the study population. It was more prevalent among females (10.3%) than males (3.5%), among non-Hispanic Caucasians (6.3%) than Hispanic Caucasians (2.6%) and African Americans (3.6%) and among elderly prisoners (4.5%) when compared to younger prisoners (3.2%).

Teplin et al, (1994) interviewed 728 prisoners using stratified random sampling. The National Institute of Mental Health Diagnostic Interview Schedule was used. 3.42% prisoners had current diagnosis of major depressive episode, while 5.04% had a lifetime diagnosis of a major depressive disorder.

Eyestone and Howell, (1994) interviewed 102 prisoners, using the Beck Depression Inventory and the Hamilton Rating scale. Major Depressive Disorder was found in 25.5% of the prisoners. They also found a significant relationship between Attention Deficit Hyperactivity Disorder and Depressive Disorder.

Herrman et al, (1991) estimated the prevalence of severe mental disorders in a representative sample of sentenced prisoners in Melbourne prisons. 189 inmates were interviewed for this purpose using the Structured Clinical Interview for DSM-III-R. 29% (n=34) were having lifetime major depression, 12% (n=10) had current major depression. They also concluded that prisons may apparently contain a large number of people with untreated major depression

Hurley and Dunne, (1994) interviewed ninety-two women prisoners using the General Health Questionnaire, the Hamilton Depression Rating Scale, a Recent Stressful Life Events questionnaire and the Structured Clinical Interview for DSM-III-R. High levels of symptoms of psychological distress were recorded. Distress was correlated with recent stressful life events and was more severe in inmates awaiting trial. Aboriginal inmates were over-represented in this sample. A follow-up survey after 4 months showed no fall in the prevalence of psychological distress and psychiatric morbidity.

Fazel and Danesh, (2002) systematically reviewed sixty-two prison surveys to determine the prevalence rates of serious mental disorders. Thirty-one reported major depression among prisoners. Overall, 10% (743 / 7631) male prisoners had the illness. There was substantial heterogeneity among these studies (x^2 =64; p<0.0001) and this was only partially explained by differences between detainees and sentenced prisoners (9 vs 11% respectively; x^2 =10.0, p=0.0002), between studies in which interviews were done by psychiatrists or not (7 vs 10%, respectively; x^2=14·2, p=0·0002), and between larger and smaller studies (9 vs 11%, respectively; x^2=6·2, p=0·008). Overall 12% (350 / 2898) female prisoners were diagnosed with major depression.

Way et al, (2008) studied the characteristics of inmates who received a diagnosis of serious mental illness upon entry to a New York State prison. Chart review was performed for inmates who entered prison between May 2007 and June 2007 and received a diagnosis of serious mental illness. Initial diagnosis was made by a psychologist or a social worker within few days after arrival in the prison. A few days later, a psychiatrist reviewed the chart material, conducted a second interview and confirmed or modified the diagnosis. Six percent (172 of 2,918 inmates) received a diagnosis of serious mental disorder. Twenty-two (13%) received a diagnosis of major depressive disorder and 33 (19%) received a diagnosis of unspecified mood disorder.

Table 1: Prevalence studies of Depression/Neurotic disorders in Prisons/Jails

Authors (year)	Venue/gender	Sample size	Sampling method	Diagnostic instruments	Prevalence rates
Daniel et al., (1988)	Female prison inmates	100 females	Not available (N/A)	Diagnostic Interview Schedule-III	Major depression – 21%
Teplin (1990)	Jail	627 inmates	N/A	Diagnostic Interview Schedule-III	Current major depression- 3.9%,
Maden et al., (1994)	Prison	301 inmates	N/A	Clinical interview schedule	Neurosis -18%
Bean et al., (1988), USA	Prison	464 inmates	Two-stage random sample stratified by facility	Initial screening by PERI, later on used SCID	Major depression – 12.7%
California department of corrections (1989), USA	Prison	413	Two stage samples; general population sample stratified on institutional security level (n=362); random psychiatric sample(n=51)	Diagnostic Interview Schedule-III (DIS-III)	Major depression-7.2% Dysthymia-3.8%
Neighbors et al., (1987), USA	Michigan Prison	1240	Two stage random sample stratified by institution type	DIS administered to sample and SCID to screened sample	Major depression-11.3% Dysthymia-6.4%
Motiuk and Porporino (1991),	Prison	2185	Random sample	DIS: wide criteria	Major depression-21.4% Dysthymia-14.3%

Canada		males	stratified by region	DIS: stringent criteria	Major depression-13.6% Dysthymia-7.9%
Roesch (1995)	Male jail detainees	790	N/A	N/A	Major Depression-10%
Brooke (1996)	Male jail detainees	750	N/A	N/A	Major Depression-10%
Powell (1997)	Male jail detainees	500	N/A	N/A	Major Depression-8%
	Male sentenced inmates	750	N/A	N/A	Major depression-12%
Simpson (1999)	Male jail detainees	441	N/A	N/A	Major Depression-10%
	Male sentenced inmates	645	N/A	N/A	Major depression-6%
Robins and Regier (1991)	Mixed sample (this study did not report results separately for detainees and sentenced inmates)	604 males	N/A	N/A	Major depression-7%
Anderson et al., (1996) + Schuckit et al., (1977) + Brinded et al., (1999) + Shoemaker and Van Zessen (1997) + Watt et al., (1993)	Male jail detainees	550	Fazel and Danesh (2002) have commented that the results of these five studies have been clubbed because of the smaller sample sizes	N/A	Major depression-5%
Roesch (1995)	Male sentences inmates	790	N/A	N/A	Major Depression-10%

Brooke (1996)	Male sentenced inmates	750	N/A	N/A	Major Depression-10%
De Cataldo (1995)	Male sentenced inmates	514	N/A	N/A	Major depression-9%
Brinded et al., (1999) + Schoemaker and Van Zessen (1997) + Gibson et al., (1999) + Bulten and Gevangen (1998) + Bland et al., (1990) + Hermann et al., (1991)	Male sentenced inmates	1244	Not available for majority of the references. The authors have commented that the results of these five studies have been clubbed because of the smaller sample sizes	Not available for most of the references	14%
Teplin (1996)	Female jail detainees awaiting trial	1272	Randomly selected stratified sample	DIS	Major depression-14%
Anderson et al., (1996) + Wilkins and Coid (1991) + Poythress et al., (1998) + Mohan et al., (1997) + Hurley and Dunne (1991) + Neary (1990)	Female detainees awaiting trial	292	N/A. The authors have commented that the results of these five studies have been clubbed because of the smaller sample sizes	N/A	Major depression-9%
Robins and Regier (1991) + Denton (1995)	Mixed sample(these studies did not report results separately for detainees and	105	N/A	N/A	Major depression-10%

	sentenced inmates)					
Jordan (1996)	Female sentenced inmates	805	N/A	N/A	Major depression-11%	
Simpson et al., (1999) + Brinded et al., (1999) + Hermann et al., (1991) + Mohan et al., (1997) + Hurley and Dunne (1991) + Daniel et al., (1988)	Female sentenced inmates	424	N/A. The authors have commented that the results of these five studies have been clubbed because of the smaller sample sizes of individual studies	N/A	12%	
Gunn et al., (1991)	Sentenced inmates	N/A	N/A. Sample included both male and female prisoners	N/A	Neurotic problems (disturbed sleep, worry, fatigue, irritability)-27%	
Maden et al., (1996)	Remand prisoners	N/A	N/A. sample included both male and female prisoners	N/A	Neurotic problems (disturbed sleep, worry, fatigue, irritability)-91%	
Birmingham et al., (1996)	Male remand prisoners	549	N/A	Semi-structured pro-forma that included well validated psychiatric scales	Major mood disorder-2%, Dysthymia-2%	
Singleton et al., (1998) [Office for National Statistics-Prison survey-1997]	Both remand and sentenced inmates	N/A	N/A	N/A	Neurotic disorder(worry, irritability, depression, disturbed sleep, fatigue)	40% (sentenced men)
						78% (remand men)
						63% (sentenced

						women)
						76% (remand women)
James et al., (2006) [Bureau of Justice Statistics in the US]	State prison, Federal prison & local jails	State prison-14,449	Stratified two stage sample. Facilities were selected in the first stage. In the second stage, samples were systematically selected.	SCID	Major depression-24%	
		Federal prisons-3686			Major depression-16%	
		Local jails-3365			Major depression-30%	
Assadi et al., (2006)	Male prisoners	351	Stratified random sampling	SCID	Current major depression & dysthymia-31% Lifetime major depression & dysthymia-49%	
Baillargeon et al., (2009)	Both male & female inmates incarcerated in the Texas department of criminal justice prison system	2,34,031	Retrospective cohort study of all inmates	Clinical evaluation	Current major depression-4.2%	
Eyestone and Howell (1994)	Male prisoners	102	N/A	Hamilton Depression Rating Scale & Beck Depression Inventory	Major depression-25.5%	
Way et al., (2008), New York, United States	State prison	172	N/A	Clinical interview	Major depression-13%	
					Unspecified mood disorder-19%	

Prevalence of Depression in Bangalore prison

In the Bangalore Prison Study (Math et al., 2011), the first systematic assessment of mental morbidity among prison population in our country, an interview with 5024 prisoners showed the prevalence of major depressive episode (lifetime) of 12.9%, and 9.1% of prisoners could be diagnosed as having a current depressive episode. 1.75% of prisoners had a current diagnosis of dysthymia and 2.9% a lifetime history of dysthymia. UTPs were significantly more likely to receive a current diagnosis of depression. When 'current' major depressive episodes were considered gender wise, we obtained the following figures: 422/4815 (8.8%) male prisoners were affected while 31/197 (15.7%) female prisoners were affected ($p< 0.001$). Prevalence rate among men in Bangalore Prison study (8.8%) was slightly less when compared to international figures (Fazel and Danesh 2002). But when compared to their prevalence in the general population (1.3% to 3.6%; Isaac and Gururaj, 2004), the morbidity was substantially more.

Table 2: Depression in the Bangalore Prison study

		UTP [n (%)]	CTP [n (%)]	Total	X^2	P-value
Major depressive episode	**Current**	377(9.9)	80(6.7)	457(9.1)	11.04	<0.001
	Past	314(8.2)	116(9.7)	430(8.6)	2.61	0.11
	Lifetime	493(12.9)	152(12.7)	645(12.9)	0.02	0.88
Dysthymia	**Current**	89(2.3)	36(3.0)	125(2.5)	1.75	0.19
	Past	34(0.9)	13(1.1)	47(0.9)	0.39	0.53
	Lifetime	107(2.8)	39(3.3)	146(2.9)	0.69	0.40

Source: Math et al., 2011

Prevalence rates show wide variation across the globe depending upon the following methodological issues: type of prisoners studied; assessment instruments used; who does these assessments; sampling methods; current disorders vs. life time prevalence. Notwithstanding these, one fact remains viz: In prisons, morbidity from depressive disorders is substantial when compared to that in the general population. The finding that significantly more UTPs and female prisoners had 'current' major depressive disorders is

also an expected one. Data from the general population unmistakably shows higher rates of depression among females (Isaac and Gururaj, 2004). International studies also reveal higher rates of depressive disorders among prisoners in local jails (which are locally operated correctional facilities that receive offenders after an arrest and hold them for shorter periods of time, pending trial or sentencing) Moreover, local jails hold inmates sentenced to short terms (James and Glaze, 2006). Prisoners in these types of jails can be conceptualised to be similar to UTPs in our jails. This trend was not observed with dysthymia which had a prevalence of 2.8% among the UTPs and 3.3% among the CTPs ($p=0.4$). Similar rates of dysthymia have been reported from Assadi et al, (2006).

In summary, the depressive disorders are amongst the most commonly prevalent illnesses among the prison population. Considering that this is one of the most disabling yet easily manageable disorders, no efforts should be spared towards identifying and treating them. Depression causes a lot of suffering as well as long-term adverse consequences if left untreated. Prevalence rates of depressive disorders in the prison population are high globally, and the Bangalore Prison study also highlights this finding. Sadly, depression is hardly ever recognised and managed in prison settings. It is important to train prison staff in the early recognition and counselling for depression, as well as establish an efficient network with mental health professionals for its effective treatment.

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6. ISSUES RELATED TO SUICIDE IN PRISONS

Suicide in prison is a tragic event that can unsettle both inmates and staff for a considerable length of time (Hill, 2004). Suicide remains a leading cause of death in prisons across the globe. It is the third largest cause of death in the US jails. Although the definitive rate of suicide is not known, estimates range from 18-188 per 100,000 population. Prison suicide rates are nine to fourteen times higher than that of the general population. Hanging and medicine overdose are the most common methods of suicide in prisons. The study of prison suicides has increased considerably since the past three decades (Goss et al., 2002; Daniel et al., 2006). A combination of institutional factors, individual vulnerabilities and poor coping skills has been consistently found to increase suicide risk among prisoners. These elements have been well documented in suicide prevention practices (Stuart, 2003). This chapter will present a glimpse of the findings on the prevalence and the causative factors identified from these studies and focus on the prevention mechanisms that need to be put in place in prisons.

Global prevalence of suicide in prisons

Anderson (2004), in his seminal paper on psychiatric morbidity in prison populations, reviewed 11 studies across the globe on prison suicides. He concludes that there is a massive overrepresentation of suicides in prisons. The very first phase of imprisonment, early phase of long-term sentences, history of psychiatric illness, history of suicidal behaviour, intoxication, isolation or solitary confinement have been identified as risk factors for prison suicides. Imprisonment stress from the following sources could also explain the high incidence of suicide rates: general stress of entering the prison system, disruption of normal life and social disruption. Though the incidence of suicides has increased over time, the intervention programmes have reduced such rates.

Daniel, (2006) reviewed the literature during the past three decades on prison suicides and identified the following demographic, clinical and institutional risk factors. A) *Demographic:* being single without job or family support; young age (below 21); upper socio economic status and high degree of social and family integration before incarceration. B) *Clinical:* Psychiatric disorders such as mood, psychotic and personality disorders; family history of mental illness, drug abuse; mental states such as depression, hopelessness and anxiety; personality traits such as antisocial personality and borderline personality traits; Psychosocial stressors such as interpersonal conflicts with other

inmates, legal processes, issues related to parole; substance abuse especially opiate abuse; medical conditions such as HIV infection, intractably painful conditions and epilepsy. C) *Institutional factors:* first 24-48 hours of confinement; overcrowded and short staffed prisons; maximum security facilities. Based on this review, he outlines that suicide-prevention programmes should incorporate comprehensive mental health services and structured psychiatric delivery system supported by the administration.

Frottier et al, (2002) have shown the relationship between suicide risk and the duration of incarceration. Using sophisticated statistical methods, they arrived at three different periods of high suicide risk: immediately after admission and 2 months thereafter for under-trial prisoners. The risk correlated with the length of the sentence.

Suicides are frequent in prisoners (Weinstein, 1989). Higher rates of psychiatric disorders among the prisoners contribute towards this high risk. Majority of prisoners who commit suicide have a treatable psychiatric illness, many of them communicate their intent before they succeed in their attempt. Rates of completed suicides among inmates with past histories of attempts are 100 times the rate in the general population (Durand et al., 1995).

A study by Durand et al, (1995) examined factors that increase the risk of suicide in a representative jail in Detroit. Over a period of 25 years, there were 37 suicides. Inmates charged with manslaughter and murders were 19 times more likely to commit suicide than were prisoners with other charges. All suicides were by hanging and most occurred at night within 31 days of admission into the prison. Many of the victims had made previous suicide attempts while incarcerated. The authors concluded that the important risk factor in jail suicide was the charge of murder or manslaughter.

Suicide may be another consequence of putting seriously mentally ill individuals in prisons. New York State data, collected between 1977 and 1982 revealed that 50% of all suicide victims were previously hospitalised for mental disorders. Another study found that more than 75% of suicide attempters had past histories of mental illness and treatment (Torrey, 1995).

Shaw et al. (2004) described the clinical and social circumstances of all self-inflicted deaths in prisons in England and Wales between January 1999 and December 2000. Information was collected from the prison governors and prison health care staff. A total of 172 suicides occurred during that period. 85 (49%; 95% CI 42-57) were remand

prisoners; 55(32%; 95% CI 25-39) suicides occurred within the first week of imprisonment; 159 (92%; 95% CI 88-96) prisoners committed suicide; 110 (72%; 95% CI 65-79) had history of mental illnesses. 89 (57%; 95% CI 49-64) had symptoms of mental illness at the time of entry into the prison. They concluded that suicide prevention measures should be concentrated in the period immediately following entry and also that potential ligature points from cells should be removed.

Fruhwald and Frottier, (2005) demonstrated significant increases in suicide rates in correctional systems over the preceding two decades in Austria. They argue that this increase could be explained by the phenomenon of 'new era institutionalisation' which is a negative consequence of the shift of care from psychiatric hospitals to community-based services: Most disadvantaged patients will not be able to cope with the new situation and eventually enter the correctional system. They note that prisoners should to be assessed for suicidal risk immediately upon entry into the system using simple screening instruments so that preventive measures could be implemented. The gap between scientific knowledge and preventive strategies and the need for further research has also been stressed.

Blaauw et al, (2005) reviewed 19 studies and identified demographic, criminal characteristics and psychiatric risk factors for suicide inside correctional settings. The following factors were identified: age 40+, homelessness, history of psychiatric care, history of drug abuse, prior incarceration, violent offences and history of suicidal attempts. Past history of psychiatric care had the maximum odds ratio [10.98; 95% CI=4.59-26.40]. They opined that these indicators are easy to identify, unambiguous, require no special knowledge from the assessor, may be useful for categorizing inmates who need further specialist assessment and intervention. Segregation housing (Bonner, 2006) has an independent association with suicidal ideation.

WHO, (1994) defines para-suicide as an act with non-fatal outcome, in which an individual deliberately initiates a behaviour that, without intervention from others, will cause self-harm. This behaviour includes attempted suicide and non-repetitive self-harm. Although para-suicide, by definition, is nonfatal, it has the potential of being fatal. Parasuicide is often used as an indicator of suicidal risk. These behaviours are highly recurrent and up-to seven percent will die by suicide within the next decade. Moreover, a history of parasuicide increases the risk of suicide by 40 times than that in the general population (Black et al., 2007). This conclusion is supported by a recent review (Daniel, 2006) that states that 45-60% of inmates who commit suicide have attempted it before. Of

those with a history of prior attempts and who eventually complete suicide, majority use lethal methods such as hanging, immolation, swallowing sharp objects and drug overdose.

A study by Black et al, (2007) used a cross-sectional design to examine the association between mental illnesses and parasuicides in a sample of male prisoners in UK (n=51). They found that the unadjusted odds ratio for having a self-reported history of parasuicide was 15.6(95% C.I=2.96-82.16). After adjusting for age, homelessness, living alone, drug and alcohol problems, the odds ratio was 11.32(95% C.I=1.80-71.13). They concluded that their study provided good evidence of an association between history of mental health problems and a history of parasuicide in a group of male prisoners in UK.

Fruehwald et al, (2006) conducted a methodologically sound case-control study to investigate risk factors for prison suicides. For each suicide that occurred in any of the Austrian correctional institutions between 1975 and 1999, two controls that matched for correctional institution, gender, nationality, age, custodial status and time of admission were chosen. Past suicidal behaviour, criminal histories, current psychiatric histories were compared. The most important predictors for pre-trial prisoners were, a past history of suicidality, psychiatric diagnosis, psychotropic medication, violent index offence and solitary confinement. For sentenced offenders, the most important predictors were psychiatric diagnosis, solitary confinement, past suicidal attempts, last offence of a highly violent nature and psychiatric medication prescribed while in custody.

As part of an effort to improve an already existing suicide prevention programme in Washington prisons, a quality improvement committee was formed in the department of adult and juvenile detention. From the data that ensued, Goss et al, (2008) reported on the characteristics of suicide attempts. First time suicide attempts were studied among inmates over a 33-month period. The prevalence of mental illness among first time attempters was 77 % compared with 15% in the general jail population.

Jenkins et al, (2005) analysed the prevalence of suicidal ideation and suicide attempts in the National Prison Survey of the UK, and their association with the presence of psychiatric disorders. These data were compared with data from a national survey of psychiatric morbidity in adults living at home. Both surveys used a two phased interviewing procedure covering general health, mental health, activities of daily living, socio-demographic data, substance abuse, life events, substance use and intelligence. Suicidal behaviours were commoner in prisons than in the general population and these

were significantly associated with various psychiatric disorders. In addition, demographic factors such as being young, single, school drop outs, poor social supports and social adversities were important factors for suicidal thoughts. The following were the adjusted odds ratios (95% confidence intervals) for selective variables: moderate lack of social support- 1.37(1.02-1.86); female gender-1.91(1.43-2.56); 16-20 years of age-3.00(1.80-4.98); remand prisoner-1.56(1.20-2.02); depressive episode-1.68(1.2-2.35); psychosis-4.87(3.53-6.72); personality disorder-1.98(1.26-3.11). All values were statistically significant at $p \leq 0.05$.

Patterson and Hughes (2008) reviewed all 154 suicides that occurred in California prisons between the periods 1999 and 2004 and examined several factors related to the suicide. Among the prisoners who committed suicide during this period, 149 (97%) were males and 73 (47%) were aged between 31-40 years. The methods utilised by prisoners included hanging (n=131; 85%), lacerations (n=5; 3%), drug overdose (n=5; 3%) and others (n=9; 6%). 87(56%) had mental illnesses. They concluded that although suicide is not predictable, there could be clues to recognise inmates at elevated risk and identify some of the health care practices and conditions of confinement to consider for provision of adequate suicide prevention programmes.

Suicide Prevention Programmes in Prisons

The American Correctional Association (ACA) has developed suicide prevention standards that require the following (Bonner, 2000):

- A written policy and procedures to ensure that all special management inmates are directly observed at least every 30 minutes
- More frequent observation for inmates who are violent or have a mental illness than for inmates who are not violent and do not have a mental illness
- Continual observation for actively suicidal inmates
- A written suicide prevention programme that has been approved by mental health professionals
- Training for all correctional staff in suicide prevention and intervention programme
- Intake screening, identification and supervision of inmates who are prone to suicide

Like the ACA, the National Commission on Correctional Health Care (NCCHC) standards of the US requires a written suicide prevention plan. Essential components of such a programme include (Hill, 2004):

- Identification through screening
- Training the staff
- Assessment by a qualified mental health professional
- Monitoring inside the facilities
- Housing: Suicide inmates should not be isolated unless under constant supervision
- Referral
- Effective communication between the correctional and health staff about an inmate's status
- Intervention: Staff should develop procedures on how to handle a suicide attempt in progress
- Notification: Development of procedures for notifying family, prison administrators and other authorities regarding potential, attempted or completed suicides
- Reporting: Staff should document in detail all potential, attempted or completed suicides
- Review: The facility should perform administrative and medical reviews of completed suicides.

NCCHC also provides recommendations for the assessment, housing and observation of suicidal prisoners through a level system that allows for a more individualised approach to the problem of suicidal potential and behaviour. Similarly, the Federal Bureau of Prisons' Five-step programme for suicide prevention (of the US) includes:

- The initial screening of all inmates for suicidal potential
- Criteria for the treatment and housing of suicidal inmates
- Standardised record keeping, follow-up procedures, and collection of data relevant to suicides
- Staff training
- Periodic reviews and audits

After the implementation of these procedures, research has documented a considerable decrease in suicidal rates in US prisons (Hill, 2004).

Hall and Gabor (2004) examined an innovative suicide prevention programme in cannada in which prison inmates acted as volunteers to identify and refer individuals with suicidal risk. Peer volunteers were trained in issues of befriending, effective and active listening, non-verbal communications, schizophrenia, bipolar disorder, depression, suicide prevention and suicide intervention. These volunteers were expected to have a minimum of 200 people utilise the service per year. After establishing contacts with suicidal inmates, they were supposed to assess the risk and make appropriate referrals. At the end of three years of this programme, the volunteers had exceeded their target number of contacts by 27%. Since the absolute numbers of completed suicides was very low in the institute where the study was carried out, no statistical comparisons were possible though they demonstrated numerical reductions in the number of completed suicides.

In contrast to the enormous literature about completed suicides, para-suicide has not received much attention. The Indian scenario is even worse. To our knowledge, we did not find any study that had examined prison suicides.

Findings from the Bangalore Prison Study

The Bangalore Prison Mental Health study (Math et al., 2011) carried out a secondary data analysis of the prison records examining the details of completed suicides. There were 6 completed suicides during the years 2008 (six out of thirty-eight total deaths) as well as 2009 (six out of thirty total deaths). Suicide rate was 119 per 1,00,000 for each of the years considering the prison population to be 5024.

Table 1 shows the details of suicidal/DSH attempts. Table 2 shows details of the current suicidal risk based on the MINI scoring. 290 inmates with suicidal risk (defined as those with MINI Suicidality score of at least one) were compared with the rest of the sample with the aim of knowing correlates of suicidal ideation. 5.8 percent of inmates had a current suicidal risk. Details of this are given in Table 3.

The commonest method of suicidal attempt among suicide attempters was consuming organophosphorous compounds (68% of UTPs and 46% of CTPs). Deliberate self-harm methods among those that attempted DSH was mainly by making cuts on the hand (65% UTPs and 10% CTPs) and slashing the face (27% UTPs and 17% CTPs).

Table 1. Details of suicidal/DSH attempts

	UTPs	CTPs	df/chi-square	p-value
Suicide attempt-life time *				
Total number of inmates[@]	3822	1195	NA	NA
[n(%)]	65(1.7)	13(1.1)	2.23	0.1
Persons who have attempted DSH-lifetime [n(%)] *				
Total number of inmates[@]	3823	1195	NA	NA
Total number	111(2.9)	18(1.5)	7.09	<0.01
Number before coming to prison	85(2.2)	10(0.8)	9.43	<0.01
Number after coming to prison	58(1.5)	10(0.8)	3.16	0.05
DSH/Current suicidality [mean (SD)]				
MINI score^	16.67(14.2)	16.57(12.5)	288	0.1
Total number of DSH attempts	4.96(7.1)	2.63(1.96)	126	0.2
DSH attempts before coming to prison	4.68(7.6)	2.50(1.3)	93	0.4
DSH attempts after coming to prison	2.78(3.3)	1.60(0.8)	66	0.3

Source: Math et al., 2011

NA-Not applicable;
DSH-deliberate self harm;
UTP-under-trial prisoner;
CTP-convicted prisoner;
* Figures are for a minimum of one attempt;
[@] information available for these many inmates;
MINI-Mini International Neuropsychiatric Interview;
^ scores are for 290 patients who displayed suicidal ideation at the time of assessment.

Between 45-63 percent of suicide victims would have had past history of attempts (Daniel, 2006; Anderson 2004). Hence it is vital to identify and intervene in persons who harbor suicidal risk. In the Bangalore Prison study, a total of 5.8% of inmates harboured current suicidal risk. In comparison with those who did not harbour such risk, these individuals were slightly older; had no spouses ($p<0.001$); had significantly more past suicidal attempts ($p<0.001$) and psychiatric disorders ($p<0.001$). Moreover, UTPs were significantly more likely to have suicidal risk when compared to the CTPs ($p<0.001$).

Table 2. Current suicidal risk based on the MINI scoring [n (%)]

Suicide Risk	UTPs	CTPs	df/chi-square	p-value
Total number of inmates*	3827	1197	N/A	N/A
Low	41 (1.1)	03(0.3)	8.38	0.06
Moderate	121(3.2)	36(3.0)		
High	72(1.9)	17(1.4)		
Total	234(6.1)	56(4.7)	N/A	N/A

Source: Math et al., 2011

NA-Not applicable; UTP-under-trial prisoner; CTP-convicted prisoner; MINI-Mini International Neuropsychiatric Interview; * information available for these many inmates.

Table 3. Comparison of prisoners with suicidal risk present and absent

Variables	Suicidal risk present (n=290)	Suicidal risk absent (n=4722)	df/chi-square	p-value
Mean (SD) age in years	31.7(12.0)	30.6(10.4)	5010	0.08
Mean(SD) years of education	5.8(4.8)	6.2(4.7)	5005	0.2
Mean(SD) number of prior attempts	1.7(4.7)	0.02(0.4)	5009	<0.001
Males [n(%)]	274(94.5)	4536(96.1)	3.1	0.2
Single/widowed/divorced [n(%)]	165(56.9)	2554(54.1)	30.5	<0.001
Under trial prisoners [n(%)]	234(80.7)	3583(75.9)	3.5	0.06
Any mental disorder [n(%)]	276(95.8)	3723(79.0)	48.0	<0.001

Source: Math et al., 2011

Bangalore Prison Study essentially confirmed the findings regarding prison suicides. The rates are exceedingly high when compared to those of the general population. Compared to the national average of 10.8 suicides per 1,00,000 population (National Crime Records Bureau, 2008), Bangalore prison study found a rate of 119 per 1,00,000 which is eleven times higher. Moreover, this figure is comparable to many of the international findings which show similar rates (Daniel, 2006).

Many of the following factors might have led to such high suicide rates: expression of mental suffering, despair, axis-I mental disorders including substance abuse, personality disorders, individual coping styles and institutional factors such as stress due to imprisonment, delay in trial and injustice. Since psychological autopsies were not conducted, exact reasons or methods for suicides cannot be commented upon. Needless to say, thorough reviews of all prison deaths (including suicides) should form an essential part of the prison health care delivery system.

The findings with respect to deliberate self-harm are also comparable to the findings from the western literature (Daniel, 2006). These are the persons who need to be targeted through suicide prevention programmes. Identification of suicidal risk should be part of the intake medical examinations. In this context, it is noteworthy that risk factors for suicide can be easily identified by non-specialists using simple checklists (Hill, 2004). Moreover, inmate volunteers have been successfully used in prison suicide prevention programmes (Hall and Gabor, 2004).

In conclusion, while individuals end up in prison as a result of going against a legal system, prisons should be an opportunity that would help them reform themselves and get back to the mainstream in society. However the deplorable conditions in prisons only adds to the negativity and enhances the sense of hopelessness that contributes to individuals' choosing the biggest escape route by taking their own lives. Preventive mechanisms should not stop only at the identification of high risk individuals for suicide and intervening with them, but rather focus more broadly on positioning prisons as reformative centres in the true sense of the term so that individuals are motivated to change and can hope to a second chance of a normal life style.

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7. PERSONALITY DISORDERS WITH SERIOUS IMPLICATIONS IN PRISONS

Are people who commit crimes different from those who do not? How are they deviant? What are the social and economic factors that influence these behaviours? Are the stressful situations they face very unlike what others face? These are the common questions which come up. Answers to these questions can be provided from various perspectives. *A sociological perspective* might look at factors like discrimination; role of media; illiteracy; law and order in the society etc., *An economic perspective* would focus more on aspects like poverty, scarcity of resources; rise in prices etc., *A psychological perspective* would be from internal factors such as personality, temperament, emotions, greed, jealousy and impulsivity of a person. While sociological and economic factors have been studied in depth, factors such as personality and temperament have not got much attention. This chapter looks at criminal and deviant behaviour as a product of dysfunctional personality and focuses more on problematic personality disorders in prisons and how they can be managed.

Personality

Everyone in this world has their distinctive personality that makes them unique. There are many definitions of personality. In simple words, personality consists of ingrained, pervasive, enduring and habitual ways of psychological functioning that characterise one's style. It is a tightly interrelated organisation of attitudes, perceptions, habits, emotions and behaviours that characterise a person's distinctive way of relating to others and to self (Millon, 1981; Millon, 1987). Each person has a unique personality moulded by his/her past experiences, attitude, culture, religion, lifestyle, mood, relationships, energy levels and hobbies. Normal personalities are productive at work, well-adjusted socially, cope well with stressful situations and operate well within the social and cultural norms. Similar to personality, 'temperament' does not have a consensual definition. A temperament refers to a distinctive profile of feelings and behaviours, rooted in biological systems and emotion is basic to temperament (Rothbart, 1989; Goldsmith et al., 1987). Personality is made up of a combination of distinguishing qualities and characteristics called traits. Traits refer to a distinctive set of attributes such as thinking, feeling, attitude and behaviour.

Personality Disorders

The combined and consistent patterns of emotion, thought and behaviour that make an individual unique comprise personality. However, when this pattern interferes and impairs the day to day functioning of the individual, it is referred to as "personality disorder" (Hales et al., 2008). In other words, they are patterns of inflexible and maladaptive personality traits and enduring behaviours that cause subjective distress, significant impairment in social or occupational functioning, or both (American Psychiatric Association, 2000). These patterns deviate markedly from the culturally expected and accepted range and are manifest in two or more of the following areas: cognition, affectivity, control over impulses and need for gratification, and ways of relating to others (American Psychiatric Association, 2000; Hales et al., 2008). The symptoms are pervasive and they are exhibited across a broad range of contexts and situations rather than in only one specific triggering situation or in response to a particular stimulus or person. Finally, the patterns must have been stably present and enduring, since adolescence or early adulthood (American Psychiatric Association, 2000).

According to the International Classification of Diseases -10 guidelines, "personality disorders are deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent either extreme of significant deviations from the way the average individual in a given culture perceives, thinks, feels and particularly relates to others. Such behaviour patterns tend to be stable and encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance (World Health Organization, 1992). People with personality disorders believe that the world should change to accommodate them and view their own features as being acceptable and not in need to change.

People with personality disorder constitute up to 10-15% of the general population (Torgersen et al., 2001; Reich et al., 1989). They are the frequent visitors to the emergency departments at hospitals , as a result of social crises, relationship breakup, violence, injuries, self-injurious behavior, suicide, over intake of drugs, impulsivity and sudden violent death (Warren et al., 2002; Verona et al., 2001; Watzke et al., 2006). They are also at a high risk of getting into conflict with the law because of self-injurious behavior, sexual offences, violence, substance use, murder and recidivism (Dunsieth et

al., 2004; Watzke et al., 2006; Black et al., 2007). As per the International Classification of Diseases, there are ten different types of personality disorders seen in the general population. However, there are many people with temperamental problems within the general population, which is also reflected in the prison population. In this chapter, we focus more on problematic personality disorders, which are commonly seen in prison population and are very difficult to manage.

Prison populations are known to house certain personality disorders

The common saying about prison is that it houses the 'SAD, MAD and BAD' of the society (Rotter et al., 2002). ***Sad*** indicates that at least 50-75% of the prison population suffer from depression, ***Mad*** depicts that at least 30-15% of them have mental illness and ***Bad*** suggests that 20-10% of them are psychopaths (Rotter et al., 2002). Persons suffering from personality disorders have their reasoning powers fully intact; hence none of the countries have granted insanity defence to those with personality disorders. However, they have been provided with an opportunity for treatment and rehabilitation.

Prevalence of personality disorders is high in prison population when compared to the general population (Brink, 2005; Andersen, 2004; Butler et al., 2006). In a systematic review of 62 surveys, it was reported that 65% of the men had personality disorders with 47% having anti-social personality disorder. 42% of the women had personality disorder and 21% had anti-social personality disorder (Fazel and Danesh, 2002). In another study, prevalence of alcohol and drug addiction was 90%, personality disorders were 80% and antisocial personality disorder was 60% (Langeveld and Melhus, 2004).

In a recent study, personality disorder was observed in 30% of the prison inmates. The distribution of personality disorders was as follows; 12% with Antisocial Disorder, 12% with Borderline Disorder, 3% with Paranoid Disorder, 2% with Narcissistic Disorder, and 2% and Schizoid disorder (Arroyo and Ortega, 2009). Presence of anti-social personality disorder is a high risk for developing mental illness (Andersen, 2004) and suicide (Verona et al., 2001). Studies have reported that 50% of the mentally ill patients also have personality disorder. Men had a higher prevalence of alcohol abuse and antisocial personality, while women more often showed depression, anxiety disorders and borderline personality disorders (Watzke et al., 2006).

Emotionally unstable personality disorder was present in 30% of the inmates. The percentage of women meeting criteria for borderline personality disorder was more than

twice that of men (Black et al., 2007). A more recent study reported that personality disorders, especially antisocial and unstable personality disorders are strongly related to the manifestation of violent acts (Fountoulakis et al., 2008). One of the possible reasons being that both disorders have a common base in impulsive personality traits, but the behavioural differences between them are shaped by gender(Paris, 1997). Prevalence of antisocial personality is more common in men and unstable personality is more common in women.

Anti-social personality disorder

Anti-social personality, usually comes to attention because of a gross disparity between the individual's behaviour and the prevailing social norms. Characteristics of Antisocial personality disorder are as follows:

Characteristics of Anti-Social Personality Disorder

(a) Callous unconcern for the feelings of others;
(b) Disregard for social norms, rules and obligations;
(c) Gross and persistent attitude of irresponsibility;
(d) Inability to maintain enduring relationships, though having no difficulty in establishing them;
(e) Very low tolerance to frustration and a low threshold for discharge of aggression, including violence;
(f) Inability to experience guilt or to profit from experience, particularly punishment;
(g) Marked proneness to blame others, or to offer plausible rationalisations for the behaviour that has brought the patient into conflict with society.

Includes: amoral, dissocial, psychopathic, and sociopathic personality

Source: World Health Organization, 1992

Conduct disorder during childhood and adolescence, though not invariably present, may further support the diagnosis. An Iranian study reported that 23% of the prison population were 'psychopaths' (Assadi et al., 2006). Antisocial personality disorder is associated

with substance use, gambling, depression, self-injurious behavior, suicide and poor quality of life (Black et al., 2010).

Systematically conducted study from India reported that thirteen for every hundred prisoners could be diagnosed as having a conduct disorder in childhood and UTPs were significantly more likely to have received this diagnosis compared to CTPs. Nearly fifteen for every 100 UTPs received a diagnosis of antisocial personality disorder. This is 7-8 times more than the general population (Math et al., 2011).

Antisocial personality disorder does not manifest out of the blue. It can be traced back to difficult behaviours in childhood and adolescence, in the form of externalising disorders (characterised by impulsivity, attentional deficits, negative and defiant attitudes to authority, conduct problems which include violation of social norms and an inability to learn from past experience). The disorder is attributed to a combination of genetic vulnerability, temperament, subtle brain dysfunction, learning difficulties and environmental adversity.

Antisocial personality and psychopaths are almost the same in terms of callousness, breaking rules, irresponsible, low frustration tolerance, lack of remorse and inability to learn from past experience (Coid and Ullrich, 2010). However, there are researchers who argue that they differ in the severity of the antisocial behaviour. Psychopaths form the most severe form of antisocial personality. They are characterised by low anxiety, egocentricity, selfishness, violent behaviour, sexual aggression, promiscuousness, high pleasure seeking and lack of emotional regulation. They deceive, manipulate, smart and destroy the lives of others for their gratification. Persons suffering from antisocial personality disorders are very difficult to treat. Most of these individuals are referred for treatment by the judiciary. However treatment options in our prison systems are poor to nonexistent. Once they understand the prison system and mental health service, they manipulate the system using several techniques, include malingering. There are high chances that they will be placed in forensic mental hospitals rather than in prisons. Such facilities are non-existent in India. Till date no medicine or therapy has been found to be effective. Recidivism continues to be high in this population because of the key personality characteristic that they do not learn from past experiences.

Emotionally unstable personality disorders

This personality is more common among young women. People with this personality often have difficulty in forming and maintaining long lasting relationships and can be particularly vulnerable for impulsive and aggressive acts such as self-harm, suicide, wrist slashing and so forth. There is a marked tendency to act impulsively without consideration of the consequences, together with mood instability. The ability to plan ahead may be minimal. Outbursts of intense anger may often lead to violence or "behavioural explosions". Two variants of this personality disorder are specified, and both share this general theme of impulsiveness and lack of self-control.

Characteristics of Emotionally Unstable Personality Disorder

There are two variants of emotionally unstable personality.

Impulsive type characterised by:

- Impulsivity
- Emotional/mood instability
- Inability to plan ahead
- Outbursts of violence or threatening behaviour which are common particularly in response to criticism by others.

Borderline type characterised by:

- Often unclear or disturbed self-image, aims, and internal preferences
- Chronic feelings of emptiness.
- Series of suicidal threats or acts of self-harm
- Liability to become involved in intense and unstable relationships
- Repeated emotional crises and may be associated with excessive efforts to avoid abandonment

Source: World Health Organization, 1992

Clinical signs of the disorder include emotional dysregulation, impulsive aggression, repeated self-injury, and chronic suicidal tendencies, which make these patients frequent users of mental-health resources.

Management of personality disorders

The behaviour management plan presented here is a guideline to address the issues of personality problems in prisons. The population with personality disorder pose a big challenge to any correctional and mental health staff. They tend to take up a huge amount of time and resources. Working with offenders with personality disorders can be emotionally very draining and stressful. The reasoning power of those with personality disorder is well preserved; hence treating them against their will is not recommended. However, treatment for personality disorder against their will is advocated with the permission of the court, in certain conditions where the individual is dangerous to self and/or others. The best policy is to work in partnership with people with personality disorder and help them develop their autonomy and promote choice by ensuring they remain actively involved in finding solutions to their problems, including during crises and encouraging them to consider the different treatment options and life choices available to them, and the consequences of the choices they make (NICE, 2009).

Treatment for any comorbid disorders should happen regardless of whether the person is receiving treatment for personality disorder or not. For, example a prisoner with personality disorder using alcohol and cannabis on a daily basis needs to undergo de-addiction before the personality disorder is addressed. Developing a good patient and doctor relationship is a crucial part of the individual therapy. A recent literature review to know the effect of personality disorder on mental illness revealed that the presence of a personality disorder is a poor predictor for response to treatment of mental disorders (Bieling et al., 2007).

The prison behaviour management plan consists of six essential elements:

1. Assessing the risks and needs of each inmate at various points during his or her detention.
2. Assigning inmates to housing.
3. Meeting basic needs of the inmates.
4. Defining and conveying expectations for inmate behaviour.
5. Supervising inmates.
6. Keeping inmates occupied with productive activities

Source: Hutchinson et al., 2009

Implementing a prison behaviour management plan requires clear directives, in the form of written policies and procedures for each step of the plan. Availability of trained staff and supervising them to ensure that the plan is implemented according to the adapted policies and procedures is crucial. Systematic documentation and recordkeeping of all activities related to the prisoner's behaviour management plan is necessary (Hutchinson et al., 2009). Another essential area that is required to be addressed is needs of the staff to be trained in crisis management.

People with personality disorders are at high risk for pressing panic buttons for crisis management. Each staff in prison needs to be trained to face the challenges of crisis management. Following are the broader aspects to be considered during a crisis situation.

Skills required in crisis management

- ✓ Ensure your safety first, before you intervene
- ✓ Quick response is the key
- ✓ Maintain a calm, relaxed and concerned look
- ✓ Use of non-threatening attitude and posture
- ✓ Investigate the reason for crisis quickly
- ✓ Try to understand the crisis from the prisoner's point of view (empathy)
- ✓ Use open ended questions during the interview
- ✓ Use counselling skills to calm the patient down
- ✓ Avoid blaming or scolding
- ✓ Avoid instigating them
- ✓ Refrain from offering solutions before receiving full clarification of the problems and know your limitation and explain them
- ✓ Provide support and short-term help until medical team/ appropriate crisis team is available
- ✓ Documentation of the incident and action taken is also essential for legal purpose

Source: Modified and adapted from Chandrashekar et al., 2007

Management of antisocial personality disorder

Individuals with antisocial personality disorder rarely seek psychiatric help for the disorder. These individuals who seek care do so for other problems such as injuries, sexually transmitted diseases, demanding sleeping medicines, alcohol or drug abuse, and suicidal thoughts. Usually, the court or the prison staff refers them to a mental health counsellor for evaluation. They lack insight into their problems. They also reject the diagnosis and help offered. Often they use these opportunities to complain against the medical officers for wrong diagnosis or else manipulate transfers to better inpatient medical facilities. Hence, antisocial personalities who seek help (or are referred) can be offered evaluation and treatment as outpatients. Inpatient care needs to evaluated and considered if there are suicidal ideas/attempts. In fact, people with antisocial personality can be disruptive in inpatient units, whenever their demands are not met. These personalities go to any extent to manipulate the environment including deliberate self-harm (wrist cutting). There are incidents when antisocial prisoners have lost their life by suicide.

To date, there is no treatment available. The failure to cure or even treat such individuals has divided the medical and legal communities, as well as society in general. They are known to manipulate the situations, be litigious and bear grudges. They are well known to split the staff by complaining to one staff against the other. Generally, complaints received by these individuals against the staff are of malicious intent. Hence, such complaints need to be thoroughly verified and investigated before proceeding against the staff.

Though there is no cure for this disorder, it is crucial to identify and manage these individuals inside the prison to ensure that they do not create trouble for others in the prison. A large part of the problems inside the prison are attributable to this group. Staff should learn to handle these prisoners. These prisoners do well in structured and high-security prisons. However, psychotropic medicines are found to be very useful in emergency and certain inevitable situations such as violence, aggression, suicide, deliberate self-harm, demanding behaviours and illicit drug intoxication related abnormal behaviour. The medicines are also useful to decrease their aggression in the long run.

Treatment for any comorbid disorders should be given regardless of whether the person is receiving treatment for antisocial personality disorder or not, because such people are often excluded from routine care (Black et al., 2010). Suicidal threats and deliberate self-

harm are very common in prison population. The tendency to rationalise irresponsible acts, minimise the consequences of these acts, violence and manipulative behaviour, needs to be confronted on a daily and immediate basis. Close supervision with structured activity have been recommended. The most effective treatment may at times be simply to consider high-security prisons. Many antisocial behaviours do tend to dissipate (or burnout) with time (Kay and Tasman, 2006; Frosch, 1983). There are studies done in the community which reported that cognitive behaviour therapy for violent men with antisocial personality disorder in the community did not show any improvement (Davidson et al., 2009).

Various countries have adopted different policies to manage prisoners with antisocial personality disorder. Majority of these policies are an immediate aftermath of certain incidents. In 1998, England was shocked by the apparently motiveless murders of a mother and two of her children by a person with personality disorder. He was convicted of their murders. Later, the government was determined to prevent this type of offence from recurring. Hence, in 1999 the UK government introduced a new concept called dangerous and severe personality disorder (DSPD). DSPD is a highly contentious concept and is not a medical diagnosis; it refers to the perceived levels of dangerousness of the individual to the society or to others. DSPD unit has subsequently become a treatment and assessment programme for individuals who satisfy three requirements: (1) have a severe disorder of personality, (2) present a significant risk of causing serious physical or psychological harm from which the victim would find it difficult or impossible to recover, and (3) the risk of offending should be functionally linked to the personality disorder (Maden and Tyrer, 2003). Later, the UK government proposed a preventive detention programme to those with dangerous and severe personality disorder (Kendell, 2002).

To manage these individuals, various countries have adopted closed monitoring systems such as ‘supermax prisons’ or ‘special housing units’ (Pizarro and Narag 2008, Mears 2008). Supermax prisons are those with high level of security with electronically operated doors, surveillance cameras, and no windows. Visitors are also not allowed inside (Mears and Castro 2006). A special housing unit is a solitary confinement of the prisoners in a closed room without windows and they are generally allowed out of their cells for only one hour a day. These are managed by using proper protocol and for limited periods only (Mears 2008). However, these kinds of settings are often misused by the prison authorities and also very costly to maintain such prisons (Pizarro and Narag 2008, Mears 2008). Certain individuals with antisocial personality disorder with severe violence and

aggressive tendency need isolation. But the need for continuing to keep them in such settings needs to be assessed periodically by risk assessment and the decision needs to taken by a group of professionals such as representative of a judiciary, prison administration, medical staff, and social worker so that human rights violations are monitored closely. This needs to be documented. Finally, management of prisoners with antisocial personality should be focused on providing symptomatic relief and clear guidelines about expected behavior from them in prison. However, there is an urgent need to do research to answer, whether supermax prions are warranted, effective, or efficient in Indian settings.

Management of emotionally unstable (Borderline) personality disorder

Borderline personality disorder is characterised by a pervasive pattern of instability in affect regulation, impulse control, interpersonal relationships, and self-image. Mood disorders, substance-related disorders, eating disorders (usually Bulimia), posttraumatic stress disorder, attention-deficit/hyperactivity disorder, suicide, deliberate self-harm and other personality disorders frequently co-occur with this disorder (Lieb et al., 2004; Zanarini et al., 1998; Gunderson and Ridolfi, 2001; Paris, 2005; NICE, 2009). On comparing individuals with antisocial personality disorders with those with emotionally unstable personality disorder, it has been found that in case of the latter, patients improve with time. There is an evidence base for treatment using both psychotherapy and psychopharmacology in emotionally unstable personalities (Paris, 2005; NICE, 2009).

Dialectical behaviour therapy, cognitive behaviour therapy, interpersonal therapy, systems training for emotional predictability and problem solving (STEPPS) programmes are effective treatments. Psychotropic medications are effective in treating emotional, impulsive, mood swings and depressive symptoms that frequently are associated with borderline disorder. Medicines can reduce depression, anxiety, and impulsive aggression but need to be used judiciously used and supervised. (Lieb et al., 2004; Paris 2005; American Psychiatric Association, 2001).

Suicidal threats and deliberate self-harm are very common in prisoners with emotionally unstable personality (Gunderson and Ridolfi, 2001). There is a need to sensitise staff about the suicide threats. There are incidents when prison staff has challenged the prisoner's suicidal ideas or threats by saying 'your suicidal threats are just an act'. This has led to actual suicidal attempt by the prisoners. There is an urgent need to implement

suicide prevention strategies inside the prison. Staff needs to be trained in handling these prisoners.

Personality disorders are a common form of mental health problems seen in prisons. Managing antisocial personality disorder and emotionally unstable personality in prison is a challenge to any staff and mental health team. The prison administration should be aware of the symptoms of these personality disorders. Antisocial personality disorders do well in a highly secured and structured environment. The borderline personality disorder needs therapy. Co-morbid conditions need to be treated irrespective of the treatment status of the personality disorder. Prison staff plays a crucial role in preventing suicide. They need to be trained in managing suicide and deliberate self-harm inside the prison.

In conclusion, there are indeed certain groups of people who by virtue of their dysfunctional personality are more prone to crimes. There are those who may have committed crimes as a way of coping with stressful situations or have made an error in judgement by taking law into their hands. While in case of the former, bringing about a change in the personality while in prison might be a herculean task, in case of the latter, appropriate counselling and behavioural interventions can help by preventing the dysfunctional behaviours and thought process leading to the crime from becoming ingrained as part of the personality.

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8. COMMON MENTAL DISORDERS IN PRISONS

Common mental disorders or neurotic disorders refer to a range of mental health disorders that cause personal distress to the sufferer but can go unnoticed by an onlooker. Prisoners have a very high incidence of mental health problems, in particular neurotic disorders, compared to the general population. By the criteria proffered under the International Classification of Diseases (ICD-10), in any week, almost half the prisoners suffer from a neurotic disorder such as anxiety or depression (Brinded et al., 2001). This chapter examines the prevalence of these disorders in prisons across the globe based on the available literature and proposes interventions for these disorders in the prison settings. Table 1 presents the major categories of the common mental disorders as per the International Classification of Diseases.

Table 1. ICD – 10: F40-F48 Neurotic Disorders (major categories)

- Phobic anxiety disorders (include agoraphobia, social phobia and specific phobias)
- Other anxiety disorders (include panic disorder and generalised anxiety disorder)
- Obsessive - compulsive disorder
- Reaction to severe stress, and adjustment disorders
- Dissociative [conversion] disorders
- Somatoform disorders
- Other neurotic disorders

Prevalence of common mental disorders in prison – International Experience

A report on Health Care in Prisons Directorate of Health Care of the Prison Service in England and Wales in 1998/9 by Marshall reported that the range and frequency of physical health problems experienced by prisoners appears to be similar to that of young adults in the community. However, prisoners have a higher incidence of mental health problems, in particular, neurotic disorders, compared to the general population (Marshall et al., 1999). In male prisoners, the prevalence of any neurotic disorder in the week before the study was, 59% in remand and 40% in sentenced prisoners. In female prisoners, 76% and 63% of remanded and sentenced prisoners respectively had a neurotic disorder. In prisons, as in the community, neurotic symptoms and neurotic disorders are more common among female than the male population. The prevalence of any neurotic

disorder in the general population (the adult population resident in private households) in the community in the UK at the time of the study was12% for men and 20% for women (Marshall et al., 1999). Highlight of this study is the difference it has drawn between the remanded and sentenced prisoners.

Neurosis and character disorders in hospital and in prison were compared among male non-psychotic patients and male prisoners in respect of hostility and direction of hostility (Foulds, 1967). Prison neurotics (as defined by the Symptom-Sign Inventory) scored significantly higher on a measure of hostility and somewhat less intro-punitively than hospital neurotics, character disorders in prison and in hospital were virtually identical in respect to both aspects of hostility. Psychopaths scored much higher on mean hostility and extra punitively on the direction of hostility.

A population-based study on the rates of imprisonment in different ethnic groups, compared the criminal behaviour and psychiatric morbidity of the prisoners. Ethnic subgroups were compared in terms of the frequency of neurotic symptoms identified from the CIS–R [Clinical Interview Scale – Revised]. Few differences were found. However, Black males were less likely to report forgetfulness/loss of concentration, and South Asian males less likely to report irritability, than White males. Black women prisoners were more likely to report worries about physical health, and less likely to report anxiety, than White women prisoners. There were no differences between either Black or South Asian subgroups or White prisoners, according to gender, for an overall measure of neurotic symptoms using a CIS–R (Clinical Interview Scale – Revised) cut-off score of 12 (Coid, et al., 2002). Implications of this study could suggest that these aspects need to be considered in a diverse culture like ours.

Estimates of mental health morbidity in UK local prisons, HMP Littlehey and HMP Whitemoor, show a high prevalence of personality and neurotic disorders of 64% and 40% respectively. This translates to a heavy burden of illness, with about 723 inmates with personality disorders and 452 with neurotic disorders in the two prisons. The prevalence rates for self-harm and suicide (7%) were also high (Joint Strategic Needs Assessment 2008).

The Office of National Statistics survey1999 (ONS survey) was carried out in 131 of the 133 English and Welsh prisons. Of 51,834 remanded and sentenced males, 5% were interviewed as the initial sample. 6,500 of that sample group had personality disorders,

55% had neurotic disorders, 60% showed hazardous drinking in the year prior to incarceration and 10% had psychiatric disorders (O'Brien et al., 1997).

In a study of psychiatric disorders among prisoners in UK and Wales, a further analysis of data from the ONS survey, 1997 demonstrated that, among the neurotic disorders, the most common presentations were sleep problems and worry (not including worry about physical health), followed by fatigue, depression and irritability (O'Brien et al., 1997). While similar symptoms were found among adults in the general population, they had a markedly low prevalence compared to the prison population (Meltzer et al., 1995a and 1995b). While 28% of the women in the general population reported sleep problems, 62% of sentenced women and upto 81% of those on remand reported sleep problems. While 11% of women in the general population reported depression, 54% of women prisoners reported symptoms of depression. Obsessive symptoms panic and phobias were also significantly more common among remand prisoners. The prevalence rate for any neurotic disorder was 66% of the sample group as a whole. These rates are much higher than that found in the general household population, where the rate was 16% (Meltzer et al., 1995a).

When specific disorders were considered, the prevalence rate was higher among remand prisoners (76%) than among those who were sentenced (63%) (Singleton et al., 1998). The prevalence rate for *phobias* in the remand group was significantly higher than that for the sentenced group. Rates of *generalised anxiety disorder* and panic disorder were the same in the two groups. *Post-traumatic stress disorder* was present in over a third of the women in the sample who reported experiencing a traumatic event likely to cause pervasive distress. The proportions of each group who met all these criteria were 5% of sentenced and 9% of remand prisoners, with 6% of the sample overall considered to be suffering from post-traumatic stress. Women prisoners were about twice as likely as men to suffer from post-traumatic stress than male prisoners (Singleton et al., 1998). *Eating disorders* presented in over 6% of women in the sample who were diagnosed with anorexia. Rates for bulimia were higher, at 14% for the whole sample (15% for remand and 14% for sentenced prisoners).

Singleton et al (1998) study found that women prisoners were significantly more likely than men to suffer from a neurotic disorder, matching the trend in the general household population survey (Meltzer etal.,1995a). Whereas 59% of remand and 40% of sentenced male prisoners in England and Wales had a neurotic disorder, the corresponding figures

for women were 76% and 63%. For all six neurotic disorders (depressive episode, Generalised Anxiety Disorder, mixed anxiety and depressive disorder, phobia, Obsessive-Compulsive Disorder and panic), the prevalence rates for male remand prisoners were higher than those of their sentenced counterparts.

Another study examined psychiatric morbidity and mental health treatment needs among women in prison mother and baby units. Sixty percent of the women who took part in the study had mental disorders; 35% had diagnoses of personality disorder; none had psychotic disorders (such as schizophrenia for example); 35% had current neurotic disorders (such as depression, anxiety disorders and phobias), nearly all of whom were depressed; 13% had been drinking alcohol at hazardous levels in the year prior to imprisonment, and 36% had been abusing or were dependent on drugs in the year prior to imprisonment. None of the participants reported using alcohol or drugs in prison (Luke et al., 1999). A rare dissociative disorder characterised by nonsensical or wrong answers, other dissociative symptoms like fugue, amnesia or conversion, often with pseudohallucinations and a decreased state of consciousness. It is also called nonsense syndrome, pseudodementia, hysterical pseudodementia, prison psychosis or Ganser syndrome. It may be present among prisoners in order to gain leniency from prison or court officials. However, there are no systematic studies to explore this lesser known and unusual disorder, but it is believed to be a reaction to extreme stress**.**

Assessment of common mental disorders among prisoners in India

Very little evaluation has been carried out to assess and address common mental disorders among prisoners in India. A study commissioned by the National Commission for women in the Central Prison, Bangalore (Murthy et al., 1998), found higher rates of symptoms of common mental disorder among undertrials compared to convict prisoners. Common symptoms were, unhappiness (73% versus 43%), worrying (65% versus 29%), poor sleep and appetite (65% of undertrials).

In the recent Prison Mental Health Study (Math et al., 2011), of 197 women who were interviewed for psychiatric morbidity, 2.5% had dysthymia (minor depression), 4.6% had specific phobia, 1.5% social phobia and one person had a panic disorder. Among the entire prison population evaluated for this study (5024), lifetime and current rates of

dysthymia were 2.9% and 2.5% respectively. Prevalence of major depressive disorders was relatively higher.

Table 1: Prevalence of common mental disorders among prisoners in Central Prison, Bangalore

Disorder	Lifetime diagnosis [%]	Current diagnosis [%]
Panic disorder	1.0	0.9
Agoraphobia	0.3	0.2
Social phobia	1.8	0.6
Obsessive compulsive disorder	-	0.1
Post-traumatic stress disorder	-	0.3
Generalised anxiety disorder	-	0.3
Hypochondriasis	-	0.1
Body dysmorphic disorder	-	0.8
Somatisation	2.1	1.7
Pain disorder	-	5.4

Source: Math et al., 2011

Excessive preoccupation with bodily symptoms was seen in a substantial number of both UTP and CTP prisoners, and a lifetime and current diagnosis of somatisation was present in about 2 out of every 100 prisoners. Current diagnosis of a pain disorder was made in 272 (5.4%) prisoners. In Asian cultures, manifestation of psychological distress through physical symptoms is relatively more common than in other cultures. Individual symptoms of psychological distress have not been analysed in this study.

Interventions for common mental disorders

A synthesis of the available literature on the management of common mental disorders in prison populations suggests the following approaches in order to address these disorders effectively:

- Assessment for common mental disorders at the point of entry into prison and during imprisonment, particularly during crisis points

- Induction into prisoners needs to be phased and counselled regarding the life style, rules, regulations and rights of the prisoners
- Violence inside prison needs to be kept under check
- Prisoner education and information about common mental disorders
- Training peers and prison staff to provide support in individual and group settings
- Counselling through trained volunteers
- Non pharmacological measures to handle sleep problems, psychological symptoms of pain
- Adequate recreational activities
- Training in problem solving
- Counselling
- Family therapy
- Cognitive Behavior Therapy
- Professional help using psychotherapeutic methods to validate the distressing experiences, reframing of symptoms, support and counselling
- Relaxation techniques such as meditation, yoga, prayers etc.
- Stress management programmes

Only a small minority may need referral to a psychiatrist for evaluation and psychopharmacological intervention. Psychosocial management remains the main stay of treatment.

In conclusion, common metal disorders unlike severe mental disorders like schizophrenia by the nature of the symptoms can very well go unnoticed especially in a prison environment when most of the symptoms are seen as a natural reaction to a prison environment. But the good news lies in the fact that once identified they can be addressed and treated by adequate counselling and other behavioral interventions and might not require formal psychiatric help. The key is to sensitise prison staff and train them in the appropriate techniques which would not just help the prisoners but also the society at large when the prisoners get back to the community.

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9. HIGH RISK BEHAVIOURS IN PRISON: THE NEED FOR BEHAVIOURAL REHABILITATION

The present prison system is a university with a difference. It serves as a fertile ground to convert small time offenders and help them graduate to being a part of an organised crime syndicate. Merely rounding people up, without offering opportunities for change in attitude and behaviour is the biggest failure of custodial settings. In India, thousands of persons enter prison each year, and a substantial number are periodically released on bail. Any opportunity to offer a corrective experience is completely lost in the 'prison mentality', which looks at time in prison as 'punishment' and has the attitude that 'nothing works'. That is certainly not the case. Rehabilitation is arguably the best approach towards correction as most prisoners are released at some stage.

There is an urgent need to explore the reasons behind the offending behaviours that lead to people getting into prisons, so that the best remedy can be offered. For example, a person who commits crimes when drunk but not when sober is likely to be suffering from harmful use of alcohol. Treating the alcohol problem may diminish the chances of the offending behaviour. Similarly, a person may become violent because of his/her difficulty in controlling anger. Anger management techniques will help such an individual in the long run. A person who gets into frequent fights with the family may benefit from family therapy. Hence, there is a need to identify the characteristics which can predispose the prisoner to commit a crime or reoffend. This is also called identifying an individual at 'high-risk'.

High risk behaviour is any behaviour that places a person at increased probability of suffering from a particular condition compared to others in the normal population. In simple words, high-risk behaviours increase the possibility of negative consequences or outcome. This chapter focuses on the prisoners with high-risk behaviours, presents brief treatment strategies for managing each and concludes with a proposed set of recommended goals for creating a national strategy to develop behavioural rehabilitative and reformative programmes in correctional settings.

Prisoners with High-Risk Behaviours

Prisoners persistently engage in a range of behaviours such as violence towards others, suicide, suicidal attempt, deliberate self-harm, substance use, unprotected sexual activity,

slavery and destruction of public property that increase their probability of being involved in serious physical diseases or mental disorders. Such behaviours result in frequent conflict with law, death, injuries to self or others.

Table 1. High-Risk Behaviours and their Consequences

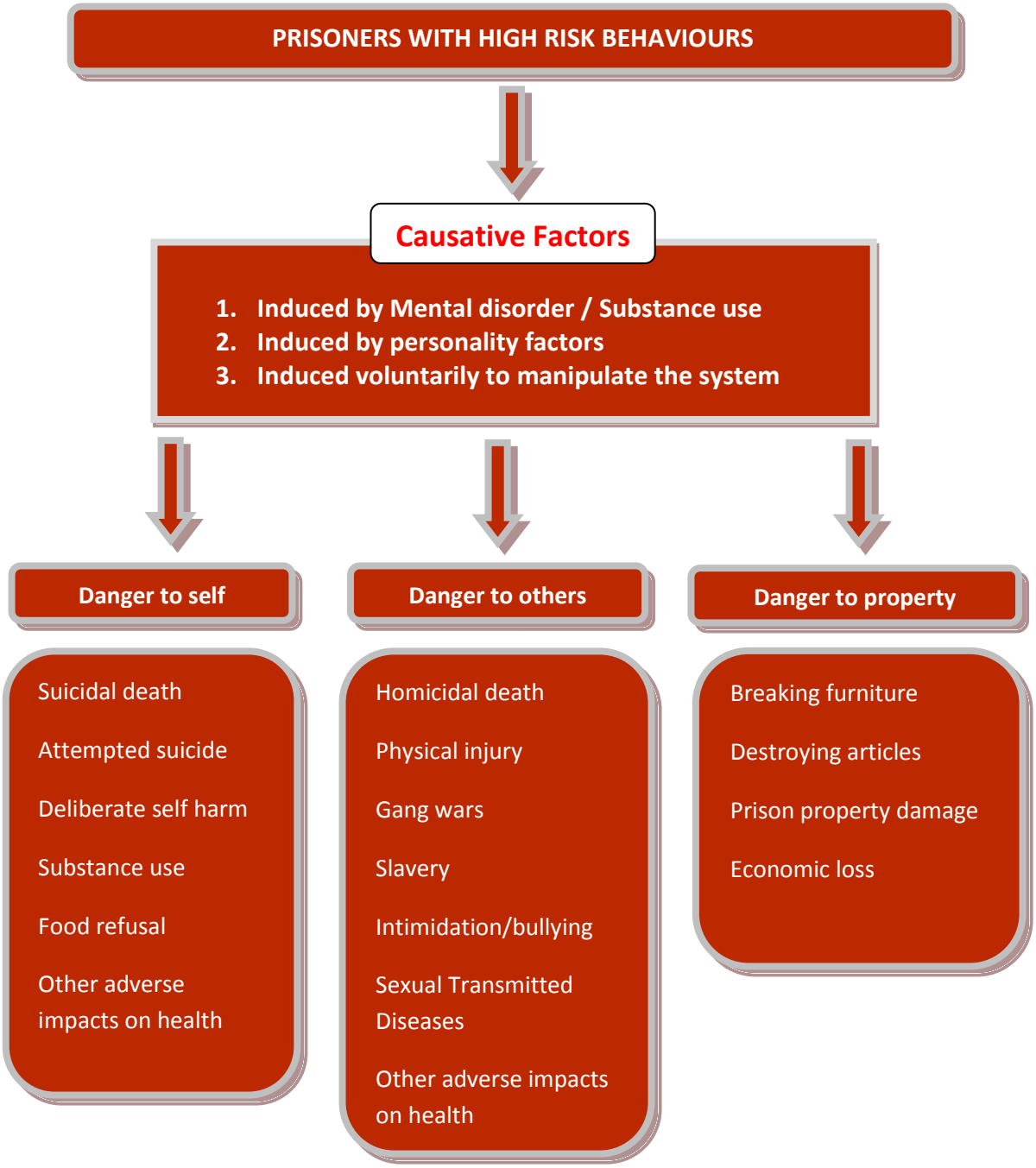
High-risk behaviours	Negative outcomes
Unprotected sexual intercourse with multiple partners	Sexually transmitted diseases, HIV, AIDS and Hepatitis
Alcohol use	Conflict with law, crime, physical cruelty, domestic violence, public nuisance, poor judgement, physical and mental illnesses
Drug use	Accidents, violence, conflict with law, physical and mental illnesses
Cannabis use	Acute intoxication, Psychosis
Intravenous drug use	HIV, Hepatitis, septicaemia
High speed driving	Accident, Death
Smoking	Cancer, Hypertension
Tobacco chewing	Oral cancers
Sedentary life style	Obesity, hypertension, diabetes and depression
Deliberate self-harm	Death, grievous injury, conflict with law
Suicidal attempt	Death, grievous injury, conflict with law

Given the poor quality of assessment and lack of remedial measures in prison, most prisoners with high-risk behaviours remain undetected and these problems remain unaddressed. For the purpose of managing prisoners with high-risk behaviours, it is useful to have a classification of these behaviours based on causative factors on the one hand and consequential dangers on the other.

It is essential to know the causes of high-risk behaviours, so that effective management can be planned. These high-risk behaviours have consequential danger and impact at various levels. Impact can occur at personal level, on others and property. Prison environments breed aggressive behaviours. Many prisoners get things done by expressing their dominance through aggression and violence. This acts as a model for other prisoners

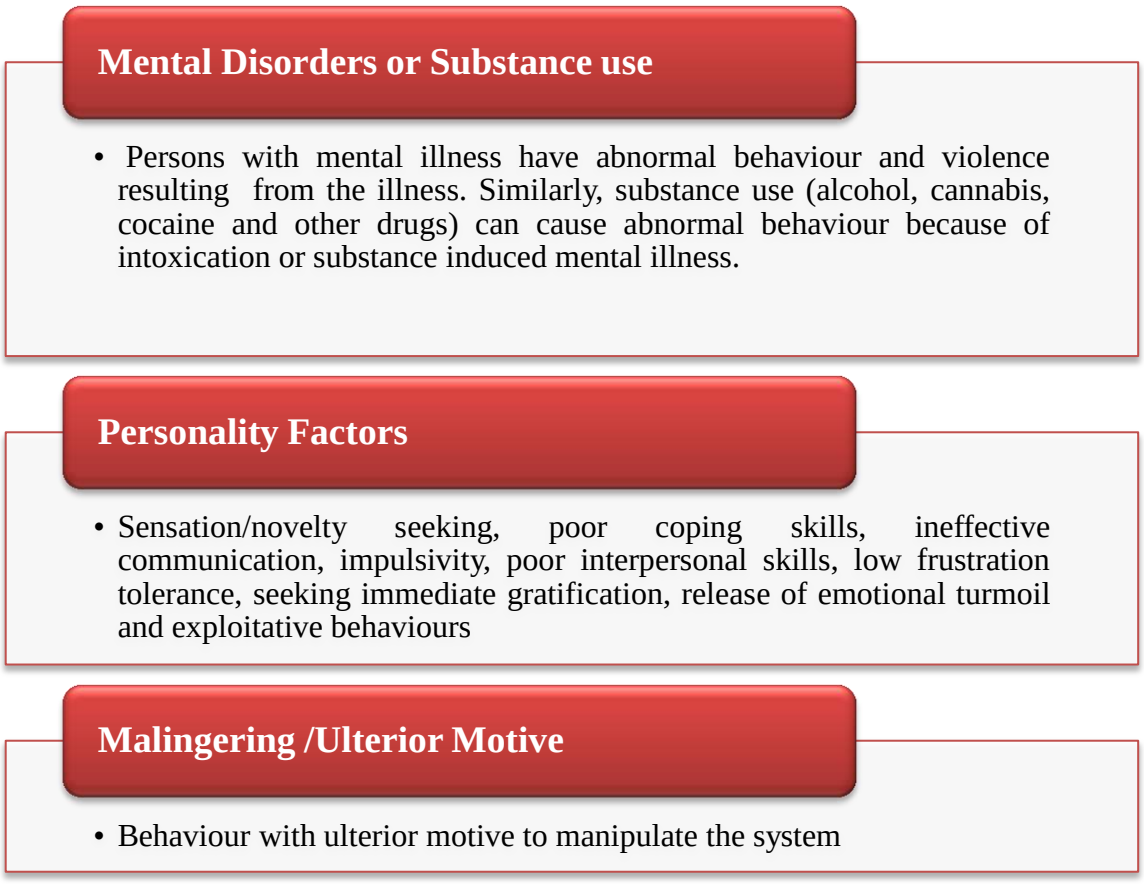
to try and emulate. Hence, it becomes essential to modify their behaviour before they leave the prison. If not intervened, this may continue even in the community. Behaviour modification needs to be considered seriously in all the correctional centres.

Figure 1: Most commonly noted high-risk behaviours in prisons



High-risk behaviours can occur for a variety of reasons as shown below.

Figure 2: Causes of high-risk behaviours in prisons



Unfortunately, the current correctional system works under the punishment principle and not for reformation and rehabilitation.

DANGER TO SELF

Dangerousness to self-behaviour in prisoners is detrimental both to the individual and the safety and morale of the prison environment. High mortality in prisoners has been attributed to various factors such as suicide, self-injurious behaviour, substance use, TB, HIV and other health related conditions (Kjelsberg and Laake, 2010). Media highlights only the custodial deaths due to police excess but unfortunately forgets that more deaths occur because of health related reasons causes, which often go unnoticed. However,

currently, many countries have been calling for action to prevent such deaths and to educate staff in prevention, early recognition and management of such behaviours.

"Dangerous to self" behaviours are those behaviours which have a direct effect on both prisoners' physical and mental health. These behaviours are shaped by a number of interacting factors such as mental disorders, personality factors, impulsivity, physical illness, personal motive, financial, family, social, cultural, situational, psychological, and biological factors. Dangerous to self-behaviours can be classified into substance use (alcohol, nicotine, cannabis, cocaine, opioid and other substance use), self-injurious behaviours and food refusal. Substance use related issues, because of their magnitude and ramifications are discussed in a separate chapter.

Food refusal

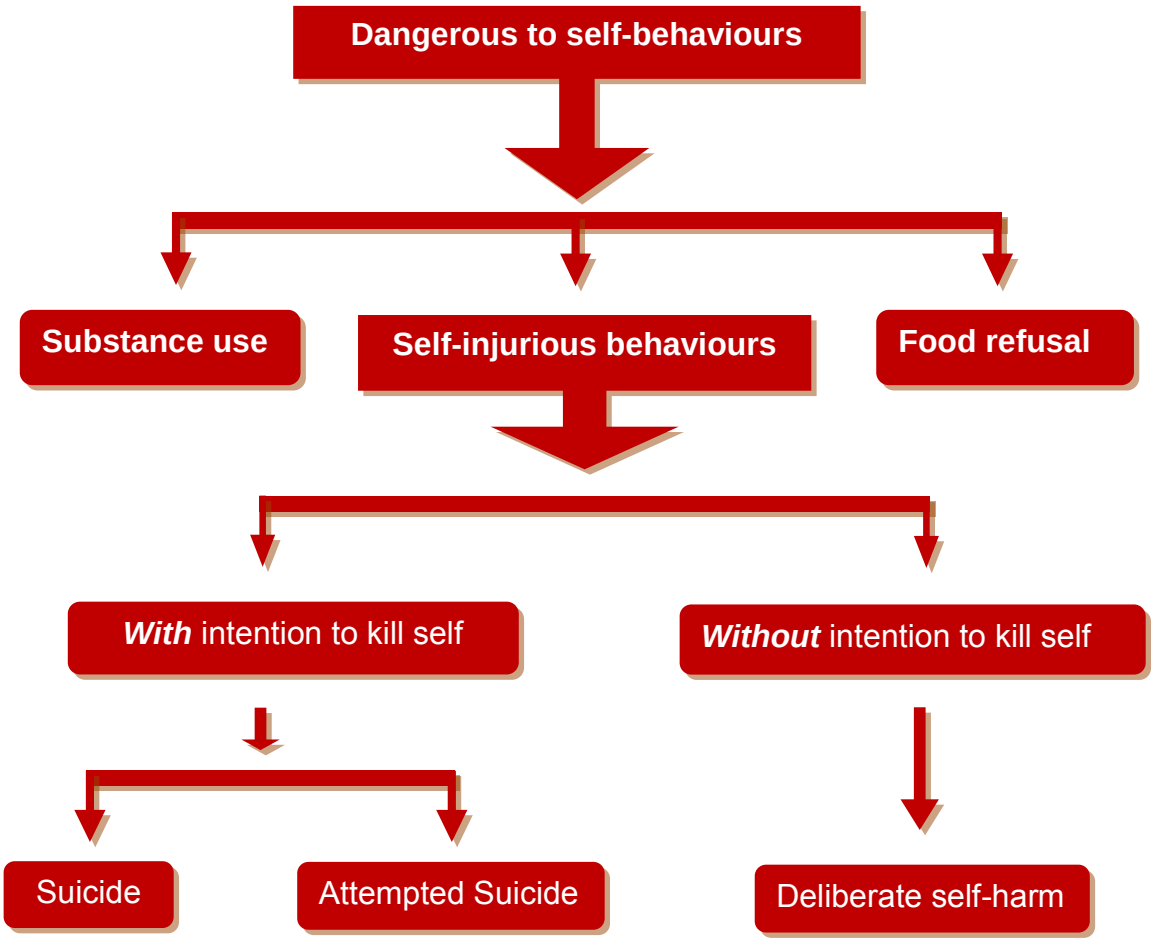
Food refusal can occur for different reasons. Prisoners, singly or in a group, can refuse food by agitating to fulfil their demands (for e.g., going on strike). The most common reason for this in prisons is poor quality of food. Another common reason for food refusal is ill- health (decreased appetite because of Cancers, AIDS, Tuberculosis, Depression, Psychosis and other illnesses). In the latter, the underlying cause needs to be treated. For all other reasons underlying this behaviour, the prison administration needs to form guidelines and standard operating procedures to deal with such situations without violating the rights of the prisoners.

Self-injurious behaviour (SIB)

The most challenging and problematic behaviour in prisons is self-injurious behaviour. Self-harm among prisoners is a common phenomenon (Knoll, 2010). A study on the prevalence of self-injurious behaviour (SIB) among Greek male prisoners revealed such behaviour among 35% (Sakelliadis et al., 2010). The most common underlying motives were to obtain emotional release (32%) and to release anger (21%). Psychiatric disorders, illicit substance use and aggression seem to be powerful predictors of SIB in prison population (Carli et al., 2010; Sakelliadis et al., 2010). Similarly, another study reported that 42% of prisoners had lifetime suicide ideation, 13% attempted suicide and 17% were self-mutilators (Carli et al., 2010).

Self-injurious behaviour among prisoners poses a great challenge to the correctional staff, mental health team, public health administrators and also to the judiciary. To address SIB, there are many barriers and obstacles to effective assessment and treatment (Fagan et al., 2010). Self-injurious behaviour resulting from suicidal and non-suicidal intent needs to be distinguished to plan for appropriate management.

Figure 3: Dangerous to self-behaviours



Defining self-injurious behaviours

Various definitions have been suggested for self-injurious behaviour. There is no single standard acceptable definition and classification. Self-injurious behaviour is a very complex behaviour with various factors contributing to it. It encompasses a range of phenomena from fatal to non-fatal behaviours. There are ongoing debates regarding what

constitutes self-injurious behaviour. From the prison and correctional centre's perspective, self-injurious behaviour needs to be understood differently than it is in the community. In a correctional setting, the behaviour needs to be de-codified from the management and rehabilitative perspective.

Prison staff and the medical team in charge must ask themselves the following questions, when they encounter SIB in a prisoner.

a) What is the medical condition of the prisoner? (For emergency medical management)

b) What is the intent of the SIB (Death or non-lethal)? (To de-codify the behaviour)

Motivation of the SIB provides clear indication of the prisoner's thoughts, emotions and behaviour. This also provides an immediate management plan and also future prevention strategies. The following classification and definitions can help in understanding and managing self-injurious behaviour.

Defining self-injurious behaviour

Suicide is the act of intentionally taking one's own life.

Attempted suicide is an unsuccessful attempt to kill oneself.

Suicidal ideations refers to thoughts of killing oneself, in varying degrees of intensity and elaboration

Deliberate self-harm is a behaviour in which people inflict harm upon themselves, without intention to die and with non-fatal outcome.

Source: Chandrashekar et al., 2007; Shneidman, 1985

SIB with intention to kill oneself

Jails and prisons are responsible for protecting the health and safety of their inmate populations, and it is the responsibility of the state to protect the prisoners. If the state is not able to protect its own citizens under their custody, it raises serious questions about protective mechanisms in place outside the prison. The World Health Organization estimates that one suicide attempt occurs approximately every three seconds, and one completed suicide occurs approximately every minute. Every year more than one million people commit suicide throughout the world, accounting for 1 to 2 per cent of total global

mortality (World Health Organisation., 2000). Suicide is a serious health problem. Suicide and attempted suicide are symptoms of emotional distress. Suicidal behaviour is "a desperate cry for help" or a way of showing one's anger and frustration. This can manifest as suicidal thoughts (suicidal ideations), and suicidal actions (suicidal attempters and completers). Data on suicides, attempted suicides and other self-harming behaviours that occurred from 1990 to 2002 was studied in Italian prisons. Over the study interval, completed suicide rates in Italian prisons were constantly about ten times higher than among the general population. Attempted suicides were about ten times higher than completed suicides. Female prisoners were significantly more likely to attempt suicide, whereas male prisoners were more likely to complete suicide (Preti and Cascio, 2006).

Higher rates of suicide in prison can be attributed to the following reasons.

These reasons operate in combination rather than in isolation.

- Jails and prisons are repositories for vulnerable groups that are traditionally among the highest risk for suicide, such as young males, the mentally ill, socially disenfranchised, socially isolated, substance abusers, or previous suicide attempters.
- The psychological impact of arrest and incarceration or the day-to-day stresses associated with prison life may exceed the coping skills of vulnerable individuals.
- There may be no formal policies and procedures to identify and manage suicidal inmates.
- Even if appropriate policies and procedures exist, overworked or untrained correctional personnel may miss the early warning signs of suicidality.
- Correctional settings may be isolated from community mental health programmes so they have poor or no access to mental health professionals or treatments.

Source: World Health Organization (2000). Preventing suicide; a resource for prison officers. Pub by; Mental and Behavioural Disorders, Department of Mental Health, World Health Organization, Geneva (WHO/MNH/MBD/00.5)

A study conducted on Australian adolescents on remand reported that 19% had made a suicide attempt during the previous 12 months compared to 4% in the community (Sawyer et al., 2010). Similar results have been replicated in adolescents on remand. It has been estimated that they is a fourfold increased risk for adolescents in correctional settings than in the community (Suk et al., 2009). Studies have also documented that

recently released prisoners are at a markedly higher risk of suicide than the general population. Factors significantly associated with post-release suicide were a history of alcohol misuse or self-harm and having psychiatric disorder (Pratt et al., 2010).

RISK FACTORS FOR SUICIDE

Risk Factors: Evidence from prison population studies

1. Previous history of suicidal attempt
2. Mental illness like-depression, bipolar disorders and schizophrenia
3. Substance use such as alcohol, cannabis, cocaine, opioid and use of other drugs
4. Poor social integration (lack of confiding relationships/long standing relationship problems)
5. Recently sentenced/convicted/serving life sentence
6. Young or elderly male
7. Impulsive and aggressive personality traits

(Baillargeon et al., 2009; Camilleri and McArthur, 2008; Carli et al., 2010; DuRand et al., 1995; Fazel et al., 2005; Fazel et al., 2008; Knoll, 2010; Pratt et al., 2010)

Risk Factors: Evidence from general population studies

1. Family history of suicide
2. Family discord
3. Poor family support, broken family, physical abuse by parents, feeling neglected by parents and loss of loved ones
4. Hopelessness
5. Barriers to accessing mental health care
6. Ongoing and /or recent life events such as relationship problems, loss of romantic relationship, financial loss, job related and social issues
7. Chronic medical/surgical illness including HIV, AIDS and cancer
8. Loss of social status / reputation in the society.
9. Easy access to lethal methods to killing oneself
10. Unwilling to seek to help because of stigma attached to mental health consultation and substance use consultation
11. Evolving personality disorders
12. Cultural and religious beliefs

(Beautrais, 2000; Hirschfeld and Davidson, 1988; Mortensen et al., 2000; Phillips et al., 2002; Satcher, 1999; Vijayakumar and Rajkumar, 1999)

In many countries, there has been a call for action to prevent such deaths and to educate staff in the early recognition of suicide risk. The best practices for preventing suicides in jail and prison settings should include the following elements: training programmes, screening procedures, communication between staff, documentation, internal resources, and debriefing after a suicide (Pompili et al., 2009). There is also a need to improve the continuity of care for people who are released from prison (Pratt et al., 2010).

SIB without intention to kill oneself

Deliberate self-harm (DSH): This is behaviour in which persons hurt or harm themselves without the motive of suicide. Most commonly noted DSH in prisoners are:

a) Superficial cuts (wrist slashing, trying to cut their own throat, abdomen, hands and legs) on the body parts using sharp objects
b) Head banging
c) Swallowing non-edible materials such as glass pieces, blade pieces and other material
d) Scratching
e) Opening old wounds

Findings suggest that self-injury occurs regularly and recurrently in a subset of inmates. The causes for DSH are mental illness, substance use, personality problems, manipulative behaviours and as a coping mechanism (DeHart et al., 2009). It has also been noted that many prisoners with anti-social personality, borderline personality, mental retardation and organic brain disorders indulge frequently in DSH behaviours (Sarchiapone et al., 2009). Many a times such behaviours occur under drug intoxication. Depression, frustration and an avenue to release their pent up emotions also play a crucial role (Jenkins et al., 2005). There are prisoners who indulge in DSH behaviours to seek attention from the prison staff, co-prisoners and family members. They also do it to manipulate the prison authorities for personal gains. Though deliberate self-harm is not lethal, it is a strong predictor of repetition of DSH and completed suicide in near future (Fazel et al., 2008; Skegg, 2005). Hence, each DSH attempt needs to be taken seriously and evaluated.

DANGEROUS TO OTHERS AND PROPERTY

Dangerousness to others in prison setting results in harm to the co-prisoners and to the prison staff. Harming others may range from physical to verbal harm. It can be considered as a spectrum, with bullying on one extreme and homicide on the other. It also encompasses violence, attempts to dominate and to obtain sexual gratification. Behavioural scientists believe that aggression is present in each of us, and can be modified by experience in both positive and negative ways. They have defined aggression as behaviour aimed at causing harm or pain to others or self. Human aggression can be manifested towards self or others, can be direct or indirect, physical or emotional, active or passive, and verbal or non-verbal (Chandrashekar et al., 2007). It may even take the form of slavery such as forcing co-prisoners to perform activities that degrades them. Violence directed towards others can be in the form of physical injury/harm (hitting), psychological pain (insulting), destruction of property and bullying (shouting or spreading rumours). Violence and aggression raises concerns about its serious impact on the correctional system, safety of others, economic and public health issue. Violence in prison settings is endemic but at times it takes epidemic forms if proper mechanisms are not in place. Prevalence of aggression and violence towards others varies depending upon the type of violence measured.

Violence in prison is a known phenomenon all over the world, but how the prison authorities deal with such behaviour is debatable from various perspectives, including health and human rights. Responses can be self-defence, physical restraint, physical torture, punishment, isolation in a dark room, withholding basic needs and at times chemical restraint. Correctional facilities have a responsibility to take "reasonable measures" to preserve and protect inmate safety (Wolff and Shi, 2009). The problem of aggression in correctional institutions should be recognised and effective preventive measures need to be put in place against violent behaviours (Merecz-Kot and Cebrzynska, 2008).

Causes for violence

Many inter-related and complex factors have been attributed to violence and include illness, personality traits, and individual as well as environment factors. However, there may be instances of violence without any identifiable causes. This is commonly seen in persons with mental illness and substance induced intoxication. They may indulge in

violence without any provocation. Often, correctional setting administration denies any sexual encounters in prison. The unisex nature of the prison institution provides a potentially fertile ground for sexual aberrations. Various kinds of sexual activity have been documented such as masturbation, transsexualism, prostitution, sex between prisoners and prison staff, consensual homosexuality and non-consensual homosexuality (rape among prison inmates) (Awofeso and Naoum, 2002). Such behaviours are often associated with dangers to self and others.

Causes for violence in prison settings:

Illness factors:

- ✓ Mental illness
- ✓ Substance use such as cannabis, cocaine, opioid and other drug use

Individual factors:

- ✓ Personality factors such as impulsivity and low self esteem
- ✓ Poor coping skills
- ✓ Revenge
- ✓ To show dominance
- ✓ To revolt against authority
- ✓ Stress

Pleasure:

- ✓ Sexual gratification
- ✓ Gambling
- ✓ Entertainment (bullying)

Environment:

- ✓ A response to dissatisfaction with food, water, entertainment and other facilities
- ✓ Gang wars
- ✓ Rigid inhuman rules and torture
- ✓ Corruption

Considering the causes of violence, the question that rises in such situations is when to intervene? How to intervene? When to seek professional help? In order to answer these questions, other important dimensions to be considered with regard to aggressive behaviour are the antecedents, situations, frequency, duration, intensity of the aggression

and deviation from the cultural and social norms. All forms of violence may not require professional help. However, there are certain prisoners at risk who require professional help. Hence, it is essential to identify these high-risk prisoners and provide the necessary professional help.

People at risk of having frequent aggressive behaviour: Learning to identify and predict those at risk of developing aggression can prevent serious consequences. The following risk factors have been identified:

People at risk of having frequent aggressive behaviour

Individual factors:

- ✓ Mental illnesses like depression, anxiety disorders, epilepsy and psychosis
- ✓ Substance use such as cannabis, cocaine, opioid and other drug use
- ✓ Personality factors
- ✓ Poor coping skills
- ✓ Childhood trauma like sexual/physical abuse

Family factors:

- ✓ Family discord
- ✓ Violence within the family (role model)
- ✓ Substance use by the parents
- ✓ Poor family support

Social factors:

- ✓ Poor social support
- ✓ Exposure to violence
- ✓ Victimisation by peers (bullying)
- ✓ Life events and stress

The notion that ‘nothing works’ in offender rehabilitation has slowly faded and evidence based behavioural interventions are being introduced in the rehabilitation programme. In recent years, correctional administrations have increasingly identified prisoners with high-risk behaviours as a key target group for rehabilitation programmess and a number of such programmes have been developed.

MANAGEMENT OF PRISONERS WITH HIGH-RISK BEHAVIOURS

'Dangerous to self'- management in prisons

Any 'dangerous to self-behaviour' such as suicide usually occurs as a process in which a chain of events leads to the final act and this process is usually triggered by a precipitant. A person may show various signals like neglecting personal care, becoming withdrawn, eating less, showing decreased interest in almost all activities, increasing use of mind altering substances. He or she may even verbalise 'directly' plans of harming self (by saying 'life is not worth living' 'I wish I had not been born' 'I will kill myself') or 'indirectly' ('everything will be all right within few days' 'saying good bye' 'meeting loved ones before the act' 'donating favourite articles/things to others'). Suicide is usually preceded by weeks/days of death wishes, suicidal ideas, depressed feelings, plans and subtle warnings. Thus, it is preventable by timely identification and response to such pre-act symptoms.

Assessment of high risk behaviours needs to be done from the first day of the imprisonment and then periodically depending upon the situation and environment. The influence of dynamic risk factors (for e.g., easy availability of substance use, mental illness, stress) highlights the importance of assessment at regular interval for the risk of imminent and repetitive violence. However, prison staff works under various constraints such as lack of trained human resources, inadequate funding and poor infrastructure. These factors also act as barriers in planning effective management. Low staff morale and burnout are the most important challenges. Acknowledging the prevailing situation, a simple assessment and management outline has been suggested here. It is essential to have a national and regional policy to prevent high-risk behaviours rather than blaming the correctional staff.

a) Need for Suicide Prevention Programmes in Correctional settings as a national policy

All correctional facilities, regardless of size, should have a reasonable and comprehensive suicide prevention policy that addresses the key components noted in the following sections. Of course, it is not the officers' but prison authorities' responsibility to approve and install such programmes (World Health Organization, 2007).

b) Training

The essential component to any suicide prevention programme is properly trained correctional staff, who form the backbone of any jail, prison, or juvenile facility. Very few suicides are actually prevented by mental health, health care or other professional staff because suicides are usually attempted in inmate housing units, and often during late evening hours or on weekends when they are generally outside the purview of programme staff. Correctional officers are often the only staff available 24 hours a day; thus, they form the front line of defence in preventing suicides (World Health Organization, 2007).

c) Intake Screening

Once correctional staffs are trained and familiar with risk factors of suicide, the next step is to implement formal screening for suicidal risk among newly admitted inmates. Since suicides in jails may occur within the first hours of arrest and detention, screening for suicide must occur almost immediately upon entrance into the institution to be effective. To be most effective, every new inmate should be screened at intake and again if circumstances or conditions change. Screening for suicide needs to be a responsibility of correctional staff and they should be adequately trained and aided by a checklist for assessing suicidal risk (World Health Organization, 2007). In a correctional setting assessment, affirmative answers to one or more of the following items could be used to indicate an increased risk of suicide and a need for further intervention by the professionals.

d) Monitoring

Screening identifies the person at risk but does not prevent an attempt. For an effective prevention programme, monitoring plays a crucial role. Around the clock monitoring requires adequate communication between the staff around the shift. Communication needs to be open, clear and precise in nature. Proper documentation is of extreme importance. If required, help needs to be taken from other prison inmates to monitor for suicidal behaviour. Signs such as withdrawn behaviour, crying, food refusal, sad mood, expressing suicidal ideas and attempts, must be the indicators for immediate referral to mental health professional care.

e) Reducing the availability of means/modes of committing suicide

The prison environment needs to be safe. Access to hanging materials (ropes, wires) and self-electrocution needs to be prevented. Keeping sharp instruments, potentially poisonous items and medications away from the person is very important. A person with a suicidal risk must never be left alone. Someone should stay with the person and keep a close vigil. A suicide monitoring environment would be a cell or dormitory that has eliminated or minimised hanging points and unsupervised access to lethal materials.

Check list for assessment of suicide by prison staff

1. The inmate is intoxicated and/or has a history of substance abuse.
2. The inmate expresses unusually high levels of shame, guilt, and worry over the arrest and incarceration.
3. The inmate expresses hopelessness or fear about the future, or shows signs of depression, such as crying, lack of emotions, lack of verbal expression.
4. The inmate admits to current thoughts about suicide
5. The inmate has previously received treatment for a mental health problem.
6. The inmate is currently suffering from a psychiatric condition or acting in an unusual or bizarre manner, such as difficulty to focus attention, talking to self, hearing voices.
7. The inmate has made one or more previous suicide attempts and/or admits that suicide is currently an acceptable option.
8. The inmate admits to current suicide planning
9. The inmate admits or appears to have few internal and/or external supportive resources.
10. The arresting/transporting officer believes that the inmate is at risk for suicide.
11. Facility records indicate that the inmate had a risk for suicide during a prior confinement.

Source: World Health Organization (2000). Preventing suicide; a resource for prison officers. Pub by; Mental and Behavioural Disorders, Department of Mental Health, World Health Organization, Geneva

f) Supportive Role

The prison staff must try to help the at-risk person in all possible ways, within their limitations. Any unnecessary delay in the process of providing help must be avoided.

Concern and support for the prisoner's recovery is vital. The staff must acknowledge his/her limitations and try to assure the person of the best possible help. A person making a suicidal attempt must never be challenged.

g) Professional Help

Availability of mental health professional for further management adds value to the services. They can provide medications, electro-convulsive therapy, counselling and psychotherapy.

If suicidal attempt occurs: Rapid response mechanisms

First aid needs to be administered and on a high priority, emergency hospital referral to save the person's life needs to be done. Training the staff in providing first aid is also the key to success of the suicide prevention programme. The higher authorities of the prison must be immediately alerted. There is an urgent need to formulate standard operating procedures to manage a suicidal attempt if it occurs. Around the clock availability of escorts to shift the person to higher centres needs to be formalised and should occur without any delay.

Malingering a suicidal attempt

At times suicidal attempt can be used with the motivation of gaining entry into hospital. Suicidal behaviour because of mental illness is usually labelled as "MAD" behaviour and with manipulative intent as "BAD" behaviour. ***Such a classification adopted by health professionals and prison staff needs to be abandoned*** because of following reasons:

a) This dictates "MAD" requires treatment and "BAD" needs punishment.
b) It also assumes that suicidal behaviour is a static phenomenon, but in fact it is a dynamic phenomenon. Today's manipulative intent of suicide may be tomorrow's completed suicide.
c) Even though a suicidal attempt may have a manipulative intent, punishment and challenging may lead to the extreme step of completed suicide.
d) 30-40% of completed suicides have a past history of attempted suicide and self-injurious behaviour.

Hence, for all practical purposes, every prisoner with a suicidal risk needs to be evaluated and managed. If there are well documented, multiple, manipulative suicidal attempts in the past, then that case definitely needs professional help for his maladaptive and poor coping ability.

If completed suicide occurs: dealing with the grief process

Suicide committed by a prisoner can have severe psychological impact on the co-prisoners and the prison staff. It can even become a model for other prisoners as a method to tackle their own problems. Hence a protocol should be developed by the prison authorities for dealing with such situations. Authorities should get adequate factual information about the event. Then information should be given to the other inmates. To avoid rumours, all inmates should get the same information. It is important not to keep discussing the suicidal event with everyone. The suicidal act must not be glorified.

At times, completed suicide can provoke anger and violence inside the prison. Hence, prisoners must be allowed to discuss their thoughts and feelings. Severely affected co-prisoners (close friends) of the deceased should be allowed to ventilate and if required counselling services should be offered. This opportunity should be utilised later for discussing or brain storming sessions or seminars about suicide, help seeking behaviour, available services, problem solving techniques and depression.

Dangerous to others and/or property - Assessment and management in prisons

The present relatively primitive level of management and treatment of violence risk needs to be replaced by evidence based management from the health and human rights perspective. Assessment plays a crucial role in predicting and preventing violence in custody. Violence is a dynamic phenomenon as already discussed. Hence, assessment needs to be done as and when required. Each assessment is relevant only for a limited time frame of days to weeks (Simon and Tardiff, 2008). There are various forms of assessment including clinical and structured assessments of violence.

Assessment of ‘dangerous to others and property’ behaviour needs to encompass the following issues a) nature; what kinds of behaviour might occur? b) consequences; what may be consequences of the high-risk behaviour? c) frequency: how often might high-risk behaviour occur? d) expecting; how soon might high-risk behaviour occur? and e) probability; what is the probability that high-risk behaviour might occur?

Factors that needs to be evaluated in the assessment risk of violence

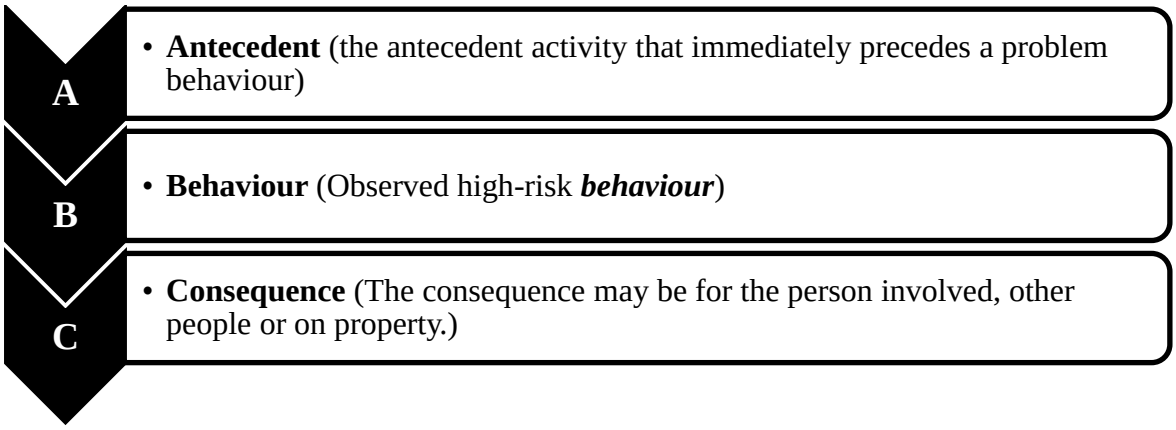
1. Nature and personality of the prisoner
2. Motivation for violence (Provoked/unprovoked)
3. Planning, means, severity, nature, place and details of violence
4. Past history of violence /Violent crime/ Domestic violence
5. Gang activities
6. Substance use such as alcohol and drugs
7. Presence of mental illness
8. Relationship instability and impulsivity
9. Ongoing stress

It is also essential to do the analysis of the behaviour in the (recent) past. This gives us a rough picture about the person's personality and gravity of the risk assessment involved. This assessment can be done by trained counsellors or a psychologist. Depending upon the assessment, risk quantification can be done on four point scale, each indicating the ascending hierarchy of the severity level. 0=no risk present, 1=mild risk, 2=moderate risk and 3=severe risk. Depending upon the available resources and results of the assessments, various actions can be initiated to curtail the current violence, to predict and prevent future violence. Action can be shifting the person to the hospital or to a high security area, requiring assessment from the psychiatrist and initiating the behavioural management rehabilitation.

'ABC' Analysis of the behaviour

An 'ABC' analysis of the behaviour helps to carry out a direct observation and to collect information about the events that are occurring within a prisoner's environment. **"A"** refers to the ***antecedent***, **"B"** refers to observed ***behaviour*** and "**C**" refers to the ***consequence*** Consequences may be positive, negative or sometimes a combination of both (O'Neill et al., 1997). It is also important to identify the settings, events that may be working to keep the behaviour going (what are the factors maintaining that behaviour). This analysis can be done on an ABC analysis chart as shown in the accompanying figure. Analysis is not one time but must be carried out over a period of days to weeks.

Figure 4: ABC analysis of behaviour



'ABC' analysis chart

Name (of the inmate)…….. **Date…….**

Referral no…….

Sl No	Date and Time Activity	Antecedents	Behaviour	Consequences	Comments
1	16.12.2009 10.30 AM Bathing	Altercation with a co-prisoner over the availability of water in the toilet	Physical abuse of the co-prisoner	Co-prisoner sustained grievous injury to the right eye and lost his vision	Un-controlled explosive violence. Urine analysis positive for cannabis
2					
3					
4					

Observer signature ……

Name…….Date……

'ABC' chart analysis helps not only in understanding the behaviour in a given situation but also the consistent pattern of behaviour and the situations in which it occurs. It also helps to make a proper plan of management. The plan of management needs to occur under the supervision of professionals including medical, prison staff and others concerned. This decision needs to be a group decision rather than an individual one, for

several reasons. In a given case, it may be decided to refer to a psychiatrist, or to a mandatory anger management programme or to a lifeskills programme. There are various behavioural rehabilitation programmes that can be intiated in correctional settings. However, there are only a few programmes which have been rigoursly researched and found to be effective. This section has only provided a bird's eye view of those programmes.

Mental Health Services and De-addiction Programme

Availability of mental health services and de-addiction services in a correctional setting is the need of the hour (Chandler et al., 2009). There is no doubt about their need and effectiveness. These services start from educating about mental illness, supportive counselling, medications, de-addiction treatment, emergency services, HIV counselling, family counselling, stress management programmes, behaviour therapy and life skills training programmes (Edens et al., 1997). They also need to be involved in providing training to the correctional setting staff. The staff spends more time with prisoners, hence it makes sense to use their expertise to train them in counselling, behaviour therapy, family therapy and other therapeutic methods of dealing with prisoners (Edens et al., 1997). This also will help us to address the lack of trained manpower in rehabilitation settings.

There are many countries providing mental health and de-addiction services in correctional settings (Adams et al., 2009; Armitage et al., 2003; Blitz et al., 2006; Gorski et al., 2008; Kolind et al., 2010). A strong linkage between substance abuse and criminal activity among young offenders has triggered a new wave of rehabilitation by adding de-addiction services in prison settings (Dowden and Latimer, 2006; Steel et al., 2007). In many countries, considering the nature of risk involved, such as dangerousness to others from the use of drugs or alcohol, A Compulsory Drug Treatment Correctional Centre (CDTCC) has been established and this is also endorsed by the judiciary. A Compulsory Drug Treatment facility in the Correctional Centre of Australia was established in 2006 for repeat drug-related male offenders (Birgden and Grant, 2010). Though compulsory treatment goes against the individual rights, the high-risk behaviours of the offenders put others at risk. This necessitates appropriate action, best done in a rehabilitation and reformation framework. Innovative approaches of collaboration between correctional settings with medical colleges for providing mental health services have been successful (Appelbaum et al., 2002). Studies have also documented that providing mental health

care and de-addiction decreases recidivism, time spent incarcerated and successful community integration (Case et al., 2009; Lamberti et al., 2001).

Anger management programme

Anger management is probably one of the most common forms of rehabilitation offered to prisoners with high-risk behaviours. For this reason, it is important to determine whether anger management works in reducing anger and anger-related problem behaviours. Five published meta-analytic studies with at least moderate effect sizes, have all suggested that anger management is effective, (Beck and Fernandez, 1998; Del Vecchio and O'Leary, 2004; DiGiuseppe and Tafrate, 2003; Edmondson and Conger, 1996; Sukhodolsky et al., 2004). Hence, anger management needs to be offered to the high-risk prisoners.

Life skills training programme

Life skills are abilities for adaptive and positive behaviours that enable individuals to deal effectively with the demands and challenges of everyday life (World Health Organization., 1997). A list of 10 life skills, described as generic life skills for psychosocial competence, was identified by WHO as core life skills applicable across a wide range of contexts in daily life and risk situations.

Ten Life skills identified by WHO
(World Health Organization., 1997)

Problem solving	Decision making,
Empathy	Self-awareness
Inter-personal relationships	Communication skills
Critical thinking	Creative thinking
Coping with emotions	Coping with stress

They are depicted in the above box. These skills have been successfully implemented to curtail sexually transmitted diseases, to prevent mental illness, in the management of

substance use, in school mental health programme, in anger management and also in correctional settings (Edens et al., 1997; Marshall et al., 1989).

Cognitive behavioural therapy for sexual offenders

A meta-analysis of 69 studies comparing treated and untreated offenders on controlled outcome evaluations of sexual offenders reported that the majority of the studies confirmed the benefits of treatment. Treated offenders showed 37% less sexual recidivism than controls. Cognitive behavioural therapy approaches revealed the most robust effect (Lösel and Schmucker, 2005). Similar results have been replicated in another meta-analysis. This meta-analysis of 10 studies was conducted to know the effectiveness of treatments for male adolescent sexual offenders (N = 644). Results from the study reported that cognitive-behavioural therapy approaches were the most effective (Walker et al., 2004).

Another interesting treatment approach called 'Multisystemic Therapy' in young sexual offenders has been found to be effective in a well conducted trial (Borduin et al., 2009). 'Multisystemic Therapy' incorporates family therapy, cognitive behaviour therapy and individual therapy. Involving family members in the treatment process has yielded positive results. Therapeutic benefits of 'Multisystemic therapy' continued even after one year of undergoing treatment (Letourneau et al., 2009). Hence, any programme having cognitive behavioural therapy component needs to be advocated in sexual offenders.

Family therapy / Assistance programme

This programme provides assistance to the family members of the inmates. Immediately after arrest, inmates are worried about their family members. They want to know about their condition and safety. Families are also in a state of transition when their family member is arrested or receives a custodial sentence. Significant reactions include shame, guilt, physical and emotional distress, loss of social mobility and income stability, stigmatisation, stress and anxiety (Hardy and Snowden, 2010).

Family intervention programmes focus mainly on the following issues:

a) To enhance communication between inmates and their families
b) Helping the family to cope with the incarceration of their dear one
c) Promoting family visits and parole

d) Addressing issues like domestic violence in the family context
e) Involving family members in treatment of the inmate such as de-addiction and aftercare (Gideon, 2007)
f) Family therapy or marital therapy (Henggeler et al., 1992)
g) Counselling in parenting (Thompson and Harm, 2000)
h) Providing educational support to the children of the inmates
i) Assisting in employment and rehabilitation and
j) Family re-integration (Gideon, 2007)

This programme helps the prisoners to relieve their anxiety and focus on rehabilitation. Family therapy can thus be used to engage prisoners into the rehabilitation programme. Adding family therapy into any rehabilitation programme gives a whole new meaning to the life and hope for the prisoner.

Other behavioural rehabilitation programmes

There are various other behavioural rehabilitation programmes that have been suggested but their efficacy has still not been backed by proper trials. These include: Mindfulness therapy (Bowen et al., 2006), Social skill training, Sex education programme as a part of HIV prevention programme, Stress management, Yoga, Relaxation, Meditation, and Spirituality.

Educational programme

Supporting educational needs of the prisoners has been occurring since many decades. There seems to be a general acceptance by the public and policy makers that education has benefits in its own right. It is based on the understanding that an educated person has a higher probability of finding a job and less recidivism. However, this surmise has never been confirmed. Only recently, a review on correctional and vocational education (MacKenzie, 2008), has yielded positive results leading to the conclusion that educational programmes reduce the recidivism of offenders as well as increase employment. This review has also raised serious concern about the content of education programmes. They need to bring about a change in thinking and cognitions and not just in their ability to directly impact the offender's ability to get employment.

In conclusion, rehabilitation should be the guiding principle of all correctional institutions. It is time to acknowledge that punishment and deterrence based interventions are ineffective. Appropriate interventions should be instituted and improved by supporting systematic research to differentiate effective and ineffective correctional interventions. It is also important to eradicate the idea that "nothing works" to change offenders. Health care and rehabilitation need to be integrated, so that multimodal approaches of public health care such as early recognition and treatment of prisoners with high-risk behaviour (secondary prevention), behavioural rehabilitation (tertiary prevention) and prevention of re-offending behaviour (primary prevention) occur hand in hand.

Evidence-based treatment and rehabilitation services are an absolute need in any correctional centre. Treatment approaches should include behavioural interventions that are effective in changing an array of human behaviour. To achieve this herculean task, correctional and health staff need to establish credibility, develop competence, learn effective communication and collaborate effectively. This constitutes the bedrock of a successful programme in any correctional setting.

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10. RIGHTS OF PRISONERS

"Convicts are not by mere reason of the conviction denuded of all the fundamental rights which they otherwise possess."

- Justice V.R. Krishna Iyer
(Sunil Batra Vs. Delhi Administration., 1978)

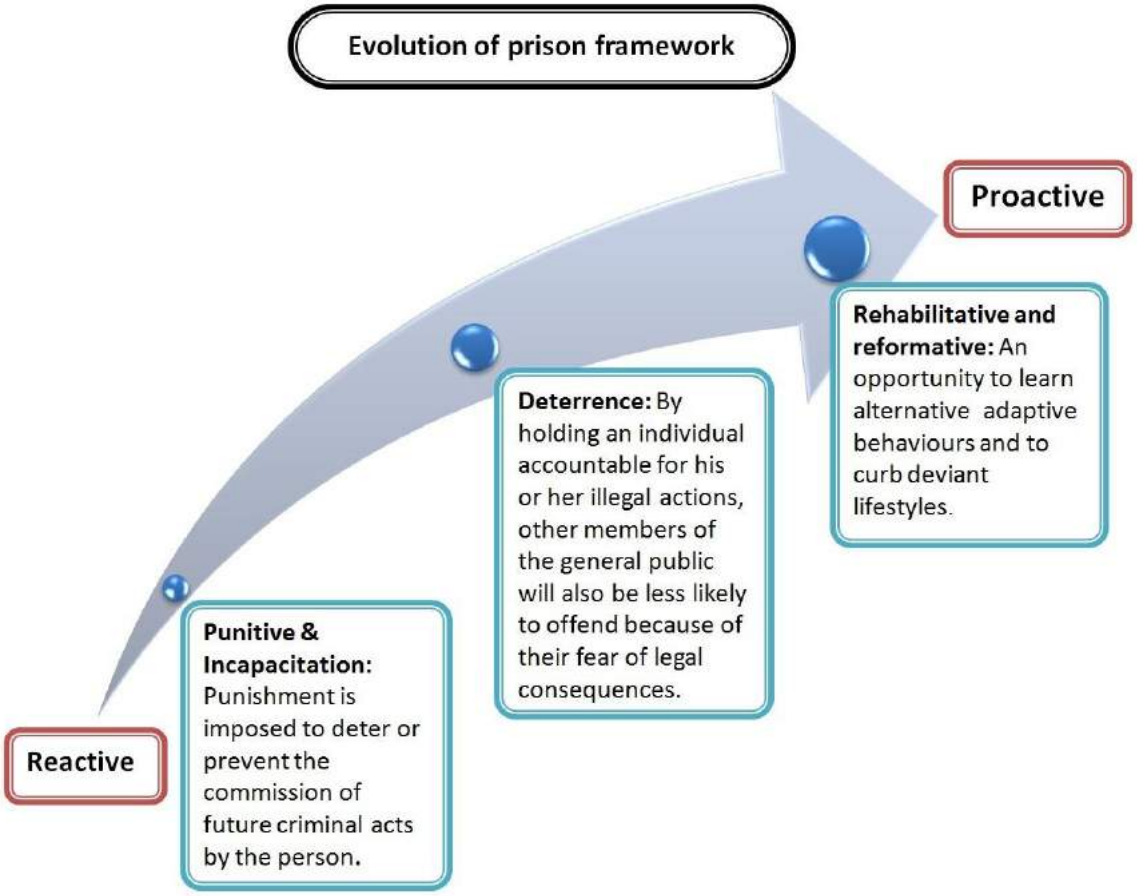
A prison, jail or correctional facility is a place in which individuals are physically confined or detained and usually deprived of a range of personal freedom. These institutions are an integral part of the criminal justice system of a country. There are various types of prisons such as those exclusively for adults, children, female, convicted prisoners, under-trial detainees and separate facilities for mentally ill offenders. In this chapter, "prisons" refer to only adult correctional facilities.

Imprisonment or incarceration is a legal punishment that may be imposed by the state for the commission of a crime or disobeying its rule. The objective of imprisonment varies in different countries and may be: a) punitive and for incapacitation, b) deterrence, and c) rehabilitative and reformative (Scott and Gerbasi., 2005). In general, these objectives have evolved over time as shown in the accompanying figure. The primary purpose and justification of imprisonment is to protect society against crime and retribution. In current thinking, punitive methods of treatment of prisoners alone are neither relevant nor desirable to achieve the goal of reformation and rehabilitation of prison inmates. The concept of Correction, Reformation and Rehabilitation has come to the foreground and the prison administration is now expected to function in a curative and correctional manner (Karnataka Prisons, 2009). Human rights approaches and human rights legislations have facilitated a change in the approaches of correctional systems, and they have evolved from being reactive to proactively safeguarding prisoners' rights. The United Nations has also provided several standards and guidelines, through minimal rules or basic principles in the treatment of prisoners (United Nations, 1977).

The State is under an obligation for protecting the human rights of its citizens as well as to protect the society at large, and is authorised to do so. To protect the citizens from any possible abuse of this authority, they are given certain basic privileges recognised by the Constitution of India as Rights. Elevation of such claims to the status of Rights, gives the

citizens the capacity to evoke the power of the Judiciary to protect themselves against violation of such rights, as well as to seek redressal for their restitution.

Figure 1: Evolution in the objectives of the prison system



Human Rights of prisoners: National and International Instruments

In India, the idea of rights of prisoners was long suppressed under the colonial rule and has only recently emerged in public discourse. The Constitution of India confers a number of fundamental rights upon citizens. The Indian State is also a signatory to various international instruments of human rights, like the Universal Declaration of Human Rights which states that:

> *"No one shall be subject to torture or cruel, inhuman or degrading treatment of punishment"* (UDHR, 1948)

Also important is the United Nations Covenant on Civil and Political Rights which states in part:

> *"All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person".* (UNICCPR, 1966)

There are many United Nations codified standards of treatment for prisoners across different economic, social and cultural contexts in a number of documents. These concern themselves with ensuring those basic minimum conditions in prisons which are necessary for the maintenance of human dignity and facilitate the development of prisoners into better human beings. International documents, which have articulated the prisoners' rights, are listed in the accompanying table.

Table 1. International Conventions/Regulations on Prisoners' Human Rights
Standard Minimum Rules for the Treatment of Prisoners (OHCHR, 1955)
Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UN Medical Ethics, 1982)
Convention Against Torture (UNCAT, 1984)
Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment. (Principles of Detention, 1988)
Basic Principles for the Treatment of Prisoners (UNPTP, 1990)
United Nations Standard Minimum Rules for Non-Custodial Measures (The Tokyo Rules, 1990)
Declaration on the Protection of all Persons from Enforced Disappearance. General Assembly Resolution 47/133 (UNDPPED, 1992)
United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules, 1985)
Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power, (UNVCAP, 1985)

Therefore, both under national as well as international human rights law, the state is obliged to uphold and ensure observances of basic human rights.

Human rights of prisoners in India

The Indian freedom struggle played a crucial role in initiating the process of identifying certain rights for the prisoners. After independence, the Constitution of India conferred a number of fundamental rights upon citizens. Article 21 of the Constitution guarantees the right of personal liberty and thereby prohibits any inhuman, cruel or degrading treatment to any person whether (s)he is a national or foreigner.

Article 21. Protection of Life and Personal Liberty; *"No person shall be deprived of his life or personal liberty except according to procedure established by law".*

The Supreme Court of India, by interpreting Article 21 of the Constitution, has developed human rights jurisprudence for the preservation and protection of prisoners' rights to maintain human dignity. Although it is clearly mentioned that deprivation of Article 21 is justifiable according to procedure established by law, this procedure cannot be arbitrary, unfair or unreasonable. In a celebrity case (Maneka Gandhi Vs. Union of India., 1978), the Apex Court opened up a new dimension and laid down that the procedure cannot be arbitrary, unfair or unreasonable. Article 21 imposed a restriction upon the state where it prescribed a procedure for depriving a person of his life or personal liberty. This was further upheld (Francis Coralie Mullin v. The Administrator, 1981) "Article 21 requires that no one shall be deprived of his life or personal liberty except by procedure established by law and this procedure must be reasonable, fair and just and not arbitrary, whimsical or fanciful".

Any violation of this right attracts the provisions of Article 14 of the Constitution, which enshrines right to equality and equal protection of law. In addition to this, the question of cruelty to prisoners is also dealt with, specifically by the Prison Act, 1894 and the Criminal Procedure Code. Any excess committed on a prisoner by the police authorities not only attracts the attention of the legislature but also of the judiciary. The Indian judiciary, particularly the Supreme Court, in the recent past, has been very vigilant against violations of the human rights of the prisoners.

Role played by the judiciary

The need for prison reforms has come into focus during the last three to four decades. The Supreme Court and the High Courts have commented upon the deplorable conditions prevailing inside the prisons, resulting in violation of prisoner's rights. Prisoners' rights have become an important item in the agenda for prison reforms.

The Indian Supreme Court has been active in responding to human right violations in Indian jails and has, in the process, recognised a number of rights of prisoners by interpreting Articles 21, 19, 22, 32, 37 and 39A of the Constitution in a positive and humane way. Given the Supreme Courts' overarching authority, these newly recognised rights are also binding on the State under Article 141 of the Constitution of India which provides that the Law declared by the Supreme Court shall be binding on all courts within the territory of India.

Following are the reasons cited in various case laws for which prisoner's rights were recognised and upheld by the Indian judiciary.

a) "Convicts are not by mere reason of the conviction denuded of all the fundamental rights which they otherwise possess"- Justice V.R. Krishna Iyer (Sunil Batra vs. Delhi Administration., 1978).
b) "Like you and me, prisoners are also human beings. Hence, all such rights except those that are taken away in the legitimate process of incarceration still remain with the prisoner. These include rights that are related to the protection of basic human dignity as well as those for the development of the prisoner into a better human being" (Charles Shobraj vs. Superintendent, 1978).
c) If a person commits any crime, it does not mean that by committing a crime, he/she ceases to be a human being and that he/she can be deprived of those aspects of life which constitutes human dignity.
d) It is increasingly being recognised that a citizen does not cease to be a citizen just because he/she has become a prisoner.
e) The convicted persons go to prisons *as* punishment and not *for* punishment (Jon Vagg., 1994) Prison sentence has to be carried out as per the court's orders and no additional punishment can be inflicted by the prison authorities without sanction (Sunil Batra vs. Delhi Administration., 1978).
f) Prisoners depend on prison authorities for almost all of their day to day needs, and the state possesses control over their life and liberty, the mechanism of rights

springs up to prevent the authorities from abusing their power. Prison authorities have to be, therefore, accountable for the manner in which they exercise their custody over persons in their care, especially as regards their wide discretionary powers.

g) Imprisonment as punishment is now rethought of as 'rehabilitative' punishment. This involves a philosophy that individuals are incarcerated so that they have an opportunity to learn alternative behaviours to curb their deviant lifestyles. Correction, therefore, is a system designed to correct those traits that result in criminal behaviour. The rehabilitative model argues that the purpose of incarceration is to reform inmates through educational, training, and counselling programmes. This development and growth requires certain human rights without which no reformation takes place.

h) Disturbing conditions of the prison and violation of the basic human rights such as custodial deaths, physical violence/torture, police excess, degrading treatment, custodial rape, poor quality of food, lack of water supply, poor health system support, not producing the prisoners to the court, unjustified prolonged incarceration, forced labour and other problems observed by the apex court have led to judicial activism (NHRC, 1993).

i) Overcrowded prisons, prolonged detention of under trial prisoners, unsatisfactory living condition and allegations of indifferent and even inhuman behaviour by prison staff has repeatedly attracted the attention of critics over the years. Unfortunately, little has changed. There have been no worthwhile reforms affecting the basic issues of relevance to prison administration in India. (Justice A N Mulla Committee, 1980-83)

Rights of the prisoners have been expressed under the Indian Constitution as well as Indian laws governing prisons. The Supreme Court and High Court rulings have played a crucial role in enumerating the rights of prisoners.

A land mark judgement by Justice V.R. Krishna Iyer enumerated basic human rights of the prisoners. Mr. Sunil Batra had written a letter from Tihar Jail, Delhi to the Supreme Court providing information about the torture and inhuman conditions of the prison. This case has become a landmark case in prison reforms (Sunil Batra Vs Delhi Administration, 1980) This case recognized the various rights of prisoners in the most comprehensive manner. The judgement held that: *"No prisoner can be personally subjected to deprivation not necessitated by the fact of incarceration and the sentence of the court. All*

other freedoms belong to him to read and write, to exercise and recreation, to meditation and chant, to comforts like protection from extreme cold and heat, to freedom from indignities such as compulsory nudity, forced sodomy and other such unbearable vulgarity, to movement within the prison campus subject to requirements of discipline and security, to the minimal joys of self-expression, to acquire skills and techniques. A corollary of this ruling is the Right to Basic Minimum Needs necessary for the healthy maintenance of the body and development of the human mind. This umbrella of rights would include: Right to proper Accommodation, Hygienic living conditions, Wholesome diet, Clothing, Bedding, timely Medical Services, Rehabilitative and Treatment programmes".

Another land mark judgement pronounce by the judiciary is the right to compensation in cases of illegal deprivation of personal liberty. The Rudal Shah case (Rudal Shah v. State of Bihar, 1983) is an instance of breakthrough in Human Rights Jurisprudence. The petitioner Rudal Shah was detained illegally in prison for more than fourteen years. He filed Habeas Corpus before the court for his immediate release and, interalia, prayed for his rehabilitation cost, medical charges and compensation for illegal detention. After his release, the question before the court was "whether in exercise of jurisdiction under Article 32, could the court pass an order for payment of money? Was such an order in the nature of compensation consequential upon the deprivation of fundamental right? There is no expressed provision in the Constitution of India for grant of compensation for violation of a fundamental right to life and personal liberty. But the judiciary has evolved a right to compensation in cases of illegal deprivation of personal liberty. The Court granted monetary compensation of Rs.35,000 against the Bihar Government for keeping the person in illegal detention for 14 years even after his acquittal. The Court departed from the traditional approach, ignored the technicalities while granting compensation.

The decision of Rudal Shah was important in two respects. *Firstly, it held that violation of a constitutional right can give rise to a civil liability enforceable in a civil court and; secondly, it formulates the bases for a theory of liability under which a violation of the right to personal liberty can give rise to a civil liability.* (Rudal Shah v. State of Bihar, 1983) The decision focused on extreme concern to protect and preserve the fundamental right of a citizen. It also calls for compensatory jurisprudence for illegal detention in prison.

In India, the courts have acknowledged and several judgements recognise a wide array of fundamental and other rights of prisoners. Table 2 enumerates the broad categories of rights, which are not exhaustive as this field is still developing and slowly evolving (Sreekumar R, 2003). These rights have been drawn from various case laws (Madhurima, 2009). Though these rights are articulated in the case laws, they do not reach the poor prisoners. There are still many rights that are not recognised by the Indian legal system. For example, in January 2010, considering the rapid increase in the number of HIV positive prisoners, the Bombay High Court asked the Maharashtra government to examine the possibility of allowing jail inmates to have sex with their wives in privacy.

Table 2. RIGHTS OF PRISONERS

1. Right to be lodged appropriately based on Proper Classification.
2. Special Right of young prisoners to be segregated from adult prisoners.
3. Rights of women prisoners.
4. Right to healthy environment.
5. Right to bail.
6. Right to speedy trial.
7. Right to free legal services.
8. Right to basic needs such as food, water and shelter
9. Right to have interviews with one's Lawyer.
10. Right against being detained for more than the period of sentence imposed by the court.
11. Right to protection against being forced into sexual activities.
12. Right against arbitrary use of handcuffs and fetters.
13. Right against torture, cruel and degrading punishment.
14. Right not to be punished with solitary confinement for a prison offence.
15. Right against arbitrary prison punishment.
16. Right to air grievances and to effective remedy.
17. Right to evoke the writ of habeas corpus against prison authorities for excesses.
18. Right to be compensated for violation of human rights.
19. Right to visits and access by family members of prisoners.
20. Right to write letters to family and friends and to receive letters, magazines, etc.
21. Right to rehabilitation and reformative programmes.
22. Right in the context of employment of prisoners and to prison wages.
23. Right to information about prison rules.
24. Right to emergency and reasonable health care.

Sources: Sreekumar 2003.

The Court for the first time noted the aspect of physical needs of the prisoners (The Conjugal Right, 2010). This *conjugal right* also has a valid argument that merely because a spouse is convicted, the innocent partner should not suffer. Another basic contention is

that as long as the prisoner is not executed, in line with the court's orders, he/she had a right to life, which includes the right to propagate species and to a sex life.

Prisoners with mental illness: prison scenario

Human rights and mental illness are closely related. Persons with mental illness are most vulnerable to violation of their rights in the society. They are stigmatised, isolated and discriminated (Lewis, 2009; Thornicroft et al., 2007). A mentally ill prisoner has a double disadvantage. Even when quality psychiatric care is provided, the inmate/patient still has been doubly stigmatized—as both a mentally ill person and a criminal (Lamb, 2009). He may not be able to defend his/her case. Many times, a person with mental illness may not receive proper treatment and remains in the custody for years. This may be an account of being unfit to stand trial, lack of support, or because the family is able but unwilling to bail out the person because of the illness.

Human rights violation itself can have a severe impact on a person's mental health and lead to a vicious cycle as shown in the accompanying figure 2 (Johnson et al., 2010; Priebe et al., 2010).

Figure 2. The vicious cycle of mental disorder and human rights violation

According to Penrose's law, outlined on the basis of a comparative study of European statistics, there is an inverse relationship between the number of psychiatric beds and prison populations within a country. Deinstitutionalisation or closing down psychiatric hospitals has in fact led to trans-institutionalisation (Kalapos, 2009).

Figure 3: De-institutionalisation and trans-institutionalisation

De-institutionalisation and downsizing of mental hospital beds on the one hand, with nonexistence of community mental health care on the other, results in many wandering and homeless mentally ill on street. These persons are booked for offences such as trespassing, creating public nuisance, indecent behaviour, planning a crime/robbery and other petty crimes. This is known as 'criminalisation of the mentally ill' (Torrey et al., 2010). Often, they are arrested for begging and kept in a beggars' home without any treatment for decades and left to perish.

Trans-institutionalisation is the movement of persons with severe mental disorders between prisons and the mental hospital and prison or other custodial settings (Pedersen

and Kolstad, 2009). Persons with mental illness are likely to remain in prisons for unnecessarily long periods of time because their illnesses go unnoticed, undiagnosed and untreated (Priebe et al., 2005). Even if they are brought to the notice of the court, he/she may not be fit to stand trial. Non availability of timely treatment and continuous care further aggravates the situation. The family in many instances is unwilling to house or care for such persons and there is no place in the community for their rehabilitation. There is an urgent need to evolve an interdisciplinary approach to provide care and uphold the rights of mentally ill prisoners (Jennifer Bard, 2007).

In conclusion, various judgements passed by Indian courts suggest that they are sensitised to the need for doing justice to people to whom justice had been denied by a heartless society for generations (Mehta and Neena Verma, 1999). Although several judgements have recognised the rights of prisoners, these have resulted in few amendments to legislation. *While judicial sensitivity and activism is appreciable, it must be borne in mind that the country's criminal justice system still suffers from substantive and procedural deficiencies; once a citizen is arrested, even if on a relatively minor charge, he/she could be held in custody for years before his/her case comes up for trial. Those who are affluent are still being able to negotiate their way around the numerous obstacles that lie on the road to justice. For an ordinary citizen, an encounter with the law is very much the stuff of nightmares. There is a long course before the Indian judiciary to be followed in order to achieve the goal of social justice* (Krishna Iyer VR, 1984).

Though various rights have been granted to prisoners, in reality, they do not reach the prisoners. An outstanding example is the right to speedy trial. A huge backlog of cases impedes the delivery of justice and this is a violation of the rights by the court itself. Similarly, free legal aid is an idealistic goal, but presently far from reality. Many of the prisoners do not know about the services and they are unable to utilise it.

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11. FITNESS TO STAND TRIAL

Mental illness, mental retardation and certain neurological conditions may incapacitate cognitive, emotional and behavioural faculties of an individual, consequently having serious impact on the ability to defend the case. Assessment of the mental abilities of individuals to defend their case is called, 'fitness to stand trial' or 'competence to stand trial'(American Psychiatric Association, 2002; Mossman et al., 2007). In law, 'fitness to stand trial' deals with the mental capacity of an individual to participate in legal proceedings. As per the guidelines approved by the Council of the American Academy of Psychiatry and the Law in 2007, 'Fitness to stand trial' is a legal construct that usually refers to a criminal defendant's ability to participate in legal proceedings related to an alleged offence (Mossman et al., 2007).

Defendants who are 'unfit to stand trial' are usually excluded from criminal prosecution and the trial is usually postponed until such time as the person is judged competent. People found psychiatrically incompetent for trial are usually sent for treatment and will be treated to regain competence. Traditionally, fitness to stand trial evolved in criminal cases, but has also been recently extended to the civil suit. In civil proceedings, fitness for proceedings is termed the capacity to sue and be sued, and is not identical in its requirements with fitness for proceedings under criminal law. The capacity to sue and be sued is related to contractual capacity (Rothschild et al., 2007). Fitness also encompasses other areas apart from trial. There are instances when the investigating officers are threatened by the defendants that they will commit suicide if the interrogation is done. In such cases, investigating officers request mental health professionals to assess the individual's, 'fitness for interrogation'. Fitness for interrogation is the capacity to understand the meaning of questions posed during police investigations and in court, and to answer such questions meaningfully (Rothschild et al., 2007). However, fitness is rarely used in this context.

Fitness to stand trial evaluations have profound significance because of their influence on court decisions, court proceedings, resources utilised and the far-ranging consequences for the defendant with regard to referral to a forensic psychiatry setting. These aspects have been applied in day-to-day practice, and researched extensively in western countries. This has become possible with growing awareness among the professionals and increased frequency of evaluations of competence to stand trial in recent years (Melton et al., 2007; Melton et al., 1997; Quinnell and Bow, 2001). In the United States

alone, conservative estimates suggest there are 60,000 competency cases per year, with rates of incompetency often falling in the 20- to 30-percent range. (Bonnie and Grisso, 2000; Melton et al., 2007; Melton et al., 1997) When extrapolated from the number of actively psychotic and mentally disordered inmates, (American Psychiatric Association, 2002) the potential number of competency evaluations could easily be twice this estimate (Rogers and Johansson-Love, 2009).

In India, there are many instances in which fitness to stand trial has delayed the proceedings for decades. Various reasons have been attributed for the delay, such as, ignorance, non-availability of the psychiatrist, non-availability of psychotropic medicines and family members not wanting the person with mental illness to be released (perceived dangerousness). This is compounded by the lack of resources to provide care and restore such individuals to their mental competency to fight their case. This chapter reviews only a small selection of the vast amount of published literature on fitness to stand trial. It provides a brief overview of the concept of fitness to stand trial, assessment and its impact.

Case Vignette

Mr. Machang Lalung, was arrested at his home village of Silsang near Guwahati in 1951 under section 326 of the Indian Penal Code for "causing grievous harm." He was detained at the age of 23, he could secure his release only when he was 77 years old.

Less than a year after he was taken into custody, Lalung was transferred to a psychiatric hospital in the Assamese town of Tezpur. Sixteen years later, in 1967, doctors confirmed that he was "fully fit" to be released, but instead he was transferred to Guwahati Central Jail, where he was imprisoned until 2005. He spent his valuable 54 years of life behind bars and could secure his release only after the intervention from the Honorable Supreme Court of India in 2005. He was able to enjoy life outside the prison for only two years. He passed away on 26 Dec 2007

Source: Supreme Court, Writ Petition [CRL] NO(s). 296 OF 2005
http://news.bbc.co.uk/2/hi/south_asia/4712619.stm

EVOLUTION OF THE FITNESS TO STAND TRIAL

In 1960, Dusky v. US trial established what is usually taken to be the minimal constitutional standard for adjudicative fitness in the United States. The appellant, Milton Dusky, faced a charge of unlawfully transporting a girl across state lines and raping her. A pre-trial psychiatric evaluation rendered a diagnosis of 'schizophrenic reaction, chronic undifferentiated type' A separate psychiatric report and psychiatric testimony at trial stated that Dusky could not "properly assist" counsel because of suspicious thoughts, including a belief that he was being "framed." Yet, the trial court found that Dusky was competent to stand trial. He was convicted of rape, and the Eighth Circuit Court of Appeals affirmed his conviction (Mossman et al., 2007).

The U.S. Supreme Court held, however, that the trial court's determination that Dusky was oriented and could recall events was not sufficient to establish his competence to stand trial. Instead, the Court stated that the test for his competence to stand trial was "whether he [had] sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he [had] a rational as well as factual understanding of the proceedings against him" (Dusky v. US 1960). It is not enough to find that the defendant is oriented to time and place and has some recollection of events, but that the test must be whether he has sufficient ability to consult with his lawyer with a reasonable degree of rational understanding and whether he has a rational as well as factual understanding of the proceedings against him (Dusky v. US 1960).

The accurate assessment of fitness to stand trial depends on a good operational definition. A good operational definition hinges on the clear identification of the criteria and components of fitness to stand trial. Several attempts have been done to identify the criteria and classify the components with varying degree of success. However, there are no agreed definitions or clear cut criteria to assess fitness to stand trial. In the US, fitness to stand trial assessment is based on three prongs of the Dusky standard. These are: (a) factual understanding, (b) rational understanding, and (c) ability to consult with counsel (Dusky v. US 1960; Rogers et al., 2001). As per the Criminal Code of Canada, an individual's ability is defined in terms of three areas of information. First, the accused must understand the nature or object of the proceedings. Second, the accused must understand the possible consequences of the proceedings, and finally, he or she must be able to communicate with counsel (Zapf et al., 2001). In the Australian legal system, a

person is deemed to be fit to stand trial if he or she has the ability to achieve a lay person's understanding of: the court process, the charges that have been made, and how s/he will instruct legal advisors to proceed in relation to the charges (Large et al., 2009; Mullen, 2002).

Almost all legislations have certain common components which are used to determine the impairment in cognitive, emotional and behavioural domains of brain functioning, with regard to assessment of fitness to stand trial. They are as follows, a) comprehending the charges framed against them, b) realising the seriousness of the penalties if proven guilty, c) following the proceedings of the court, d) helping their lawyer to defend their case and e) appropriate behaviour in the court. Hence, fitness to stand trial plays a crucial role in persons with mental illness or mental retardation. 'Un-fitness to stand trial' therefore depends upon the presence of a mental disorder during the adjudication process (i.e either during the initiation of the trial, continuation of the trial or else during the verdict). Though presence of a mental disorder is obviously an important factor in determining an individual's fitness, mental disorder by itself is not sufficient to determine that a defendant is unfit. There are many mental illnesses in which individual's rational thinking capacity is preserved and such a person will be deemed fit to stand trial. For example, in the case of mild to moderate depression, individuals do not lose their rational thinking capacity.

Invoking the fitness to stand trial assessment in court

The court may order an assessment of the defendant's mental condition if it believes that such evidence is necessary to determine a) fitness to stand trial, b) whether the defendant was, at the time of the commission of the alleged offence, suffering from a mental disorder, c) whether that mental disorder impairs reasoning power of the defendant and d) for placement of the individual in an appropriate place such as a mental hospital, rehabilitation, or high security prison.

In a case in the US, (Medina v. California 1992), a defendant faced several criminal charges, including three counts of first-degree murder. Upon the defense counsel request, the trial court granted a hearing on his client's competence. The court clearly stated that in every case it presumes that defendants are competent until the contrary is proven. Hence, invoking the fitness to stand trial assessment would be by the defendant or his/her family

members or by his/her attorney. At the same time, burden of proof is also on the defendant. However, the level of proof needed to show that a defendant lacks adjudicative competence is by proving it by a preponderance of the evidence.

NEED FOR ASSESSMENT OF 'FITNESS TO STAND TRIAL'

Principle of natural justice

The Principle of natural justice is based on two legal maxims namely, a) ***nemo judex in sua causa* – '**nobody shall be a judge in his own cause', invalidating any judgement where there is a bias or conflict of interest or duty; and b) ***audi alteram partem*-** 'hear the other side', giving at least a fair opportunity to present one's case. The aim of the p**rinciple of natural justice** is to secure justice and to prevent miscarriage of justice. They do not supplant the law but supplement it (Maneka Gandhi v. Union of India 1978, Gabriel v. State of Madras 1959). These two fundamental principles are widely held to be legally necessary for a fair trial or valid decision in a legal system. This chapter is not concerned with the former. The question is only in regard to audi alteram partem rule in the lawsuit related to person with mental illness so that the trial is fair.

In a recent landmark judgement in India, the Supreme Court has voiced that each one has an inbuilt right to be dealt with fairly, in a criminal trial. Denial of a fair trial is as much injustice to the accused as is to the victim and the society. Fair trial obviously would mean a trial before an impartial judge, a fair prosecutor and an atmosphere of judicial calm. Fair trial means a trial in which bias or prejudice for or against the accused, the witnesses, or the cause which is being tried is eliminated (Zahira Habibullah Sheikh v. State of Gujarat 2006).

Violation of 'Right to a fair trial'

Fitness to stand trial is to assure the autonomy and individual right of the person to defend himself/herself. The question which is of utmost importance is whether the person can do so, so that fair adjudication of trial is given. Hence, fitness to stand trial has a direct impact on deciding the Right to a fair trial.

The reasons for determining fitness to stand trial are as follows (a) to safeguard the accuracy of the proceedings, (b) to ensure procedural fairness, (c) to preserve the dignity

of the legal system, and (d) to achieve the objectives of sentencing (Wiener, 1985). Bonnie (1992) identified a three-part rationale: (a) dignity, (b) reliability, and (c) autonomy. Trying a defendant who lacks an understanding of wrongdoing and subsequently punishing that defendant would offend the moral ***dignity*** of the legal proceedings. The term ***reliability*** addresses the issue that the construct of competency must be operationalised within the attorney-client relationship. That is, in order to present an

Right to fair trial is a human right

- Article 14 of the International Covenant on Civil and Political Rights, which has been ratified by India and is now part of the Protection of Human Rights Act 1973 recognises the right to fair trial as a human right.
- The concept of a fair trial is a constitutional imperative recognised in Articles 14, 21, 22 and 39-A
- The Code of Criminal Procedure (CrPC) 1973 (Procedure in case of accused being lunatic, CrPC Sec 328, 329 and 330)

adequate defense, the defendant must have the capacity to appreciate the utility of certain facts and the wherewithal to provide counsel with that information. If a defendant is not able to provide counsel with such information, then the reliability of the criminal process is jeopardised. Lastly, Bonnie's rationale of ***autonomy*** is based on the legal rules that certain decisions regarding the defense must be made by the defendant (Bonnie, 1992)

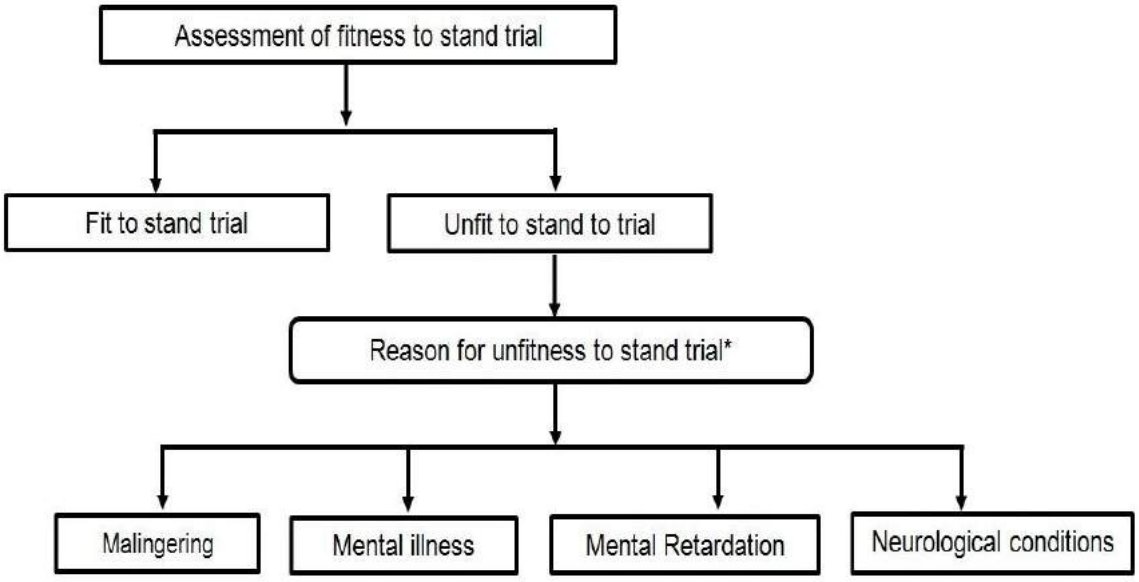
ASSESSMENT OF FITNESS TO STAND TRIAL

Assessment is usually done by a forensic psychiatrist. Presence of a mental disorder is a necessary but not sufficient condition to determine that a defendant is unfit (Roesch and Golding, 1980). Even if a person is suffering from mental disorder, it should be assumed that he/she has the mental capacity to decide on various matters unless the contrary can be shown. Hence, it must be demonstrated that the mental disorder affects the defendant's performance on adjudicating process. Roesch and his colleagues reported in their study that, while nearly all defendants who had been found unfit to stand trial had some form of

psychosis, almost one-third of those found fit to stand trial were also considered to suffer from psychosis (Roesch et al., 1981).

Assessment can be done on an outpatient or inpatient basis depending upon the nature of the case. On a simple outpatient basis examination it

Figure 1: **Assessment of fitness to stand trial**



*It is also essential to report that 'unfitness' is reversible (treatable conditions such as schizophrenia, bipolar disorders, acute psychosis, delirium) or irreversible (no treatment currently available such as mental retardation, dementia, irreversible brain damage).

can be easily assessed for the fitness to stand trial. On the contrary, to report unfitness, the forensic psychiatrist has to ascertain the nature of the illness, nature of impairment and also reason out how the defendant's illness is an impediment to the adjudicating process. It is the responsibility of the professional to inform the court regarding the restorability of the fitness (reversible and irreversibility of the condition) and time required for the same.

Inpatient assessment is a time consuming and costly affair. The time required in inpatient assessment and treatment for restoration of fitness may require approximately 4-8 weeks. Hence, fitness assessment is sometimes used as a strategy to delay the proceedings of the case. Rarely, it can also be used to determine the feasibility of a later insanity defence. Forensic psychiatrists also need to keep in mind that at least ten percent of defendants referred for competence evaluations attempt to feign mental problems that would impair competence (Gothard et al., 1995; Rogers et al., 1994).

Absence of forensic psychiatrists to do the assessment is a serious limitation in India. There are only a few hospitals providing inpatient forensic psychiatry services across India. Unfortunately, there are very few psychiatrists trained in forensic issues. There is neither a formally approved forensic psychiatry training course in India nor a certified course.

Ethical and legal issues regarding fitness to stand trial:

Fitness to stand trial also involves diverse ethical and legal challenges that need to be discussed and debated. Many of them revolve around the individual rights of the defendants.

Reversibility: It refers to restorability of fitness to stand trial in the future, whereas irreversibility means non-restoration (eg. *lack of treatment response* as in refractory schizophrenia, and *absence of any effective treatment* as in dementia, mental retardation). Reversibility certification needs to be accompanied with adequate safeguards. For example, a defendant found unfit to stand trial should not be held indefinitely for treatment for restoration of his/her fitness. There must be a time period stipulated for successful restoration within a reasonable time. However, irreversibility of the fitness to stand trial raises various issues such as the need to wait for the availability of new treatment. What should be the next legal proceedings? Where the accused should be kept? What will happen to the legal proceedings? What is the kind of care to be provided to the individual in prison?

Forced treatment: On assessment for fitness, if a defendant is found to be suffering from mental illness, then he/she should be offered treatment. In certain situations the defendant may refuse treatment and even threaten self-harm if coerced. This gives rise to a conflict

between an individual's right to refuse treatment versus restorability of the fitness to stand trial through forced treatment. Another hot debate in forensic psychiatry and among the legal fraternity in western countries is the use of electro-convulsive therapy in defendants. These issues need to be addressed.

Case Vignette

Mr. R, 55 years old, was accused of killing his neighbour over a property issue. He was arrested and charges framed against him. During his stay in prison, he started behaving abnormally, forgetting his barrack, passing urine in his clothes. He was unable to remember his family member's name and had difficulty in remembering day-to-day events.

He was referred for assessment to NIMHANS. He was admitted and a complete evaluation was done. Blood investigations, Cerebrospinal fluid analysis and CT scan of the brain were also done. He was diagnosed to be suffering Alzheimer's dementia (early onset), and certified as unfit to stand trial.

Self-Incrimination: During the assessment of fitness to stand trial, defendants may admit to certain actions either spontaneously or in response to the psychiatrist's question. Documentation of such self-incriminatory evidence had led to debate in the US as to whether a court can convict a defendant based on information in a competence assessment. This became the subject of two U.S. Supreme Court cases (Estelle v. Smith 1981) and (Buchanan v. Kentucky 1987). In the earlier case (Estelle V. Smiths 1981), the Supreme Court upheld the right against self-incriminatory evidence, because the defendant did not initiate the psychiatric examination or attempt to introduce psychiatric evidence at trial. However, in Buchanan V. Kentucky, the privilege against self-incrimination was not violated, because the defendant had requested a psychological evaluation and the evidence gathered during the procedure was used.

Confidentiality: Forensic psychiatrists usually get into a dilemma between the 'respect for the individual's right of privacy' and 'duty to do forensic assessment of the defendant and provide an accurate report to the court or the investigating agency'. Psychiatrists should maintain confidentiality to the extent possible, given the legal context. There is a need to disclose the role of assessment and submission of report to the court. The

psychiatrist also needs to inform the defendant that the collateral sources of information will be collected, such as, past history of treatment, past history of offences, family history, personality history from his/her family members and so forth. Hence, limitations of confidentiality need to be disclosed to the defendant. If the defendant raises an objection regarding the confidentiality, then it should be brought to the notice of the court and further directions need to be as per the court orders.

Fitness to stand trial is different from Insanity defence

It is important to note that the 'insanity defense' is completely different from 'fitness to stand trial'. Fitness to stand trial refers to current ability to understand and participate in the adjudicating process. The "insanity defense" refers to one's state of mind at the time of the alleged crime (Sec 84 Indian Penal Code). In simple, words 'insanity defense' is concerned with the state of mind during the commission of crime and is considered static. Whereas, fitness to stand trial is the assessment of the state of mind during the adjudicating process and it is considered dynamic since it changes over a period of time. Therefore, it needs to be assessed periodically in vulnerable populations such as people with mental illness. Insanity defense is the retrospective assessment of the state of mind during the crime but fitness to stand trial is a prospective assessment of the state of mind.

A person suffering with schizophrenia may commit a crime during his/her active phase of illness. Immediately after initiating the treatment, his/her fitness to stand trial is restored within a few weeks. In such a scenario, the primary concern will be the insanity defence- the state of mind during commission of the crime. In another scenario, a normal person may commit a crime and become mentally ill after incarceration or he/she may develop illness during the adjudication of the case. This distinction is important because of the popular sentiment that the insanity defence it as a way of "getting away with a crime", and avoiding accountability and culpability for a criminal action. In fitness to stand trial, ability to understand and participate in the trial process is assessed rather than the defendant's condition or functioning at the time of the alleged offence. The distinction sounds simple but mistakes are often made by both psychiatrists and lawyers.

INDIAN SCENARIO

A person with a mental disorder should be assumed to have mental capacity to decide on various matters unless the contrary can be shown. In many instances, persons with mental

illness need to undergo a medical examination called 'fitness to stand trial' as per the Code of Criminal Procedure, 1973 Sec 328, and Sec 329. Section 328 of CrPC (Procedure in case of the accused being lunatic) states that **'**when a Magistrate holding an inquiry has reason to believe that the person against whom the inquiry is being held is of unsound mind and consequently incapable of making his/her defense, the Magistrate shall inquire into the fact of such unsoundness of mind, and shall cause such person to be examined by the civil surgeon of the district or such other medical officer as the State Government may direct, and thereupon shall examine such surgeon or other officer as a witness and shall reduce the examination to writing'. If a person is found incompetent to stand trial, the trail is usually postponed until such time as the person is judged competent. A person found psychiatrically incompetent for trial is usually sent for treatment to regain competence (even against his/her will).

Need for a screening instrument

Considering the lack of forensic psychiatrists in countries like India, there is a need for developing a simple screening instrument for assessment of fitness to stand trial by a lawyer, medical professionals or a trained psychologist. Various instruments and screening questionnaires have been devised to assist in the assessment of fitness to stand trial of mentally ill patients with greater efficiency and accuracy (Pinals et al., 2006). Some of the well-known instruments are MacArthur Competence Assessment Tool-Criminal Adjudication (MacCAT-CA) (Poythress et al., 1999), Evaluation of Competency to Stand Trial-Revised (ECST-R) (Rogers et al., 2004) and Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR) (Everington and Luckasson, 1992). For more information readers are requested to read the article by Rogers & Johansson-Love (2009). These instruments are intended only as a tool to facilitate the assessment of fitness to stand trial, so that a mentally ill person need not wait for a fitness assessment certificate from a qualified psychiatrist. On assessment using such a screening instrument, if he/she is found fit, the trial will proceed. If he/she is found unfit, the defendant needs to undergo detailed evaluation, mental status examination and diagnosis by a psychiatrist before the defendant is declared unfit to stand trial. Hence, certification of incompetence to stand trial can be done only by a qualified psychiatrist after thorough examination and the reason for the same should also be mentioned clearly in writing about the diagnosis and nature of interference in the defendant's mental capacity to participate in legal proceedings.

A brief screening instrument would save time and money because the screening procedure could be done within a couple of hours, without placing the individual in a costly psychiatric institution. This will help to protect their human rights, right to fair and speedy trial and also avoids unnecessary detention in psychiatric settings. Unfortunately, there is no validated screening instrument available at this point of time for the Indian population.

Methods of restoration of fitness to stand trial

A brief explanation may be necessary regarding the use of the words, "restoration" of fitness to stand trial. Restoration involves the following interventions:

- Use of medication or pharmacotherapy
- Psycho-social interventions and
- Legal counselling.

Treatment of the underlying condition (schizophrenia, depression) through medication restores the fitness to stand trial. Psycho-social interventions include cognitive behavior therapy in depressed patients, cognitive retraining in patients with cognitive deficits, social skill training in schizophrenia, anger management techniques, counselling for drug abuse, relaxation training and behavior therapy for anxiety disorders. Other interventions include stress management and teaching coping skills, so that the defendant learns to handle stress during the litigation and also cope with possible negative outcome/ judgment of the case.

Legal counselling involves educating the defendants in the trial process, including the roles of the courtroom personnel, pleas, charges, sentencing, and how to assist the attorney in planning the case. Further, it also involves expected behavior in the court of law. Guest lectures, group discussions, discussing with survivors, workshops and meeting with the court personnel, all help the defendant in gaining knowledge of various legal procedures. Also helpful are question and answer sessions with legal experts. Role-play by defendants acting as actors of various courtroom personnel in a scripted mock trial, with discussions led by legal experts, videotapes of actual courtroom proceedings watched by defendants, with discussions led by lawyers all help in restoration of the fitness to stand trial (Mossman et al., 2007). There are various educational modules and programmes that have been developed and used in the competence-restoration curriculum

(Noffsinger, 2001; Wall et al., 2003). Further, educating their rights and mechanisms to restore them if they are violated plays a crucial role in developing a rights based environment inside the correctional settings.

In conclusion, fitness to stand trial is a legal construct, which discusses the issues regarding the defendant's mental capacity to participate in legal proceedings. Assessment of fitness to stand trial assures the court that the defendant has adequate mental capacity to make a defense. Psychiatrists should clearly describe the opinion regarding the fitness to stand trial. If the opinion is of an "unfit" state, it needs to be accompanied by details regarding psychiatric diagnosis, the causes for defective reasoning and how it interferes with the ability to participate in legal proceedings. Fitness to stand trial is an important area in the context of Indian law, and is only evolving. It needs to be utilised judicially to protect the rights of the mentally ill, without becoming a tool for misuse.

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12. WOMEN IN PRISON

The fact that prisoners have higher rates of psychological distress and mental health problems when compared to the general population are well established (Fazel and Danesh, 2002). Needless to say, the rates are much higher in the case of women in custody. Although women still constitute a small minority of the prison population across the world, the number of incarcerated women is increasing (Slotboom et al., 2007). In addition to the common kinds of distress both men and women experience in prison, women are more vulnerable for gender discrimination, neglect, violence, physical and sexual abuse. Studies have documented that relative to their male counterparts, women incarcerated in state prisons are more likely to have mental disorders and a history of physical and sexual abuse (Blitz et al., 2006; Brown et al., 1999; Hartwell, 2001). Despite the magnitude of problems, little attention has been given to the unique health concerns of women prisoners. Mental health care and attention to the psychological distress that occurs because of imprisonment of women, is almost non-existent.

The relevance of gender issues

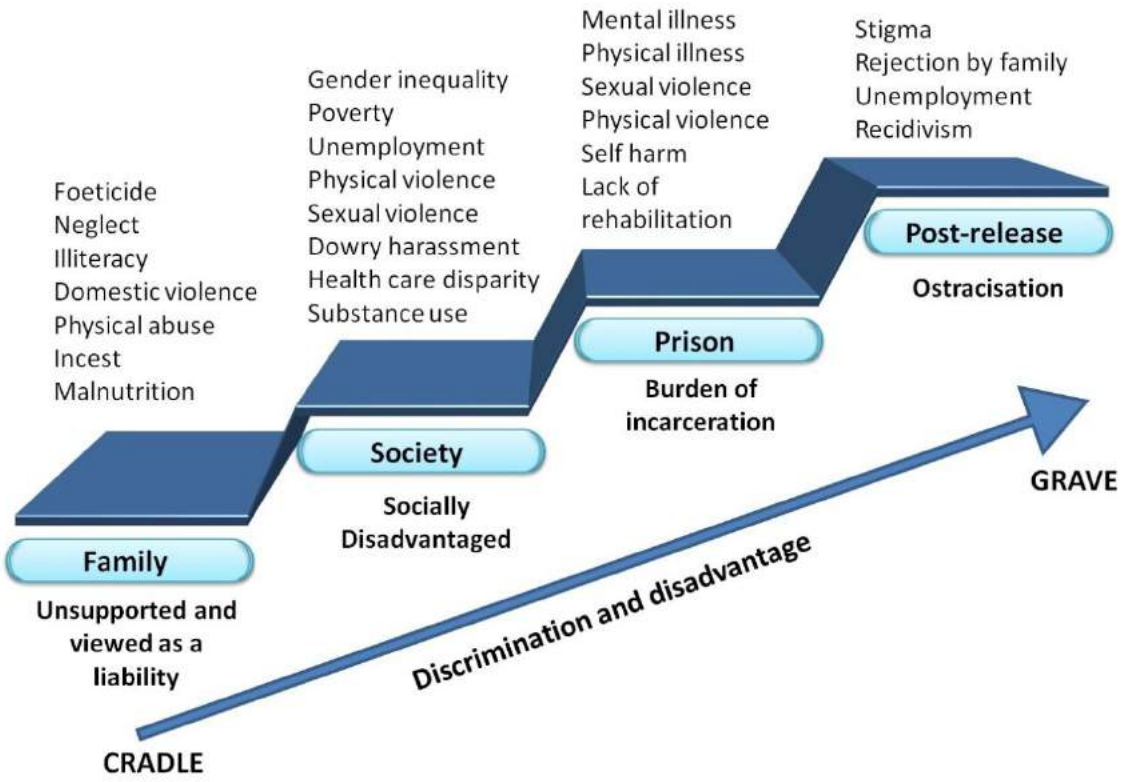
Women usually lead protected lives and are good home makers. They are not exposed to the travails of the outside world. When they come in conflict with law and are imprisoned, they find it very difficult to cope with the prison environment. Prison isolates the women from their family and friends. They cannot perform their usual duties. This causes sadness, guilt and puts tremendous stress on them. The physical and mental health needs of women are different compared to men. Traditionally, most of the prison inmates are males, and the prison environment is therefore shaped by the needs of males (Slotboom et al., 2007) and do not cater to the special needs of women prisoners.

Women in prison have a double disadvantage. The gender disadvantage and discrimination gets worsened during imprisonment, which is further amplified upon their release from prison. Gender sensitive interventions need to take into account psychological distress in a life stage perspective.

As women in prisons are frequently victims of physical and sexual abuse, United Nations on Human Rights *Rule 53* of the *Standard Minimum Rules for the Treatment of Prisoners* states that women prisoners must only be guarded by female officers (United Nations,

1955). Male staff continue to have unchecked visual and physical access to women in what constitutes their rehabilitation rooms, bedrooms, restrooms and living rooms in many Indian prisons. At times, male staff does not hesitate to do frisk search on female prisoners. There are instances when prison staff have endorsed and supported bullying and verbal abuse of women prisoners, if they do not listen to them (Human Rights Watch 1996).

Figure 1: Women and discrimination



International Review

Women prisoners are found to suffer from a variety of health problems in the custodial environment. A recent study on women prisoners in the UK reported that imprisonment impacted their health negatively. The initial shock of imprisonment, separation from families and enforced living with other women suffering drug withdrawal and serious mental health problems affects their own mental health. Over the longer term, women complained of detention in unhygienic facilities by regimes that operated to disempower

them, even in terms of management of their own health (Douglas et al., 2009). Women described responses to imprisonment that were also health negating such as increased smoking, eating poorly and seeking psychotropic medication. The study avers that there is little evidence that the UK policy initiatives have been effective in addressing the health needs of women prisoners (Douglas et al., 2009). According to the fact sheet of Amnesty International on women in prison, women are denied essential medical resources and treatments, especially during pregnancy.

There are studies which have reported high prevalence of syphilis among women prisoners as compared to general population. HIV infection is also high (M.C.De Azcarraga Urteaga et al., 2010). Women prisoners suffer menstrual disorders, stress, and depression. The WHO guidelines on HIV infection and AIDS in prisons (World Health Organization, 1993) contain the following recommendations specific to women in prison.

a) Special attention should be given to the needs of women in prison. Staff dealing with detained women should be trained to deal with the psychosocial and medical problems associated with HIV infection in women.

b) Women prisoners, including those who are HIV-infected, should receive information and services specifically designed for their needs, including information on the likelihood of HIV transmission, in particular from mother to infant, or through sexual intercourse. Since women prisoners, either upon release or during parole may be sexually active, they should be enabled to protect themselves from HIV infection, e.g., through imparting skills in negotiating for safe sex. Counselling on family planning should also be available, if national legislation so provides. It is possible that the woman discovers her pregnancy only after incarceration. For such women, there should be no pressure placed to terminate their pregnancies. Women should be able to care for their young children while in detention regardless of their HIV status.

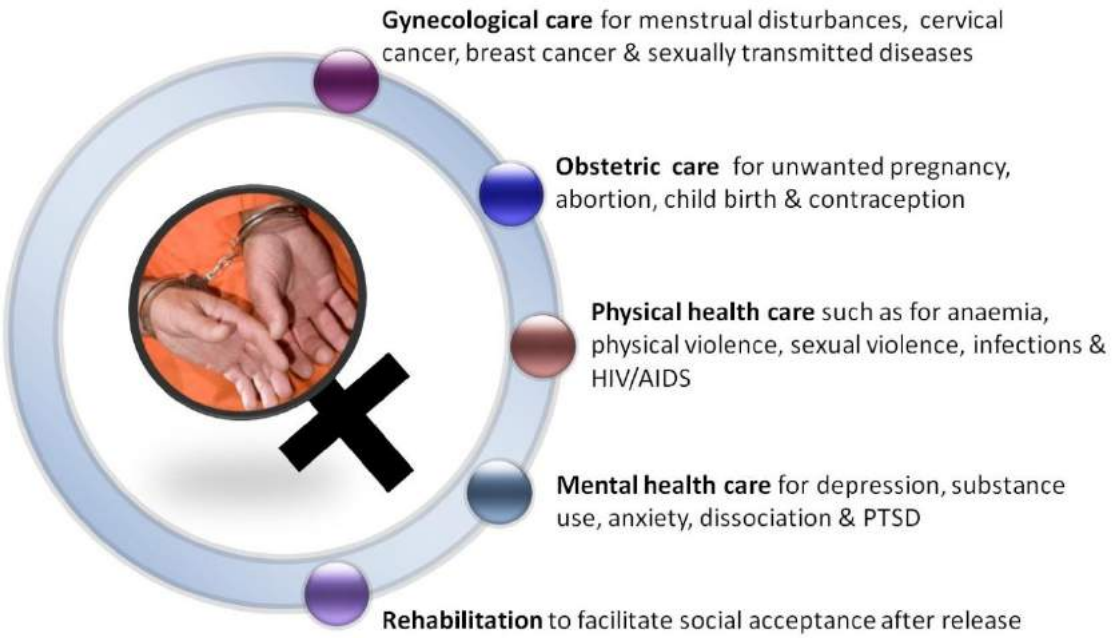
c) The following should be available in all prisons holding women:

- Gynaecological consultations at regular intervals, with particular attention paid to the diagnosis and treatment of sexually transmitted diseases;
- Family planning and counselling services oriented to women's needs;
- Care during pregnancy in appropriate accommodation;
- Care for children, including those born to HIV-infected mothers; and
- Condoms and other contraceptives during detention and prior to parole periods or release.

There is also a need to focus on the preventive health care aspects for the women prisoners, especially with respect to cervical cancer screening, breast cancer, HIV testing and hepatitis (Nijhawan et al., 2010). Opportunities need to be provided for sex education, smoking cessation and drug de-addiction programmes (Jolley and Kerbs, 2010). US based studies have reported that access to substance abuse treatment for women is necessary because at least half the women in state prisons were under the influence of illicit drugs/alcohol at the time of their offence and most women are in prison on drug-related convictions (Greenfeld and Snell, 2000).

Women have a considerably greater risk of contracting HIV and Hepatitis C from sexual activity than men. Women who engage in injecting drug use have a particularly high risk through sharing syringes and needles. They might have had unprotected sex with their drug partners or have been engaged in sex work. Women's cultural and societal conditions might be such that they are not in a position to control their own sexual lives (Bastick and Townhead 2008; Reyes, 2000; UNODC, 2009; World Health Organization, 1993). Women prisoners have important mental health and drug treatment needs. Studies have shown that the beneficial effects of treatment components oriented toward women's health needs in prison sustain even after 12 months after release (Nena et al., 2010). The majority of offences for which women are imprisoned are non-violent such as property, dowry-harassment, drug-related offences, prostitution, bar dancing and so forth (Kumari, 2009; UNODC, 2009). Many women serve a short sentence, which means that the turnover rate is high.

Figure 2: Spectrum of gender specific health care required in prisons



Specific mental health problems among women in prison: International perspective

Mental health problems among women in prisons all over the world are very high. These include both mental disorders and a high level of drug or alcohol dependence. Women in prisons frequently come from deprived backgrounds, and many have experienced physical and sexual abuse, alcohol and drug dependence and inadequate health care before imprisonment (Messina et al., 2006; Reyes, 2000). Further, women entering prisons are more likely than men to have poor mental health, often associated with experiencing domestic violence and physical and sexual abuse (Reyes, 2000; UNODC, 2009).

Research indicates that women in prisons have mental health problems to a much higher degree than both the general population and male prisoners (Bastick and Townhead, 2008). A systematic review of the literature on prevalence of post-traumatic stress disorder (PTSD) in prisoners reported that PTSD rates ranged from 4% of the sample to

21%. Women were disproportionately affected (Goff et al., 2007). A study conducted by the Bureau of Justice Statistics of the United States, showed that 73% of the women in state prisons and 75% in local prisons in the United States have symptoms of mental disorders compared to 12% of women in the general population (Covington, 2007). In England and Wales, it was noted that 90% of the women prisoners have a diagnosable mental disorder, substance use or both (Møller et al., 2007). Nine out of ten had at least one of the following: neurosis, psychosis, personality disorder, PTSD, self harm, alcohol abuse and drug dependence. Prevalence rate of current serious mental illness for male inmates was 14.5% and for female inmates it was 31.0% (Steadman et al., 2009). Women were 14 times more likely to harm themselves than men and also repeat such self harm (Møller et al., 2007).

Recognising that the public health importance of prison health is neglected, the World Health Organization (WHO) Regional Office for Europe established the Health in Prisons Project (HIPP) in 1995 (World Health Organisation, 1995). This continuously expanding network of 38 Member States in Europe is committed to reducing the public health hazards associated with prisons along with protecting and promoting health in prisons. Published reports of the HIPP during recent years, including the widely used WHO guide to the essentials in prison health in 2007 (Møller et al., 2007) and the Trencin Statement on Prisons and Mental Health in 2008 (World Health Organization, 2008), have combined the latest research and analysis from experts throughout the world and have clearly raised the profile of prison health issues.

NATIONAL SCENARIO

In spite of several legislations and committees, the condition of jails is deplorable. Though the hard fact is known to the administration, nothing is done to address these issues. A prison officer listed the various issues relating to women inmates which are: (i) Admission (ii) Classification (iii) Reformation Programme (iv) Vocational Training (v) Health and Hygiene (vi) Psychological or emotional issues (vii) Visitors and emergency leave (viii) Rehabilitation on release (ix) Resocialisation and acceptance. Women prisoners on admission are in a mentally disturbed condition. He has also highlighted the fact that nearly 60% of inmates suffer from various issues of mental health like psychosis, major depression and personality disorder (Nataraj, 2009).

Imprisonment of a mother with dependent child/children is a problematic issue and it needs to be addressed immediately (Pandy and Singh, 2006). The effects of incarceration can be particularly catastrophic on the children and costly to the state in terms of providing for their care, and because of the social problems arising from early separation (Pandit Govind Ballabh Pant Institute of Studies in Rural Development, 2004).

The shocking survey on children of women prisoners, conducted by the National Institute of Criminology and Forensic Sciences, Delhi, during 1997-2000, documents the conditions of deprivation and criminality in which they are forced to grow up, lack of proper nutrition, inadequate medical care, and little opportunity for education. Indian Council of Legal Aid and Advice also filed public interest litigation in the Supreme Court, asking that state governments to formulate proper guidelines for the protection and welfare of children of women prisoners (Upadhyay v. State of A.P., 2006). The jail authorities said that they were doing what they could within their limited resources to give children the best possible facilities.

The majority of women offenders convicted for homicidal activities were poorly adjusted to the family settings. In many cases, their offence directly stemmed from their husband and in-law's cruelty, rejection and humiliation. Husband's illicit affairs with other women, alcohol and substance use, domestic violence contributed significantly in motivating married women to resort to crimes (Saxena, 1994).

In another study by Kumari (2009), women prisoners perceived that they would face problems in all spheres of life in future because of their imprisonment. They were also worried about economic and family problems. There is hope about the redemption of the prisoners through counseling and rehabilitation. A study supported by the National Commission for women evaluated mental health problems among women in the Central Prison, Bangalore (Murthy et al., 1998). Among both women undertrials and convicts, common emotional responses were unhappiness, feelings of worthlessness, worry, and somatic symptoms. All these were aggravated during crises points in prison (entry into prison, court hearing, around the time of pronouncement of judgment, victimization, release of a fellow prisoner, death of a fellow prisoner, illness or death of a family member and imminent release).

Protection and promotion of women prisoners' health requires multidimensional approach starting from political will, empowerment policy, police and prison reforms,

therapeutic approach of rehabilitation and social reforms (Kumari, 2009; Maniyar, 2004; Mishra, 2002).

Judicial Contribution

Unfortunately, the largest democratic country in the world has a ***'very poor political** will*' to improve the conditions of the women prisoners and children of the prisoners. Laudable and commendable work regarding women prisoners has been initiated by the Indian judiciary. In response to a public interest litigation, the Supreme Court has formulated guidelines regarding pregnancy, antenatal, child-birth and post-natal care and child care (Upadhyay v. State of A.P., 2006). The Apex court has clearly stated the following:

Regarding Gynaecological examination

a. *Gynaecological examination of female prisoners shall be performed in the District Government Hospital. Proper pre-natal and post-natal care shall be provided to the prisoner as per medical advice.*

Regarding Pregnancy

a. *Before sending a woman who is pregnant to a jail, the concerned authorities must ensure that the jail in question has the basic minimum facilities for child delivery as well as for providing prenatal and post-natal care for both the mother and the child.*

b. *When a woman prisoner is found or suspected to be pregnant at the time of her admission or at any time thereafter, the lady Medical Officer shall report the fact to the superintendent. As soon as possible, arrangement shall be made to get such prisoner medically examined at the female wing of the District Government Hospital for ascertaining the state of her health, pregnancy, duration of pregnancy, probable date of delivery and so on. After ascertaining the necessary particulars, a report shall be sent to the Inspector General of Prisons, stating the date of admission, term of sentence, date of release, duration of pregnancy, possible date of delivery and so on.*

Regarding Child birth in prison

a. *As far as possible and provided she has a suitable option, arrangements for temporary release/parole (or suspended sentence in case of minor and casual offender) should be made to enable an expectant prisoner to have her delivery outside the prison. Only exceptional cases constituting high security risk or cases of equivalent grave descriptions can be denied this facility.*
b. *Births in prison, when they occur, shall be registered in the local birth registration office. But the fact that the child has been born in the prison shall not be recorded in the certificate of birth that is issued. Only the address of the locality shall be mentioned.*
c. *As far as circumstances permit, all facilities for the naming rites of children born in prison shall be extended.*

Regarding child care

a. *Female prisoners shall be allowed to keep their children with them in jail till they attain the age of six years*
b. *After six years, the child shall be handed over to a suitable surrogate as per the wishes of the female prisoner.*
c. *Expenses of food, clothing, medical care and shelter shall be borne by the respective state.*
d. *There shall be a crèche and a nursery attached to the prison for women where the children of women prisoners will be looked after. Children below three years of age shall be allowed in the crèche and those between three and six years shall be looked after in the nursery. The prison authorities shall preferably run the said crèche and nursery outside the prison premises.*
e. *A dietary scale prepared by the National Institute of Nutrition, Council of Medical Research, Hyderabad , for a balanced diet for infants and children up to the age of six.*
f. *Jail manual and/or other relevant rules, regulations, instructions etc. shall be suitably amended within three months so as to comply with the above directions.*

The Apex court clearly highlighted the need to uphold the fundamental rights. It articulated the provisions under Article 15(3)-special provisions for women and children,

Article 21-Right to life and liberty, and Article 21A-free and compulsory education to all children from the ages of six to 14 years.

Table 1: Women and child care in prisons

The directive principles of state policy articulated in the judgement (Upadhyay v. State of A.P., 2006)

Article 39(f) - State to ensure that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity, and that childhood and youth are protected against exploitation and moral and material abandonment.

Article 42 - Provisions for just and humane conditions of work, and maternity beliefs.

Article 45 – Provision for free and compulsory education for children up to the age of 14.

Article 47- Duty of the State to raise the level of nutrition and the standard of living and to improve public health.

Source: (Directive Principles of State Policy)
Available online at http://indiacode.nic.in/coiweb/coifiles/p04.htm

In this landmark judgment by the Supreme court, the directive principles of state policy (as shown in the table), were brought under the 'legal obligation' of the state to provide protection, prevention and promotion of human rights and health care of marginalised imprisoned women and children.

Specific mental health problems and needs

There are hardly any systematic studies regarding the mental health problems of women in prison. A study conducted by Murthy and her colleagues in 1988 is the first of its kind in India (Murthy et al., 1998). Collaborators of the study were the National Institute of Mental Health and Neuro Science (NIMHANS), Bangalore and the National Commission for Women (NCW), New Delhi. The objective of the study was to organise training and

awareness programmes for prison staff and also to bring out literature relevant to the care of women in custody. Unhappiness was the most common psychological reaction to imprisonment among women prisoners.

Table 2: Common psychological reactions seen in undertrials

Feelings of	Percent
Unhappiness	73
Feeling of worthlessness	69
Frequent worrying	65
Poor sleep and appetite	65
Headache	56
Tiredness	52
Inability to work	52
Fearfulness	46
Thoughts of ending life	44
Source: Murthy et al., 1998	

During the study, it was noted that most women are financially dependent and are not in a position to plan, or get help, for example, to arrange for bail. It is also difficult for them to reintegrate into society after release. In addition to the stigma of having been in prison, women face a multitude of other problems. For example, the spouse might have remarried and may reject her, her in-laws or parents may not be willing to keep her in their home, her children may have grown up and may not need her, or she may feel too humiliated to return to her place of origin. All these can come in the way of her successful rehabilitation and reintegration into society (Murthy et al., 1998).

The study also reported that women were unable to defend themselves, and ignorant of the ways and means of securing legal aid. They were unaware of the rules of remission or premature release, and live a life of resignation at the mercy of officials who seldom understand their problems. Women prisoners need to be psychologically and emotionally supported in crisis situations such as separation from family, legal problems, during the verdict, violence in the prison, release of a fellow prisoner, death of a fellow prisoner and illness/death in a family member. Another important issue which needs to be kept in the mind of policy makers is that women need to be empowered through vocational rehabilitation and provided information on various organizations that they can approach

for further support so that post-release they can earn their livelihood without being dependent on others.

Figure 3: Psychosocial care for women in prisons

Source: Murthy et al., 1998

Bangalore Prison Mental Health Study Findings

Mental health problems and substance use among women as well as their needs in prison were assessed as part of the Bangalore Prison Mental Health Study (Math et al., 2011). At the time of conducting the study, there were 210 women prisoners (4%) of whom 197 were interviewed for the study. Table 3 depicts that most of the women in prison were housewives, unskilled and semi-skilled workers. The mean educational status in years is

3.9 years and 49.7% were illiterate. Both these factors have strong bearings in vocational rehabilitation and integration into the community.

Table 3: Socio-demographic characteristics of women evaluated in the Bangalore Prison Study

Variable		N	%
Legal status	Undertrials	123	62.4
	Convicts	74	37.6
Marital status	Single	15	7.6
	Married	160	81.2
	Widowed	16	8.1
	Divorced	6	3.0
Domicile	Urban	93	47.2
	Village	20	10.2
	Semi-urban	84	42.6
Occupation	Housewife	43	22.3
	Unskilled work	25	13.0
	Semiskilled work	54	28.0
	Skilled work	14	7.3
	Business	12	6.2
	Agriculture	28	14.5
	Others	17	8.7
		Mean	**SD**
Age		37.5	14.4
Years of education		3.9	4.7
Duration of stay in prison months(SD)		20.3	21.3

Source: Math et al., 2011

Regarding the nutritional status of women in prison, one in four was underweight, but a greater number were overweight or obese (26.3%) compared to males (10.9%).

Nearly one third of women could be diagnosed as having a mental health or substance use problem. About one in four women had a diagnosis of either a current or past major depressive episode. A very small number had a diagnosis of deliberate self harm or suicidal attempt.

Table 4: Prevalence of diagnosable mental disorders among women in the Bangalore Prison study

Mental Disorders	***N***	***%***
Major Depressive Episode (current)	33	16.7
Major Depressive Episode (past)	18	9.6
Dysthymia	5	2.5
Deliberate self harm	3	1.5
Lifetime suicidal attempt	4	2.0
Panic disorder (current)	1	0.5
Social Phobia	3	1.5
Specific Phobia	9	4.6

Source: Math et al., 2011

Tobacco and alcohol use

More than one in ten women reported chewing tobacco use in their lifetime and 5% reported smoking. As in the general population, prevalence of smoking is much higher among males than females. However, in comparison to smoking tobacco use among women in Karnataka, the prevalence is higher among women prisoners. Smokeless tobacco prevalence among women in prison is also higher than among women in Karnataka. Six women (3%) reported ever use of alcohol. This is lower than the prevalence of alcohol use among women in Karnataka, which has been estimated at 5.8% (Benegal et al., 2005).

Urine drug screening among women in the Bangalore Prison study

Sixty women were randomly screened for urine drugs in an anonymous manner. In total, 18 women (30%) tested positive for one or more drugs. Thirteen samples (21.7%) tested positive for benzodiazepines, 3 (5%) for cocaine, 2 (3.3%) for opioids and amphetamines

respectively and one (1.7%) for cannabis. One person each tested positive for two drugs and three drugs respectively.

Table 5: Urine drug screening in the Bangalore Prison study

Sl. no	Drug use	FEMALE n=60	MALE n=661	X^2	P
1	Cannabis	1 (1.7%)	221 (33.4%)	26.050	0000
2	Opioids	2 (3.3%)	22 (3.3%)	0.000	1.000
3	Cocaine	3 (5%)	107 (16.2%)	5.325	0.023
4	Barbiturates	0 (0%)	65 (9.8%)	6.485	0.004
5	Benzodiazepines	13 (21.7%)	297 (44.9%)	12.148	0.001
6	Amphetamines	2 (3.3%)	42 (6.4%)	0.876	0.570

Source: Math et al., 2011

In summary, the Bangalore Prison Mental Health Study (Math et al., 2011) found that nearly a third of women prisoners had a diagnosable mental disorder. Depressive disorder was relatively more common. Lifetime smokeless tobacco use among the women in prison was higher than that reported in the general community. Though there was a negligible self-report of drug use, nearly one in 3 women tested positive on urine screen for one or more drugs. This study highlights the need for gender specific mental health interventions for women in prison.

Recommendations

The main goal of imprisonment must be rehabilitation and reformation instead of punishment. There is a need to enable prisoners to lead useful and law-abiding lives on their return to the community. Keeping such a focus, the negative effects of imprisonment should be minimised; mental health should be maintained and promoted. Women prisoners must feel safe, be treated with respect and dignity and need to be assisted towards developing insight into their offending behavior. The Supreme Court directions need to be implemented regarding women prisoners' requiring assistance in pregnancy, ante-natal, natal and post-natal care. Children of the women prisoners must be provided care as per the guidelines.

Any intervention must start with the prisoner, the moment she enters the prison.

Privacy and dignity: Women prisoners' privacy and dignity must receive the topmost priority.

Female staff: There must be a female doctor inside the prison as well as female guards in charge of the female prison premises.

Health check-up: Women prisoners must be routinely screened for physical and mental health problems and provided treatment at the earliest.

Peer support group: Self-help groups among women prisoners can be of great help during stressful situations – Entry into prison, during bail, preparation for court appearances, unpleasant events at home like death of a family member, before, during and after judgement.

Mental health and counselling: Considering the mental health morbidity in women prisoners, mental health services and counselling needs to be provided. Effective planning for mental health care after release is vital, particularly for women with severe mental illness.

De-addiction facility: De-addiction facility should be made available to women with substance use problems.

Family counselling: Involvement of family members in counselling is an essential component to good health of women prisoners.

Vocational Rehabilitation: Adequate opportunities must be provided to work and keep them busy. Adequate planning for livelihood after release, particularly for women without family support is extremely important.

Behavioural rehabilitation: High-risk behaviors such as aggression, violence, self-injurious behavior, impulsivity, sexual behavior and substance use need to be addressed with appropriate techniques.

Suicide prevention strategies: Frequent meetings with prisoners will help in prompt identification of their problems, generation of solutions and reduction in distress. Prison

staff requires training on how to identify mentally illness and use crisis intervention techniques.

Adequate planning before release, safeguards against prison re-entry, halfway home support systems for women without family support, and treatment continuation after release are critical components of effective treatment. Life skills training and encouraging further education in prison and health education also play a crucial role in empowering women and preventing recidivism and poor mental health outcomes. The circumstance of being within four walls of a prison is upsetting enough. It is important that mental health of women prisoners is preserved and enhanced, so that the prison experience will not scar their lives.

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13. MENTAL HEALTH NEEDS OF PRISON STAFF

One of the key determinants of the performance of any organisation is its staff. In the case of a correctional facility, the challenges faced by the staff are very unique. They include a closed coercive work environment, the need to deal with violence and perform arduous tasks, an occupation dependent on the maintenance of security and order inside prisons, as well as more general constraints affecting, in particular, the organisation of work, such as certain work schedules, and relationships within the prison hierarchy (Goldberg et al., 1996). Though there is a significant body of research on the impact of the work environment on correctional staff, there are only a few attempts that have been made to address such issues. Burnout is a common problem among correctional staff (Schaufeli and Peeters, 2000). Burnout can be devastating not only for the staff member but also for the co-workers, inmates, rehabilitation programmes and the correctional organisation itself. This chapter provides insights into the prison staff – the roles they play, their work environment, the stressors that are around them and what can be done to reduce such stress.

Defining the role of prison staff

The role of the prison staff is to (i) Maintain secure custody, in a context where people are held in confinement against their will; (ii) Provide care for the prisoners with humanity; (iii) Provide prisoners with opportunities to unlearn and correct their offending behaviour; and (iv) Assist with day-to-day management in the complex organisational environment of the prison" (Liebling, 2000; Price and Liebling, 1998).

In addition to the above roles, prison staff also needs to:

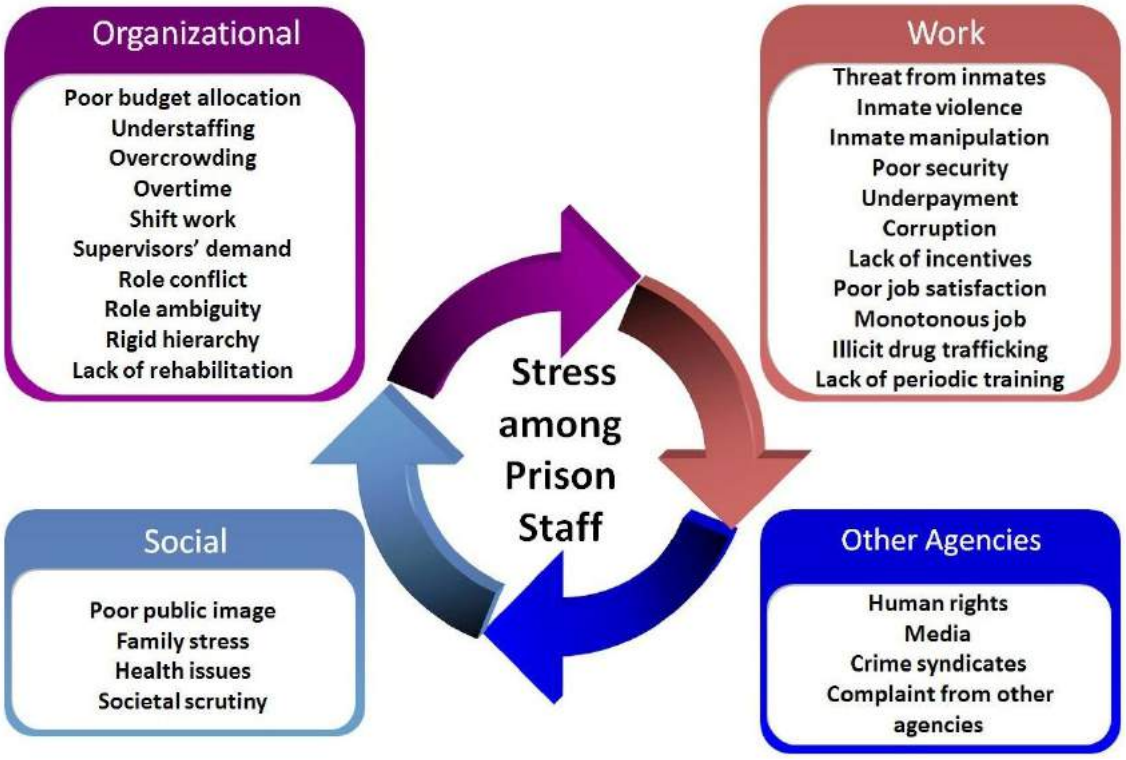
1. Protect, promote and endorse human rights of the prisoners
2. Take care of the needs of the prisoners to the extent feasible within the prison environment
3. Identify patients who have health problems and get them the needed health care
4. Pay special attention to the vulnerable sections of the prison population, such as women, children, mentally ill and disabled by ensuring that medical treatment and counselling is made available to them.

These additional roles are endorsed by Andrew Coyle, who in his article on "A human rights approach to prison management" emphasises the correctional aspect of the prison inmates (Coyle, 2002). The prison is not just a place of confinement. It needs to focus on behavioural corrections of the prisoners thereby veering them away from the path of crime and enable them to become good citizens after their release. However prison officers are rarely cognisant of this role. ***'Role Conflict'*** of the correctional officers arises when they have to engage in custodial responsibilities (maintaining security, such as preventing escapes and inmate fights) as well as engage in prisoners' treatment functions (helping in rehabilitation of prisoners). ***'Role ambiguity'*** may be created by supervisors who expect officers to "go by the rules" and at the same time insist that officers must be flexible and use judgement in their interactions with inmates. Such role conflict and ambiguity arises in the prison environment because of dichotomous perception of their role as custodial versus curative, punishment versus rehabilitative, administrative versus treatment, segregation versus inclusion and human rights versus duties. In addition, legislations, judiciary case rulings, human rights laws and department rules. The strict hierarchy inside the organisation and security issues inside and outside the prison further complicates the issue.

International Scenario

Prisons as organisations are charged with managing a complex offender population. Staff must successfully accomplish this mission without fanfare or scandal. Obviously, prisons are twenty-four hour operations and staff must constantly tend to the needs, concerns, and issues of the offender population. Staff must be sensitive to the lighting, caloric intake of inmates, food temperature, recreational needs, cell size and population density, racial and ethnic composition of offender living areas and cells, disciplinary requirements and personal security, health care, mail and correspondence needs, hygiene needs, and a host of other issues on a daily and hourly basis. Their job is complex, dangerous, stressful and it is a thankless task (Marquart, 2005). Therefore, the relationship and interactions between staff and inmates play a crucial role on safety, security, control and providing a rehabilitative environment (Gilbert, 1997). Staff responses to stress include high turnover, absenteeism, psychosomatic diseases, high levels of job dissatisfaction and burnout (Schaufeli and Peeters, 2000).

Figure 1: Sources of stress for prison staff



The performance of prison staff is of paramount importance in the prison system. Their approach can determine whether the experience of imprisonment is a survivable or destructive one. The prison staff play a mediation role in addressing the needs of prisoners, provide access to the required goods and services, help in establishing contacts with the prisoners' friends and family (Mathiesen, 1965) Similar observations indicate that the prison staff stand between humane and brutal imprisonment from a psychological perspective (Bottoms and Rose, 1995).

A study that was done in the UK revealed that lack of training for the prison staff contributed significantly to the development of stress and in reducing confidence in dealing with the many traumatic situations encountered (Holmes and Maclnnes, 2003). However, interpersonal relationships provided mutual support during crises. General working conditions, including workload and staff redeployment, were also important contributors to high levels of sickness-absence which, in turn, exacerbated stress. Poor

management practices, combined with a perceived lack of support, further aggravated stress (Holmes and Maclnnes, 2003).

The literature indicates that working in correctional settings is a hard and often stressful occupation (Armstrong and Griffin, 2004). The stress on correctional staff is harmful over time, can increase medical problems; can promote substance abuse, cause divorce, suicide, and death (Cheek and Miller, 1983). Staff attributed their problems to administrative malfunctions which place them in a classic double-bind predicament in relation to rule enforcement (Woodruff, 1993). The job-related stressors may include inmate defiance, maintenance of discipline, compliance with prisoners' rights, overcrowded conditions, and the confining nature of the jail or prison environment. Stressors associated with organisational structure and administration include lack of participation in decision making, lack of positive recognition, lack of administrative support, role conflict and ambiguity, and supervisory behaviours (Woodruff, 1993).

Burnout in prison staff can have a direct effect on providing care for the prisoners. It also affects the co-workers, prisoners and also the organisation. Impact of stress ranges from adverse health conditions to economic consequences. Direct impact of stress on health leads to absenteeism, which has a direct economic repercussion on the organisation. Further, staff may attempt and at times commit suicide because of the overwhelming stress.

Job related stress, quality of supervision, job variety, and job autonomy have been theorised to affect the job satisfaction and organisational commitment of correctional staff members. All four job characteristics had a significant impact on correctional staff members' job satisfaction and organisational commitment (Lambert, 2004). Further, job stress has been linked to decreased job satisfaction and absenteeism among correctional staff (Slate and Risdon, 1997).

A meta-analysis of twenty studies on the predictors of job stress in correctional officers revealed that work attitudes (i.e., participation in decision-making, job satisfaction, commitment, and turnover intention) and specific correctional officer problems (i.e., perceived dangerousness and role difficulties) generated the strongest predictive relationships with job stress. Furthermore, both favourable (i.e., human service/ rehabilitation orientation and counselling) and unfavourable (i.e., punitiveness, custody

orientation, social distance, and corruption) correctional officer attitudes yielded moderately positive relationships with job stress (Dowden and Tellier, 2004). Role conflict, role ambiguity, role overload, perceived dangerousness of the job, work-family conflict, and role strain have all been found to lead to increased job stress (Lambert & Hogan, 2009).

Figure 2: Impact of stress on prison staff

Research has also indicated that favouritism, decision making without a rational basis, lack of empowerment for staff, lack of trust in supervisors, lack of task control, and low

administrative and supervisory support lead to increased job stress (Dowden and Tellier, 2004; Slate and Risdon, 1997).

In addition to the other stressors, World Health Organization (WHO) fact sheet refers to mental disorders of inmates as stress for the staff and underscores the need for mental health care. Good mental health care is one of the central aspects of good prison management.

Benefits of addressing prison staff job stress

a) Saves money and time because of absenteeism
b) Decreases substance use in prison staff
c) Decreases the probability of having illnesses
d) Decreases depression and suicide in staff
e) Improves their work performance and subsequently output
f) Facilitates protection of human rights of the prisoners
g) Leads to pro-active involvement of the staff in rehabilitation programmes
h) Improves their family life
i) Enhances quality of life

World Health Organization (WHO) advocates for training on mental health for prison staff at all levels. It states that such training increases awareness of the mental disorders, makes the staff adhere to human rights, reduces suicidal attempts by inmates, and helps the prison staff to get over stigmatising attitudes. This will be a catalyst for improved mental health of both, staff and inmates (Møller et al., 2007; World Health Organisation, 1998).

Indian Scenario

The fact sheet (table no-1) on prisons in India clearly demonstrates that the prison population rate is 33 per 100,000, which is much lower than in many other countries in the world. However, there is an increasing trend and in addition, the prisons are also overcrowded by more than 132%. Such overcrowding adds to the stress levels of the prison staff. Despite worrying statistics and call for reforms, adequate funds are not

provided for the prison administration. Lack of resources contributes significantly to prison staff stress.

Table 1: Prison population of India

Ministry responsible	Ministry of Home Affairs		
Prison population total (including pre-trial detainees / remand prisoners)	385023 (30 June 2008)		
Prison population rate (per 100,000 of national population)	33 (30 June 2008)		
Pre-trial detainees / remand prisoners (percentage of prison population)	263108 (68%) 30 June 2008		
Female prisoners (percentage of prison population)	16145 (4.2%) 30 June 2008		
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	0.1% (31.12.2007 - under 18)		
Number of establishments / Institutions	1,347		
Official capacity of prison system	277,304 (31.12.2007)		
Occupancy level (based on official capacity)	132% (30 June 2008)		
Recent prison population trend	Year	Total Population	Prison population rate
	1999	281,380	28
	2001	313,635	30
	2003	326,519	30
	2005	358,368	32
	2007	371147	32
	2008	385023	33
Source: National Human Rights Commission, 2008; Walmsey R, 2008			

Problems faced by Prison staff

Central to the prison administration is the problem of demoralisation and lack of motivation of the prison staff. The prison officers today are working in very hostile and highly adverse conditions. Almost all the prisons are understaffed and residential quarters are devoid of any security. Even senior prison officers are not provided with fire arms for self-defense. There is no guarantee for their life either inside the prison or outside the prison. Prison staff is the most neglected personnel and the least important in the government sector. No steps are taken by the government to ensure their safety and security (Reddy, 2010).

While governments and non-governmental agencies plan and implement several programmes for prisoners, institutional training for them and for their rehabilitation, no efforts is made to redress the problems being faced by the prison staff (Reddy, 2010). The unhealthy work environment discourages initiative, and leadership qualities of the prison staff. This indifference among the prison staff could get translated into aggression on prisoners.

Findings of the Prison Mental Health Study, Bangalore

The Bangalore Central Prison exemplifies some of the major inadequacies in Indian prisons (Math et al., 2011). It is overcrowded by 150% and this has caused problems in health care, monitoring, and resulted in enormous stress for the staff. More suicides are reported, violence and rampant substance use is on the rise, suicidal ideation has been observed in some of the prison staff and there were two recent staff suicides (both died of hanging, one of them was a senior official of the prison) and one more death is suspected to be a case of suicide. The prison staff is overworked and the level of motivation has been inadequate. There are incidents of supervisory abuse and staffs do not find rewards and recognitions that are commensurate with their performance.

Prisoners tend to group together and threaten staff, including the doctors. The prisoners sometime make unfounded allegations to Human Rights organisations and to courts. This has caused considerable stress for the staff and has added to their reduced motivation. The job is not just viewed as thankless – it is also seen as hazardous and risky.

Lack of proper security is another worry for the prison staff at Bangalore. The lady staff has to further bear disinhibited behaviour of the male prisoners. The staff are also threatened with violence and revenge if they do not comply with the 'special' needs of prisoners (like demands for fake certificates when they want to avoid court proceedings, demand for admission in the prison hospital without any ailment, and refusing discharge despite recovery). There are frequent cases of malingering of ailments, manipulative behaviour, and abuse of prison staff. Lack of adequate numbers of prison staff has also compounded the problems. Prison environment has increased stress levels of the staff and little has been done to improve the situation. Training on mental health has been inadequate and some of the staff themselves stigmatise mentally ill prisoners. There is only one psychiatrist for the whole prison and clearly there is a need to provide more supporting staff, train the staff on mental health related issues along the lines of WHO recommendations.

Due to the perceived risk and dangerousness of the prison environment, many of them present with depressive episodes, somatoform disorders and substance use, abuse and dependence. During personal interviews with the prison staff of the Central Prison, Bangalore, they expressed that they were not happy working in this environment at all. They also said that '*All the authorities are concerned with the prisoner's wellbeing and nobody is there to care for us'*.

Prison staff spends very less quality time with their families. Their spouses, many of them homemakers also suffer from mental health problems. The accompanying tables give details of the Bangalore Prison study and reflect staff attitudes towards their work, environment, and stress. The plights of smaller prisons are even worse. In such prisons, there is no proper health care. Awareness levels of staff in such places are very low and it is a distressing situation for both inmates and for officers.

In the Bangalore Central Prison study (Math et al., 2011), data was collected from 201 staff out of 207. Out of the 201 staff, 191 were male (92.3%) and about 16 of them were female (7.7%). Of the 201 staff for whom available data on education was, 12(5.8%) were postgraduates, 79(38.2%) had undergraduate degrees, 63 (30.4%) had pre-university education, 46 (22.2%) were high school educated and 1 (0.5%) staff had primary education.

General Medical Conditions among the prison staff

5 of 207 had heart related problems and about 17 reported blood pressure problems. Two staff had chest related ailments and 16 had diabetes. One staff had epilepsy. A large number of inmates had digestive disorders (20%). None self-reported mental illness.

Table 2: Self-reported general medical problems among the prison staff

Sl No	Presence of general medical problems (Self-reported)	n(%)
1	Physical disability	0
2	Heart problem	5(2)
3	Blood pressure	17(8)
4	Chest disease	2(1)
5	Diabetes	16(8)
6	Mental illness	0
7	Epilepsy	1(0.5)
8	Digestive problems	41(20)
9	Back pain	21(10)
10	Rheumatic problem	22(11)
11	Eye problems	23(11)
12	Skin disease	18(9)
13	Dental	18(9)

Source: Math et al., 2011

21 staff reported back problems and 22 complained of rheumatic problems. One staff had shoulder, arm, and wrist/hand problems. 23 had eye related problems. 18 staff had skin problems and a similar number had dental problems. Only one staff reported taking regular medicine. This clearly indicates that many staff were living with their problems and did not go for proper treatment.

Mental Health Problems in prison staff

Structured assessment of the staff on MINI instrument revealed the following mental

disorders in staff. Many of the illnesses noted appeared secondary to the work atmosphere and stressful job situation.

Table 3: Mental disorders among staff

Sl No	Presence of mental disorders	n(%)
1	Depression current	10(5)
2	Depression past	12(6)
3	Depression lifetime	22(11)
4	Substance induced mood disorder	7(3)
5	Suicide (low risk)	1(0.5)
6	Deliberate self-harm	1(0.5)
7	Panic disorder current	2(1)
8	Agoraphobia current	1(0.5)
9	Agoraphobia lifetime	1(0.5)
10	Social phobia current	9(4)
11	Social phobia generalized	2(1)
12	Specific phobia current	3(1)
13	Post-traumatic stress disorder current	1(0.5)
14	Alcohol dependence current	23(11)
15	Alcohol abuse current	3(1)
16	Alcohol dependence lifetime	29(14)
17	Alcohol abuse lifetime	3(1)
18	Tobacco dependence lifetime (smoking)	7(3)
19	Tobacco dependence lifetime (smokeless)	(2)
19	Generalized anxiety disorder	5(2)
20	Pain disorder	2(1)
21	Conduct disorder	1(0.5)
22	Anti-social personality disorder	1(0.5)

Source: Math et al., 2011

On summarizing the findings;

- About 5% of the staff were suffering from depression at the time of this study.
- 6% of the staff had past history of depression

- 11% of the staff had lifetime major depressive episodes and this calls for proper psychiatric intervention.
- One of the staff presented with deliberate self-harm
- There were 2 staff who presented with panic disorder at the time of this study.

As evident, upon evaluation using standardised psychiatric assessment tools, conditions like major depression, alcohol and tobacco dependence, social phobia, agoraphobia and post-traumatic stress disorder were identified, necessitating further psychiatric evaluation and intervention. The findings of mental morbidity are somewhat similar to other international studies (Goldberg et al., 1996). The minor variations noted can be attributed to differences in methodology, sampling technique and instrument used to assess the pathology.

Improvements Suggested for Staff issues:

Adequate remuneration: Generally speaking, prison staffs are held in lower regard than other people who work in the criminal justice field, such as the police. In order to attract and retain high quality personnel, it is essential that salaries are set at a proper level and that the other conditions of employment are the same as in comparable work elsewhere in public service. Work on shifts is inevitable. Due care and proper scheduling of night duties, apart from special incentives for doing the night duty can be of help.

Basic amenities: The following basic amenities need to be provided to the staff at the work place;

- Clean and safe drinking water
- Provision of appropriate facilities at the place of duty
- Adequate toilet facilities / Rest room / Changing room
- Recreational room / Exercising facilities
- Self-defense training
- Security of staff
- Security for the family members of the prison staff

Periodic training of staff in counselling and self-defense: Lack of a congenial working environment that is of a hierarchical nature, direct contact with difficult prisoners who

are abusive, depressed and violent can all exacerbate the stress levels of the prison staff. There is a need to decongest the prisons, increase the number of prison staff, train the staff on counselling, conflict resolution, and enhance the safety procedures and mechanisms apart from ensuring that fit warders with self defence skills are employed in prisons.

Health screening of staff and their family members: Routine screening of staff and their family members for physical and mental health issues, and providing appropriate interventions as and when required is important.

Health Insurance: Given the difficult, risky environment the prison staff face, they need to get more allowances and free insurance with a good health cover.

Job Transfer: Prison staff is stressed about transfers and clear guidelines should therefore be followed. Transparency and zero tolerance for corruption need to be the ensured in all matters in prison settings, particularly on issues like transfers and promotions.

Training staff in human rights approach: Andrew Coyle (2002) has exemplified the need for improvement in staff working conditions and their remuneration. According to him, prison staff works in an isolated environment and this can make them inflexible. The staff needs to be open to accept prisoners without biases and be sensitive to changes in the broader society from where prisoners come and go back.

Periodic soft skills training for the prison staff: Towards improving the prison work environment, enhanced staff communication and conflict resolution skills are recommended. There is a need for the following improvements in the prison environment towards making it a more congenial and less stressful environment:

- Improve staff teamwork
- Improve interdepartmental cooperation
- Improve morale
- Reduce conflict

Handling allegations by prisoners: The Board of Visitors needs to be established and active. Complaints given by prisoners need to be investigated from all possible angles. Monitoring of the prison by using advanced visual technologies such as CCTVs etc., can prevent untoward incidents in the prison. Adequate support and time needs to be given to the staff to defend his/her behaviour. Regular meetings need to be held with the staff to discuss key problems faced by prisoners. In addition, regular review meetings with the human rights organizations can certainly foster greater awareness of human right issues of the prison staff. Further, such interactions increase trust among the prison staff. The meetings can address the issues of the prisoners, the allegations against the staff, and action taken can also be shared at these meetings. Routine interviews of the staff to get their feedback, provision of a secure environment and focus on the safety needs of women prison staff is of paramount importance.

Stress management programmes: There is an urgent need to address the issue of stress among prison staff. Periodic stress management programmes, adequate sanction of leave and holidays need to be implemented.

Mental Health Promotion in Prisons: The Prison environment is stressful and can make people depressed or can worsen their mental health problems. These can become aggravated if staff is not aware of mental health problems and their identification and management. This is a reality in many prisons. The presence of prisoners with unrecognised and untreated mental disorders can further complicate and negatively affect the prison environment, and place even greater demands upon the staff.

WHO report on mental health promotion in prisons (1998) at Copenhagen, details the benefits of mental health promotion. According to the report, mental health promotion can result in better emotional and physical health, confront and correct offending behaviour, reduce the incidence of mental health disorder apart from reducing the severity of the disorders, be an amenable place for rehabilitation and can result in enhanced confidence and social skills. Mental health promotion improves job environment for staff, reduces their stress levels, helps in enhanced security at prisons, improves relationship between staff and prisoners and this can result in better family relationships for prison staff.

Stress management for prison staff:

a) Stress counselling
b) Family counselling
c) Availability of de-addiction treatment
d) De-briefing at work place
e) Anger management training
f) Problem solving and decision making training
g) Communication skills training
h) Time management training
i) Regular exercise
j) Relaxation exercise
k) Meditation, yoga, prayer and other forms of relaxation
l) Paid holiday
m) Staff redressal mechanisms

Many roles and duties traditionally attributed to clinicians can and often should be performed not only by other mental health professionals, but by prison staff such as correctional officers and nurses. Moreover, the optimal climate for effective treatment is one in which mental health professionals and line staff work collaboratively, especially since prison staff alone are in contact with prisoners all 24 hours. The specific activities which comprise mental health treatment in prison include:

1) Counselling and psychotherapy—talking *with* inmates,
2) Consultation—talking *about* inmates,
3) Special housing, activities, and behavioural programmes, and
4) Medication.

(Appelbaum et al., 2001).

Recognition and nurturance of these activities will improve the quality of services and reduce stress on staff and inmates alike. Consultation with onsite staff, joint training, and use of multidisciplinary treatment teams are advocated as methods of reaching these goals (Appelbaum et al., 2001). The training should equip prison staff in identifying and managing mental health conditions of prisoners. Mental health training enhances the staff

understanding of mental disorders, increases the knowledge of human rights and challenges stigmatising attitudes of the staff. The focus needs to be on mental health promotion for both staff and prisoners (World Health Organisation, 2008).

In conclusion, the current international literature on prison staff and the study conducted at Central Prison Bangalore, highlight that prison staff need better working environments in terms of safety, reduced stress, and better relationships between themselves and the prisoners. Their job needs greater role clarity, their needs for wellbeing in terms of support, incentives, training thereby motivating them to better deliver their services need to be addressed. Prison staff are not aware of mental health issues of prisoners and proper training in this regard is required across the prisons. Appropriate measures are required to provide psychiatric help for the prisoners and staff, to ensure all the staff are provided training on mental and physical health issues of the prisoners. Further, the prison staff require training on conflict resolution and also have effective listening and empathetic communication skills. The staff should be aware that their quality of interactions can go a long way in correctional aspects of prisoners and this is a very important job objective for them. They should be aware of human rights and treat prison inmates with respect and avoid stigmatising prisoners with mental illness.

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14. MENTAL HEALTH CARE IN PRISON: THE WAY FORWARD

Prison health is often neglected and continues to be ignored despite accumulating objective evidence supporting the need for rational health policies in prisons. Many prisoners with serious physical and mental disorders fail to receive care while incarcerated. Furthermore, public-health strategies adopted in the community are ignored in the prison setting. Developing countries like India face challenges of both communicable diseases and as well as non-communicable diseases. Despite the high prevalence of tuberculosis, drugs use and HIV in prisons, screening for such diseases is rarely available on entry into prison. There is no access to health promotion and comprehensive treatment. Unfortunately mental health needs of prisoners are completely unrecognised. Even in situations where they might be recognised, the responses are largely individualised and systemic response to the problem is absent. Providing treatment for substance use, mental illness and high risk behaviours benefits both prisoners and the wider community. Improvements are needed both in correctional health care and in community mental health services in order to prevent crime, incarceration and violation of human rights.

There are many lacunae in health care in prisons in developing countries like India. Prisons have few health care professionals delivering comprehensive health care. A few skeletal staff like doctors and nurses is often on deputation from state health services. Services are poorly organised and there is no adequate networking with facilities available in the community. Prison systems tend to be closed and often do not facilitate collaborative partnerships with other governmental and non-governmental organisation. Prison staffs are poorly trained in identifying and dealing with health, particularly mental health issues. Given this scenario, the following strategies merit immediate consideration and implementation.

HEALTH CARE IN PRISONS

Access to general health care

Right to health needs to become the rights of the citizen and also the prisoners, who are also rightful citizens. Availability of emergency health care services needs to be made mandatory for central prisons.

1) Separate health personnel need to recruited for all correctional centres, rather than deputation from the health and family welfare department
2) Local medical colleges needs to provide the specialist support for providing health in prison
3) Telemedicine needs to be considered for obtaining specialist opinion for health care, legal and other purposes.
4) A separate budget needs to be allotted for the health in prisons
5) Screening for health needs to be mandatory for all the prisoners when they enter prisons
6) Periodic health screening is also required in prisons
7) Prison hospital needs to be upgraded and appropriate resources needs to be provided. Adequate health staff needs to be provided according to the standard prescribed in the Mental Health Prison Project report of the Central Prison, Bangalore
8) Availability of essential medicines needs to be ensured in every prison hospital.
9) Inpatient treatment, whenever required needs to be encouraged within the prison hospitals.
10) Maintenance of health records in prison should be made mandatory

Emergency health care

All central prisons housing more than thousand prisoners need to provide emergency health care inside the prison. At least one ambulance needs to be provide for each central prison.

National health programme

Prison health needs to be considered a public health priority. All the national health programmes needs to be implemented in prisons.

HIV prevention programme

HIV prevention programme needs to be available for prisoners. Pre-test and post-test HIV counselling needs to be done. Provision of anti-retroviral medicines needs to be ensured inside the prisons. Protection of the human rights of HIV positive prisoners needs attention. Segregation, isolation and discrimination of HIV prisoners must not occur. If isolation is required as per medical advice (required only in few cases) then the person needs to be shifted to the district hospital rather than isolating in prison. Health education

regarding HIV transmission and prevention need to be emphasised. There is also a need to educate vulnerable populations regarding safe sex practices.

Tuberculosis prevention programme

Screening of prisoners for tuberculosis must occur routinely. The screening needs to be done when the prisoner is inducted into the prison and also as and when cases report to the medical officer incharge of prison. Anti-tubercular treatment needs to available in all the prisons. Prison authorities needs to take responsibility of procuring these medicines and making them available to the prisoners. Periodic check for drug resistant cases and appropriate measures need to be taken.

Health care for women and children

Women and child health needs topmost priority. Availability of a lady medical officer is a mandatory in all the central prisons. As far as possible screening and periodic examination needs to be done by a female doctor. In case of gynaecological examination, only a female doctor must carry out the examination. If a female doctor is not available, then the women prisoners needs to be referred to the district hospital for further needful. Antenatal, natal and post-natal care needs to be made available to women prisoners.

MENTAL HEALTH CARE

Access to mental health care

Mental health care needs to be an integral part of the general health services. The District Mental Health Programme needs to be implemented at the prison without fail. Health services provided to prisoners should be better than or at least an equivalent level to that in the community. However, non-availability or poor standard of health care at the community level cannot be an excuse. Minimum essential psychiatric medicines need to be made available as per the District Mental Health Programme. Psychiatric services needs to be provided in the prison hospital. If the psychiatric specialist is not available, then the services at general hospitals must be utilised. When prisoners require acute care they should be temporarily transferred to psychiatric wards of the general hospitals with appropriate security levels. There should also be a mechanism in place to provide care after release.

Access to de-addiction treatment

Prison should be a tobacco free zone and also be free from illicit drugs. De-addiction facilities need to be available and offered to prisoners. A system needs to be in place for clinical assessment of substance use, urine drugs screening and treatment. Psycho-social management of substance use, such as educating regarding the ill-effects of substance use, motivation enhancement, family counselling and stress management also needs to be available in prisons.

Suicide prevention programme

Another essential element of mental health care in prison is prevention of suicide. Prevention in suicide starts from training all levels of prison staff, guards, prisoners and medical staff in the recognition and prevention of suicides. There needs to be a written policy regarding prevention of suicide in prison. Standard operating procedure needs to be formed in case of suicidal attempt, deliberate self-harm and death due to suicide in prison.

Behavioral rehabilitation

Prisoners high-risk behavior needs to be addressed before they go back into the community after release. This can be done by various methods including education, lectures, seminars, workshops, dramas, group therapy and individual psychotherapy. Many prisoners may require family counselling, anger management training, life skills training, individual therapy, stress management and cognitive behavior therapy. Such high-risk behavior management reduces recidivism.

Challenges for providing mental health care

Lack of trained manpower can be addressed by providing periodic mental health training to prison staff, medical personnel and health workers. They need to be trained in identification of mental health problems, counselling and referral to the medical officer in prison. The district psychiatrist or a consultant psychiatrist, from a nearby medical college needs to visit to prison for providing mental health care on a weekly basis. Training of prison staff needs to focus on identification of mental disorders, treatment and counselling. They also need to be trained in the area of raising awareness on mental health to the prisoners and their family members. Mental health programmes need to be owned and driven by the prison staff rather than being dependent on the psychiatrist.

Mental Health Visiting Board

Independent inspection mechanisms through mental health visiting boards, mental health authority, mental health welfare committee and monitoring by a disability commissioner can also be established through legislation. Such agencies must inspect prisons as well as other mental health facilities in order to monitor the conditions for people with mental disorders. Strict vigilance needs to be kept regarding the violation of human rights in prison.

Collaboration

Collaboration between various sectors such as health and family welfare department, correctional department, health department, law department, human rights agencies and social welfare department needs to be enhanced. Non-governmental organisation and public-private partnership models can also provide very useful collaborations. Many problems and issues can be solved by bringing relevant authorities and stakeholders to discuss the needs of the prisoners.

STAFF TRAINING

Prison staff training is crucial in providing mental health care and suicide prevention. The essential component to any programme is properly trained correctional staff, who form the backbone of any jail, prison, or correctional facility. Identification of the cases, counselling and referral is done by the staff. Hence, they need to be sensitised by providing adequate training.

Module for mental health training

One day training module for prison staff

1. Introduction to mental disorders
2. Depression
3. Psychosis
4. Substance use (Alcohol, tobacco, cannabis and other drugs)
5. Suicide and deliberate self-harm
6. Stress management
7. Counselling
8. Identification and referral

Very few suicides are actually preventable by health care staff in prisons. Most suicides are usually attempted by inmates in barracks, and often during late evening hours or on weekends, when health staff are not on duty. Correctional officers are often the only staff available 24 hours a day; thus, they form the front line of defense in preventing suicides.

Need for National Correctional Centre

A National Institute of Corrections needs to be formed at the centre. Such an agency needs to focus on research, training, innovation, policy issues, human rights, health and legal aid issues that shape and advance effective correctional practices and public policy. The national institute needs to contribute significantly towards research, reformation and rehabilitation to achieve correctional goals and priorities. They also need to provide effective policy, planning, management and operational strategies that uphold human rights and prison safety. Access to reasonable health care in general and mental health care in particular needs to be ensured for prisoners, who are also rightful citizens.