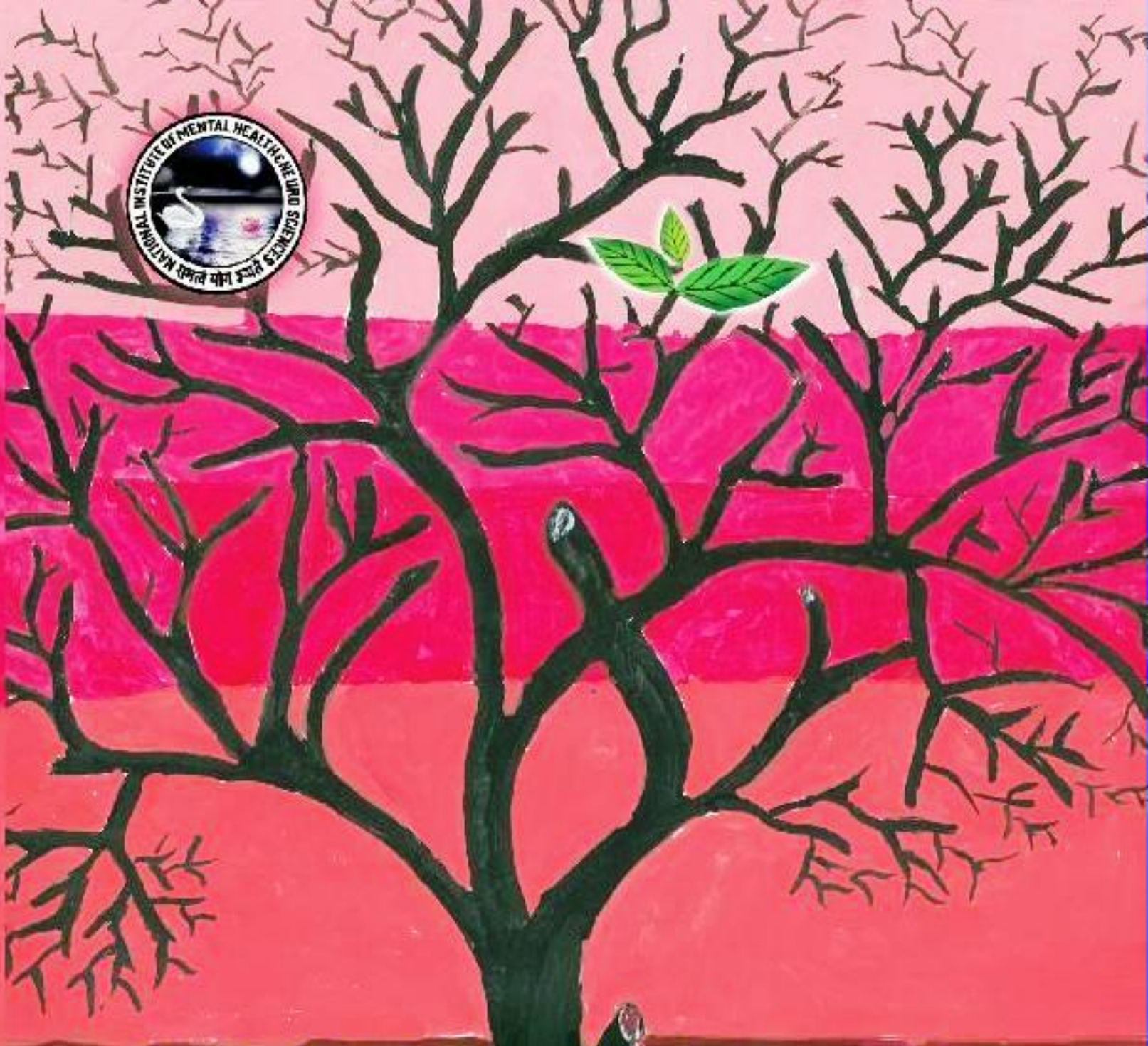

Mental Health and Substance Use Problems in Prisons:

Local Lessons for National Action

Editors:

Suresh Bada Math
Pratima Murthy
Rajani Parthasarathy
C Naveen Kumar
S Madhusudhan

2011

Editors:

Dr. Suresh Bada Math, MD, DNB, PGDMLE, PGDHRL,
Associate Professor, Department of Psychiatry,
National Institute of Mental Health and Neuro Sciences, Bangalore, INDIA
Email: sbm@nimhans.kar.nic.in, nimhans@gmail.com, sureshbm@nls.ac.in

Dr. Pratima Murthy, DPM, MD
Professor & Chief, Centre for Addiction Medicine, Department of Psychiatry,
National Institute of Mental Health and Neuro Sciences, Bangalore, INDIA
Email: pratimamurthy@gmail.com

Dr. Rajani Parthasarathy, DPM
Prison Psychiatrist, Central Prison, Bangalore, INDIA
Email: drrajanibalaji@gmail.com

Dr. C Naveen Kumar, DPM, MD
Assistant Professor, Department of Psychiatry,
National Institute of Mental Health and Neuro Sciences, Bangalore, INDIA
Email: cnkumar1974@gmail.com, naveen.nimhans@gmail.com

Dr. S Madhusudhan, MD
Lecturer, Department of Psychiatry,
Bangalore Medical College and Research Institute, Bangalore, INDIA
Email: drmadhunimhans@gmail.com, madhusudhan_27@yahoo.co.in

Mental Health and Substance Use Problems in Prisons

The Bangalore Prison Mental Health Study: Local Lessons for National Action

National Institute of Mental Health and Neuro Sciences, (Deemed University), Bangalore

in collaboration with:

Karnataka State Legal Services Authority, Bangalore

and

Department of Prisons, Government of Karnataka

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Karnataka State Legal Services Authority, Bangalore.

Collaborators

Karnataka State Legal Services Authority (KSLSA)

Hon. Sri Justice V Jagdish Singh Khehar
Chief Justice, High Court of Karnataka
Patron-in-Chief, KSLSA

Hon. Smt Justice Manjula Chellur,
Judge, High Court of Karnataka,
Chairperson, KSLSA

Hon. Sri Justice V Gopala Gowda,
Chief Justice, High Court of Orissa,
Former Chairperson, KSLSA

Sri Vishwanath V Angadi,
District and Sessions Judge,
Member Secretary, KSLSA

Sri Veeranna G Tigadi,
Principal District and Sessions Judge,
Former Member Secretary, KSLSA

Department of Prisons, Government of Karnataka

Sri Kuchanna Srinivasan, ADGP and IG Prisons,
Sri Bipin Gopalakrishna, Former ADGP and IG Prisons,
Sri Dharam Pal Negi, Former ADGP and IG Prisons,
Sri ST Ramesh, Former ADGP and IG Prisons,
Sri VS Raja, Former DIG Prisons,
Sri MC Vishwanathaiah, DIG Prisons

Consultants, Expert Committee

Prof P Satish Chandra, Director Vice-Chancellor, NIMHANS
Dr D Nagaraja, Former DirectorVice-Chancellor, NIMHANS
Dr Santosh K Chaturvedi, Professor and Head of Psychiatry, NIMHANS
Dr BN Gangadhar, Professor of Psychiatry, NIMHANS
Dr CR Chandrashekar, Professor of Psychiatry, NIMHANS
Dr. Kishore Kumar, Consultant, Community Psychiatry, NIMHANS
Dr. Vishal B Karur, Joint Director, Dept of Health and Family Welfare,
Dr. H Chandrashekar, Secretary, State Mental Health Authority

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Altamas Kabir
Judge
Supreme Court of India
&
Executive Chairman
National Legal Services Authority

17,Safdarjung Road
New Delhi - 110011
Tel : 23017059

MESSAGE

The Universal Declaration of Human Rights was adopted by the General Assembly of the United Nations on 10th December, 1948, calling upon its member countries to promote universal respect for and observance of human rights and fundamental freedom. The basic philosophy of the Declaration was to recognize that the inherent dignity and the equal and inalienable rights of all members of the human family are the foundations of freedom, justice and peace in the world. Articles 1 and 7 of the Declaration proclaim that all human beings are born free and equal in dignity and rights and that all are equal before the law and are entitled without any discrimination to equal protection of the law. Article 7 also declares that all are entitled to equal protection against any discrimination and violation of the Declaration. Article 3 declares that everyone has a right to life, liberty and security of person. Article 13 declares that everyone has a right of freedom of movement and residence within the borders of each State.

The aforesaid Declarations sound familiar when considering Part III of the Constitution which embodies the fundamental rights guaranteed to all citizens. The same values and rights are contained in Articles 14, 15, 16, 19 and 21 of our Constitution. In terms of the Universal Declaration of Human Rights and Part III of the Indian Constitution every citizen of this country and every human being is entitled to be treated with dignity, decency, equality and freedom, irrespective of caste, creed, religion or sex. Unfortunately, the constitutional obligations are yet to be fulfilled by those who have been entrusted with the affairs of the State and particularly in the case of persons with mental illnesses. One area of concern is the condition in prisons or correctional institutions, as they are now referred to, wherein custody itself is a cause for serious mental stress. In addition, if the living conditions in prisons are unsatisfactory, it is bound to affect both the physical and mental health of the inmates. It has been seen in certain cases that persons with severe mental illness land up in prisons without being referred for proper treatment. In detention, without any treatment which they require, the situation for them becomes even worse. As a matter of fact, there is a close relationship between drug use, crime and imprisonment and as long as the problem of drug abuse is not dealt with sternly within the community itself, it will worsen the atmosphere which is already vitiated. One of the major problems is with reference to identification, treatment and rehabilitation which is almost non-existent in many correctional institutions.

At times, purported mental illness has also landed many innocent victims behind prison walls mainly in property-related cases, but even if a person is mentally unstable, his or her place is not in a prison but in a mental home where proper mental care is available.

Justice . J. S. Khehar
Chief Justice

"Shanthi Gruha"
1, Palace Road
Bangalore - 560 001

10th January, 2011

MESSAGE

There still exists a yawning gap in the treatment of mental, neurological and substance use disorders all over the world, particularly so in underprivileged countries. The deficiencies in community care are likely to be many times magnified in settings like prisons. Despite several decades of prison reform in our country, many problems continue to plague our prisons. The infrastructure and attitudes are still colonial, and the approach still largely custodial. A lot needs to be done to improve the health conditions of our prisoners. The theme of the World Mental Health Day last year was "Mental Health and Long-term Illness: The Need for Continued and Integrated Care". Prison settings are an ideal venue for integrated physical and mental health care. Sadly, both physical and mental health disorders flourish in prison settings, and one aggravates the other. There is an urgent need for a complete re-look at health care delivery in prison settings in general and mental health care in particular. The latter is not present even in a rudimentary fashion in most prisons within the country. Every single prisoner must have access to basic mental health care. In addition to prompt identification of any mental disorder and immediate treatment, mentally ill prisoners must have a right to speedy trial, so that they are not incarcerated in prisons unjustifiably.

Tel : 080 - 22954601 (O), 22954604 (R). Fax: 080 - 22954603 (O), 22954606 (R)

Justice . J. S. Khehar
Chief Justice

"Shanthi Gruha"
1, Palace Road
Bangalore - 560 001

I understand that there have been several developments in the recent understanding and treatment of a range of mental disorders, including substance use disorders. It is important that the benefit of such understanding reaches the disenfranchised and vulnerable sections of society. As prison populations have large numbers of persons at risk for mental illness, it is very important that they are promptly identified and treated.

I am hopeful that the findings with respect to the mental illness and substance use problems of the Central Prison, Bangalore, will galvanise all stakeholders into setting in place appropriate systems for optimal physical and mental health care.

Jagdish Singh

(J.S. KHEHAR)
CHIEF JUSTICE

Tel : 080 - 22954601 (O), 22954604 (R), Fax: 080 - 22954603 (O), 22954606 (R)

Justice Manjula Chellur

JUDGE, HIGH COURT OF KARNATAKA
&
EXECUTIVE CHAIRMAN
Karnataka State Legal Services Authority

☎ Chamber : 22863571
Office : 22954123
Resi.: 22954124
22954125

1st Floor, High Court Building,
BANGALORE - 560 001

10th Janaury, 2011

MESSAGE

National Institute of Mental Health and Neuro Sciences (NIMHANS) is one of the prides of State of Karnataka. From this prestigious institution several initiatives to improve mental health care in the country have originated. NIMHANS is a leader in the quality assurance of mental health in the country and it has explored the very disturbing state of mental hospitals in many parts of the country. It helped to formulate minimum standards of mental health care in mental health care institutions. When NIMHANS, in dialogue with the Prison Department, Government of Karnataka, mooted the idea of carrying out an evaluation of the mental health and substance use problems in the Central Prison, Bangalore, the Karnataka State Legal Services Authority (KSLSA), was more than delighted to support this initiative. We have always been concerned about the needs of prisoners, not just their legal needs, but several other needs from a rights based perspective. This study has provided an opportunity for us to make an in-depth understanding of the ground realities concerning physical and mental health care needs of prisoners. If the situation in the Central Prison, Bangalore, could be so alarming, as evident from this report, one can only imagine the sorry state of prisons in other regions of the country. Both the earlier National Commission for Women's study on mental health problems of women in custody and the current findings of mental health and substance use problems among women in custody highlights the need for gender sensitive approach to meet women's needs. We are also extremely disturbed with the findings of high levels of stress and mental health problems among the prison staff.

Justice Manjula Chellur

JUDGE, HIGH COURT OF KARNATAKA
&
EXECUTIVE CHAIRMAN
Karnataka State Legal Services Authority

☎ Chamber : 22863571
Office : 22954123
Resi.: 22954124
22954125

1st Floor, High Court Building,
BANGALORE - 560 001

I am glad that Karnataka State Legal Services Authority has supported this remarkable initiative, which will serve as a blueprint not just to improve conditions in the prisons of Karnataka, but also in other parts of the country. We hope this is a humble beginning of service development for comprehensive mental health care in the prisons. We are deeply committed in taking this issue forward.

I would like to acknowledge my predecessors at KSLSA for having approved and supported this study. The Department of Prisons must be acknowledged for rendering un-stinted support to carry out this sensitive but important study. I hope all the hopes and dreams to make prisons a setting for correction and rehabilitation will indeed become a reality.

(MANJULA CHELLUR)

EXECUTIVE CHAIRPERSON

KSLSA.

Justice N.K. Patil
JUDGE, HIGH COURT OF KARNATAKA
BANGALORE - 560 001

Off.: 22954151
Resi.: 22954322
22954232
B4, Ministers' Quarters,
Jayamahal Extension,
Vyalikaval,
Bangalore-560 046.

10th January, 2011

MESSAGE

The need for a thorough psychiatric evaluation of the inmates of central prison Bengaluru, was felt by Dr. S.T. Ramesh, who was the Inspector General of Prisons, in the State of Karnataka during 2006. In this regard, Dr. Ramesh approached Karnataka State Legal Services Authority (KSLSA) to provide all assistance to get the evaluation done by experts from NIMHANS. The study was done by the experts under the able guidance of Hon'ble Mr. Justice J.S. Khehar, Chief Justice, High Court of Karnataka and Patron-in-Chief of KSLSA, Hon'ble Mr. Justice V. Gopala Gowda, the then Executive Chairman of KSLSA & Hon'ble Mrs. Justice Manjula Chellur, Executive Chairperson of KSLSA. This was done under the joint auspices of KSLSA and the Department of Prisons, Government of Karnataka.

The thorough study of inmates of the Central Prison Bengaluru, has brought out many astonishing causes for

Justice N.K. Patil
JUDGE, HIGH COURT OF KARNATAKA
BANGALORE - 560 001

Off.: 22954151
Resi.: 22954322
22954232
B4, Minister's Quarters,
Jayamahal Extension,
Vyalikaval,
Bangalore-560 046.

various types of mental illnesses in the inmates. After studying the report submitted by NIMHANS, KSLSA has thought it fit to hold a Southern Regional Seminar to deliberate upon various dimensions and to make suitable recommendations to the concerned. The Evaluation Report of the inmates of the local prison will be the basis for National Action. The Report is an eye opener to those who manage the Correctional Homes especially the prisons in our Country. I am confident that the Report will be the basis for very useful deliberations to make important recommendations and implementation thereof.

I congratulate all those who have contributed for this unique effort.

Justice N.K. PATIL
Chairman
High Court Legal Services Committee.

NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES
(DEEMED UNIVERSITY)
P.B. 2900, Bangalore – 560 029 (India)

Dr. P. Satish Chandra
MBBS, DM (Neuro), FAMS, FIAN
Director / Vice Chancellor
Professor of Neurology

Off : 91-80-26564140, 26561811
26565822, 26995001 / 2
Res : 91-80-25720506, 25727475
Fax : 91-80-26564830 / 26562121
Email : psatish@nimhans.kar.nic.in
Grams : "NIMHANS"

10 January 2011

Message

The evolution of civilization in a society can be judged by entering its prisons. Prison populations are expected to have an over-representation of members of the most marginalized groups in society, people with poor health, malnourished drug users, alcohol dependents, those who are vulnerable and who have high risk behaviours such as injecting drugs and commercial sex work. Prisoners are at an increased risk of developing a wide variety of communicable diseases (tuberculosis, HIV, hepatitis and other blood-borne diseases) and also non-communicable diseases (diabetes, hypertension, epilepsy, heart diseases and cancer). Studies have established that mental disorders and substance use (alcohol, tobacco, cannabis and cocaine) are also highly prevalent in prisons.

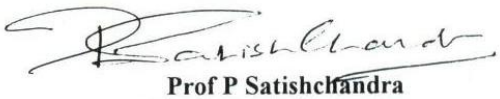
Prison receives (*receiver*) people with mental illness, personality disorders and substance use on a daily basis from the community. It (*amplifier*) increases the prevalence and severity of the above conditions inside the prison. It (*transmitter*) disseminates them in a more severe form back to the community. Ultimately, it broadcasts the poor health care facility of our community. Many of the mental health problems may be present before admission to prison, and may further exacerbate by the stress due to imprisonment. Mental disorders may also develop during imprisonment, as a consequence of prevailing environmental conditions and also possibly due to torture or other human rights violations. Mental health problems continue to haunt these people even after release from the prison.

People with mental disorders are sometimes inappropriately locked up in prisons simply because of unawareness of the Mental Health Act, 1987 or else, the lack of trained manpower to treat them. People with substance abuse disorders, at least in part due to a mental disorder, have committed minor offences are often sent to prisons rather than for treatment of their disorder. These disorders therefore continue to go unnoticed, undiagnosed and untreated. Hence, steps need to be taken for early detection, prevention and proper treatment of mental disorders, together with promotion of good mental health. The imprisonment of people with mental disorders due to lack of public mental health service alternatives should be strictly prohibited by law.

Access to treatment in prison should be a top priority. More often, public-health strategies adopted in the community are ignored in the prison setting. Hence, the health services provided to prisoners should, as a minimum, be equivalent to those in the community. There is an urgent need to integrate public health services and prison health services. National health programmes and District mental health programmes need to be implemented at the earliest. Local medical colleges need to provide specialised care inside the premises of the prisons. De-addiction facility and behavioral rehabilitation needs to be provided in the prison. Harm-reduction strategies such as substitution maintenance therapy, needle-exchange programmes and health promotion—can be cheaply and easily incorporated into prison health programmes.

Availability of qualified manpower is the most important factor in providing care in prison. Hence, World Health Organization (WHO) has advocated training of prison staff on mental health issues. Training needs to be targeted in prisons including prison administrators, prison guards and health workers. Training should enhance the staff's understanding of mental disorders, raise awareness on human rights, challenge stigmatising attitudes and encourage mental health promotion for both prison staff and prisoners. Another important element of training for all levels of prison staff should be recognition and prevention of suicides.

A team of psychiatrists from the National Institute of Mental Health and Neurosciences (NIMHANS), along with the psychiatrist of the central prison, Bangalore have taken immense trouble to carry out this study of mental health and substance use in prison. I commend them both for their academic rigour and hard work to bring together this publication. I sincerely hope that the local lessons learnt from this prison study will indeed be translated into national action.



Prof P Satishchandra
Director-Vice Chancellor
NIMHANS, Bangalore

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KUCHANNA SRINIVASAN, I.P.S..
Addl. Director General of Police
And Inspector General of Prisons

ನಂ. 4, ಶೇಷಾದ್ರಿ ರಸ್ತೆ,
ಬೆಂಗಳೂರು - 560 009.

No. 4, Seshadri Road,
Bangalore - 560 009.
Off. : 080 - 22267169 / 22942213
Fax : 22267290
Res : 080 - 26684885 / 22943136
Mobile : 9483503999

MESSAGE

On our request The Karnataka State Legal Services Authority very graciously came forward to fund a comprehensive study of mental health problems in the Central Prison Bangalore. India's apex mental health institute, NIMHANS volunteered to lead the study with the support of the prison staff. They completed the painstaking study in a short time. Given the extensive nature of the study, it is indeed a noteworthy accomplishment. It is expected to help improve the policy framework of prison management here, and at the national level.

Recommendations made are aimed at correctional aspects & mental health care of prisoners, de-addiction planning and improving the working conditions of staff. It is our fervent hope that we get all the support that is needed to introduce these reforms in prison management and to enable transforming themselves, from being just custodial care centers into truely correctional institutions.

I would like to thank the Karnataka State Legal Services Authority, NIMHANS, our own prison staff, particularly our psychiatrist, the volunteers all of whom have worked so hard, and the eminent doctors & professionals who led them ably to make this study a resounding success.

(Kuchanna Srinivasan)

Editors' Foreword

All of us are practicing psychiatrists, and have trained at the National Institute of Mental Health and Neuro Sciences, Bangalore. During our formative years, we have been struck by the difficulties persons with mental illness face, in the community in general and in custodial settings in particular. Working in the criminal ward at NIMHANS has exposed us to a wide range of psychiatric problems, including undetected substance use among prisoners. We have also been aware that prisoners experience a lot of emotional distress consequent to imprisonment and the harsh conditions of imprisonment.

We have been acutely conscious of the need to address mental health needs of people from a human rights perspective, and this perspective is especially relevant in prison and other custodial settings. We were thus very keen and looking for opportunities to better understand mental health and substance use problems among prisoners, with a view to setting up infrastructures and programmes for mental health care in these settings. The encouragement from the Department of Prisons, Government of Karnataka and the support of the Karnataka State Legal Services Authority helped to translate this into reality. Having an empathetic prison psychiatrist on our team has greatly enriched this initiative. This study, to our knowledge, is only one of its kind in the country.

The experience of carrying out the study, understanding the complexities of the prison system and the needs of prisoners, the circumstances in which prison staff work, and the various environmental factors that impact on prisoners' mental health has been really illuminating, as well as disturbing. We hope that the lessons we have learned from our local prison in Bangalore, will pave the way for a national dialogue on health care in prisons in general and mental health care in particular. It is our earnest hope that prisons in India will indeed transform from custodial to correctional institutions, and provide the mental health care and support which can help not just in improving human resilience but also pave the way for the transformation of offenders.

That hope can be realised only by positive action along several lines. We hope that all the key stakeholders will be sensitised to the glaring lacunae in mental health care in prisons in India and galvanise the system in order to ensure a healthier and safer world for those unfortunate enough to end up in custodial settings.

The Editors

Acknowledgements

Carrying out a study of this magnitude is no mean task and was possible only with the help and support of several people. We would first like to express our gratitude to the prisoners and staff of the Central Prison, Bangalore, for trusting us and providing us the important information that formed the basis of this study. We hope this effort will bring a sea-change in providing better mental health care in prisons all over the country.

We express our sincere thanks to Hon'ble. Sri Justice Jagdish Singh Khehar, Chief Justice of the High Court of Karnataka for his encouragement and support during the most critical stage in the project.

This project could never have taken off without the support of the Karnataka State Legal Services Authority who sponsored this initiative. We would like to place on record the encouragement given by Hon. Smt Justice Manjula Chellur, Hon. Sri Justice NK Patil and Hon. Chief Justice Sri .V. Gopala Gowda. We would like to thank the member secretaries, Sri Vishwanath V Angadi and Sri Veeranna G. Tigadi, for their constant support. We are also grateful to members and staff from the Karnataka State Legal Services Authority, Bangalore for their help and support.

The Prison Department played a key role in carrying out this study successfully and in an extremely professional manner. The freedom and support they provided helped us to conduct the research in an unbiased and confidential manner. Sri S T Ramesh (former ADGP and IG, Prisons) was pivotal in initiating this study, and during several stages, support was provided by his successors, Sri Dharam Pal Negi and Sri Bipin Gopalakrishna. We are indebted to Sri Kuchanna Srinivasan, current ADGP and IG Prisons for his commitment in carrying out the recommendations of the project.

The prison DIGs, Sri V S Raja and Sri M C Vishwanathaiah and prison superintendent, Mr. Lakshminarayana also deserve a special mention for the support they provided. The chief medical officers and other medical officers of the Central Prison, Bangalore, also played an extremely facilitatory role in executing this project. We thank prison medical officers, Dr Vijay Kumar and Dr K Kumar for their help and support. Warders Sri Praveen N Yalawara, Sri P Pradeep Kumar, Sri Keerthi helped us immensely during the project. We are also extremely grateful to Sri Ravi N, Sri Jagadeesha S, Sri Aravind, Sri Siddaraju S, Sri Naga Naik and many others for their active co-operation and support.

We thank Dr H Chandrashekar, Head of the Department of Psychiatry, BMCRI, for sharing the kannada translation of the MINI schedule for use in this study.

Prof P Satishchandra, Director and Vice-Chancellor, NIMHANS and Prof. D Nagaraja (Former Director, NIMHANS) provided unconditional support and inputs for this study and we are extremely grateful to them. We thank the expert consultants' team for their valuable inputs. We also thank the junior resident doctors, psychologists and psychiatric social workers from NIMHANS for their time and efforts in carrying out health camps in the Central Prison. We are also thankful to our research staff, Sri Lakshminarayana, Smt Savitramma and Smt Manjamma and computer data technician, Smt N Roopa.

We owe a great deal to our friends and family members for their unconditional support and encouragement. There are several other people, too many to individually name, who have shared their valuable ideas and comments during different phases of the project. We express our sincere thanks to all of them.

The Editorial Team

Abbreviations

ADGP	Additional Director General Of Police
AIDS	Acquired Immune Deficiency Syndrome
AIHW	Australian Institute of Health and Welfare
AMP	Amphetamines
ASP	Antisocial personality
ASPD	Antisocial personality disorder
AUDIT	Alcohol Use Disorder Identification Test
BAR	Barbiturates
BMI	Basal metabolic index
BPR&D	Bureau of Police Research and Development
BZO	Benzodiazepines
CO	Carbon monoxide
COC	Cocaine
CP	Convict prisoner
CTP	Convict prisoner
DGP	Director General of police
DIG	Deputy Inspector General
DSH	Deliberate Self Harm
DSM	Diagnostic and Statistical Manual
ECDDA	European Monitoring Centre for Drugs and Drug Addiction
HIV	Human Immune Deficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICD	International Classification of diseases
ICESR	International Covenant on Economic, Social and Cultural Rights
ICMR	Indian Council of Medical Research
IDU	Injection Drug Users
IG	Inspector General
INR	Indian Rupees
KSLSA	Karnataka State Legal Services Authority
MDR	Multi-Drug Resistant
MHSA	Mental Health and Substance Abuse
MINI	Mini International Neuropsychiatric Review

MLA	Member Legislative Assembly
MP	Member of Parliament
MTB	Mycobacterium Tuberculosis
NALSA	National Legal Services Authority
NFHS	National Family Health Survey
NHSDA	National Household Survey on Drug Abuse
NIMHANS	National Institute Of Mental Health and Neurosciences
NWFP	North Western Frontier Province of Pakistan
OPI	Opioid Substances
OST	Opioid Substitution Therapy
PTSD	Post Traumatic Stress Disorder
QOL	Quality Of Life
SD	Standard Deviation
SMART	Stress Management And Rehabilitation Training
STI	Sexually Transmitted Infection
TB	Tuberculosis
THC	Tetra Hydro Cannabinol
UN	United Nations
UNODC	United Nations Office on Drug and Crime
UT	Undertrial
UTP	Undertrial Prisoner
WHO	World Health Organization
WHO SEARO	World Health Organization South-East Asia Regional Office

Contents

Executive Summary

Mental Health and Substance Use Problems in Prisons

The Bangalore Prison Mental Health Study:
Local Lessons for National Action

EXECUTIVE SUMMARY

Background

World over, it has been established that prisons have a high prevalence of mental health and substance use problems. Estimates from different countries suggest that the prevalence of mental health problems in prisons is three to five times higher than in the general population. The World Health Organization in 2008 noted that of the nine million prisoners world-wide, at least one million suffer from a significant mental disorder and even more suffer from common mental disorders such as depression and anxiety. There is often co-morbidity with conditions such as personality disorder, alcohol and drug dependence. Mental disorders and substance use (tobacco, alcohol and other drugs) may either be present prior to prison entry or get exacerbated in prison.

Health problems in Indian prisons have not been systematically studied. Islands of information suggest that prisons in different parts of the country have HIV prevalence four to eight times higher than the general population (1.76-6.9% in prison compared to 0.36 in the community). The Human Rights Watch Report 2001 suggests high rates of tuberculosis in India. However, physical health problems among prisoners in India has not been systematically studied or addressed.

Mental disorders and substance use in Indian prisons

The knowledge of mental health and substance use problems in Indian prisons is even sparser. A retrospective review in 1996 of files of inpatients referred to the National Institute of Mental Health and Neurosciences (NIMHANS) from the Central Prison, Bangalore over 12 decades, suggested that a significant number were diagnosed as having a serious psychotic disorder, namely schizophrenia.

A collaborative study between NIMHANS and the National Commission for Women in 1998 examined mental morbidity among women in the Central Prison, Bangalore and found high levels of mental distress (unhappiness, worrying, thoughts of worthlessness, poor sleep and appetite). A report from Tihar Jail, Delhi, found that 8% of new entrants had drug abuse. Apart from a few such reports and anecdotal information, there has been no systematic study of mental disorders and substance use problems among prisoners in India.

THE BANGALORE PRISON MENTAL HEALTH STUDY

This was a collaborative project between the National Institute of Mental Health and Neurosciences, Department of Prisons, Government of Karnataka and the Karnataka State Legal Services Authority. The objectives of the study were to:

a. Estimate the prevalence and patterns of major and minor psychiatric morbidity and substance use in the Central Prison Bangalore
b. Assess the mental health needs of prisoners
c. Prepare a response in conjunction with the service providers in prison
d. Conduct training for the prison staff to recognise and develop systematic interventions to address mental health issues
e. Develop minimum guidelines for mental health care of the prisoners which can serve as a blueprint for all the prisons in the country.

METHODOLOGY

The Assessment included administration of the following questionnaires:

1. Socio-demographic questionnaire
2. Life Style Questionnaire to capture details of lifetime use and use in the year prior to imprisonment of substances including tobacco, alcohol (using the World Health Organization AUDIT questionnaire) and other drugs, gambling, high risk sexual behaviour.
3. MINI Plus interview schedule to assess mental health morbidity
4. Needs Assessment Questionnaire
5. General Health Check

The study was conducted after formal approval by the NIMHANS Ethics Committee. It was carried out in three phases:

Phase I

Stage 1: Assessment of prisoners (n=5024) in Parappana Agrahara (Central Prison) Bangalore on a structured instrument for mental health morbidity after informed consent

Stage 2: Anonymous urine screening of the prisoners with strict confidentiality regarding test results

Phase II

Stage 1: Development of a brief screening tool for assessment of mental illness in the prison population

Stage 2: Mental health training programme for the prison staff in early identification and treatment of mental health problems

Stage 3: Assessment of Mental health morbidity of prison staff at the Central Prison, Bangalore

Phase III

Stage 1: Development of guidelines for the assessment and management of mental health and substance use problems in prisons

Stage 2: Preparation and dissemination of the findings of the project.

Components of the evaluation included:

- Personal interview with all the prisoners to assess mental health morbidity including substance use as well as perceived needs in prison
- Anonymous random urine screening of UTP and CTP prisoners as well as new entrants
- Cross-sectional health screening of a randomly selected prison sample with checking for urine sugar and protein, breath carbon monoxide as a proxy indicator for smoking and breath alcohol estimates
- A similar exercise was also conducted for the prison staff.

FINDINGS OF THE STUDY

A brief profile of the prison population

- There were 5200 prisoners during the period of conduct of the study (2008-2009) as against an approved capacity of 2100, indicating 248% occupancy rate. 5024 prisoners were interviewed for the study.
- A majority of the prisoners (65.4%) were Under Trial Prisoners (UTPs).
- Undertrials were mostly males, in their late 20's, a majority single (53.7%) or married (41.4%) and two-thirds were from urban area while one in four was from a semi-urban background. One in five UTPs was illiterate or had only informal education.
- Convict prisoners were older, a substantial number were married (73.8%) and a majority were from semi-urban background (59%). Nearly one in four (23.4%) convict prisoners was illiterate.
- Approximately 15% of both UTP and convict prisoners were educated upto pre-university or higher.
- Most UTP and convict prisoners were employed prior to imprisonment.
- A third of UTPs (33.5%) and a higher proportion of CTPs (44.4%) reported family incomes below Rs 3000 per month.
- A majority (86%) reported staying with their families prior to prison entry.
- For a majority (80.4%), this was the first imprisonment.

A brief profile of women prisoners

- There were 210 women prisoners (4%) at the time of conducting the study and 197 of them were interviewed.
- Women prisoners were significantly older (mean age 37.5 $\pm$ 14.4 years) compared to the men (30.4 $\pm$10.3).
- A majority of the women were undertrial prisoners (62.4%), were or had been married (92.3%) and among those who responded, all lived with their families prior to prison entry.
- 47.2% came from urban and 42.6% from semi-urban backgrounds.
- About one in five (22.5%) was a housewife, others were engaged in unskilled or semiskilled work (42%) or agriculture (14.5%).

General health status

- Self report of health problems was very low. The commonest problems reported were back or neck problems (16%), arthritis (14.7%), digestive disorders (13%) and skin disease (10.5%). Spontaneous self report of mental illness was as less as 2%.
- Though only 3.6% of prisoners self reported a history of high blood pressure, on recording of blood pressure, 20.5% were found to be hypertensive thus increasing hypertension detection rates by five times.
- About 5% of the resident prisoners and 4.5% of new entrants tested randomly had positive urine sugar. Only 3% reported a prior history of diabetes. Urine screening helped to double the diabetes detection rate in prison. The screened prevalence is probably representative of the prevalence of diabetes in the general population (3% in rural and 9% among urban populations). Proteinuria was identified in 4.6% of prisoners randomly screened and in 7.3% of the new entrants. This indicates the presence of renal dysfunction from diverse causes.
- Nearly one in three prisoners was underweight with a BMI below 18.5. UTP were significantly more likely to be underweight (33.8%) compared to CTP(19.8%).

- Among new entrants to the prison, nearly one in four was underweight (24.3%), and 17.6% were in the overweight category.
- Approximately one in 10 resident prisoners could be classified as being overweight or obese. A higher percentage of convict prisoners were in the overweight/obese category.
- Women prisoners face problems of both under and overnutrition with one in four being underweight and approximately a similar proportion, overweight or obese (26.3%), higher compared to 10.9% of male prisoners who are overweight or obese. While this probably reflects better food within the jail than outside, it raises important concerns about the lack of exercise in prison and a greater risk to non communicable diseases like hypertension and diabetes.
- Data from the prison hospital suggests that there were between 4500 to 7000 consultations each month, and the most common consultations were for skin diseases (40%), and gastrointestinal problems (20%). In 10% of consultations, no diagnosis was made. Mental illness constituted 4% of monthly new referrals.
- HIV seropositivity in 2008 was 3% which is much higher than seroprevalence figures for Karnataka at 0.69% (figure from NFHS 3 2005-2006).
- On an average there were 18 to 30 deaths annually between 2007 and 2009. During this period, there were 9 deaths from suicide, mainly hanging.
- In 2008, there were 38 deaths of male prisoners in custody, which translates to 7.3 deaths per 1000, more than double that in the general population (the annual death rate for men was 3.2 per 1000 for 2007), and much higher than in prisons in developed countries. Underlying causes recorded in these deaths were HIV (26%), cardiac causes (23%), cancer (17%), suicide (11%) and tuberculosis (9%). One death (3%) was recorded as being drug related.
- As there has been no systematic screening for tuberculosis, it is not possible to comment on tuberculosis prevalence.
- Only 196 respondents (3.9%) reported taking medication regularly at the time of interview. Only 13 of them were able to mention what medicines they were taking.

Health Care in the Central Prison

Health care is provided largely through the prison hospital located within the prison premises

- There was only one psychiatrist for the entire prison of over 5000. Apart from this, the prison hospital had only 3 doctors (one physician, one dermatologist, one ophthalmologist) and 1 staff nurse, one lab technician, one x ray technician and 2 pharmacists. The four doctors saw all routine clinical referrals to the prison hospitals in addition to their own specialty referrals. They also run an inpatient service with 100 beds (this facility is usually overflowing with about 250 patients at any given time), provide health reports in response to court orders, co-ordinate medical retransfers across the prisons in the state, and provide emergency cover as needed. Thus, the ratio of medical doctors to patients was 1: 1300 at the time of the study. Contrast this with Australia where there are three full time professionals for every 100 prisoners in custody.
- The scarcity of human health resources makes it impossible to screen prisoners for manifest and latent health problems, which range from under nutrition to chronic conditions like hypertension and diabetes. A sample survey in the prison revealed that 5% of the urine samples were positive for diabetes and proteinuria was present in 4.6%. Screening was able to pick up twice the number of diabetics compared to self-report.
- Inadequate self awareness of illnesses among the prison population. This possibly reflects the low awareness in the general community.

Mental Morbidity

This section details mental health morbidity, substance use, including regular patterns of use which suggest dependence or addiction.

- According to the MINI psychiatric diagnosis, 4002 (79.6%) 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.
- After excluding substance abuse, 1389 (27.6%) prisoners still had a diagnosable mental disorder. 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.

Tobacco Use

- 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. Undertrial prisoners had started tobacco use at a mean age of 18.3 years, and had been smoking for a mean number of 6.6 years. Those chewing tobacco had started at a mean age of 19 years and had been regularly chewing tobacco for 5.1 years.
- Convict prisoners who smoked had initiated smoking at 20.4 years and had been smoking for a mean of 9.8 years. Chewers in this group had started chewing at 20.2 years and were regularly chewing for 7.5 years.
- 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 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. Convicted 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 a half times among UTPs.

Breath CO monitoring

- On breath carbon monoxide monitoring, which is a proxy indicator for smoking, 42.6% of the male prisoners tested (n=169) had CO levels of above 7 ppm indicating that they had recently smoked.

Alcohol use

- More than one in two prisoners (51.5%) reported consuming alcohol in their lives. This is nearly 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.
- 43.5% of resident prisoners fulfilled diagnostic criteria for lifetime alcohol dependence and 14% for current alcohol dependence (in the year prior to prison entry). Current alcohol dependence rates in the prison population are nearly three times more than in the general population.
- 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.

- Among new entrants, 58% reported ever use of alcohol and 51.9% reported use in the last month.
- Among women resident prisoners, 3% reported ever using alcohol.

Other drugs of abuse

- 13% of respondent prisoners reported ever having used a drug apart from tobacco and alcohol. This was more commonly reported by UTPs (13.8%) than CTPs (10.5%).

Urine Drug Screening

A random urine drug screening was carried out on 721 resident prisoners in an anonymous manner. Of these, 442 (61.3%) tested positive for one or the other drug.

- Among those who tested positive:

  43% tested positive for benzodiazepines
  31% tested positive for cannabis
  15% tested positive for cocaine
  9% tested positive for barbiturates
  6% tested positive for amphetamines
  3% tested positive for opioids

- Nearly a third of positive urine sample were positive for two or more drugs.
- Generalising the findings among resident prisoners, urine testing revealed extraordinarily high levels of drug use (61.3%) compared to self report (1.5%).
- 325 consecutive new entrants were also screened for drugs by urine screening. 146 (44.9%) tested positive for one or the other drug. Among those positive:

  28.3% tested positive for benzodiazepines
  17% tested positive for cocaine
  13.2% tested positive for cannabis
  4.3% tested positive for amphetamines
  1.5% tested positive for barbiturates
  1.2% tested positive for opioids

- On comparison of percentages of positive urine drug tests between resident prisoners and new entrants, 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 and 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.

Expressed need for help for addiction

- Among substance users, 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.

Gambling

- About one in ten prisoners had indulged in some form of gambling during their lifetime. The commonest form was playing cards for stakes.

Other psychiatric illnesses

- 12.7% of resident prisoners had a lifetime history of major depressive episode and 9.1% had a current major depressive episode. This is twice the rate of the general population.
- Two out of every 100 prisoners reported having attempted suicide sometime in the past and more than seven per 100 had deliberately caused injury to themselves.
- About 2 to 3 UT prisoners out of every 100 is at risk of attempting self harm in prison. Of those who had made an attempt of deliberate self harm after coming to prison, 50% had made an attempt prior to coming to the prison. Thus past attempt at self harm should be identified as a risk factor for repeated self harm.
- 2.2% of the prison population had a diagnosis of psychosis, primarily schizophrenia. This is twice that of the general population.
- A substantial number of psychotic disorders (16.9%) were substance related.

Excessive preoccupation with bodily symptoms

- A substantial number of both UTP and CTP prisoners had a lifetime and current diagnosis of somatisation. This diagnosis could be made in about 2 out of every 100 prisoners. Current diagnosis of a pain disorder was made in 272 (5.4%). In Asian cultures, manifestation of psychological distress through physical symptoms is relatively more common than in other cultures.

Antisocial Personality Disorder

- 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.

Needs of Resident Prisoners

- The major areas of dissatisfaction were with the cleanliness (33%-44%), access to safe drinking water (38%), quantity (25%) and quality of food (59%) and with the visiting facilities (21%).
- One in two prisoners (50%) felt they were not treated with respect by the staff.
- More than a third (34%) found it difficult to access health care.
- Most prisoners (90.3%) did not attend any form of rehabilitation or occupational therapy.
- One in five prisoners (22%) was not aware of the legal charge against them.
- A majority (70%) did not get escorts to attend court proceedings regularly and 51% were unhappy with the pace of legal proceedings.

Prison Staff

- Prison staff (n=201) were interviewed with respect to their health, particularly mental health issues as well as their needs in the workplace.

- A sizeable number (29.2%) was overweight. Symptoms causing moderate to high levels of stress included ulcer symptoms (97%), headaches (46%), worries (39%), aches and pains (34%), inability to relax (32%), depression and sadness (32%), tiredness (33%), anger/irritation (30%), reduced sleep (15%) and backache (18%).
- A majority (81%) reported moderate to high levels of overall stress, attributed to personal safety concerns (82%), difficulties in managing prisoners (69%), family problems (40%), fear of suspension (39%), financial problems (38%), and fear of transfer (23%). 40% of the staff felt unappreciated by their superiors and of even greater concern is that 91% reported verbal abuse from their superiors and 12 % physical abuse.
- The low staff morale is best exemplified by the fact that 28% had considered resigning from the job because of job stress. Though 18% of them reported specific physical problems only one staff was on regular medication. Though none of them reported having symptoms of mental illness, 11% could be diagnosed as having a lifetime major depressive episode and 5% a current major depressive episode.

IMPLICATIONS

The findings from the study highlight the high proportion of mental health problems among prisoners and the need for mental health care in prisons. There is also a need to sensitise and train the staff of the prisons ineffectively managing the prisoners, as well as identifying and responding to the mental health problems. Prisons can provide a corrective, rehabilitative role only if these concerns are adequately addressed. The recommendations of this project are relevant to prisons not only in India, but throughout the developing world. The local lessons can then indeed be translated into national as well as global action.

RECOMMENDATIONS FOR NATIONAL ACTION BASED ON THE LOCAL LESSONS

The findings from the study highlight the need for addressing the mental health care issues of prisoners and staff of prisons. Prisons can provide a corrective, rehabilitative role only if these concerns are adequately addressed. Major areas requiring action include the following:

1. **Proper evaluation and assessment of every prisoner upon entry** into prison, and a good system of documentation, with a focus on general health, mental health and substance use. This includes objective testing for substance use and referral for evaluation and treatment.
2. **Attention to the general conditions in prison**, including overcrowding, cleanliness, potable water, quality and serving of food, adequate recreation particularly for women prisoners.
3. **Improving mental health care in prison** through prompt and proper identification, sensitive handling with established protocols for crisis intervention, behavioural emergencies including psychotic behaviour and suicidal ideations, availability of adequate medications as well as psycho-social interventions, adequate rehabilitation measures, and specific attention to the aftercare needs of persons with mental illness (education about illness, engaging the family, vocational guidance, treatment compliance and monitoring) as well as non-treatment support, particularly for those without families (shelter, health care, social schemes).
4. **Help to all prisoners to deal with the stress of prison** life through appropriate counselling, staff sensitisation, enhancing peer group and staff support, and by improving living conditions in the prison.
5. **Addressing substance use problems in prison** through proper identification at entry, prompt referral for treatment, periodic screening of resident prisoners for drug use, ensuring strict policies for possession and use of substances in prison, encouragement for help seeking for addiction including appropriate medications and psychosocial support for detoxification, long-term abstinence and addressing of co-morbid physical or psychological problems.
6. **Improvement of human and financial resources for running the prison**, including having adequate doctors, nurses, counsellors and prison staff to provide

health care in a graded manner, from health education to inpatient care. This includes a minimum of 1 doctor for every 500 patients, and attending specialists including a physician, psychiatrist, dermatologist, gynaecologist and surgeon; 2 nurses for every 500 prisoners, 4 counsellors for every 500 prisoners, to provide integrated health, legal and lifestyle counselling and support; a 20 bed facility for every 500 patients. As the support from the State Health Departments has been very variable, creating a prison health corps along the lines of the army health corps to attend to all the health needs in custodial settings must be seriously considered.

7. **All national health programmes must be implemented in prisons.**
8. **Prison staff training and addressing their needs** should focus on improving work conditions, improving staff morale and cohesion, better communication with prisoners and greater sensitivity to their needs. Special training in human rights and mental health issues is required. Such training is also required for other personnel not directly manning the prison, including the judiciary, lawyers and police. The Legal Services Authority and Human Rights Commissions are ideally poised to carry out such training in liaison with mental health professionals.
9. **Other health problems in prison**, **both acute and chronic, both communicable and non-communicable must be adequately addressed.** This includes but is not limited to skin infections, cardiac and respiratory disorders, tuberculosis, HIV, other sexually transmitted illnesses, hypertension, diabetes, stress related symptoms, anxiety, depression, and affected persons must be encouraged to seek help for such symptoms.
10. **Other needs of prisoners including legal and vocational needs and better interactions with families should be adequately addressed.** Support for this can be facilitated by active liaison with educational institutions such as law, social work and similar institutions.
11. **Proper documentation** – computerized data base, regular surveillance of health conditions, health status records, pre-and post discharge records must be maintained meticulously.
12. **Ensuring continuity of health care beyond the prison** is absolutely necessary if prisons should cease becoming reservoirs of infection and ill health. This is possible through effective education, screening, intervention, rehabilitation and monitoring.

13. **Another vital area requiring attention is addressing the systemic needs.** These include:
    a. **Raising prison standards** to meet the prescribed UN standards.
    b. **Seting up of a prison working group** for improving and monitoring health care in prisons, particularly from rights based perspective.
    c. **Reduction in the prison population** through promoting alternatives to imprisonment
    d. Ensuring an active **Board of Visitors.**
    e. **Systematic training of all professionals** including judiciary, lawyers and police.
    f. **Mandatory allocation of resources** for improving financial and human resources to prisons.
    g. **Improvement in trial procedures** to reduce delays, reduce duration of incarceration and mental anguish.
14. Ensuring a good prison environment conducive to correction and rehabilitation thus becomes a joint responsibility of the prison department, legal services authorities, human rights commissions, governments, non-government organisations as well as civil society.
15. Serious consideration must be given to institute a National Institute of Correctional Services, under which umbrella health related prevention, intervention and research activities in correctional settings can be undertaken.

CONCLUSION

Prisons are the mirror of our society. Prisoners are from our community and they return to our community. Data from the study reports of high prevalence of mental health problems and substance use in prisoners. Suicidal attempts and deliberate self harm by the prisoners are immediate concerns. Prison health needs must be considered as a priority in public health and mandatory implementation of all the national health programmes inside the prison must be done. Providing intervention for communicable diseases, substance use, mental illness and high risk behaviour thus benefits both prisoners and the wider community and reduces the burden on a country's health system as a whole.

Mental Health and Substance Use Problems in Prisons

The Bangalore Prison Mental Health Study: Local Lessons for National Action

Sponsored by KSLSA, Bangalore NIMHANS Publication

1. Overview of mental/behavioural and substance use disorders

India presently has the double burden of both communicable and non-communicable diseases. Among the non-communicable diseases, cancer, hypertension, obesity and diabetes are relatively well recognised problems. The problem of mental health and substance use are under-recognised and inadequately addressed in all spheres of the public health system. About 450 million people suffer from mental and behavioural disorders worldwide. One person in four will develop one or more of these disorders during their lifetime. Neuropsychiatric conditions account for 13% of the total Disability Adjusted Life Years (DALYs) lost due to all diseases and injuries in the world and are estimated to increase to 15% by the year 2020. Five of the ten leading causes of disability and premature death worldwide are psychiatric conditions (WHO 2005).

There are a wide range of mental and behavioural disorders. Mental disorders can affect the way a person thinks, feels, behaves and interacts with others around. They can thus result in erratic behaviour, irritability and occasionally violence, marked withdrawal and suicidal tendencies. Mental and behavioural disorders are commonly found in all societies and cultures, but access to health services is often very low. They are more disabling than many chronic and severe physical diseases. There is a need to improve the identification and management of mental disorders at all levels of care, particularly among vulnerable populations.

World over, it has been established that prisons have a high prevalence of mental health and substance use problems. Estimates from different countries suggest that the prevalence of mental health problems in prisons is three to five times higher than in the general population. In India, there has been little systematic assessment of the prevalence and patterns of mental morbidity among prisoners, their mental health needs and system responses or the lack of it. Mental disorders are caused by a complex interaction between genetic factors, early development, personality, current environment, physical health, life events, coping skills and social support. The disorders can be classified as indicated in the accompanying box.

Mental Disorders can be classified broadly as follows:

- **Organic brain disorders,** (arising from a demonstrable problem in the brain or due to a specific cause like underlying physical illness) which includes dementia, confusional states and personality and behavioural change associated with epilepsy.
- **Substance use disorders** (alcohol, tobacco, benzodiazepines, cannabis, opioid, cocaine inhalants and other drugs).
- **Psychotic disorders,** which are characterised mainly by a loss of touch with reality, inability to meet the demands of daily life, abnormal thoughts (delusions), and abnormal perceptions (hallucinations). The main psychotic disorders include schizophrenia, schizoaffective disorders and delusional disorders.
- **Mood disorders** which are characterised by persistent changes in the person's emotional state and affect how a person thinks, acts and reacts to the environment. People with mood disorders may suffer from depression or episodes of depression alternating with mania (bipolar disorder). Dysthymia is another condition characterized by frequent feelings of sadness, aggravated or maintained by stressful life situations.
- **Anxiety disorders,** which are characterised by physical and psychological symptoms of anxiety in varying combinations, may occur in bouts (panic disorder) or be present continuously (generalized anxiety disorder). These disorders may also include irrational fears (phobias), fear of social situations (social phobia), repetitive thoughts and actions (obsessive compulsive disorders) or follow significant psychological trauma (posttraumatic stress disorder).
- **Dissociative disorders,** which are characterised by a loss of bodily function following a psychological stress (conversion) or an inability to remember personal information.
- **Somatoform disorders,** which are characterised by persistent physical complaints that cannot be explained by an underlying physical illness.
- **Impulse control disorders,** which are characterised by an intense desire to perform an act that may be harmful to the person or to others. Examples include kleptomania (an irresistible impulse to steal) and pathological gambling.
- **Personality disorders,** which are deeply ingrained characteristics in an individual that are expressed in adolescence or earlier and can cause problems to self or to others.
- **Stress related disorders** –both acute and chronic stress can lead to changes in mood, anxiety and behaviour either when the stress is severe or when the person does not have the ability to adequately cope with the stress.

All psychiatric disorders can affect biological (sleep, appetite and sex), social and occupational function.

Substance use disorders

Substance use related disorders also 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.

Psychoactive substance use disorders include problems arising from acute intoxication, harmful use and dependence. The term "substance" includes tobacco, alcohol and illicit drugs (e.g. opioids, cannabinoids and cocaine) as well as psychoactive prescription drugs and inhalants. Worldwide, there are 1.1 billion tobacco users. Tobacco use, a human-made epidemic kills about 5.4 million people a year. Deaths due to tobacco are likely to be more than double between 1998 and 2030, and there may be more than 8 million deaths. In the 21st century, it is estimated that tobacco will be the cause of one billion deaths worldwide with three quarters of these deaths occurring in low income countries. Worldwide, about two billion people consume alcoholic beverages and over 75 million are diagnosed with alcohol use disorders (WHO, 2004). Alcohol consumption is the leading risk factor for disease (WHO, 2004). Apart from the direct effects of intoxication and dependence resulting in alcohol use disorders, alcohol is estimated to cause about 20–30% of each of the following conditions: 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 (WHO, 2004). According to an UNODC drug report, of the 4343 million persons aged 15-64 years across the world in 2007, 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, 2009).

The problem of mental health and substance use disorders in India

The prevalence of mental disorders reported in Indian epidemiological studies has been found to be 6-7% (Math et al 2007). This would mean that more than 6 to 7 crore people in our country are presently in need of mental health services.

Mentally ill in prisons

Prison populations have a disproportionately high prevalence of mental illnesses. It has been estimated that the prevalence of severe mental illness in jails and prisons is three to five times higher than that in the community (Lamb et al 1998). Mental illness may develop during imprisonment or be present even before admission to the prison. Among people who are biologically prone to mental disorders, the stress of being in prison can precipitate the illness. Such disorders can also develop due to the prevailing prison conditions (structural and social factors such as overcrowding, dirty and depressive environment, poor food quality, inadequate medical care, lack of meaningful activity, enforced solitude or lack of privacy, isolation from social networks, etc), due to torture or other human rights violations. In addition, prisoners are deprived of their liberty leading to deprivation of choices taken for granted in the outside community: they can no longer freely decide where to live, with whom to associate and how to fill their time, and must submit to discipline imposed by others. Communication with families and friends is often limited. Moreover, prisoners may have guilt feelings about their offences and anxiety about how much of their former lives will remain intact after release in addition to the stigma associated with having been in a prison.

The literature on the prevalence of mental illness in jails and prisons has shown that prisons have higher rates of mental morbidity when compared to those in the community. A systematic review by Fazel and Danesh in 2002 of 62 studies from 12 countries (Australia, Canada, Denmark, Finland, Ireland, Netherlands, New Zealand, Norway, Spain, Sweden, UK, and USA) included 22790 prisoners. Psychiatric disorders in prison populations were as follows: 3.7% of men had psychotic illnesses, 10% had major depression, and 65% had a personality disorder. Among women, 4.0% had psychotic illnesses, 12% had major depression, and 42% had personality disorder. They concluded that about one in seven prisoners had a psychotic illness or major depression indicating that the risks of having serious psychiatric disorders are substantially higher in prisoners than in the general population. Anderson (2004) noted that an overwhelming majority of the prevalence surveys are done in the developed world and hence, the conclusions are valid only in westernised industrialised countries.

At the National Institute of Mental Health and Neuro Sciences, a file review of all referrals from the Bangalore Prison to the erstwhile mental hospital and NIMHANS for 12 decades between 1870 to 1990 was analysed. A total of 433 prison detainees had been referred over this period. While the number of referrals had increased over time, the age of the referred persons had decreased. The single most common diagnosis recorded was schizophrenia (41.5%). Although 56.4% of the referred patients improved with treatment, there was virtually no follow-up information on their outcome after discharge and their psychiatric status (Murthy et al 1996).

Mentally ill in prisons-specific relevance for the developing world

Mental illness causes severe disadvantages to the sufferer. If he is a prisoner, then he is in a doubly disadvantaged position. For a mentally ill woman prisoner, the disadvantage triples. In developing countries, these disadvantages are even more magnified because of the inadequacies in the prison systems, which are further discussed below.

Inadequate penal and judicial systems

Judicial differences between developed and developing countries play a very important role in prevalence of mental disorders among persons in prison. Notable differences are process of investigations, availability of resources, access to justice, speedy trial, different cultural and social practices, prison legislation, prison practices, implementation of legislations, protection of human rights and access to good health care systems. Developed countries have much more resources and are in an advantageous position in providing justice and health care for the prisoners. At the same time developing countries have fewer resources and huge population needs.

Inadequate attention to human rights

The stigma, discrimination and human rights violations that individuals and families affected by mental disorders suffer, are intense and pervasive. At least in part, these phenomena are consequences of a general perception that no effective preventive or treatment modalities exist for these disorders. Effective prevention can do a lot to alter these perceptions and hence change the way mental disorders are looked upon by the society. Human rights and mental illness are inextricably linked. In fact, limitations on the basic human rights of vulnerable individuals and communities may act as powerful

determinants of mental disorders (WHO 2004). Human rights violation breeds mental illness and at the same time persons with mental illness are the most vulnerable for violation of their rights. Prison populations represent an important group vulnerable to mental disorders.

Prisoners with mental illness are entitled to treatment with the same dignity and decency as any other human being. Their human rights include the following: Right to living, decent livelihood, income, clean and congenial existence, right to speedy trial, information and means of communication. Patients with severe mental disorders in custody by virtue of their illnesses are especially vulnerable to human rights violations. A number of cases have come to light where mentally ill persons who have been facing trial for an offence have been undergoing incarceration for long periods till their plight and predicament surfaced through public interest litigation and the much needed relief was provided by the courts.

All human rights are universal, individual, inter dependent and interrelated. The international community must treat human rights issues globally in a fair and equal manner, on the same footing and with the same emphasis. While the significance of national and regional peculiarities must be borne in mind, it is the duty of the States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms.

Unlocking the padlock report

A public interest litigation filed in 1989 by Sheela Barse challenged the unconstitutional practice of locking up non-criminal mentally ill persons in jails in West Bengal. Following a series of affidavits and counter affidavits, the Court appointed a commission to evaluate the situation. The commissioners highlighted the problems in providing effective mental health services in jails-namely, lack of human resources, lack of supervision of care, absence of a mental health team and absence of an adequate range of mental health treatment services. The Supreme Court, in a judgement, subsequently held that the practice of keeping non-criminal mentally ill in jails contravened Articles 21 and

supervision of care, absence of a mental health team and absence of an adequate range of mental health treatment services. The Supreme Court, in a judgement, subsequently held that the practice of keeping non-criminal mentally ill in jails contravened Articles 21 and 32 of the Constitution of India and ordered that such persons be examined by a mental health professional/psychiatrist and based on the advice be sent to the nearest place of treatment and care. It held that all mentally ill persons kept in various central, district and sub jails must be medically examined immediately after admission; specialized psychiatric help must be made available to all inmates who have been lodged in various jails/sub jails (Murthy and Nagaraja 2008).

Another important issue from a human rights perspective is the issue of 'fitness to stand trial'. If an accused is suffering from mental illness at the time of trial, the presiding judge will not be able to proceed with the case until the accused becomes mentally fit to stand trial. There is no clear provision in the Mental Health Act (1987) with regard to further proceedings if a patient is chronically ill, treatment resistant and

NEW DELHI: In a nether world where reality peeps in only occasionally, Hitler Baba Khan lives in a world of his own, feeding off fantasies scripted by his despair and pain. Once Roy Varghese and now a statistic in a Jaipur jail, Khan has been in prison for 18 years, the last seven as an undertrial.

At age 53, Varghese is a long-detected schizophrenic with failing eyesight who ran away from his home in Kerala when he was a teenager. He ended up with a conviction on a drug charge in 1992 and received the maximum 10-year sentence. Some time later, he began to develop signs of mental illness and in 2001, was admitted to a district hospital where he was diagnosed as schizophrenic. In police records, his self-given name became Hitler Baba Khan.

His condition made him unfit for release even after he completed his sentence and this is where his fate got sealed. While receiving treatment, on July 2, 2003, Roy allegedly set two other mentally ill patients on fire causing their deaths. The police arrested Varghese and charged him with murder and culpable homicide under section 302 and 301 of IPC.

On July 3, 2003, he was presented before court where the medical board concluded that Varghese was a schizophrenic and not in a mental condition to understand court proceedings or fit to stand trial. Yet, human rights activists allege, he was sent back to prison instead of being moved to a facility to treat the mentally ill.

"Roy was sent back to prison, kept in solitary confinement instead of being taken to a mental institution," Pujya Pascal from the Commonwealth Human Rights Initiative (CHRI) said. Since then, time has not only stood still for Varghese but the windows to the outside world closed forever. Despite being diagnosed as in need for institutional care seven years ago, he remains trapped by a system in which he is voiceless.

Excerpt from The Times of India May 28, 2010

never likely to be fit to stand trial. For such mentally ill prisoners arrested for crimes for which they will never be fit to stand trial, there must be provisions in law for further care outside the prison setting.

Transinstitutionalisation

Another disturbing trend in our country is that people with severe mental disorders are inappropriately locked up in prisons because of the lack of mental health services, or move between mental hospital and prison or other custodial settings. The latter phenomenon is referred to as transinstitutionalisation. In prisons, these disorders often go unnoticed, undiagnosed and untreated.

A mentally ill under-trial prisoner, Mr. Machang Lalung, had been languishing in the mental institute in Tejpur, Assam as an under-trial prisoner for 54 years. Detained at the age of 23, he could secure his release only when he was 77 years old, only after the intervention from the Honorable Supreme Court of India. (Supreme Court, Writ Petition (CRL.) NO(s). 296 OF 2005).

Poor staff support

In addition, prison staff dealing with difficult prisoners may experience work-place stress, with disastrous implications to their physical as well as their mental health and also their work performance (WHO 1998).

Mental Health Care beyond diagnosed mental illness

"*Health is a state of complete physical, psychological, social and spiritual well-being and not just the absence of disease or infirmity".*

It is important to understand that most persons who are incarcerated go through a whole lot of psychological stress, though they may not develop diagnosable psychiatric disorders. This was amply demonstrated in a NIMHANS study supported by the National Commission for Women (Murthy et al 1998). Unhappiness, worrying, feelings of worthlessness, poor appetite, sleep and tiredness are common symptoms among undertrials. Loss of autonomy, privacy, intimacy, influence and lack of physical and psychological stimulation are all contributory factors for psychological distress among prisoners. Behavioural responses like becoming withdrawn, distrustful, angry and belligerent are common. Death wishes and suicidal behaviour can often be the manifestation of extreme feelings of helplessness and hopelessness.

Substance use disorders in India

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) is the first systematic effort to document the nation-wide prevalence of drug use (Srivastava et al., 2002). 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). 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 Saddichcha 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; & 16.4% among rural women (ICMR 2001).

Substance use in Prison

Substance users are over-represented in prisons. Despite this fact, data on patterns of drug use among prisoners are rare and difficult to interpret. A large part comes from non-controlled or local studies, using different data collection methods. Furthermore, the fear of confidentiality breaches may bias prisoners' answers.

Substance use in prison may occur as a continuation of pre-prison substance use, may also either begin, or intensify, in prison (i.e., change from use of less harmful substances to more harmful ones). Prison administrations have a responsibility to guard against (a) creating new problems and (b) exacerbating problems that already exist. Prevalence of substance use among the prison population has largely been studied in the United States and Europe and must be understood in the context of prevalence of substance use in the general populations of these countries. Most studies of prison inmates in the European Union (some countries in Eastern Europe have the highest imprisonment rates in the world),

Substance use treatment and rehabilitation- Case studies in Prison

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 organizations, 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, etc.

No other drug treatment programmes in prisons were identified. 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.

Drug abuse among prison population – a case study of Tihar Jail. New Delhi, UNODC/Ministry of Social Justice and Empowerment, 2002. Prisons in Asia. Human Rights Watch, 2006

report use of an illicit drug to be over 50% (EMCDDA, 2002). Figures from the EU for 2001 reveal that 16-54% of prison inmates report use of drugs within the prison, and between 0.3 and 34% report injecting in prison. Between 3 to 36% of drug users reported their first use of drugs while in prison, while between 0.4 and 21% began injecting drugs in prison (NR 2001). Penal institutions have grossly elevated rates of HIV infection. Prevalence varies between six and fifteen times higher than that of the general population. Rates of HIV infection in many countries in Europe and Central Asia are higher among prisoners than among the general population outside prisons. Prisons are extremely high-risk environments for HIV transmission because of overcrowding, poor nutrition, limited access to health care, illicit drug use and unsafe injecting practices, unprotected sex and poor knowledge of HIV transmission. Higher rates of tuberculosis, sexually transmitted infections, including Hepatitis B and C have been reported among prison populations (UNODC-UNAIDS-World Bank, 2007).

A study in a Nigerian prison population in 2005 (Williams et al) reported a very high lifetime use for any substance among the prisoners (85.5%), with alcohol being the highest (77.5%). Prevalence of current use of any drug was 27.7% with nicotine being the highest (22.9%).

In a study in prisons in the United States (James et al 2006), inmates with mental health problems had higher rates of substance abuse and dependence. Those with mental health problems were two and a half times more likely to be dependent on drugs than prison inmates without a mental problem.

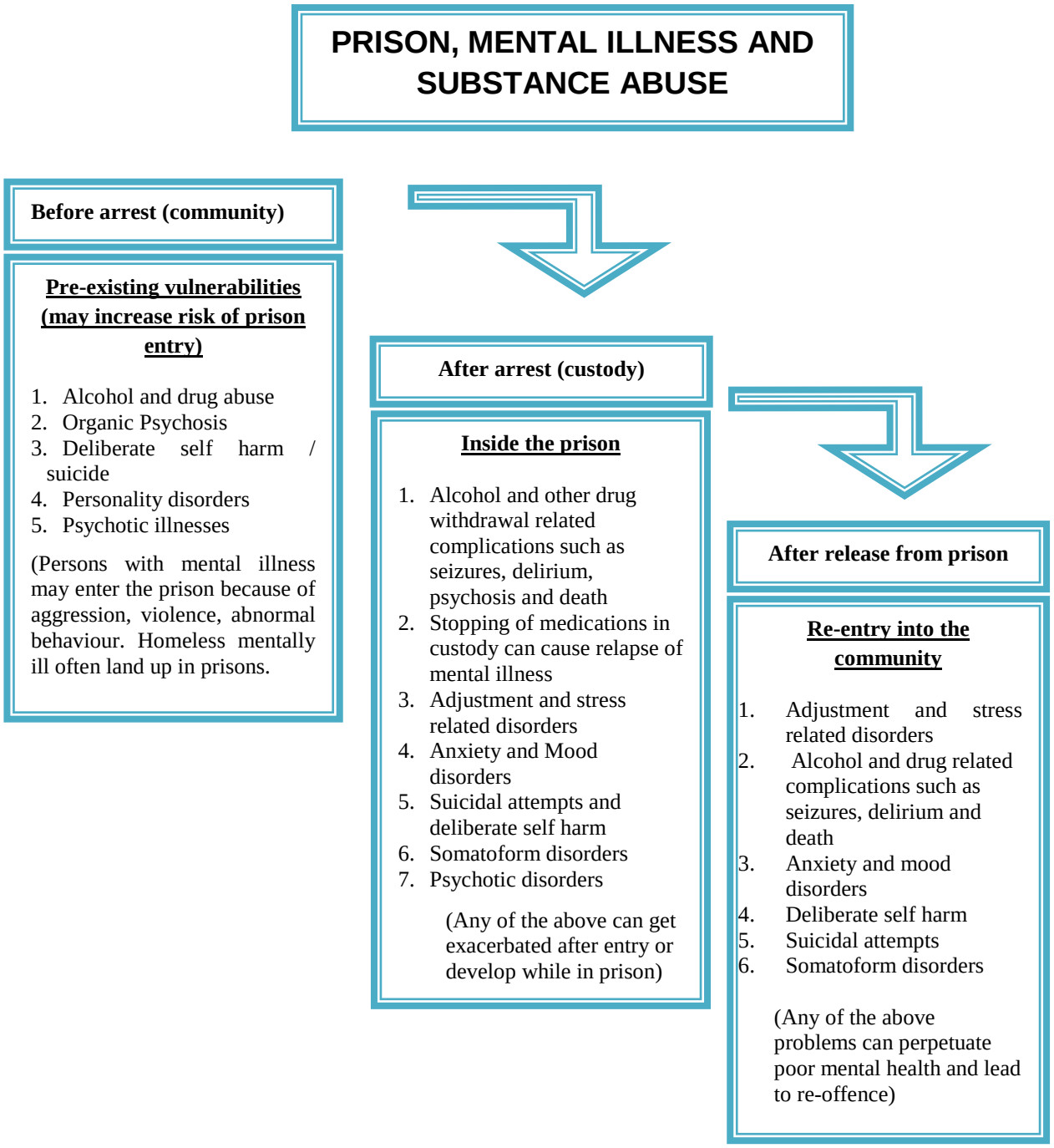
The United Nations General Assembly Special Session on the World Drug Problem in 1998 explicitly identified prisoners as an important group to intervene with, to reduce demand for the substances (United Nations, 1998). In 1999, the European Union endorsed an action plan to combat drugs for 2000–2004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

Large numbers of entrants to the prison come with a history of drug use. The experience from Tihar Jail shows that about 8% of new entrants come with drug addiction problems (UNODS, ROSA and MSJE, 2002). 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 become violent during this period and may also become dangerous to others in prison. Prisons are also used as detoxification centres for drug users. In prisons in Delhi, drug offenders are housed separately from other inmates (Tihar Jail 2006). There is very little information on treatment available in other prisons in India. There is no data on prevalence of drug use from prisons in India.

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

In summary, various mental illnesses and substance use problems may occur at the point of entry into prison, or develop while in prison. These problems have an impact during the prisoner's tenure in the prison as well as following discharge. An awareness of such problems and the steps to be taken to prevent and intervene become a necessary part of effective prison management.

Figure 1: Range of mental health and substance use disorders in prison settings



2. Prisons in India: An overview of reforms and current situation

In this chapter, we provide a broad overview of the international obligations and guidelines, with respect to the care of prisoners, and summarise the various steps taken towards prison reform in India. We then provide a brief overview of prisons in India. We also deal with the general problems of Indian prisons, which undoubtedly play an important part in understanding the challenges in providing mental health services to prisoners and to staff in prisons.

International Obligations and Guidelines

The International Covenant on Civil and Political Rights (ICCPR) remains the core international treaty on the protection of the rights of prisoners. India ratified the Covenant in 1979 and is bound to incorporate its provisions into domestic law and state practice. The International Covenant on Economic, Social and Cultural Rights (ICESR) states that prisoners have a right to the highest attainable standard of physical and mental health. Apart from civil and political rights, the so called second generation economic and social human rights as set down in the ICESR also apply to the prisoners.

The earlier United Nations Standard Minimum Rules for the Treatment of Prisoners, 1955 consists of five parts and ninety-five rules. Part one provides rules for general applications. It declares that there shall be no 'discrimination on grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. At the same time there is a strong need for respecting the religious belief and moral precepts of the group to which a prisoner belongs. The standard rules give due consideration to the separation of the different categories of prisoners. It indicates that men and women be detained in separate institutions. The under- trial prisoners are to be kept separate from convicted prisoners. Further, it advocates complete separation between the prisoners detained under civil law and criminal offences. The UN standard Minimum Rule also made it mandatory to provide separate residence for young and child prisoners from the adult prisoners. Subsequent UN directives have been the Basic Principles for the Treatment of Prisoners (United Nations 1990) and the Body of

Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (United Nations 1988).

On the issue of prison offences and punishment, the standard minimum rules are very clear. The rules state that 'no prisoner shall be punished unless he or she has been informed of the offences alleged against him/her and given a proper opportunity of presenting his/her defense'. It recommends that corporal punishment, by placing in a dark cell and all 'cruel, in-human or degrading punishments shall be completely prohibited as a mode of punishment and disciplinary action' in the jails.

Prison Reforms in India – a brief background and overview

The history of prison establishments in India and subsequent reforms have been reviewed in detail by Mahaworker (2006). A brief summary of the same is presented below.

The modern prison in India originated with the Minute by TB Macaulay in 1835. A committee namely Prison Discipline Committee, was appointed, which submitted its report on 1838. The committee recommended increased rigorousness of treatment while rejecting all humanitarian needs and reforms for the prisoners. Following the recommendations of the Macaulay Committee between 1836-1838, Central Prisons were constructed from 1846.

The contemporary Prison administration in India is thus a legacy of British rule. It is based on the notion that the best criminal code can be of little use to a community unless there is good machinery for the infliction of punishments. In 1864, the Second Commission of Inquiry into Jail Management and Discipline made similar recommendations as the 1836 Committee. In addition, this Commission made some specific suggestions regarding accommodation for prisoners, improvement in diet, clothing, bedding and medical care. In 1877, a Conference of Experts met to inquire into prison administration. The conference proposed the enactment of a prison law and a draft bill was prepared. In 1888, the Fourth Jail Commission was appointed. On the basis of its recommendation, a consolidated prison bill was formulated. Provisions regarding the jail offences and punishment were specially examined by a conference of experts on Jail

Management. In 1894, the draft bill became law with the assent of the Governor General of India.

Prisons Act 1894

It is the Prisons Act, 1894, on the basis of which the present jail management and administration operates in India. This Act has hardly undergone any substantial change. However, the process of review of the prison problems in India continued even after this. In the report of the Indian Jail Committee 1919-20, for the first time in the history of prisons, 'reformation and rehabilitation' of offenders were identified as the objectives of the prison administrator. Several committees and commissions appointed by both central and state governments after Independence have emphasised humanisation of the conditions in the prisons. The need for completely overhauling and consolidating the laws relating to prison has been constantly highlighted.

The Government of India Act 1935, resulted in the transfer of the subject of jails from the centre list to the control of provincial governments and hence further reduced the possibility of uniform implementation of a prison policy at the national level. State governments thus have their own rules for the day to day administration of prisons, upkeep and maintenance of prisoners, and prescribing procedures.

In 1951, the Government of India invited the United Nations expert on correctional work, Dr. W.C. Reckless, to undertake a study on prison administration and to suggest policy reform. His report titled 'Jail Administration in India' made a plea for transforming jails into reformation centers. He also recommended the revision of outdated jail manuals. In 1952, the Eighth Conference of the Inspector Generals of Prisons also supported the recommendations of Dr. Reckless regarding prison reform. Accordingly, the Government of India appointed the All India Jail Manual Committee in 1957 to prepare a model prison manual. The committee submitted its report in 1960. The report made forceful pleas for formulating a uniform policy and latest methods relating to jail administration, probation, after-care, juvenile and remand homes, certified and reformatory school, borstals and protective homes, suppression of immoral traffic etc. The report also suggested amendments in the Prison Act 1894 to provide a legal base for correctional work.

The Model Prison Manual

The Committee prepared the Model Prison Manual (MPM) and presented it to the Government of India in 1960 for implementation. The MPM 1960 is the guiding principle on the basis of which the present Indian prison management is governed.

On the lines of the Model Prison Manual, the Ministry of Home Affairs, Government of India, in 1972, appointed a working group on prisons. It brought out in its report the need for a national policy on prisons. It also made an important recommendation with regard to the classification and treatment of offenders and laid down principles.

The Mulla Committee

In 1980, the Government of India set-up a Committee on Jail Reform, under the chairmanship of Justice A. N. Mulla. The basic objective of the Committee was to review the laws, rules and regulations keeping in view the overall objective of protecting society and rehabilitating offenders. The Mulla Committee submitted its report in1983.

The Krishna Iyer Committee

In 1987, the Government of India appointed the Justice Krishna Iyer Committee to undertake a study on the situation of women prisoners in India. It has recommended induction of more women in the police force in view of their special role in tackling women and child offenders.

Subsequent developments

Following a Supreme Court direction (1996) in *Ramamurthy vs State of Karnataka* to bring about uniformity nationally of prison laws and prepare a draft model prison manual, a committee was set up in the Bureau of Police Research and Development (BPR&D). The jail manual drafted by the committee was accepted by the Central government and circulated to State governments in late December 2003. How many have acted on it is anybody's guess. As in the case of the recommendations of the National Police Commission (1977), which had sought the creation of a State Security Commission and

the promulgation of a new Police Act to replace the 1861 enactment, implementing jail reform recommendations rests with the States. The Home Ministry can do precious little if there is no political will on the part of States to push through both police and prison reforms.

In 1999, a draft Model Prisons Management Bill (The Prison Administration and Treatment of Prisoners Bill- 1998) was circulated to replace the Prison Act 1894 by the Government of India to the respective states but this bill is yet to be finalized. In 2000, the Ministry of Home Affairs, Government of India, appointed a Committee for the Formulation of a Model Prison Manual which would be a pragmatic prison manual, in order to improve the Indian prison management and administration.

The All India Committee on Jail Reforms (1980-1983), the Supreme Court of India and the Committee of Empowerment of Women (2001-2002) have all highlighted the need for a comprehensive revision of the prison laws but the pace of any change has been disappointing (Banerjea 2005). The Supreme Court of India has however expanded the horizons of prisoner's rights jurisprudence through a series of judgments.

Prisons in India – a brief summary

According to the UN Global Report on Crime and Justice 1999, the rate of imprisonment in our country is very low, i.e. 25 prisoners per one lakh of population, in comparison to Australia (981 prisoners), England (125 prisoners), USA (616 prisoners) and Russia (690 prisoners) per one lakh population. A large chunk of prison population is dominated by first offenders (around 90%) The rate of offenders and recidivists in prison population of Indian jails is 9:l while in the UK it is 12:1, which is quite revealing and alarming. Despite the relatively lower populations in prison, the problems are numerous.

As of 2007, the prison population was 3,76,396, as against an official capacity of 277,304, (representing an occupancy rate of 135.7%) distributed across 1276 establishments throughout the country. The prison population has been steadily increasing during the last decade. A majority of the prison population is male (nearly 96%) and approximately two-thirds are pre-trial detainees (undertrials).

Prison Reforms – a Summary

1.'Prisons' is a State subject under List-II of the Seventh Schedule to the Constitution of India. The management and administration of Prisons falls exclusively in the domain of the State Governments, and is governed by the Prisons Act, 1894 and the Prison Manuals of the respective State Governments. Thus, States have the primary role, responsibility and authority to change the current prison laws, rules and regulations.

2. The existing statutes which have a bearing on regulation and management of prisons in the country are:

(i) The Indian Penal Code, 1860.	(ii) The Prisons Act, 1894.
(iii) The Prisoners Act, 1900.	(iv) The Identification of Prisoners Act, 1920.
(v) Constitution of India, 1950	(vi) The Transfer of Prisoners Act, 1950.
(vii) The Representation of People's Act, 1951.	(viii) The Prisoners (Attendance in Courts) Act, 1955.
(ix) The Probation of Offenders Act, 1958.	(x) The Code of Criminal Procedure, 1973.
(xi) The Mental Health Act, 1987.	(xii) The Juvenile Justice (Care & Protection) Act, 2000.
(xiii) The Repatriation of Prisoners Act, 2003.	(xiv) Model Prison Manual (2003).

3. Various Committees, Commissions and Groups have been constituted by the State Governments as well as the Government of India (GoI), from time to time, such as the All India Prison Reforms Committee (1980) under the Chairmanship of Justice A.N. Mulla (Retd.), R.K. Kapoor Committee (1986) and Justice Krishna Iyer Committee (1987) to study and make suggestions for improving the prison conditions and administration, inter alia, with a view to making them more conducive to the reformation and rehabilitation of prisoners. These committees made a number of recommendations to improve the conditions of prisons, prisoners and prison personnel all over the country. In its judgments on various aspects of prison administration, the Supreme Court of India has laid down three broad principles regarding imprisonment and custody. Firstly, a person in prison does not become a non-person; secondly, a person in prison is entitled to all human rights within the limitations of imprisonment; and, lastly there is no justification for aggravating the suffering already inherent in the process of incarceration.

4. CENTRAL ASSISTANCE TO STATES

Based on the recommendations of various Committees, Central assistance was provided to the States on a matching contribution basis to improve security in prisons, repair and renovation of old prisons, medical facilities, development of borstal schools, facilities to women offenders, vocational training, modernization of prison industries, training to prison personnel, and for the creation of high security enclosure. The total assistance provided to the State Governments from 1987 to 2002 was Rs. 125.24 crore. The Eleventh Finance Commission had also granted an amount of Rs 10 crore to the Government of Arunachal Pradesh for the construction of jail.

5. NON-PLAN SCHEME ON MODERNISATION OF PRISONS (2002-2007)

An assessment was made by the Bureau of Police Research and Development (BPR&D) on the requirements of the States depending on their prison population and available capacity etc. and a non-plan scheme involving a total outlay of Rs 1800 crore to be implemented over a period of five years from 2002-03 to 2006-07 was launched with the approval of Cabinet.

SALIENT FEATURES OF THE SCHEME

- Total Outlay: Rs. 1800 Crores
- Covering: 27 States (Except Arunachal & UTs)
- Cost Sharing (CS:SS): 75:25
- Project Duration: 2002-03 to 2006-07
- Scheme Extended: Upto 31.3.2009 (without Additional Funds)

MAJOR COMPONENTS OF THE SCHEME

- Construction of new prisons and additional barracks
- Repair and renovation of existing prisons
- Improvement in water and sanitation
- Living accommodation for prison personnel

As against the total Central share of Rs1350 crore over a period of 5 years, an amount of Rs. 1346.95 crores has been released to the State Governments upto 31.3.2009. Out of total central share of Rs. 1350 crore, Rs. 3.05 crore was uncommitted fund and central share of J&K which Rs 1.55 crore was uncommitted fund and Rs. 1.50 crore was the central share of J&K which could not be released to the State Government due to non-submission of utilization certificate. The progress of the Scheme is being monitored closely with a view to ensure that the funds released to the States are properly utilized for the purpose for which they have been released.

Source: Ministry of Home Affairs 2009. Available from: http://mha.nic.in/pdfs/Modprison.pdf

Table 1: Prisons in India (data for 2007)

Ministry responsible	Ministry of Home Affairs		
Prison administration	Governments of States (28) and Union Territories (7)		
Prison population total (including pre-trial detainees / remand prisoners)	**376,396** at 31.12.2007 (National Crime Records Bureau)		
Prison population rate (per 100,000 of national population)	**32** based on an estimated national population of 1,160.9 million at end of 2007 (from United Nations figures)		
Pre-trial detainees / remand prisoners (percentage of prison population)	**66.6%** (31.12.2007)		
Female prisoners (percentage of prison population)	**4.1%** (31.12.2007)		
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	**0.1%** (31.12.2007 - under 18)		
Foreign prisoners (percentage of prison population)	**1.3%** (31.12.2007)		
Number of establishments / institutions	**1,276** (31.12.2007 - comprising 113 central jails, 309 district jails, 769 sub jails, 16 women's jails, 28 open jails, 25 special jails, 10 Borstal schools and 6 other jails)		
Official capacity of prison system	**277,304** (31.12.2007)		
Occupancy level (based on official capacity)	**135.7%** (31.12.2007)		
Recent prison population trend (year, prison population total, prison population rate)	1999	**281,380**	**(28)**
	2001	**313,635**	**(30)**
	2003	**326,519**	**(30)**
	2005	**358,368**	**(32)**
	2007	**376,396**	

Major Problems of Prisons Relevant to India

Despite the relatively low number of persons in prison as compared to many other countries in the world, there are some very common problems across prisons in India, and the situation is likely to be the same or worse in many developing countries. Overcrowding, prolonged detention of under-trial prisoners, unsatisfactory living conditions, lack of treatment programmes and allegations of indifferent and even inhuman approach of prison staff have repeatedly attracted the attention of the critics over the years.

Overcrowding

Congestion in jails, particularly among undertrials has been a source of concern. The Law Enforcement Assistance Administration National Jail Census of 1970 revealed that 52% of the jail inmates were awaiting trial (Law Commission of India 1979).

Obviously, if prison overcrowding has to be brought down, the under-trial population has to be reduced drastically. This, of course, cannot happen without the courts and the police working in tandem. The three wings of the criminal justice system would have to act in harmony.

Tihar courts trouble again

The high-security Tihar Jail is back in the news. The Delhi High Court has directed the Registrar-General to visit the jail and the Rohini district prison after inmates alleged serious violation of their fundamental and human rights by the authorities.

At a 'mahapanchayat' organised by the inmates to voice their concerns, they alleged that incidents of violence among prisoners like stabbing and blade attacks are on the rise. The security personnel, they said, have done nothing to contain the situation. Overcrowding is a big problem in the jail that has around 13,000 inmates against the combined capacity of 6,200.

The Hindustan Times June 27, 2006

Speedy trials are frustrated by a heavy court workload, police inability to produce witnesses promptly and a recalcitrant defence lawyer who is bent upon seeking adjournments, even if such tactics harm his/her client. Fast track courts have helped to an extent, but have not made a measurable difference to the problem of pendency. Increasing the number of courts cannot bring about a desired difference as long as the current `adjournments culture' continues (Raghavan 2004).

Corruption and extortion

Extortion by prison staff, and its less aggressive corollary, guard corruption, is common in prisons around the world. Given the substantial power that guards exercised over inmates, these problems are predictable, but the low salaries that guards are generally paid severely aggravate them. In exchange for contraband or special treatment, inmates supplement guards' salaries with bribes. Powerful inmates in some facilities in Colombia, India, and Mexico enjoyed cellular phones, rich diets, and comfortable lodgings, while their less fortunate brethren lived in squalor. An unpublished PhD dissertation from Punjab University on 'The Functioning of Punjab Prisons: An appraisal in the context of correctional objectives' cites several instances of corruption in prison. Another article suggested that food services are the most common sources of corruption in the Punjab jails. Ninety five percent of prisoners felt dissatisfied and disgusted with the food served (quoted in Roy 1989)

Conditions in Jails

Chaotic conditions prevail in UP jails. Massive overcrowding, understaffing and rampant corruption have completely derailed the management. The presence of large number of Mafiosi has also badly affected the jail administration. The State Jail Department data indicates that as against the capacity of nearly 44000 there are 85000 prisoners in 62 jails in the state. In some jails like Shahjehanpur, Moradabad, Fatehgarh and Deoria the numbers are four times more than the capacity. Even as ten new jails are under construction, the existing ones are as old as more than 150 years, which according to a senior department officer require large-scale modernisation.

"In fact the government comes out of hibernation only after jail break," commented the officer on the condition of anonymity. The situation is unlikely to improve without "de-crowding", he said.

The crowding could be gauged from the fact that as against the provision of 40 sq-feet area for each prisoner, 150 to 200 prisoners are locked in each barrack.
The department with Rs 700 crore annual budget has been facing rampant corruption due to lack of facilities in jails.

"The prisoners bribe the jail officers for all sorts of facilities," said the officer.
There is feeling in the department that rampant corruption could not be contained in the jails without their modernisation.

Interestingly there is no dearth of "well-connected" prisoners. At present, there are 11 MLAs and one MP in UP jails.

Excerpted from: M Hasan in the Hindustan Times, June 30,2010; Available from: http://www.hindustantimes.com/Overcrowding-corruption-crumble-UP-jails/Article1-565439.aspx

Unsatisfactory living conditions

Overcrowding itself leads to unsatisfactory living conditions. Although several jail reforms outlined earlier have focused on issues like diet, clothing and cleanliness, unsatisfactory living conditions continue in many prisons around the country. A special commission of inquiry,

appointed after the 1995 death of a prominent businessman in India's high-security Tihar Central Jail, reported in 1997 that 10 000 inmates held in that institution endured serious health hazards, including overcrowding, "appalling" sanitary facilities and a shortage of medical staff (Human Rights Watch 2006)

'No one wants to go to prison however good the prison might be. To be deprived of liberty and family life and friends and home surroundings is a terrible thing.'

To improve prison conditions does not mean that prison life should be made soft; it means that it should be made human and sensible.

Staff shortage and poor training

Prisons in India have a sanctioned strength of 49030 of prison staff at various ranks, of which, the present staff strength is around 40000. The ratio between the prison staff and the prison population is approximately 1:7. It means only one prison officer is available for 7 prisoners, while in the UK, 2 prison officers are available for every 3 prisoners.

Inequalities and distinctions

'Though prisons are supposed to be leveling institutions in which the variables that affect the conditions of confinement are the criminal records of their inmates and their behaviour in prison, other factors play an important part in many countries' (Neier et al 1991). This report by the Human Rights Watch, specifically cite countries like India and Pakistan, where a 'rigid' class system exists in the prisons. It states that under this system, special privileges are accorded to the minority of prisoners who come from the upper and middle classes irrespective of the crimes they have committed or the way they comport themselves in prison.

Inadequate prison programmes

Despite the problems of overcrowding, manpower shortage and other administrative difficulties, innovative initiatives have been undertaken in some prisons. For e.g. the Art of Living has been carrying out a SMART programme in Tihar Jail. This includes two courses per month and follow up sessions every weekend. Two courses are annually

conducted for prison staff. But these are more by way of exceptions and experiments. A Srijan project there is aimed at providing social rehabilitation. However, such programmes are few and far between. Many prisons have vocational training activities, but these are often outdated. Hardly any of the prisons have well planned prison programmes providing structured daily activities, vocational training, pre-discharge guidance and post-prison monitoring.

> Prisons, though for a short or longer period are places of living for both accused as well as convicts. The reformative objective expects that it should also be a place of learning and earning. To provide physical, material and mental conditions of decent living to prisoners, it requires recreating almost a miniature world inside the prisons. This is difficult if not impossible. European countries are increasingly in search of alternatives to confinement, as they realised more resources for assimilation of deviant are available in open society rather than inside the closed walls. This has not happened so far in India as governments across the ideological spectrum are illiberal and society is unsympathetic to rights of the incarcerated.
> The result is lowest priority to the prison management.
>
> Karnam M. Commonwealth Human Rights Initiative 2008

Poor spending on health care and welfare

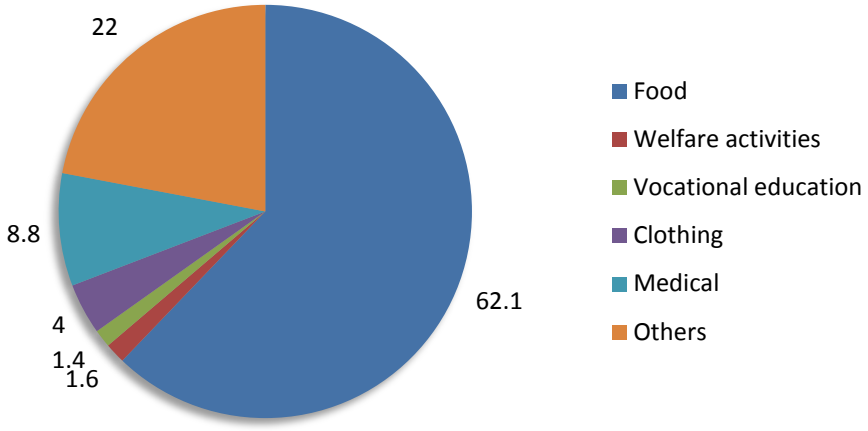
In India, an average of US$ 333 (INR 10 474) per inmate per year was spent by prison authorities during the year 2005, distributed under the heads of food, clothing, medical expenses, vocational/educational, welfare activities and others.(National Crime Records Bureau 2005). This is in contrast to the US, where the average annual operating cost per state inmate in 2001 was $ 22,650 (the latter presumably also includes salaries of prison staff). The maximum expenditure in Indian prisons is on food. West Bengal, Punjab, Madhya Pradesh, Uttar Pradesh, Bihar and Delhi reported relatively higher spending on medical expenses during that year, while Bihar, Karnataka and West Bengal reported relatively higher spending on vocational and educational activities. Tamil Nadu, Orissa and Chattisgarh reported relatively higher spending on welfare activities.

Table 2: Spending on prisons in states of India

SL. NO.	STATE/UT	TOTAL SANCTIONED BUDGET (IN Rs. LAKHS)		PERCENTAGE VARIATION IN 2005-06 OVER 2004-05
		2004-2005	2005-2006	
1	ANDHRA PRADESH	9336.8	9292.0	-0.5
2	ARUNACHAL PRADESH	-	-	-
3	ASSAM	4493.7	4229.8	-5.9
4	BIHAR	6828.5	7042.6	3.1
5	CHHATTISGARH	2994.3	2280.4	-23.8
6	GOA	364.1	210.8	-42.1
7	GUJARAT	2601.4	3761.8	44.6
8	HARYANA	6260.8	6253.0	-0.1
9	HIMACHAL PRADESH	1259.0	1129.4	-10.3
10	JAMMU & KASHMIR	2454.3	2857.7	16.4
11	JHARKHAND	6737.3	3240.1	-51.9
12	KARNATAKA	4952.2	5646.7	14.0
13	KERALA	3343.8	3457.1	3.4
14	MADHYA PRADESH	6579.4	7101.5	7.9
15	MAHARASHTRA	9759.3	9723.3	-0.4
16	MANIPUR	853.7	825.6	-3.3
17	MEGHALAYA	304.8	283.2	-7.1
18	MIZORAM	684.6	809.0	18.2
19	NAGALAND	1125.4	1093.2	-2.9
20	ORISSA	2934.3	3101.7	5.7
21	PUNJAB	6139.7	6751.0	10.0
22	RAJASTHAN	3530.1	3588.1	1.6
23	SIKKIM	522.3	522.9	0.1
24	TAMILNADU	9051.1	8101.6	-10.5
25	TRIPURA	988.1	1298.6	31.4
26	UTTAR PRADESH	18795.3	20376.1	8.4
27	UTTARANCHAL	896.3	915.7	2.2
28	WEST BENGAL	7271.7	7632.0	5.0
TOTAL(STATES)		**121062.3**	**121524.6**	**0.4**
29	A & N ISLANDS	214.0	227.0	6.1
30	CHANDIGARH	289.0	301.1	4.2
31	D & N HAVELI	6.0	6.0	0.0
32	DAMAN & DIU	25.0	21.0	-16.0
33	DELHI	7073.0	6549.6	-7.4
34	LAKSHADWEEP	1.0	1.0	0.0
35	PONDICHERRY	126.1	143.3	13.6
TOTAL(UTs)		**7734.1**	**7248.9**	**-6.3**
TOTAL (ALL-INDIA)		**128796.3**	**128773.6**	**0.0**

Source: National Crime Records Bureau

Figure 2: Percentage distribution of expenditure on various items on prison inmates (2005)



Source: National Crime Record Bureau.

Press Information Bureau, Govt of India
Press Release August 4, 2009

Lok Sabha

The Union Government has received proposals from State Governments regarding modernisation of prisons in their respective States.

Considering the demand of various States for granting further financial assistance for construction of new jails/additional barracks so as to address the problem of overcrowding, the Ministry of Home Affairs has initiated the process of formulating second phase of the scheme of modernization of prisons. Necessary steps are being taken in this regard in consultation with the Ministry of Finance.

The proposal so received from the state Governments will be considered only after the proposal mooted by the Ministry of Home Affairs is approved by the Cabinet. The proposals of State Governments shall be processed depending upon the terms of approval of the scheme as also the funds sanctioned by the Cabinet and provided in the budget.

This information was given by the Minister of State in the Ministry of Home

The scheme for modernisation of prisons was launched in 2002-03 with the objective of improving the condition of prisons, prisoners and prison personnel. The components include construction of new jails, repair and renovation of existing jails, construction of additional barracks, improvement in sanitation and water supply and construction of staff quarters for prison personnel. Activities under the scheme have been construction of 168 new jails, renovation, repairs and construction of 1730 new barracks, construction of 8965 staff quarters as well as improvement of water and sanitation in jails. The scheme was extended upto 31.3.2009 without affecting the total outlay of Rs.1800 crore (Govt of India, Ministry of Home Affairs). A second phase has been envisaged in 2009 with a financial outlay of Rs 3500 crores. However, questions have been raised whether modernisation can bring about change without integrity of purpose. Can isolation of any institution from public support and scrutiny make it transparent and attentive to its objectives? Any government that claims attempting to integrate the felon into society first of all should declare prison is as much a public institution as that of a university or hospital; remove its isolation and integrate it functionally and physically into society; make police, judiciary, medical and educational departments, conscious of their accountability for pathetic prison conditions (Karnam 2008). Otherwise things are not going to change just with allocation of crores of rupees and launching of schemes.

Lack of legal aid

In India, legal aid to those who cannot afford to retain counsel is only available at the time of trial and not when the detainee is brought to the remand court. Since the majority of prisoners, those in lock up as well as those in prisons have not been tried, absence of legal aid until the point of trial reduces greatly the value of the country's system of legal representation to the poor. Lawyers are not available at the point when many of them mostly need such assistance.

A workshop conducted by the Commonwealth Human Rights Watch in 1998 in Bhopal, focused on several aspects related to legal aid. It was pointed out that 70% of the prison population is illiterate and lacks an understanding of prisoner's rights. Thus the poor in prison do not always get the provisions in law though the State is obliged to provide legal

aid. As also observed by the Mulla Committee, most prison inmates belong to the economically backwards classes and this could be attributed to their inability to arrange for the bail bond. Legal aid workers are needed to help such persons in getting them released either on bail or on personal recognisance. Bail provisions must be interpreted liberally in case of women prisoners with children, as children suffer the worst kind of neglect when the mother is in prison.

The lack of good and efficient lawyers in legal aid panels at that time was also a concern raised. Several suggestions were made to speed up trial processes so that the population of undertrials could be reduced. Some of the suggestions provided were expeditious holding of trials, making it possible for undertrials to plead guilty at any stage of the trial, system of plea bargaining. In a seminar, efforts made at the Tihar Jail by the University of Delhi faculty and students of law in the field of legal aid were highlighted. These included imparting legal literacy to the prisoners, sensitizing the prison administration, taking up individual prisoners to provide legal aid, involving para-legal staff to work with prisoners, both convicts and undertrials. The seminar suggested for Lok Adalat involvement to be greater and that constant monitoring of prisons was necessary to identify inadequacies and shortcomings in the prison administration. It finally suggested the need for law reform as essential to the entire system of legal aid.

A similar finding was noted in the NIMHANS-National Commission for Women study in the Central Prison, Bangalore. Many of the women were illiterate, had never stepped out of their houses, had no financial resources and many had been arrested on petty charges. Most had no idea about legal procedures, such as, what is the process of trial, how to arrange for a defense lawyer, what laws exist to protect their children or property etc.

Abuse of prisoners

Physical abuse of prisoners by guards is another chronic problem. Some countries continue to permit corporal punishment and the routine use of leg irons, fetters, shackles, and chains. In many prison systems, unwarranted beatings are an integral part of prison life.

Women prisoners are particularly vulnerable to custodial sexual abuse. The problem was widespread in the United States, where male guards outnumbered women guards in many women's prisons. In some countries, Haiti being a conspicuous example, female prisoners were even held together with male inmates, a situation that exposed them to rampant sexual abuse and violence.

A book reviewing prison services in Punjab, reported that, 'to get food supplements, or blankets in winter, class c-prisoners must fan the convict officers, or massage their legs, or even perform sexual favours for them. The enslavement of other prisoners to the convict officers who effectively run the prisons is particularly severe for new comers (known as amdani). They are teased, harassed, abused and even tortured as part of the process of breaking them in (Human Rights Watch 2001).

Consequence of prison structure and function

Physical and psychological torture resulting from overcrowding, lack of space for segregation of sick, stinking toilets for want of proper supply of water, lack of proper bedding, restrictions on movement resulting from shortage of staff, parading of women through men's wards for lack of proper separation, non-production of undertrial prisoners in courts, inadequate medical facilities, neglect in the grant of parole, rejection of pre-mature release on flimsy grounds, and several such afflictions result not from any malfeasance of the prison staff but from the collective neglect of the whole system (Human Rights Watch 2001).

In many places, non-governmental organisations provide rehabilitation programmes and a few provide aftercare. Some notable examples include the Prison Fellowship International. Most prisoners are ill prepared for release. No steps are taken to minimise their chance of committing re-offences. Programmes to develop a set of values, the ethos of honest labour and to build pro-social ties with the community are essential.
Well-established prisons with continuous good leadership generally impart literacy to the illiterate inmate and offer facilities for higher education to those who are already reasonably educated and are willing to improve on their knowledge so that they are usefully employed after getting back to the community

Health Problems in prisons

The overcrowding, poor sanitary facilities, lack of physical and mental activities, lack of decent health care, all increase the likelihood of health problems in prisons. Kazi et al (2009) mention that prisons are 'excellent venues for infectious disease screening and intervention, given the conditions of poverty and drug addiction'.

It is surprising and indeed shocking that despite the large prison population in India, there is a complete dearth of published information regarding the prevalence of health problems in prisons. An exception is a small study in the Central Jail at Hindalga in the Belgaum district of Karnataka, 850 prisoners were evaluated (letter in the Indian J Community Medicine, Bellad et al 2007). Follow-up of these prisoners for a period of 1 year revealed that anaemia (54.82%) was the commonest morbidity among chronic morbidity followed by respiratory tract infections (21.75%) and diarrhoea (13%) for acute morbidity. Pulmonary TB and HIV contributed 2% and 1.5% respectively. Other morbidity included, diabetes (3.6%), senile cataract (7%), pyoderma (12%) etc. Very few details are available of this work including criteria for diagnosis, investigations carried out etc. In another study, anemia was the common physical problem noted in prisons (Gupta et al., 2001).

Tuberculosis

TB notification rates in prisons are many times greater than that for the general population. TB is considered to be the single biggest cause of death among the world's prison populations. Despite TB's endemic nature in Asia, TB among prisoners is not well documented.

Prisoners are vulnerable to TB because:

- They are from the most disadvantaged socioeconomic strata of society, mostly young males, and therefore may enter the prison with a high risk of prior TB infection/disease.
- They have poor nutrition, before entering the prison as well as the poor diet inside the prison plays a contributing role.
- They may be HIV-positive before due to injecting drug-use. In some countries, up to 70% of prisoners with TB are also infected with HIV. The vulnerability of

prisoners to punishment, sexual violence can increase the risk of transmission of HIV, which accelerates the progression to TB.

- Prisons are overcrowded and have poor ventilation.
- Budgetary allocations for health care are low and poor treatment is inadequate
- Antituberculous treatment may not be completed prior to release or transfer.

Prisons are reservoirs of TB and threaten not only the inmates, but the prison staff, visitors and community. As with any confined and limited environment effective TB control activities can be initiated. (Jeet India 2004)

Tuberculosis (TB) is a serious problem among prison populations around the world. The spread of TB was especially worrisome in Russia, in light of the country's enormous inmate population--over one million prisoners as of September 2000--and the increasing prevalence of multi-drug resistant (MDR) strains of the disease. Approximately one of out every ten inmates was infected with tuberculosis, with more than 20 percent of sick inmates being affected by MDR strains, constituting a serious threat to public health. High rates of TB were also reported in the prisons of Brazil and India (Human Rights Watch Report 2001).

High rates of pulmonary tuberculosis have been reported from prisons in Pakistan (Shah et al 2003, Hussain et al 2003, Rao et al 2004). The stratified random sample study of 425 of a total sample of 6607 male prisoners from the NWFP in Pakistan (Hussain et al 2003) found an overall prevalence of latent mycobacterium tuberculosis infection at 48%. Using multiple logistic regression, a prisoner's age, educational level, smoking status, duration of current incarceration, and average accommodation area of 60 ft^2 or less in prison barracks were found to be statistically significant ($P < 0.05$) predictors of latent MTB infection. In a Bangladesh study, the main risk factors of TB in prison were exposure to TB patients (adjusted odds ratio 3.16, 95% CI 2.36–4.21), previous imprisonment (1.86, 1.38–2.50), longer duration of stay in prison (17.5 months for TB cases; 1.004, 1.001–1.006) and low body mass index which is less than 18.5 kg/m^2 (5.37, 4.02–7.16) (Banu et al 2010). The study recommends entry examinations and active symptom screening among inmates to control TB transmission inside the prison.

HIV/STIs

'The HIV/AIDS epidemic ravaged prison populations, with penal facilities around the world reporting grossly disproportionate rates of HIV infection and of confirmed AIDS cases. Inmates around the world frequently died of AIDS while incarcerated, often deprived of even basic medical care' (Human Rights Watch Report 2001). In countries like India, Indonesia and Thailand, HIV prevalence in prisons is between two and 15 times greater in the prison populations than in the general community. This could be on account of risky heterosexual or homosexual encounters, voluntary or coerced, injecting drug use, interpersonal violence or on account of practices like tattooing (reported from the other countries). TB/HIV co-infection is also well known (WHO 2007).

Table 3: Subnational HIV prevalence in prisons in India

City/region/prison	Year	Sample size	HIV prevalence (%)
Nationally	2000	Data inaccessible	1.7% of inmates; 9.5% of female inmates
West Bengal	2006	384	2.3%
Amritsar Central Jail	2005	500	2.4%
Ghaziabad	1999	249	1.3% of inmates aged 15–50 years
Orissa, three prisons	1999	377	6.9%
Madurai	1996	Data inaccessible	4.3%; 2% of male and 14.2% of female inmates
Central Prison,Bangalore	1995	1114	1.8% of male inmates
Madras	1995	Data inaccessible	3.5%
Thirunelveli	1995	Data inaccessible	0.5%

Source: WHO SEARO 2007

HIV prevalence in prisons in India is much higher than in the community (1.7–6.9%,

compared with 0.36%). Among female prisoners, prevalence levels of 9.5–14.2% have been reported.

Most prisoners bring in HIV infection when they enter the prison. High risk sexual behaviours are common in prisons, and combined with a lack of poor knowledge of HIV/other STI transmission and a paucity of services makes this a very hidden and difficult problem to tackle (Guin 2009). The tedious prison environment, crowding and hostility, lack of occupation of mind and body and just plain boredom lead to accumulated frustration and tension. This environment leads to high risk activities such as use of drugs and unprotected sex. Some become involved because of monetary gain. Risky lifestyle leads to the transmission of diseases from one prisoner to another and poses a serious public health risk if unchecked.

There continues to be stigma associated with discussing HIV/AIDS particularly in correctional settings where many HIV risk behaviours (e.g. injection drug use, unprotected anal sex) are disallowed. However, there are hardly any reports of sexual activity in prisons in India and no prevalence data is available. A study from Thailand shows that of 689 male inmates, one quarter reported ever having sex with men; of them, more than 80% reported sex with men during incarceration (WHO SEARO 2007). Sex between men is reported to be common in prisons in India, though homosexuality is illegal in India. In a study conducted in Arthur Road Jail, 71.6% of 75 employees and 677 inmates said that they thought sex between men was common in prisons. Eleven per cent of inmates and staff engaged in homosexual activity in prisons. A study in a district jail near Delhi found that 28.8% of 184 male inmates had a history of sex with men (WHO SEARO 2007).

A study conducted in Chennai in 2005 found that the HIV prevalence was 37% among 48 IDUs who were “ever in jail”, compared with 21% among 20 IDUs who had never been incarcerated. The authors found that 16% of HIV risk among IDUs in Chennai could be attributed to having been imprisoned (Panda et al 2005).

The co-infection rates between tuberculosis and HIV are very high. In a random selection of 365 imprisoned men in Karachi, Pakistan, Kazi et al (2010) found the prevalence of confirmed tuberculosis was 2.2%, 2.0% were HIV-infected; syphilis was confirmed in 8.9%, HBV in 5.9%, and HCV in 15.2%. By self-report, 59.2% had used any illicit drugs, among whom 11.8% had injected drugs.

In India, there is no clear policy on testing for HIV in prisons in general, nor is there a uniform policy on access to voluntary counselling and testing. Anecdotal reports suggest that a few state prisons require testing at entry; some require it during custody and others before release. Lack of privacy is a common issue for those diagnosed as HIV positive.

There are adhoc interventions on HIV education, information and communication in Indian prisons. These are listed in the accompanying box. The national policy on segregation of prisoners with HIV is unclear. There are reports of segregation of HIV-positive prisoners, with approximately 20 HIV positive inmates in Maharashtra's prisons lodged in separate cells. In Arthur Road Jail, there is an HIV

Although there is no uniform policy on HIV prevention and intervention in prisons in India, several prisons have undertaken such programmes.

The Government of Andhra Pradesh started a sexual health programme titled Partnership for Sexual Health (PSH Prison Project) in January 2000. The project was managed by the Andhra Pradesh AIDS Control Society and operated in eleven jails in Andhra Pradesh. Three trained staff members provided HIV education. The programme also included counselling, referral and medical treatment.

In Mumbai, the Mumbai District AIDS Control Society and the International Labour Organization together with the Department of Preventive and Social Medicine, Sion Hospital conducted a workplace intervention programme at the Arthur Road Jail from 2004 to 2006. The intervention employed a peer educator's approach to raise awareness of HIV/AIDS. Jail employees and inmates were given training for three half-days, following which peer educators were selected from different cells. The intervention led to the drafting of an HIV/AIDS Workplace Policy for provision of voluntary counselling and testing (VCT) and condoms in prisons, and provision of antiretroviral therapy (ART), with JJ Hospital, Mumbai as the ART centre. The draft policy will be submitted to the Maharashtra Home Ministry for approval (personal communication, Palve A, Mumbai District AIDS Control Society, 12 September 2007).

In West Bengal, Vivekananda International Health Centre has been delivering an AIDS intervention programme in 20 prisons. The programme, reaching 50 000 prisoners and staff, includes education about sexually transmitted infection (STI) and HIV.

In Gujarat, an information and education programme conducted by NGOs aims to change prisoner attitudes and HIV risk behaviours.

Harm reduction programmes

The distribution of condoms is against prison policy as male-to-male sex is regarded as a crime in India.32 However, a government-run prison intervention in Andhra Pradesh includes condom distribution.33 There are no prison needle and syringe programmes (NSPs) in India.

Education and counselling services as well as treatment for STI is provided in 42 prisons in Andhra Pradesh by Hindustan Latex Limited under an agreement with the Andhra Pradesh State AIDS Control Society.33 Partnership for Sexual Health and other NGOs provide STI treatment in prisons in Surat, Gujarat.32

WHO SEARO 2007

barrack, which houses all HIV-positive prisoners. (WHO SEARO 2007). There are no ongoing programmes for drug abuse treatment (except in Tihar Jail), no programmes for reduction of HIV risk for high risk sexual behaviour like condom distribution or reducing risk in injecting drug users, like needle syringe exchange programmes, bleach distribution (for cleaning injecting equipment) or opioid substitution programmes. In some prisons in India, antiretroviral treatment is provided to persons who are HIV positive, but the numbers are not clear. Treatment for STI (Sexually Transmitted Infections) is also provided in some prisons as are adhoc support and care services.

Women and Health Care in Prisons

Although the population of women in prisons is relatively low, their adverse social positions and social disadvantage make them more liable to rejection from families and greater dejection when they are in prison. Low levels of education and poor legal awareness makes women more likely to serve longer sentences in prison.

Table 4: Women in Prisons of South Asia

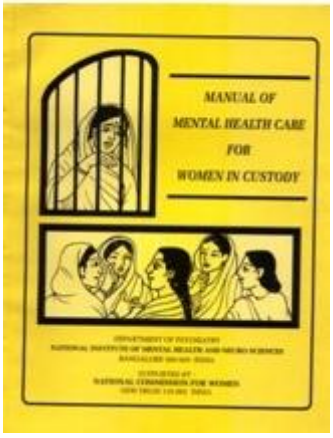
S. No.	Country	Female Prisoners (Percentage of prison population)
1.	India	3.7 %
2.	Nepal	8.3 %
3.	Sri Lanka	3.8 %
4.	Maldives	21.6 %
5.	Pakistan	1.5 %
6.	Bangladesh	2.8 %
7.	Bhutan	No data available
8.	Afghanistan	2.8 %

(Source: International Centre for Prison Studies, 2004)

Studies from developed countries find that mental illness is grossly over-represented among incarcerated women. It is a substantial contributor to the poor health status of this population. Of particular concern are the effects of trauma and substance use disorders, which are often a result of past victimisation. Mental ill health may also be appreciated in relation to psychological distress in the form of suicidality and self-harm, both of which are elevated among women compared with both their male counterparts and the general population. The prison experience frequently compounds this disadvantage and

psychological distress by failing to address the underlying trauma and the particular mental health needs of female prisoners. Women are "unable to defend themselves, and ignorant of the ways and means of securing legal aid. They are unaware of the rules of remission or premature release, and live a life of resignation at the mercy of officials who seldom have understanding of their problems." (Agarwal 1994).

Women in the contemporary prison face many problems; some resulting from their lives prior to imprisonment, others resulting from their imprisonment itself. Women in prison have experienced victimization, unstable family life, problems in education and work, and substance abuse and mental health problems. Social factors that marginalise their participation in mainstream society and contribute to the rising number of women in prison include poverty, lack of social support, separation or single motherhood, and homelessness. Lack of financial support and social ostracisation makes life after release a veritable hell.



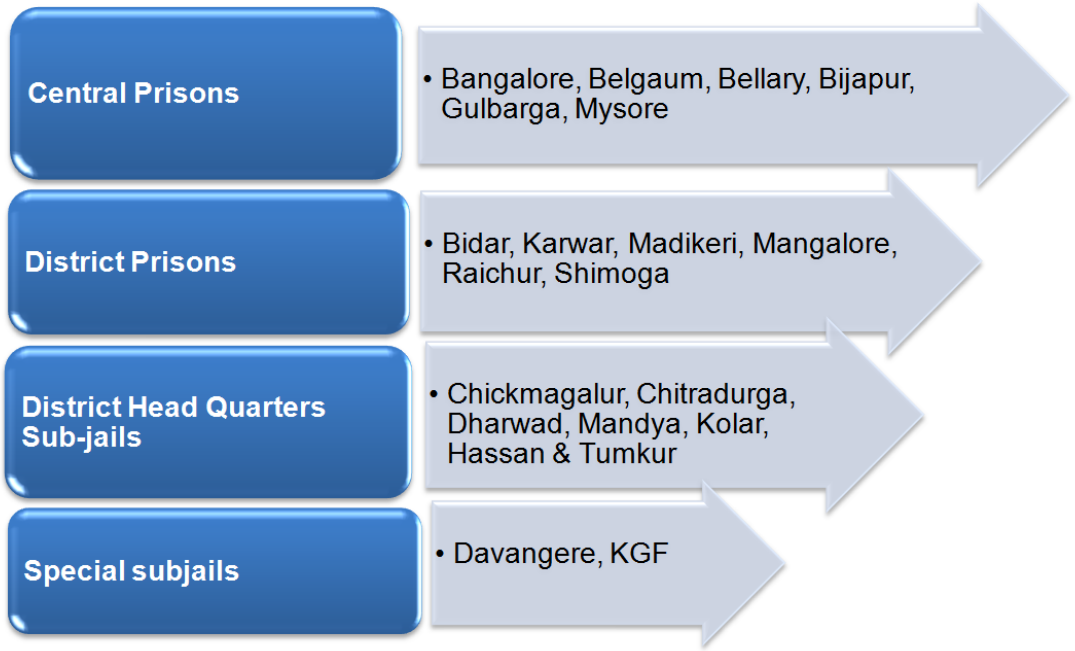
NIMHANS carried out a study of the women prisoners in the Central Prison Bangalore with support from the National Commission for Women in 1998. (Murthy et al 1998)

Particularly difficult situations for women are separation from children and other significant people, including family. Some women are pregnant when they come into prison and this can be a particularly difficult time, physically and psychologically. World over, it has been found that prison services are not sensitive enough in timely recognition and treatment of their mental health problems and do not address their vocational and educational needs adequately when compared to men. As mentioned earlier, women are more liable to abuse. In some parts of the world, it is said that women in prison are likely to be subject to more disparate disciplinary action than the men. The characteristics of women offenders and their pathways to crime differ from male offenders. The system responds to them differently, therefore there is the need for gender-responsive treatment and services.

3. Prisons in Karnataka with special reference to The Central Prison Bangalore- A brief background

As elsewhere, prisons in Karnataka are among the oldest public institutions and so are the buildings in which they are located. The Central Prison in Bijapur is the oldest in Karnataka. Built in 1593 to cater as a guesthouse for King Adil Shahi's guests, the monument was converted into a prison in 1888. This occurred when Bijapur was made the district headquarters. Many other prisons were built during the 18th and 19th century, including the Sub Jail at Ramanagaram (1783), Central Prison, Mysore (1862), District Sub jail, Dharwad (1858), District Prison, Mangalore (1850), and Central Prison, Bellary (1884).

Figure 3: Prisons in Karnataka



Karnataka reports a total of 100 prisons of various classifications with an authorized capacity of 11290 male prisoners and 923 female prisoners, totalling 12213 prisoners. All prisons situated in Karnataka fall under the following classes: Central Prisons(8), District

Prisons(13), District Hq Sub Jails(4), Special Sub Jails(2), Taluka Sub Jails(70), Borstal School (1), Juvenile Jail (1) and Open Air Jail(1). Conditions of prisons in Karnataka have been recently reviewed by the Commonwealth Human Rights Initiative. As of 2008, only 83 out of 99 institutions were functioning, which were under the general supervision of the Prison Department. Of the remaining institutions, the oldest ones were closed owing to defects in the buildings, such as leaking roofs and clogged drainage systems; while the newly built ones were not open due to a shortage of staff. The central government had sanctioned Rs. 21.51 crores for the construction of 11 new prisons in Karnataka. Of the seven newly constructed prisons in the state, only three are functioning; and the opening of the other four is uncertain due to lack of staff and suitable quarters for them (CHRI 2010).

Acts and Rules

Legislation pertaining to the management and administration of prisons in Karnataka is scattered under different Acts and Rules as follows:

Legislations of Prison

Sl No	**Acts**
1	Karnataka Prisons Act, 1963
2	Karnataka Prisoners Act, 1963
3	Borstal School Act, 1963
	Rules
1	Karnataka Prison Rules, 1974
2	Borstal School Rules, 1969
	Manual
1	Karnataka Prison Manual, 1978

Conditions of detention in the Prisons of Karnataka

The CHRI report highlights that the conditions of prisons in Karnataka mirror the problems of prisons throughout the country. These problems have been discussed in an earlier chapter. On the basis of its evaluation of the Karnataka prisons, the CHRI recommends the following areas of enquiry for Prison Visitors.

Guidelines for Prison Visitors

1. Buildings	10. Punishment
2. Overcrowding	11.Undertrial Prisoners
3. Drainage and Sewerage	12. Adolescents
4. Water Supply	13. Medical Care
5. Food	14. Parole
6. Clothing	15. Advisory Board Meetings
7. Bathing	16. Conservation of Human Rights
8. Labour	17. Rehabilitation Programmes
9. Discipline	

Source: CHRI 2010

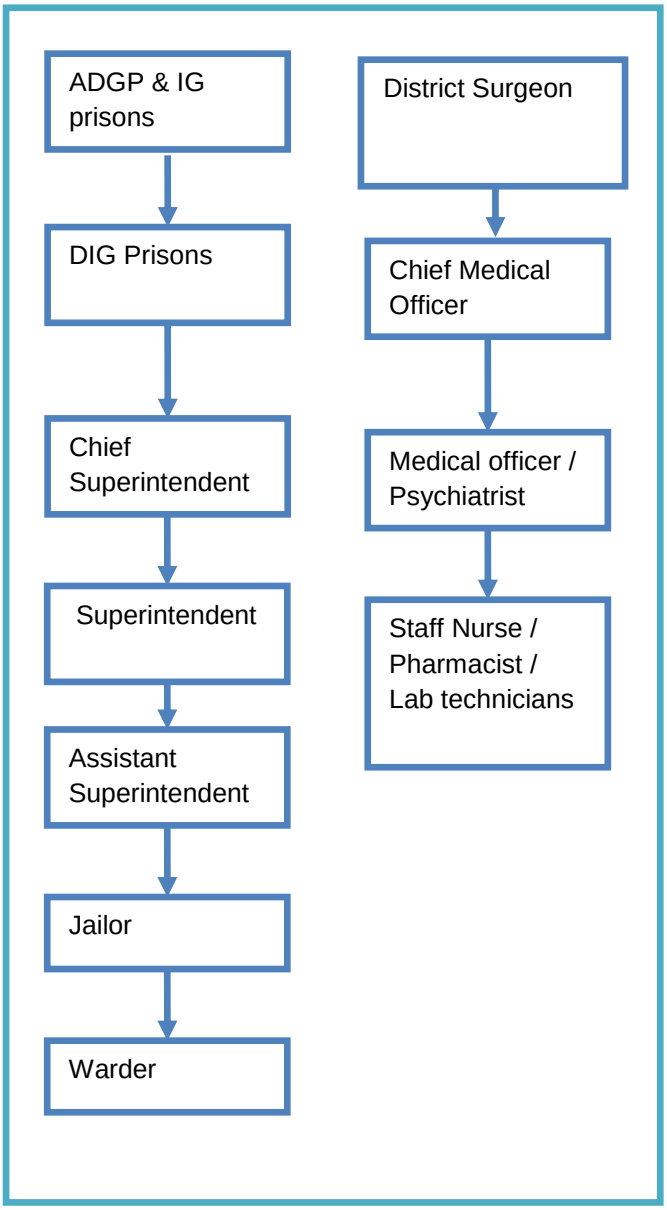
The Central Prison, Bangalore

The Central Prison, Bangalore, constructed in 1867, functioned from the busy Seshadri Road until it was shifted to its present location at Parappana Agrahara in the year 2000. The old prison has now been developed into the Freedom Park by the city corporation and was inaugurated on 28 Feb 2009.

Organisational Structure of the Prison

The Prison Department in Karnataka is headed by an Inspector General of Prisons (also the Addl. Director General of Police), assisted by two Deputy Inspector Generals of Prisons and Gazetted Managers at the Head Quarters. All the Central Prisons, District Prisons, District Head Quarters Sub-jails, Special Sub jails and Taluka Sub Jails are managed by departmental staff. Out of 70 Taluk sub jails, 29 under department control and 41 are under Revenue control.

Figure 4: Organogram of the Prison



In the Bangalore prison, there is only one psychiatrist for the entire population of over 5000. Apart from this, the prison hospital has three doctors (one physician, one

dermatologist and one ophthalmologist) and one staff nurse, one lab technician, one x-ray technician and two pharmacists. The four doctors see all clinical referrals to the prison hospitals, run an inpatient service with 100 beds (this facility is usually overflowing with about 250 patients at any given time), provide health reports in response to court orders, co-ordinate medical retransfers across the prisons in the state, and provide emergency cover as needed.

Free Legal Service Centre, Central Prison, Bangalore

WRIT PETITION FILED AGAINST CENTRAL PRISON, BANGALORE

There was a writ petition filed against Central Prison, Bangalore *(Shri Rama Murthy Vs State of Karnataka (1997) 2SCC 642).* This has its origin in a letter dated 12.4.1984 by a prisoner of Central Jail, Bangalore to the Hon'ble Chief Justice of this Court submitting a complaint about conditions in the jail.

On the basis of a detailed report (300 pages report) submitted by a District & Sessions Judge of Bangalore, the Apex Court raised concerns and discussed various problems which afflict the system and which needed immediate attention were; overcrowding;

delay in trial; torture and ill-treatment; neglect of health and hygiene; insubstantial food and inadequate clothing; lack of prison escort services; deficiency in communication; streamlining of jail visits; and management of open air prisons.

The understanding of the problems of prisons in India in general and Karnataka in particular, formed the basis of carrying out the study on mental health and substance use in the Central Prison, Bangalore.

4. Mental Health and Substance Use Problems in Prisons (The Bangalore Prison Mental Health Study): An Introduction

Background

The lack of information on specific health problems among prisoners in Indian prisons is shocking. There is virtually no information on mental health and substance use issues. It is very difficult to plan appropriate and quality services in the absence of such data. Detection and proper treatment of mental disorders and substance use should be a part of public heath goals in any country.

Addressing mental health and substance use issues will improve the health and quality of life of both mentally ill prisoners and of the prison population as a whole. Stigma and discrimination can be reduced. Prison mental health cannot be addressed in isolation from the health of the general population since there is a constant inter-change between the prison and the broader community. Prison health must therefore be seen as a part of public health. Addressing the mental health needs of prisoners increases the probability that upon leaving prison they will be able to better adjust to community life, reduce the number of people who return to prison, help divert people with mental disorders away from prison into treatment and rehabilitation and ultimately reduce the high costs of prisons.

The World Health Organization (WHO) strongly recommends that all prison authorities, health authorities and prison staff recognise and seize all the opportunities which the prison setting presents to eliminate or reduce the mental harm which imprisonment may cause and to promote mental health. Governments and authorities responsible for all forms of compulsory detention need to get involved in this issue in accordance with their particular legal requirements (WHO 1998).

Staff of the jails and prisons is in contact with persons with mental illness in the prison. Sadly, many of these mentally ill prisoners remain undiagnosed, remain in the same condition without ever coming to the attention of a doctor and receive no treatment (Birmingham et al 1996 and 1998). The mentally ill in prison are confined in the prison

for many years. Prison staff needs to be trained to identify mental illness and to respond appropriately to the mentally ill and this would be possible only with an active collaboration between mental health professionals and prison staff.

In India, there is a shortage of mental health manpower (psychiatrists, psychologists, psychiatric social workers and psychiatric nurses) (Agarwal et al 2004, Nagaraja and Murthy 2008). Most of the prison hospitals in India do not have psychiatrists. Shortage of trained mental health professionals is a reality and can adversely influence care of the mentally ill in prisons. Given the situation, the solution is to develop effective mental health training programs for prison staff (Emily 2005). It has been suggested that it would be in the best interest of all parties to educate the prison staff about ways to manage persons with mental illness (Heidi et al 2005).

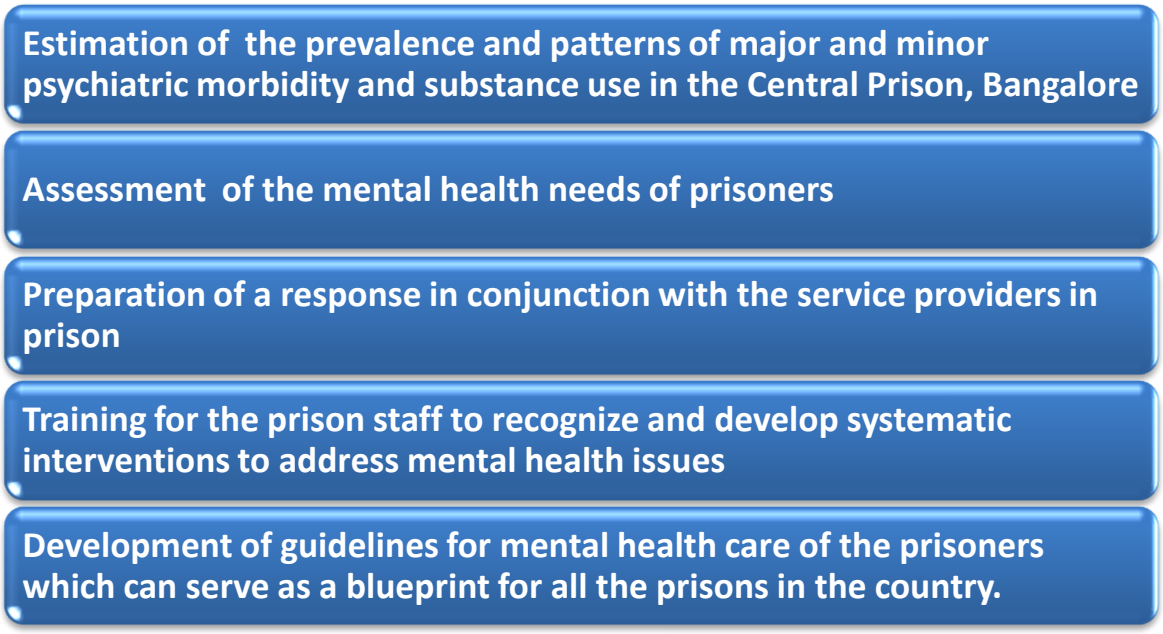
Conception of the Study

The National Institute of Mental Health and Neuro Sciences (NIMHANS) has a separate ward where prisoners with mental illness or suspected mental illness are admitted for evaluation and treatment. All of us in the project team had some experience in dealing with these patients. We knew that the patients that we saw represented only the tip of the iceberg-that there would be a large number of persons with mental illness in the prisons they were sent from. The prison psychiatrist, a co-investigator on our team attested to this fact. We also observed transient psychotic disorders among patients which recovered when they were in the protected environment of the ward. These could be attributed to drugs like cannabis, and we had occasionally confirmed this association through urine testing in the forensic ward of NIMHANS. However, we realized that nowhere in India had there been a systematic assessment of mental health and substance use problems among prisoners with a view to improve their care. This was the background to the Bangalore Prison Study. Several meetings were held with the Additional Director General of Police and Inspector General of Prisons, Government of Karnataka to highlight the need for such a study and discuss its logistics.

Initiation

The study was initiated as a collaborative project in June 2007 between the Prisons Department, Government of Karnataka and the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore, with the objective of improving mental health care among prisoners in Karnataka.

Figure 5: Specific objectives of the prison study



Methodology

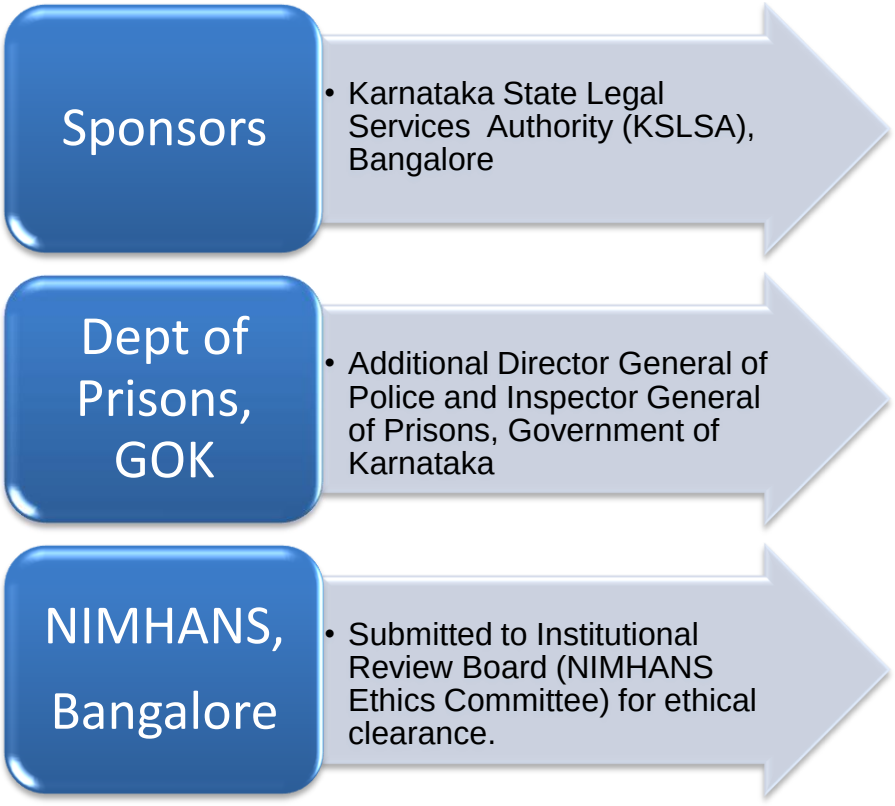
A team from NIMHANS undertook the responsibility of designing the study, developing the instruments, training the field staff and monitoring the study, in collaboration with the prison psychiatrist. The project was funded by the Karnataka State Legal Services Authority. The study protocol was prepared by the study team including, one principal investigator, two co-investigators and two sub-investigators. An independent expert committee of consultants was also formed to review the protocol and to monitor the study. This expert committee included the Director and Vice-Chancellor, Head of the Department of Psychiatry, Deputy Medical Superintendent and Consultant community

psychiatrist from NIMHANS; the Joint director- Mental Health, Department of Health and Family Welfare, Karnataka State Government and the Member Secretary, Karnataka State Mental Health Authority, Bangalore. The roles of the above experts were to provide advisory inputs to the protocol and its execution.

Protocol approval

The study protocol was submitted to Additional Director General of Police and Inspector General of Prisons, Prison Department, Government of Karnataka for permission to conduct this study in the Central Prison, Bangalore. It was submitted to the Karnataka State Legal Services Authority (KSLSA), who sponsored the study. After, approval from both the above agencies, it was submitted to the Ethics Committee, NIMHANS, Bangalore. The study was formally approved by NIMHANS Ethics Committee on 10 January 2008.

Figure 6 : Study collaborators



The study was launched on the 19th of March, 2008 at Bangalore Central Prison

Health Camp inside the barrack at Central Prison, Bangalore

The study was launched in March, 2008 at the Bangalore Central Prison in the presence of his Excellency the Governor of Karnataka, the Hon'ble Chief Justice of the High Court of Karnataka, the Executive Chairman of the KSLSA, Chairman of the High Court Legal Services Committee, Advisor to the Governor of Karnataka, the Director and Vice-Chancellor of NIMHANS and the Additional Director General of Police and Inspector General of Prisons.

Phases

The project has been carried out in three phases (as shown in figure 7). During the first phase, the assessment of mental health morbidity in prison was carried out; in the second phase training and assessment of prison staff was undertaken.

The training programme for the prison staff focused on a) early identification and treatment b) effective rehabilitation in prison and c) addressing needs of prisoners during prison stay and during preparation for release.

In the final phase minimum guidelines for mental health care of prisoners were developed with the further plan to disseminate the guidelines for implementation throughout the prisons in the country.

Three research assistants were appointed for the project. Prior to initiating the project, they received a one month orientation which included an overview of psychiatric illness and substance use, a training on how to carry out assessments, maintain ethical standards including confidentiality and how to document the information.

Figure 7: Phases of the project

Phase I

Stage 1: Assessment of prisoners (n=5024) in Parappana Agrahara (Central Prison) Bangalore on a structured instrument for mental health morbidity after informed consent

Stage 2: Anonymous urine screening of the prisoners with strict confidentiality regarding test results

Phase II

Stage 1: Development of a brief screening tool for assessment of mental illness in the prison population

Stage 2: Mental health training programme for the prison staff in early identification and treatment of mental health problems

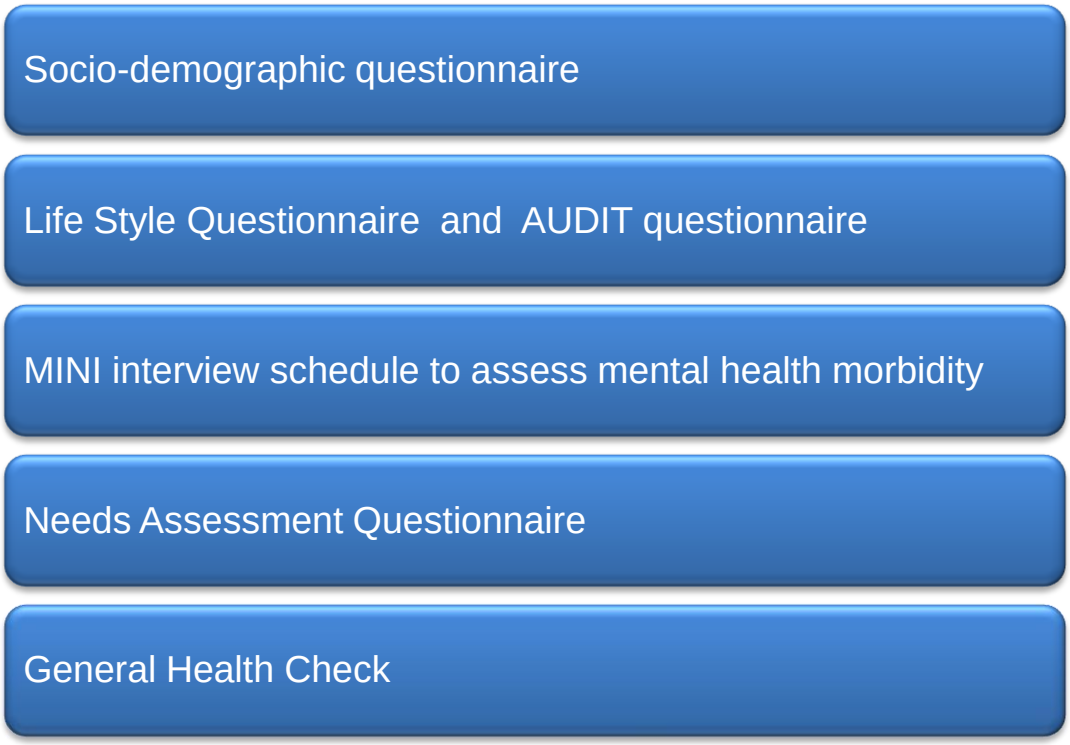
Stage 3: Assessment of Mental health morbidity of prison staff at the Central Prison, Bangalore

Phase III

Stage 1: Development of guidelines for the assessment and management of mental health and substance use problems in prisons

Stage 2: Preparation and dissemination of the findings of the project.

Figure 8: Assessments used in the Prison Study



The **Alcohol Use Disorders Identification Test (AUDIT)** has been developed by the World Health Organization (WHO) as a simple method of screening for excessive drinking (to identify persons with hazardous and harmful patterns of alcohol consumption) and to assist in brief assessment.

The **Mini-International Neuropsychiatric Interview (M.I.N.I.)** is a short structured diagnostic interview, developed jointly by psychiatrists and clinicians in the United States and Europe, for DSM-IV and ICD-10 psychiatric disorders (Sheehan et al 1998). With an administration time of approximately 15 minutes, it is designed to meet the need for a short but accurate structured psychiatric interview for multicenter clinical trials and epidemiology studies. MINI plus 5.00 belongs to the family of the MINI interview schedules. It elicits all the symptoms listed in the symptom criteria for DSM-IV and ICD-10 for 15 major Axis 1 diagnostic categories, one Axis II disorder and for suicidality. The validated Kannada translation of the MINI plus 5 was used in the study.

Procedure

Personal Interview with prisoners

Each of the potential respondents was first explained the purpose of the study. The project staff answered any questions or doubts the respondent had regarding the study. Written informed consent was taken. The interview was carried out confidentially in cubicles, and none of the prison authorities were in the vicinity of the interview area. No form of coercion or incentive was provided. The interview recorded socio-demographic information, lifestyle questionnaire, MINI Plus 5 psychiatric schedule and the Needs questionnaire. A similar approach was adopted in the female barracks.

Personal Interview with new entrants into prison

All new entrants to the prison over one calendar month were briefly interviewed after written informed consent regarding their health status and lifetime as well as current use of tobacco, alcohol and other drugs. This was carried out in the prison hospital.

Health Screening

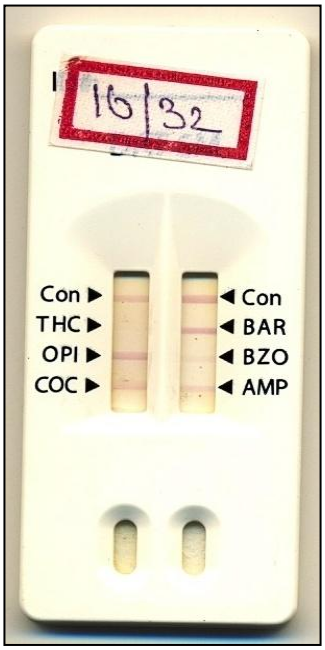
A cross-sectional random screening for hypertension and diabetes was carried out by doctors and project staff through personal interviews of male prisoners in the barracks. The respondents were asked for a history of hypertension or diabetes, current use of alcohol and tobacco. Each respondent's blood pressure was recorded, and the respondent was subjected to an alcohol breathalyzer and carbon-monoxide analyser. The participation in this screen was voluntary and no personal information was recorded. The respondent was also asked to provide a urine sample which was tested for sugar and protein. A fresh urine specimen was collected in a clean, dry, disposable container numbered to match the record containing the health information. MagiSTIK reagent strips were used for this analysis. Each reagent strip was immersed in the urine sample and removed immediately. The strip was held in a horizontal position and the reagent area was compared to the corresponding colour chart on the canister label. The value was recorded after careful colour matching.

Urine testing for drugs of abuse

Testing for drugs of abuse was carried out in two populations, prisoners who had been in the prison and consecutive new entrants into the prison.
In the first instance, a random urine testing was carried out among convict prisoners and undertrial prisoners. In the randomly selected barrack, the individual prisoner was requested to provide a urine sample after guarantee of confidentiality. The urine was collected in a disposable container, and the number of the sample was labeled, without any personal identification.

The following measures were taken to ensure confidentiality:

a) No individual identification information was recorded on the urine cassette
b) The cassette was safely stored after use, and the urine samples discarded
c) Results generated were interpreted and documented only by the investigators. No prison staff was involved in this process of interpretation and documentation.



Urine Cassette test

In the second instance, undertrials consecutively coming into prison were asked about drug use history, and requested for a urine sample. Both the questionnaire and sample were completed after written informed consent. In these cases, the identification details were labeled on the urine sample, so that the findings could later be correlated with the individual's self report of drug use.

Procedure for urine analysis for drugs

The samples were then taken to the prison hospital, where each urine sample was subjected to the Nano-Check DAT6 multidrug screening test. In this test, 80 ul of urine is placed in the sample well of the urine cassette using a pipette, and the test is read after 5

to 10 minutes. A valid test is indicated by the presence of a control line. A positive test is indicated by the absence of development of a line at the position indicated for each drug, but the presence of the control line. Care was taken to avoid cross-contamination of urine samples by using a new specimen pipette for each urine sample. The sensitivity of these tests are as follows:

Table 5: Urine drug analysis cutoffs

Compound Name	Cutoff level	Comment
THC (Cannabinoids)	50 ng/ml	The metabolite compounds can be found within hours of inhalation and remain detectable for 3-10 days after smoking
OPI (Opioids)	300 ng/ml	Metabolites are detectable in urine 1-3 days after opiate use
COC (Cocaine)	300 ng/ml	Can be generally detected 12-72 hours after cocaine use or exposure
BAR (Barbiturates)	300 ng/ml	Detection time varies from a day to less than weeks. Intermediate and short acting barbiturates can be detected for 2-4 days after ingestion
BZO (Benzodiazepines)	300 ng/ml	Long acting benzodiazepines are detectable in urine for weeks to months after chronic use Short acting benzodiazepines may be detectable for a few days
AMP (Amphetamines)	1000 ng/ml	Detectable in urine for 3-5 days after use

Personal Interview with Prison Staff

All working prison staff was contacted for consenting to a personal interview. They were interviewed after completion of their duty. They were administered a Staff Needs Assessment which covered areas of Personal Safety, Stress, Basic Needs, Personal Health, Training, Family Stress and Attitudes to mental illness.

Prisoners at the Central Prison, Bangalore- A Background

At the time of conducting the study there was 248% overcrowding in the Central Prison, Bangalore.

During the course of the study, a total of 13,700 persons had been admitted to the prison. The average count was 5200. A majority (65.4%) were undertrial prisoners. Women prisoners constituted 4% of the prison population. A total of 5024 prisoners, including 197 women were interviewed as part of the study.

Table 6 : Strength of the Central Prison, Bangalore at the time of the study

	Number* of prisoners
Approved capacity	2100
Average total strength	5200
Under Trial Prisoners (UTP)	3400 (65.4%)
Convicted Prisoners (CTP)	1800 (34.6%)
Female prisoners	210 (4%)

(*The numbers are approximate as there are steady admissions and discharges from prison on a daily basis)

Socio-demographic background

Undertrial prisoners were mostly males in their late 20s, and had been in prison for nearly two years (mean 23.76 months). A majority were Hindus. A majority were single (53.7%), but a sizeable number (41.4% were married). While nearly two-thirds came from urban areas, about one in four (26.4%) came from semi-urban areas. The convict prisoners were considerably older (mean age 38 years). A substantial number were married, widowed or divorced (73.8%). A majority of them came from semi-urban areas.

Table 7: Socio-demographic details

Variable		Under trial prisoners (UTP)	Convicted prisoners (CTP)	Total	t/X^2	P-value
Legal status [n (%)]		3827(76.2)	1197(23.8)	5024	N/A	N/A
Mean age in years (SD)		28.39 (8.9)	38.00(12.1)	30.68(10.6)	29.74	<0.001
Gender [n (%)]	Males	3699 (96.7)	1123 (93.8)	4822(96.0)	22.81	<0.001
	Females	123(3.2)	74(6.2)	197(3.9)		
	3rd gender	5(0.1)	0	5(0.1)		
Religion [n (%)]	Hindu	3000(78.4)	1020(85.2)	4020(80.0)	41.40	<0.001
	Christians	386(10.1)	59(4.9)	445(8.9)		
	Muslims	440(11.5)	115(9.6)	555(11.0)		
	Others	1(0.01)	3(0.3)	4(0.1)		
Marital status [n (%)]	Single	2056(53.7)	346(28.9)	2402(47.8)	255.14	<0.001
	Married	1583(41.4)	717(59.9)	2300(45.8)		
	Widowed	166(4.3)	131(10.9)	297(5.9)		
	Divorced	22(0.6)	3(0.3)	25(0.5)		
Domicile [n (%)]	Urban	2427(63.4)	332(27.7)	2759(54.9)	496.59	<0.001
	Village	376(9.8)	159(13.3)	535(10.6)		
	Semi-urban	1024(26.8)	706(59.0)	1730(34.4)		
Duration of stay in months(SD)		23.76(12.51)	50.99(39.60)	N/A	40.95	<0.001

Educational and Occupational Status

While about one in five UTPs were illiterate, more than half the CTP prisoners was either illiterate or had some informal education. Approximately 15% of both UTP and CTP had been educated to pre-university level or higher (Table 8). Prior to their imprisonment, both groups had been involved in diverse occupations (Table 9). What was striking was that about one-third (34.6%) of convict prisoners had been agriculturists. Very few in both groups had been unemployed prior to imprisonment.

Table 8. Educational level attained:

	UTP [n(%)]	CTP [n(%)]	Total	t/X^2	P-value
Illiterates	808(21.1)	280(23.4)	1088(21.7)	27.49	<0.001
Informal education	180(4.7)	89(7.4)	269(5.4)		
Primary education	435(11.4)	127(10.6)	562(11.2)		
High school	1846(48.2)	521(43.6)	2367(47.1)		
Pre-university	348(9.1)	96(8.0)	444(8.8)		
Degree	178 (4.7)	71 (5.9)	249(5.0)		
Post-graduation	30(0.8)	9(0.8)	39(0.8)		
Professional course	2(0.1)	3(0.3)	5(0.1)		
Total			**5023**		

Table 9. Occupational status of the inmates

	UTP [n (%)]	CTP [n (%)]	Total [n (%)]
Unemployed	77(2.0)	9(0.8)	86(1.7)
Farmers	261(6.8)	414(34.6)	675(13.4)
Unskilled	510(13.3)	204(17.0)	714(14.2)
Semi-skilled	1258(32.9)	184(15.4)	1442(28.7)
Skilled	996(26.0)	160(13.8)	1156(23.0)
Clerk	110(2.9)	30(2.5)	140(2.8)
Professional	80(2.1)	25(2.1)	105(2.1)
Business	443(11.6)	128(10.7)	571(11.4)
Student	38(1.0)	13(1.1)	51(1.0)
Home-maker	18(0.5)	25(2.1)	43(0.9)
Others	36(0.9)	5(0.4)	41(0.8)
Total			**5024**

Family Income

One in 3 prisoners reported monthly income below Rs 3000 prior to entry into prison. Convicted prisoners were significantly more likely to report very low levels of family income (Table 10) compared to undertrial prisoners, with 44.4% reporting family monthly incomes below Rs 3000. A majority in both groups reported family incomes between Rs 3000 to Rs 10,000. About 7% of UTP and convict prisoners reported family incomes of over Rs 10,000 per month.

Table 10. Family Income categories-monthly income in rupees

	UTP [n (%)]	CTP [n (%)]	Total	X^2	P-value
0 through 1000	110(2.9)	79(6.6)	189(3.8)	86.15	<0.001
1001 through 3000	1171(30.6)	452(37.8)	1623(32.3)		
3001 through 10000	2165(56.6)	522(43.6)	2687(53.5)		
10001 through 50000	256(6.7)	84(7.0)	340(6.8)		
50001 through 100000	15(0.4)	4(0.3)	19(0.4)		
More than 100000	8(0.2)	5(0.4)	13(0.3)		
Total			4871		

Living arrangements prior to prison entry

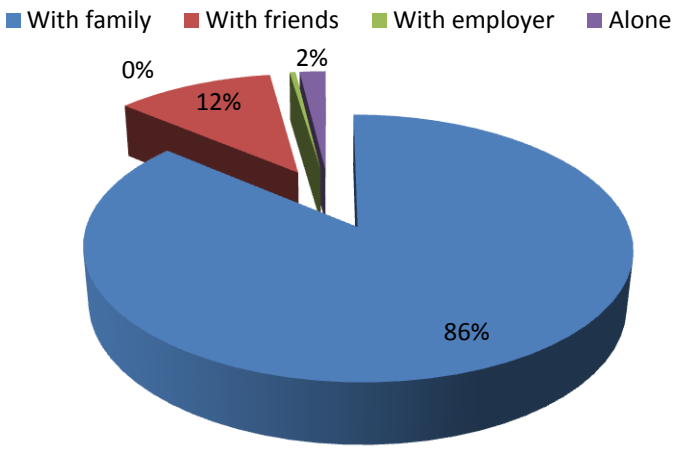


Figure 9: Living arrangement prior to prison entry (n=2286)

Past imprisonment

The respondents were asked about details of past imprisonment. Of the present prison population that replied to this question, 4035(80.4%) said that this was their first imprisonment.

General Health Status

Each of the respondents was asked a question regarding their current health status. Various types of joint pains were the commonest symptoms reported, followed by skin, eye and dental problems. The number self reporting chronic medical conditions was very low and was below that reported in countries like the United States. There, a substantially greater number of persons are aware of diagnosed medical conditions.

Table 11: **Self Report of Current Health Problems**

Health Problem	N (Positive Responses only)	Valid %
Any disease of the heart/blood vessels	363	7.2
High blood pressure	182	3.6
Any chest diseases like TB	173	3.5
Diabetes	151	3.0
Any mental illness	100	2.0
Epilepsy or fainting attacks	118	2.4
Digestive disorders	652	13.0
Back or neck problems	800	16.0
Arthritis or rheumatism	738	14.7
Shoulder, arm, wrist or hand problems	308	6.1
Eye problems	497	9.9
Skin disease	524	10.5
Dental Problems	485	9.7

A study by Wilper and Woodhandler (2009) analyzed the prevalence of chronic illnesses including mental illness and access to health care among 10,668 inmates of State prisons, Federal correctional facilities and local jails in the United States.

A review of mental health services for prison inmates in 24 countries in the European Union and EFTA showed many shortcomings in standards of mental health care, including lack of even the most rudimentary health reporting standards, lack of any quality psychiatric screening procedures at prison entry and during imprisonment and inadequately trained staff to provide such screening (Dressing , Salize 2009)

They were asked questions about symptoms or medical diagnoses received prior to incarceration including diabetes mellitus, hypertension, HIV / AIDS, paralysis, prior or current malignancy, stroke or brain injury, chest pain or other heart problems. They also answered questions pertaining to chronic problems with kidneys, asthma, cirrhosis, hepatitis, arthritis or sexually transmitted diseases.

Health records were not used to confirm the diagnoses. Questions were asked about serious injuries. They also answered questions about health care, including mental health care since incarceration. Questions included whether they were taking medications for psychiatric illness at any point in the past, and since incarceration. Among inmates in federal prisons, state prisons, and local jails, 38.5%, 42.8% and 38.7% respectively, suffered a chronic medical condition. The authors concluded that many inmates with a chronic physical illness fail to receive care while incarcerated. Among inmates with mental illness, most were off medication at the time of arrest.

In contrast, in our prison settings, there was extremely low awareness of underlying medical conditions among prisoners, particularly of mental illness. Even those currently receiving treatment were unable to provide details of their medical condition and treatment.

Only 196 respondents (3.9%) reported taking medication regularly at the time of interview. Only 13 of them were able to mention what medicines they were taking.

Deaths in the prison

This information was obtained from the secondary data maintained by the prison hospital. In 2006, there were 17 deaths. In 2007, there were 22 deaths. There were 38 deaths in 2008, and 29 in 2009 (until November). During this three year period, there have been 9 deaths from suicide, mainly hanging. Of the 38 deaths in 2008, HIV was recorded 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 specialized hospitals. Other details of the deceased prisoners were not available.

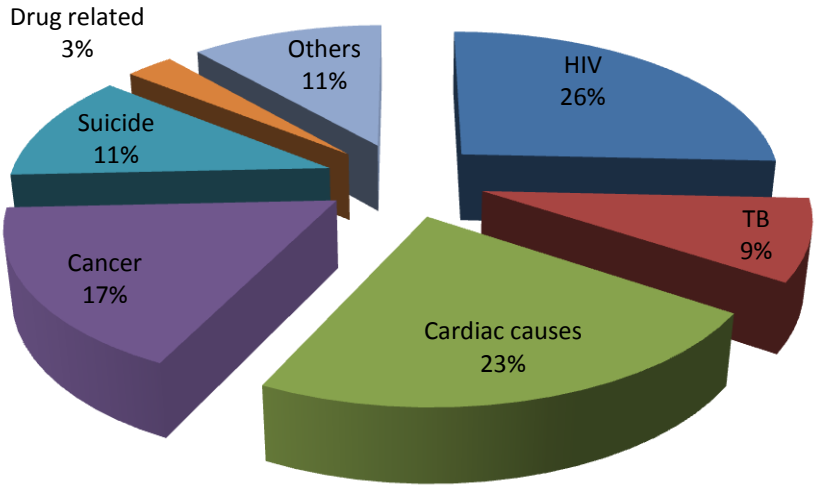


Figure 10: Causes of mortality

Hypertension

Among 667 randomly selected patients blood pressure was recorded. The following definition as given by Fauci et al. (2008) was followed: Systolic blood pressure of greater or equal to 140 mm Hg or diastolic blood pressure of greater or equal to 90 mm Hg. 135/667(20.5%) had hypertension going by this definition. Thus, though only 3.6% of prisoners self reported a history of high blood pressure, recording of blood pressure increased hypertension detection rates by five times.

Random testing of urine sugar and protein

A small proportion of the existing prison population underwent urine testing for sugar and protein. The urine sugar is a provisional test for diabetes, and urine protein, indicative of kidney damage may be helpful in screening for urinary infection, diabetes, hypertension, kidney disease, or other serious conditions that may require further investigation.

About 5% of the prisoners randomly tested in the prison as well as new entrants had positive urine sugar. Although a very small percentage self report being diabetic, it is possible to identify the condition by urine testing, particularly among prisoners above 40 years of age, so that longer-term complications of the condition can be prevented. The crude prevalence of diabetes in India is 3% among rural populations and 9% among urban populations (Diabetes India). Our findings suggest that diabetes prevalence is roughly equivalent to the general population. Proteinuria was identified in 4.6% of prisoners randomly screened and in 7.3% of the new entrants.

Table 12: Random testing for urine sugar among consecutive prisoners

Urine Sugar	Male n(%)	Female n(%)	Total n(%)
Absent	568(95)	57(95)	625(95)
Present	30 (4.0)	3(5)	33 (5.1)
Examined Total	598(100)	60(100)	658(100)

Table 13: Urine Sugar testing for consecutive new entrants

Urine Sugar	Total n(%)
Absent	275(95.5)
Present	13(4.5)
Examined total	288(100)

Table 14 : Random Testing for Urine Protein among consecutive prisoners

Urine protein	Male n(%)	Female n(%)	Total n(%)
Absent	569(95.2)	59(98.3)	628(95.4)
Present	29 (4.8)	1 (1.7)	30 (4.6)
Examined Total	598(100)	60(100)	658(100)

Table 15: Urine Protein Testing for New Entrants

Urine protein	Total n(%)
Absent	267(92.7)
Present	21(7.3)
Examined total	288(100)

Undernutrition

The World Health Organization (WHO) classification of obesity as given below was used to classify prisoners by weight.

Table 16: Categories of underweight and obesity

BMI	Classification*
<18.5	Underweight
18.5 -24.9	Normal weight
25.0 -29.9	Overweight
30.0-34.9	Class I obesity
35.0-39.9	Class II obesity
≥40.0	Class III obesity

*World Health Organization classification

Based on the WHO classification, nearly one in three prisoners was underweight with a BMI below 18.5. UTP prisoners were significantly more likely to be underweight

(33.8%) compared to CTP prisoners (19.8%). Approximately one in 10 prisoners could be classified as being overweight or obese (Table). A higher percentage of convict prisoners were in the overweight/obese category. This is of concern and probably reflects better food within the jail than outside, lack of exercise and a greater risk to non communicable diseases like hypertension and diabetes.

Table 17: Weight classification of all the prisoners (according to legal status)

BMI	Classification*	UTP n(%)	CTP n(%)	Total n(%)
<18.5	**Underweight**	**1282(33.8)**	**235(19.8)**	**1517(30.5)**
18.5 -24.9	Normal weight	2147(56.6)	748(63.1)	**2895(58.1)**
25.0 -29.9	Overweight	295(7.8)	160(13.5)	**455(9.1)**
30.0-34.9	Class I obesity	50(1.3)	31(2.6)	**81(1.6)**
35.0-39.9	Class II obesity	18(0.5)	9(0.8)	**27(0.5)**
≥40.0	Class III obesity	3(0.1)	2(0.2)	**5(0.1)**
		3795(100)	**1185(100)**	**4980(100)**

*World Health Organization classification

Figure 11: Percentage of prisoners under or overweight

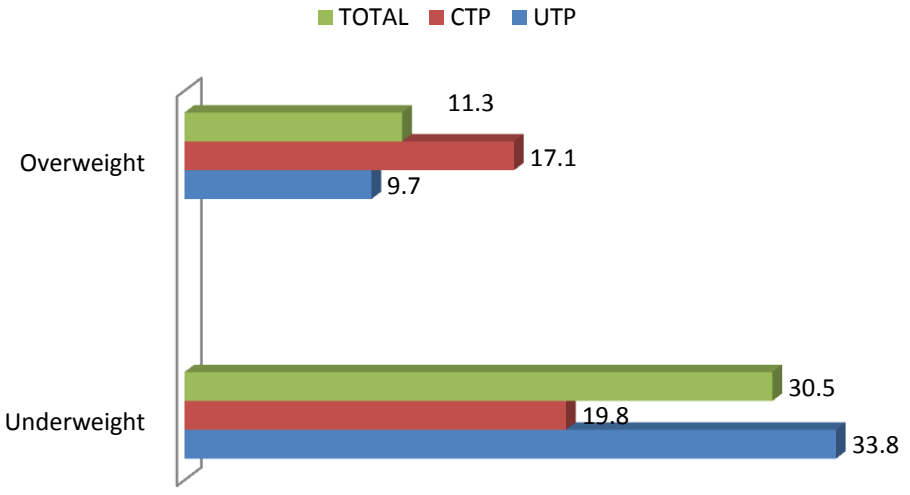
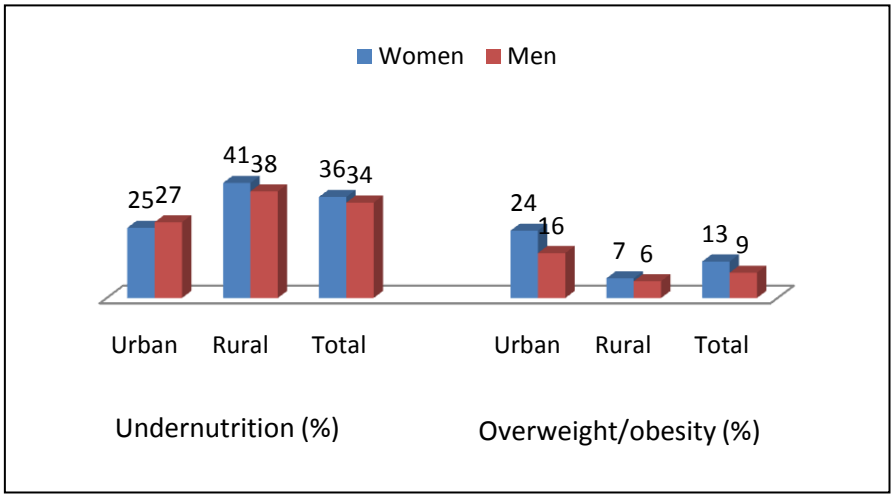


Figure 12: NFHS 3: Presence of undernutrition and overweight/obesity among adults by region (%)



In comparison to the NFHS 3 data, the undernutrition pattern among the prisoners lies intermediate between urban and rural populations; although a substantial proportion of the prison population is urban. Among new entrants to the prison, nearly one in four was underweight, and 17.6% were in the overweight category.

Table 18: Weight classification of consecutive new entrants (all male)

BMI	Classification*	Total N (%)
<18.5	Underweight	**70(24.3)**
18.5 -24.9	Normal weight	**167(58)**
25.0 -29.9	Overweight	**39(13.5)**
30.0-34.9	Class I obesity	**9(3.1)**
35.0-39.9	Class II obesity	**2(0.7)**
≥40.0	Class III obesity	**1(0.3)**
		288(100)

Nearly 24.3% of the new entrants into prison were underweight, and 17.6 % had weights above the normal range. In countries undergoing nutrition transition, it is well known that

overnutrition often co-exists with undernutrition. These findings are slightly higher than the National Family Health Survey (NFHS 2006) for Karnataka which found that 14% of men weighed above normal.

Health Problems in Prison

Data regarding health problems was gathered from the hospital records maintained at the prison. The data for the year during which the present study was carried out is tabulated for one representative month in April 2008 and April 2009.

Table 19: Patients seeking health referral at the prison hospital

	April 2008		April 2009	
No of prisoners screened	4385		6917	
No of consultations for	N	%	N	%
Scabies	680	15.5	1400	20.2
Other skin diseases	1100	25.1	1400	20.2
Gastroenterological problems	1050	23.9	1400	20.2
Renal problems/UTI	330	7.5	540	7.8
Heart ailments	230	5.2	300	4.3
Tuberculosis	15	0.3	11	0.2
HIV+	80	1.8	266	3.8
Mental illness	248	5.7	279	4.0
Epilepsy	20	0.5	43	0.6
Cancer	4	0.1	1	
Leprosy	5	0.1	5	0.1
Other diseases	900	20.5	1600	23.1
No diagnosable disease	1000	22.8	700	10.1

The commonest reasons for patients to seek health referrals are skin diseases, particularly scabies and gastric problems. Since 2009, there is a separate record of patients with diabetes, and there are about 500-650 patients seen each month for diabetes (8-9% of referrals). Considering that only 3% of prisoners self reported history of diabetes, diabetes screening has helped to pick up a larger number of persons with undiagnosed diabetes. Mental illness referrals are largely for major mental illnesses like psychosis.

This is discussed in detail in subsequent chapters. There is only one psychiatrist for the entire prison.

HIV Testing

The Integrated Counselling and Testing Centre for HIV/AIDS was initiated in the Central Prison in 2007. Every new entrant into the prison is offered counselling and testing. All UT and CT prisoners are also offered these facilities

Table 20: HIV sero-positivity

Year	Total screened	No HIV positive	%
2008	3078	80	3.0
2009	3573	68	1.9
2010 (until Aug)	1861	32	1.71

Table 21: Comparison of HIV sero-positivity across gender

Year	No of males screened	No HIV positive	%	No of females screened	No HIV positive	%
2008	2673	60	2.2	405	20	4.9
2009	3090	56	1.8	483	12	2.5
2010 (until Aug)	1577	28	1.8	284	4	1.4

In 2008, HIV sero-positivity was 3%, (2.2% among males, 4.9% among females) which is much higher than the sero-prevalence in the general population as per the NFHS 3 (2005-2006) finding which suggests a sero-prevalence of 0.69% in Karnataka (0.86 among males and 0.54 among females). There is a suggestion that this might be declining in subsequent years. As there has been no systematic screening for tuberculosis, it is not possible to comment on tuberculosis prevalence.

5. Mental Health Problems among Prisoners

Past mental health problems are very important to elicit for a variety of reasons. A person may have developed mental health problems prior to entering prison, and the same may be continuing. Persons with a past episode of mental illness may have another episode upon imprisonment, due to the stress of imprisonment and lack of social support. During various crises points during the imprisonment, such persons may be prone to develop mental health problems. Mental health problems may also develop for the first time during imprisonment. Thus many of the questionnaires have questions relating to a lifetime diagnosis of mental illness as well as a current diagnosis.

Mental health problems:

- May be present prior to entry into the prison
- Develop following entry into prison
- Develop or recur during imprisonment
- May occur at crisis points during imprisonment
- May occur prior to or post-release

Any Mental Illness or Substance Use

According to the MINI psychiatric diagnosis which is mentioned earlier, 4002 (79.6%) individuals could be diagnosed as having a diagnosis of either mental illness or substance use. The details of substance use are discussed in the subsequent chapter.

Table 22: Any diagnosable mental illness or substance use condition according to legal status

	UTP n (%)	CTP n (%)	Total	X^2	P-value
Diagnosable mental illness or substance use condition	3095 (81.3)	899 (75.5)	4002 (79.7)	18.8	<0.001

The presence of either a mental illness or substance use related disorder was significantly higher among UTPs compared to CTPs. The significantly higher likelihood of diagnosis

among male prisoners can be attributed to significantly higher rates of substance use among men. After excluding substance use disorders, 1389 prisoners (27.6%) had a diagnosable mental health disorder.

Mental illness prevalence in other countries

The WHO Trencin statement (2008) noted that of the nine million prisoners world-wide, at least one million suffer from a significant mental disorder and even more suffers from common mental health problems such as depression and anxiety. There is often co-morbidity (dual-diagnosis) with conditions such as personality disorder, alcoholism and drug dependence.

Anna Kokkevi and Costas Stefanis in 1995 studied opioid-dependent men recruited from prison and treatment services. The Diagnostic Interview Schedule (DIS) was used for psychiatric assessment. 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%. Higher rates of affective and anxiety disorders were diagnosed in the treatment sample than in the imprisoned sample. The psychiatric interview showed a strong association between drug dependence (opioids) and mental disorders. High levels of depressive symptoms on the Center for Epidemiological Studies-Depression (CES-D) scale (71.5%) were seen in this group. They also had increased rates of self-reported suicide attempts (27.4%) and psychiatric hospitalisations (26.8%). Psychiatric disorders seemed to precede drug dependence in majority of cases. Similar findings are reported from other parts of North America (Kokkevi et al 1996).

In the Iranian prison study (Assadi et al 2006), 88% of prisoners met DSM IV Axis I criteria for any mental disorder (including substance use). In an Australian study carried out in New South Wales (Butler et al 2006), the 12 month prevalence of any psychiatric illness 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 (OR=11.8, 95% CI=7.5–18.7), substance use disorders (OR=11.4, 95% CI =9.7–13.6) and personality disorders (OR=8.6, 95% CI=7.2– 0.3). The research from this group suggests that undertrial prisoners have higher rate of mental illness than sentenced prisoners (46% vs. 38%), women have greater psychiatric morbidity than men (61% vs. 39%) (Butler et al 2005). The American Psychiatric Association (1999) reports that 20% of prison inmates has a serious mental disorder. In a more recent study in the US Steadman et al (2009) estimating current prevalence rates among male and female inmates is five jails found that 14.5% of males and 31% of females had serious mental illness during the assessment. Petersilia (2003) has estimated that one in six prison inmates has a mental illness. In the UK, mental disorders were present in 148 (26%) of the 569 inmates at the time of reception into prison (Birmingham et al 1996). Rates of psychiatric morbidity among prisoners are estimated to be three times more than the general population (Teplin et al 1990, Assadi et al 2006).

Depression: Hopelessness and Helplessness

Mr R was an only son. Due to financial constraints he could not study beyond 10th grade. R fell in love with a girl of his own village. Once, his girl friend revealed the fact that his close friend was troubling her for sexual favours. One day after confirmation of this issue, he became furious and killed him in a fit of rage. He ended up in prison.

Three months after coming to prison he presented with depression. He was started on treatment and kept under observation for more than 2 months as inpatient. He was later shifted to the barracks as he had improved. One month later, one of his friends came and showed us around 40 tablets collected by the patient. When he was called and interviewed, he reported that he was fed up with life because of the following reasons: father had died recently; his mother had developed mental illness; he was not able to get bail. He was again admitted to hospital and supportive psychotherapy was given. When his mentally ill mother visited him, she was examined and started on treatment. He started to improve.

Depression

Depression is a very common mental disorder that generally occurs as an episode or series of episodes. People suffering from this disorder may not only exhibit a depressed mood but may also lose interest in life's activities and become easily lethargic. They may have difficulty concentrating or making simple decisions. They may possess ideas of hopelessness, worthlessness or helplessness. Severe

depression may be accompanied by psychotic symptoms such as delusions, hallucinations and catatonic symptoms. 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 depression. 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. Criteria for depression are:

ICD-10 criteria to diagnose depression

Major criteria:

(a) Persistent Sadness

(b) Reduced energy leading to easy fatigability. Marked tiredness even after slight effort is common

(c) Inability to enjoy previously pleasurable activities (anhedonia)

Minor criteria:

(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 & sexual functioning

(g) Death wishes, suicidal ideas or attempts

Duration criteria:

At least two of the major criteria plus two of the minor criteria should be fulfilled to qualify for a depressive episode. The symptoms should be present continuously for a period of at least two weeks.

Source: ICD-10 criteria (World Health Organization 1992)

While a substantial proportion of both UTPs and CTPs had symptoms of depression like low mood, about 13 of every 100 prisoners were likely to have suffered from a major depressive episode during their lifetime. While lifetime diagnoses were similar among both UTPs and CTPs, a current diagnosis of a major depressive episode was significantly more likely among UTPs than CTPs ($p<0.001$). Rates of dysthymia were comparatively lower and not substantially different among both categories of prisoners.

Table 23: Depressive disorders

		UTP n (%)	CTP n (%)	Total n(%)	X^2	P-value
Major depressive episode	**Current**	377 (9.9)	80 (6.7)	457 (9.1)	11.04	<0.001
	Life-time	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
	Lifetime	107 (2.8)	39 (3.3)	146 (2.9)	0.69	0.40

Under trial prisoners (UTP) =3822, Convicted prisoners (CTP) = 1195, Total prisoners = 5017

Depressive disorder is the most common mental disorder in the community that affects 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 functioning. They suffer considerable distress. The lowered mood varies little from day to day, and is often unresponsive to circumstances (WHO 1992, Murthy et al. 2005).

Nearly one in 10 prisoners in our study qualified for a current major depressive episode, which is double that of the general population

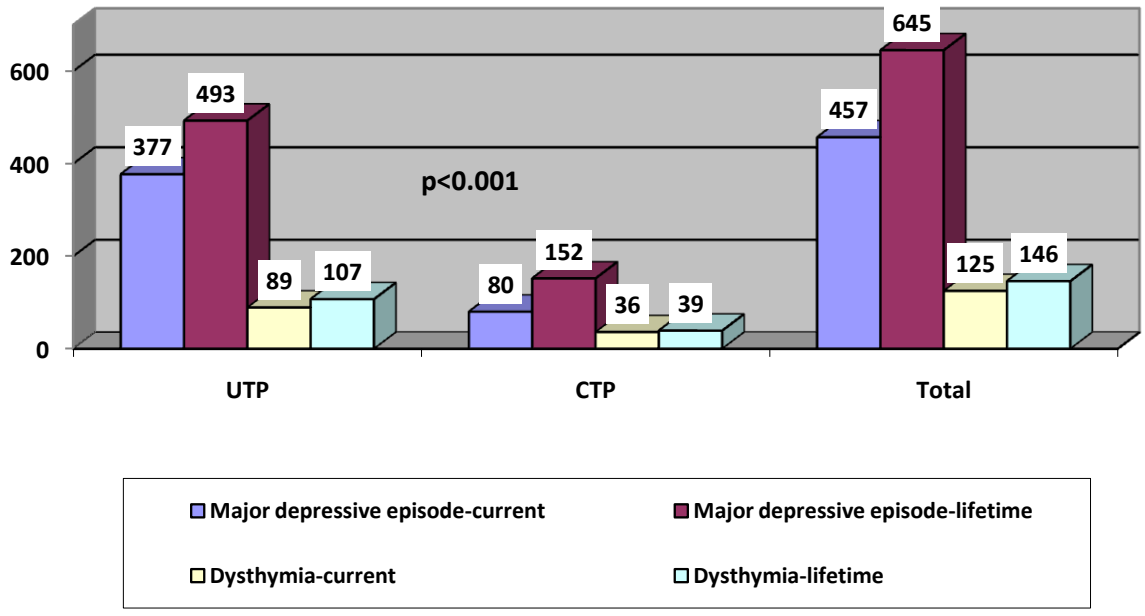
Lifetime prevalence of major depressive disorder in the prison population was 13%

Undertrial prisoners were more likely to receive a diagnosis of major depressive disorder compared to convict prisoners

Overall, the prevalence of depressive disorders has been found to be higher in the prison population than in the general population although there is wide variation depending on which disorders are included. Generally, mild to moderate depressive states are found rather than severe depression. Fazel & Danesh (2002) found an average prevalence of 10% major depression among male prisoners and 12% among female prisoners with differences as to the status of the prisoner (remand or sentenced), whether interviews were made by psychiatrists or not and whether samples were large or small.

Our study showed that the life time prevalence of major depressive disorder was 13%. Prevalence of current depression was found to be 10%, similar to that in the Copenhagen solitary confinement study (Anderson et al., 2004), equal to that of the systematic review by Fazel and Danesh (2002) and to that of a recent study by Way et al (2008) in a New York State prison.

Figure 13: Rates of depression



The BJS survey in the US (James et al 2006), using DSM IV diagnosis found that 24% of State prison inmates, 16% Federal inmates and 30% local jail inmates had a major depressive disorder during the past one year or since admission to their respective

facilities. Assadi et al (2006) found that 29% met the criteria for a major depressive disorder. Notably, in our study, depressive episodes were more among undertrials when compared to that of convicted prisoners. Similar rates of dysthymia have been reported from Iran (1.5%)

Suicidality and Deliberate Self Harm

Suicide is one of the most tragic events that could occur inside prisons and is a leading cause of death in these settings (Hill 2004).
Suicide is most commonly an expression of mental suffering, despair, depression, severe anxiety and/or hopelessness. Factors that provoke suicidal behaviour may be internal or external stressors. Imprisonment in itself is a severe stressor and can induce severe behavioural consequences in afflicted individuals. Considering the high rates of psychiatric morbidity in prison inmates, it is not surprising that suicidal behaviours are common in prisons. Generally, the initial period of imprisonment has the highest risk of suicide. Most suicide takes place at night and hanging is the commonest method (Anderson 2004).

The questions commonly asked to assess suicidality are summarized in the accompanying box. The questions in the MINI interview are for a period of one month before the interview, as well as during the lifetime.

Suicides in Prison always make newspaper headlines

- *DIG (Prisons) commits suicide on jail premises*- The Hindu, Aug 5, 2007
- *Convict attempts suicide, dies in hospital*-The Hindu, May 18, 2008
- *Murder accused attempts suicide in Chanchalguda jail* – The Times of India, Nov 26, 2009
- *Convict on death penalty attempts suicide in jail*- Express News Service, Jan 28, 2010
- *Life convict commits suicide at Puzhal jail*- The Times of India, Sep 27, 2010

Common features of suicidality

Intention of harming oneself with the desire to die

Thoughts about suicide

Plans for suicide

Making an attempt with the expectation or intention of dying

Western statistics show that suicidal rates among the general population is 12 per 1,00,000 per year. In comparison, suicides in prisons occur at the rate of 21 per 1, 00,000 per year and suicides in jails occurs at the rate of 107 per 1, 00,000 per year.

In India, the National Crime Records Bureau statistics for the year 2008 show that the rate of suicides in the general population of India was 10.8 per lakh population (0.18 per 1000 population). In our study, there were 6 reported cases of suicidal deaths in the years 2008 (6 out of 38 deaths) and 2009 (6 out of 30 deaths) (1.19 per 1000 population). This rate is not only higher than that the national average, but is also comparable to those from the western studies (Daniel, 2006). Moreover, our data shows that the UTPs are over represented when compared to the CTPs.

Preventing Suicide – The power of counselling

Mr J, 37 years old male came to jail on charges of creating public nuisance and destroying property. Inside the prison, he was very restless and agitated and was brought to the prison psychiatrist . His first words to the doctor were, "Don't ask me anything, I want to end my life". Then the doctor sat him down and asked him what it was that made him feel there was no way out and that the only solution to his problem was suicide.

J said that he had been married for ten years and had a seven year old son. He loved his family but his wife was interested only in money. She constantly fought with him to get more money home. He secured the job of a hotel manager, but the owner paid him a much lower salary than promised. Mr. J, requested him to keep his promise and increase his salary to Rs 5000. An altercation ensued between them. The owner called the police and got J arrested.

Mr. J then started to cry and said that there was no point in living. The doctor allowed him to cry for some time. After a while, when he was more relaxed, the doctor asked him why he could not secure an alternate appointment. Mr J said that he had not explored other options and that he could definitely get better offers.

The doctor then asked him, "Do you think your life's value is only Rs 5000?" and "What will happen to your child if you die?" Mr J suddenly rose. He told the doctor that he has realised his mistake. He could earn better and take care of his child. He promised that he will never attempt suicide again. He told the doctor he felt much better after sharing his problems.

Deliberate self harm

Deliberate self harm refers to intentionally harming oneself without the intent or expectation of causing death. In contrast to the literature on completed suicides, there are very few studies which have assessed non-fatal deliberate self harm behaviours. But these non-fatal self harm behaviours can be seen on a continuum of severity, not as distinct problems. Moreover, significant proportion of people would have attempted previously before they become successful (Daniel 2006). In a recent National Prisoner Health Census from Australia (AIHW 2009), 18% reported a history of self harm.

Two out of every 100 prisoners report having made a suicidal attempt sometime during their life and more than seven per 100 have deliberately caused injury to themselves.

Undertrial prisoners are significantly more likely to have made a suicidal attempt or deliberate self harm during their life compared to CTP prisoners. Suicide risk severity on the MINI was assessed by the Mean Suicidality Score. A score of 1-8 indicates low suicide risk currently, 9-16 indicates moderate suicide risk and 17 or more indicates high suicide risk. Current mean suicidal risk among people who expressed any suicidal ideation was 11.5 and 10.6 for UTPs and CTPs respectively, indicating a moderate suicidal risk.

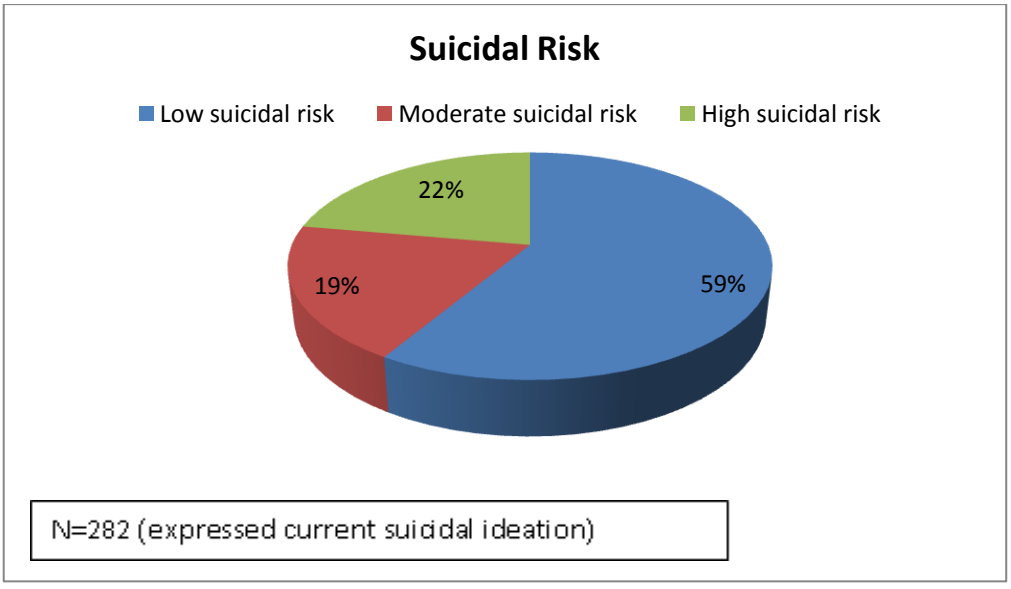
About 2 to 3 UT prisoners out of every 100 is at a risk of attempting self harm in prison. Of those who had made an attempt of deliberate self harm after coming to prison, 50% had also made an attempt prior to coming to the prison. Thus past attempt at self harm should be identified as a risk factor for repeated self harm. Among those who currently had suicidal ideation, 22% could be classified as high suicidal risk (=/>17 points), 19% could be classified as moderate suicidal risk (9-16 points) and 59% as low suicidal risk (1-8 points)

Table 24: Deliberate self harm (DSH) and suicidality

	UTP	CTP	Df/chi-square	P-value
Suicide attempt ever in life [n(%)]*	65(1.7)	13(1.1)	2.23	0.14
DSH-lifetime [n(%)]*	111(2.9)	18(1.5)	7.09	0.008
DSH before coming to prison [n(%)]*	85(2.2)	10(0.8)	9.43	0.002
DSH after coming to prison [n(%)]*	58(1.5)	10(0.8)	3.16	0.08
Mean suicidality-MINI score (SD)	11.5(13.7)	10.6(13.1)	280	0.6
Mean total number of DSH attempts(SD)	4.96(7.01)	2.62(1.96)	126	0.19
Mean number of DSH attempts before coming to prison(SD)	4.68(7.60)	2.50(1.34)	93	0.37
Mean number of DSH attempts after coming to prison(SD)	2.78(3.28)	1.60(0.84)	66	0.27

*Figures are for a minimum of one attempt

Figure 14: Assessment of suicidal risk among prisoners who expressed suicidal ideation



Risk factors for suicides in prisons:

(a) Presence of a severe mental disorder
(b) Past history of suicidal attempts
(c) 31-40 years of age
(d) Male gender
(e) Substance use
(f) Early period of imprisonment (Hill 2004)

Table 25 : Nature of suicidal/DSH attempts*

DSH attempt by	UTP [n(%)]	CTP [n(%)]	chi-square	P-value
Slashing face	30(27)	3(16.7)	0.87	0.35
Cutting neck	21(18.9)	2(8.7)	0.64	0.42
Cutting abdomen	31(27.9)	1(5.6)	4.16	0.04
Cutting hands	72(64.9)	10(12.2)	0.58	0.45
Cutting legs	5(4.5)	1(5.6)	0.39	0.84
Cutting multiple body parts	12(11)	0	2.19	0.14
Suicidal attempt by				
Consuming Organophosphorus poisoning (including Tik 20)	44(67.7)	6(46.2)	0.51	0.47
Consuming other insecticides	13(20)	1(7.7)	1.11	0.29
Consuming phenyl	3(4.6)	0	0.62	0.43
Consuming glass pieces	4(6.2)	1(7.7)	0.04	0.84
Consuming blade pieces	1(1.5)	1(7.7)	1.64	0.20
Consuming other articles	13(20)	1(7.7)	1.11	0.29

* total exceeds 100% because a single person had harmed more than one body part / had used more than one means.

The most common method of attempting suicide was consumption of organophosphorous compounds and other pesticides. Organophosphorous poisoning continues to be one of

the most common methods for attempting suicide among males in India (Saddichha et al 2010).

Completed Suicides in the Prison: This information was obtained from the secondary data maintained by the prison authorities. As mentioned earlier, 11% of the deaths recorded in 2008 were from suicide, mainly hanging.

Key components of a suicide prevention programme

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

- Training of all staff on suicide prevention strategies, followed by regular refresher courses focused on why prison settings are conducive to such behaviours, address staff attitudes, identify potential predisposing factors, high-risk periods and warning signs
- Intake screening for static (historical demographic) as well as dynamic (situational and personal) variables
- Post intake observation
- Management following screening
- Monitoring
- Communication (between prison staff, between staff and prisoners, between staff and mental health professionals
- Psychosocial interventions
- Mental health treatment
- Attention to the physical environment (to reduce specific risks)
- Attention to the general prison environment (levels of activity, safety, culture and staff-prisoner relationships)
- Responding to a suicidal attempt
- Responding to a completed suicide
- Responding to manipulative attempts
- Links to community-based mental health services

Source: WHO and IASP 2007

Neurotic disorders

Neurotic disorders (also called minor mental disorders) are characterised by increased emotional responses to life events due to decreased ability to cope with life changes. Unlike psychosis, neurotic individuals do not lose touch with reality and they are able to carry out routine activities of daily life. Though they do not pose problems to others, they themselves experience varying degrees of personal distress and suffering.

Main features of neurotic disorders are worries and mental tension. These people are not able to cope with life situations and are not able to overcome their tensions and worries. The tensions and worries tend to interfere with the sense of well-being and disturb normal functioning. Most of them have stress factors either precipitating or perpetuating the symptoms. The stress can be in the form of relationship disturbance, a family quarrel, occupational difficulty or a serious illness in a family member.

Adjustment Disorder

Mr. M was a student. He also worked in a xerox shop to maintain his family. His father came home intoxicated daily, and one day, in an intoxicated state, tried to molest his daughter who was in the 9th standard.

In a fit of anger, Mr. M, pushed his father to save his little sister. The father sustained a head injury and died. Mr. M was arrested and brought to jail for murdering his father. Inside the jail Mr. M became depressed, refused food and used to cry most of the time. He also attempted to commit suicide by hanging, but was rescued by a co-prisoner. He was referred to a psychiatrist. During the counselling session, he reported being very worried about his sister and mother. He was also very sad because there was nobody to take care of his family and to help him to apply for bail or hire a lawyer. Later, he was counselled and given antidepressants. He was helped with free legal aid and got bail within 8 months.

Independent surveys by Gunn et al. (1990; including sentenced prisoners) and Maden et al. (1995; 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.

Table 26: Prevalence of anxiety disorders in the Bangalore prison population

		UTP [n(%)]	CTP [n(%)]	Total	Chi-square	P-value
Panic disorder	Current	36(0.9)	11(0.9)	47(0.9)	0.004	0.95
	Lifetime	38(1)	13(1.1)	51(1)	0.8	0.78
Agoraphobia	Lifetime	12(0.3)	2(0.2)	14(0.3)	0.70	0.40
	Current	12(0.3)	0	12(0.2)	3.76	0.052
Social phobia	Current	24(0.6)	6(0.5)	30(0.6)	0.24	0.62
	Lifetime	79(2.1)	9(0.8)	88(1.8)	9.1	0.002
Obsessive compulsive disorder (current)		3(0.1)	0	3(0.1)	0.94	0.33
Post traumatic stress disorder (current)		13(0.3)	1(0.1)	14(0.3)	2.15	0.14
Generalized anxiety disorder (Current)		12(0.3)	4(0.3)	16(0.3)	0.01	0.91

Generalised anxiety, panic disorder and social phobia were the commonest anxiety spectrum disorders identified in this population.

In a study from Butler et al (2005), 36% of all prisoners screened had experienced an anxiety disorder in 12 months prior to the interview. The prevalence of anxiety disorder was similar in the reception and sentenced group (38% vs. 33%) and substantially higher among women than men (55% vs. 32%). Post traumatic stress disorder (PTSD) was the most common disorder, diagnosed in 26% of receptions and 21% of sentenced prisoners. Panic disorder, agoraphobia, obsessive-compulsive disorder, and social phobia were relatively rare in both the reception and sentenced groups. Women were more likely than men to suffer from anxiety disorder in their study.

Table 27: Bodily Preoccupation

		UTP [n(%)]	CTP [n(%)]	Total	Chi-square	P-value
Hypochondriasis (current)		2(0.1)	2(0.1)	4(0.1)	1.51	0.22
Body dysmorphic disorder (current)		35(0.9)	6(0.5)	41(0.8)	1.92	0.17
Somatization	Lifetime	77(2.0)	28(2.3)	105(2.1)	0.47	0.49
	Current	63(1.6)	23(1.9)	86(1.7)	0.41	0.52
Pain disorder(current)		205(5.4)	67(5.6)	272(5.4)	0.10	0.75

Excessive preoccupation with bodily symptoms was seen in a substantial number of both UTPs and CTPs, 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. A total of 6 patients (0.1%) were diagnosed as having a Tic disorder at the time of assessment (4 UTPs and 2 CTPs).

Mr S, a 25 year old male has no parents or relatives. He grew up in a market place along with other street children. They used to sleep in lodges paying 20 rupees per day. He learnt to threaten people and collect money. He started smoking beedis, taking sleeping tablets and solvents. He used to get arrested repeatedly and end up in jail. There, he learnt to smoke cannabis. He came to the doctor with depressive symptoms and treatment was started. While treatment was still on, he came with at least 30 DSH attempts by slashing his neck. He was repeatedly evaluated at the National Institute of Mental Health and Neurosciences (NIMHANS) and later was diagnosed to have antisocial personality disorder and poly substance dependence. With treatment he continued to be impulsive and did not stop DSH attempts. He threatened the treating team he would harm himself as well as the treating doctor if re-admitted.

To manage such patients, a high intensity monitoring unit was started in the prison hospital, where a separate room with an independent warder was set up. He improved in 4 months time with medicines and close monitoring. However, on asking him how he plans to lead the rest of his life, he says that he would continue to threaten people and make money.

Conduct disorder and antisocial personality

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. Similarly, nearly fifteen for every 100 UTPs received a diagnosis of antisocial personality disorder.

Table 28: Conduct disorder and antisocial personality disorder

	UTP [n(%)]	CTP [n(%)]	Total	Chi-square	P-value
Conduct disorder (childhood)	563(14.7)	90(7.5)	653(13)	41.71	<0.001
Antisocial personality disorder (ASPD)	571(14.9)	88(7.4)	659(13.1)	45.83	<0.001

Prisoners attempting deliberate self harm were thrice more likely to have a diagnosis of antisocial personality disorder (OR 3.2, 95% CI=2.2-4.8,p<0.000) and conduct disorder in childhood (OR 2.76, 95% CI=1.8-4.1).

Personality disorders comprise deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent either significant deviation from the way the average individual in a given culture perceives, thinks, feels, and relates to others. Such patterns tend to be stable and

Criteria for antisocial personality disorder:

(a) Callous unconcern for the feelings of others;

(b) Gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations;

(c) Incapacity to maintain enduring relationships, though having no difficulty in establishing them;

(d) Very low tolerance to frustration and a low threshold for discharge of aggression, including violence;

(e) Incapacity to experience guilt or to profit from experience, particularly punishment;

(f) Marked proneness to blame others, or to offer plausible rationalisations, for the behaviour that has brought the patient into conflict with society (WHO 1992)

encompass multiple domains of behaviour and psychological functioning. They are frequently associated with varying degrees of subjective distress and problems in social functioning and performance. Personality disorders tend to appear in late childhood or adolescence and continue into adulthood (WHO 1992).

ASPD is one of the personality disorders that has been extensively researched among prison samples. ASPD diagnosis varies anywhere between 25-75 % depending on the nature of the prison population and also based on the assessment instrument used. Higher prevalence has been noted in North America compared to European samples. Fazel & Danesh (2002) reported a prevalence rate of 47% among male prisoners and 21% prevalence among female prisoners. Our study showed a prevalence rate of 13 % [571(14.9%) among UTPs versus 88(7.4%) among CTPs; p<0.001] which is much less compared to the Western data. Prevalence of childhood conduct disorder was also 13% overall [563(14.7%) among UTPs versus 90(7.5%) among CTPs; p<0.001]. This diagnosis was more prevalent among males 654(13.6%) than 5(2.5%) among females.

Bipolar Affective Episodes

This refers to alternating episodes of depression with mania or hypomania (characterised by an irritable or elated mood, overactivity, decreased need for sleep and expansive or grandiose thoughts). Based on the interview, a small number of patients could be diagnosed as having a lifetime diagnosis of mania.

Table 29: Bipolar Affective episodes (Mania and hypomania)

		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
	past	4(0.1)	2(0.2)	6(0.1)	0.30	0.58
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
	past	3(0.1)	0	3(0.1)	0.94	0.33

Schizophrenia and other psychotic disorders

Schizophrenia and related psychotic disorders closely correspond to the layman's concept of 'madness'. These disorders usually have their onset in the age group of 15-25 years. The most basic functions that gives the normal person a feeling of individuality, uniqueness, and self-direction are disturbed in these conditions. The most intimate thoughts, feelings and acts are often felt to be known to or shared by others. They are characterised by abnormalities of thinking, perceptions and emotions resulting in abnormal behaviour, action or speech. Persons with schizophrenia may possess abnormal ideas and thoughts of various kinds, which are unshakeable. They perceive things that do not exist in reality (e.g. they may hear voices). They may misinterpret the environment and give special meaning to normal events. They may be inappropriately happy, sad or apathetic and unconcerned. They may talk either too much or too little. They are found laughing or talking to self. They can become withdrawn from their immediate surroundings, may become suddenly hostile, abusive or assaultive. Such disorders interfere with an individual's personal and social functioning and if untreated, run a chronic course.

Both genetic and environmental factors are important in the etiology of schizophrenia. Factors like family relationships, socio-cultural issues and severe psychological stresses all contribute to schizophrenia. These factors operate in different combinations and degrees to predispose, precipitate or perpetuate the illness (Murthy et al. 2005). The prevalence of these illnesses is roughly around 5 per 1000 population at any given point in time. These illnesses occur all across the world in all cultures at approximately the same rates.

Schizophrenia and related psychotic disorders are generally found in a higher proportion in prison compared to that in the general population. Prevalence rates are highest in the age group of 25-44 years followed by the age group of 18-24 years. Rates vary between two and four percent. Fazel and Danesh's large review (2002) reported a rate of 3.7% for the psychotic illnesses. In the UK study of new remand prisoners (Birmingham et al 1996), schizophrenia and other psychotic disorders were present in 4% and, affective psychosis in 1% of prisoners screened. In a study from Australia, 3% of 189 inmates

evaluated, received a current diagnosis of psychotic disorder while 6% had a lifetime diagnosis (Herrman et al 1991).

ICD-10 diagnostic guidelines for schizophrenia

(a) thought echo, thought insertion or withdrawal, and thought broadcasting;
(b) delusions of control, influence, or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception;
(c) hallucinatory voices giving a running commentary on the patient's behaviour, or discussing the patient among themselves, or other types of hallucinatory voices coming from some part of the body;
(d) persistent delusions of other kinds that are culturally inappropriate and completely impossible, such as religious or political identity, or superhuman powers and abilities (e.g. being able to control the weather, or being in communication with aliens from another world);
(e) persistent hallucinations in any modality, when accompanied either by fleeting or half-formed delusions without clear affective content, or by persistent over-valued ideas, or when occurring every day for weeks or months on end;
(f) breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech, or neologisms;
(g) catatonic behaviour, such as excitement, posturing, or waxy flexibility, negativism, mutism, and stupor;
(h) "negative" symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses, usually resulting in social withdrawal and lowering of social performance; it must be clear that these are not due to depression or to neuroleptic medication;
(i) a significant and consistent change in the overall quality of some aspects of personal behaviour, manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude, and social withdrawal.

In the UK, Gunn et al's (1991) study of 16 prisons for adult males and 9 institutions for young male offenders found that 2% had psychosis including affective and paranoid psychosis. Higher rates have been found in the United States. In the US BJS survey (James et al. 2006) **s**ymptoms of psychotic disorder were present among 20% of the State

prison inmates, 12.6% of the Federal prison inmates and among 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.

At the Central Prison Bangalore, on the MINI interview, there was very low reporting for symptoms of 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 indicates that a total of 112 cases (2.2%) who had a diagnosis of psychosis, primarily schizophrenia. A substantial number of psychotic disorders are substance induced (16.9%).

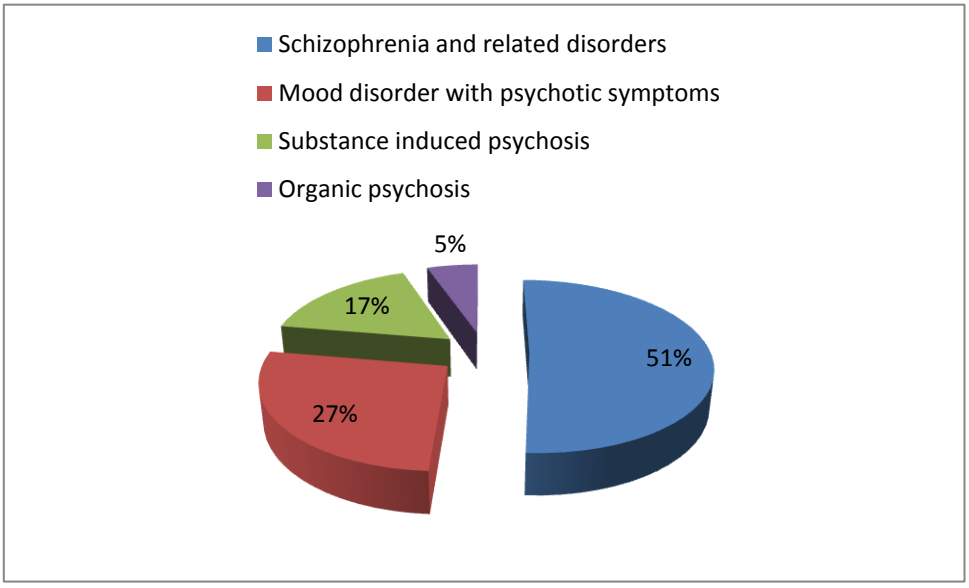
Table 30: Diagnosed psychotic disorders

Sl No	Type of Psychosis	Number (%)
1.	Schizophrenia and related disorders	57 (50.9)
2.	Mood disorder with psychotic features	30 (26.8)
3.	Substance induced psychosis	19 (16.9)
4.	Organic psychosis	6 (5.4)
	Total	112

The breakup of psychotic disorders are also presented diagrammatically in the accompanying figure. To reiterate, among psychotic disorders, schizophrenia is the commonest diagnosis. In an earlier study carried out at NIMHANS, the commonest diagnosis of all prison referrals to the inpatient forensic services across several decades was schizophrenia (Murthy et al 1996).

In summary, the lower rate of psychotic disorders among the prison population in India is striking. There may be several explanations for this. Self report has certainly been very low, and even patients with a known history of psychiatric illness have not reported symptoms, presumably as they are presently on treatment and asymptomatic.

Figure 15: Categories of psychotic disorders



Nevertheless, the findings also suggest the possibility of a weaker relationship between psychotic illness and crime in our context, possibly because a large number of persons with psychotic illness live with their families and not on the street and are thus not pushed into crime.

6. Prison and substance abuse

World over, it is well known that prison populations have high levels of drug use. In the European Union [European Monitoring Centre for Drugs and Drug Addiction or ECDDA 2004], 22% to 86% of prison populations in EU countries reported ever having used an illicit drug. Cannabis was the most frequently reported illicit drug, with lifetime prevalence rates among inmates of 11–86%. Prisoners' lifetime prevalence of cocaine (and crack) use was 5–57% and heroin 5–66%. 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%.

Drugs and Violence in prison settings

Mr. X, a 38year old, was brought to the prison hospital for killing his co-prisoner. Upon questioning him patiently, he reported that his co-prisoner was demanding excessive money for providing cannabis. They had an altercation over this issue for two days. Mr. X's repeated request for cannabis was not honoured by his co-prisoner. Mr.X decided to teach him a lesson, so he smashed his co-prisoner's head with a stone when he was asleep. The co-prisoner died immediately because of the severe head injury.

In a prison in Nigeria (William et al 2005), lifetime use for any substance was 85.5%, highest for alcohol at 77.5%. Current drug use prevalence was 27.7% with nicotine being the highest (22.9%). Prevalence of dependence on any substance was 12.5%. Another study in Lithuanian prisons (Narkauskaitė et al 2007) showed that 48.7% of prisoners had ever used drugs, 92.1% had drunk alcohol at least once in their lives, 13.8% currently used narcotic drugs, and 39.8% had first used illicit drugs in prison, and 85.3% currently smoked tobacco.

Although few studies have been made on the prevalence of tobacco use in penal facilities, American data suggests that the majority of inmates smoke [Bobak et al 2000]. In the European Union, it is estimated that 16-54% of inmates use drugs in prisons and 5-36% use them regularly (ECDDA 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 (NR 2001).

Bangalore Prison –Use of tobacco

Any use of tobacco (smoking or chewing) was reported by 3229 of the 5024 respondents (67.3%).

Table 31: Ever and current use of tobacco in any form

	UTP [n(%)]	CTP [n(%)]	Total	Chi-square	P-value
Ever used any form of tobacco					
Ever smoked tobacco	2403 (63.0)	614 (51.4)	3017 (60.2)	50.7	0.000
Ever chewed tobacco (smokeless)	633 (16.6)	129 (10.8)	724 (14.4)	23.6	0.000
Ever consumed alcohol	2046 (53.6)	535 (44.8)	2581 (51.5)	28.3	0.000
Ever used any other drug	527 (13.8)	125 (10.5)	652 (13)	8.9	0.001

A majority of tobacco users reported ever smoking tobacco (60.2%) in their lives, and among those who reported a lifetime use of tobacco, 97% had smoked tobacco in the year prior to imprisonment. Fourteen percent reported ever having chewed tobacco and 97% of this group had used smokeless tobacco in the year prior to imprisonment.

Undertrials had started smoking at a significantly lower age. However, convicts reported a longer duration of smoking and more frequent smoking. Chewing patterns were more or less comparable across the two groups, although convicts reported chewing for a significantly longer period compared to UTPs.

Prevalence figures for tobacco use in Karnataka (ICMR and WHO SEARO 2001) show that 29.6% of the adult population and 42.8% of the male population used tobacco. The fact that 67.3% of the prison population consumes tobacco indicates much higher levels of tobacco consumption compared to the general population.

Table 32: Comparison of tobacco use between UTPs and CTPs

LIFESTYLE QUESTIONAIRE	(UTP /CTP) (n)	Mean	Std	t	df	sig
At what age did you first smoke?	U(2399)	18.3	9.9	4.6	3009	0.0
	C(612)	20.4	9.5			
How many did you usually smoke in a day?	U(2368)	9.2	11.1	4.2	2967	0.0
	C(601)	11.4	9.8			
For how many years did you smoke the above numbers?	U(2363)	6.6	9.8	5.3	2961	0.0
	C(600)	9.8	22.8			
In the last one week how many cigarettes / beedis have you Smoked per day?	U(2379)	34.3	69.3	3.3	2981	0.001
	C(604)	44.9	76.0			
At what age did you first chew?	U(626)	19.0	7.0	1.5	751	0.117
	C(127)	20.2	7.9			
How many did you usually chew in a day? (packets or pottanas)?	U(615)	8.3	14.8	3.3	738	0.739
	C(125)	8.7	12.6			
For how many years did you chew the above number?	U(612)	5.1	7.9	2.9	732	0.003
	C(124)	7.5	8.9			
In the last one week how many packets or pottanas have you chewed per day?	U(623)	20.9	93.5	1.19	745	0.234
	C(124)	10.8	29.3			
How many times have you tried to give up chewing in the past? (If never tried, say never tried)	U(559)	0.9	1.3	1.62	673	0.104
	C(116)	1.2	1.7			

Change in tobacco smoking after prison entry

Smoking among UTPs has increased four times following 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. Convicted prisoners **had increased their smoking** from 11.4 sticks to 44.9 sticks.

Figure 16: Change in frequency of smoking following prison entry

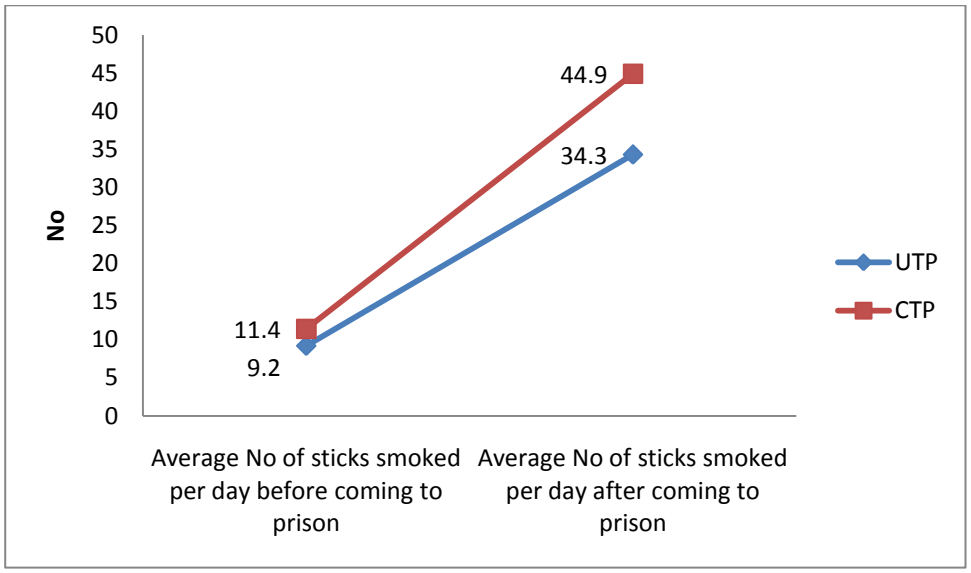
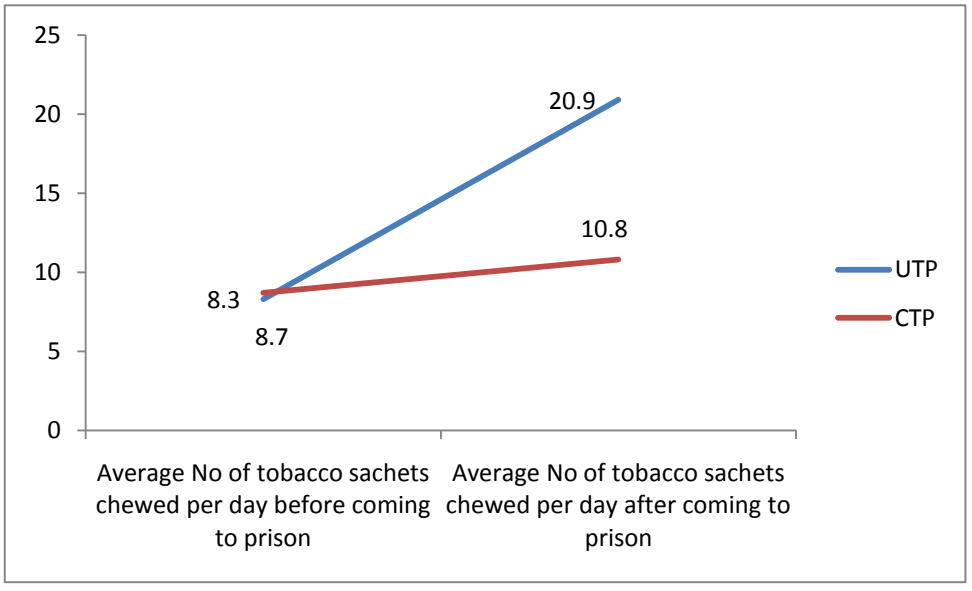


Figure 17: Change in frequency of chewing tobacco use following prison entry



Change in chewing tobacco use after prison entry

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.

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. Such high use of tobacco suggests a dependent pattern of use. The increase in tobacco use after coming into prison is startling and is a source of very serious concern, both from the point of direct health damage from tobacco and the inter-relationship between tobacco and diseases like tuberculosis, which have been shown to have a higher prevalence in prison populations. The striking relationship between smoking, tuberculosis and mortality has been unequivocally demonstrated in community populations.

Use of Alcohol

2717 (52.4%) reported alcohol use in the year prior to imprisonment. This is more than double the rates of alcohol use reported among males (21.4%) in the National Household Survey of Drug Use (Srivastava et al 2002).

Frequency of alcohol use in the year prior to prison entry

Nearly one in five persons (18.9%) with a history of alcohol reported consuming alcohol four or more times per week. Nearly a third (31.4%) reported drinking more than 3-4 drinks on a typical drinking day and more than a third reported drinking more than six drinks on one occasion. Forty three percent said their drinking had been criticised by a family member, friend or other person.

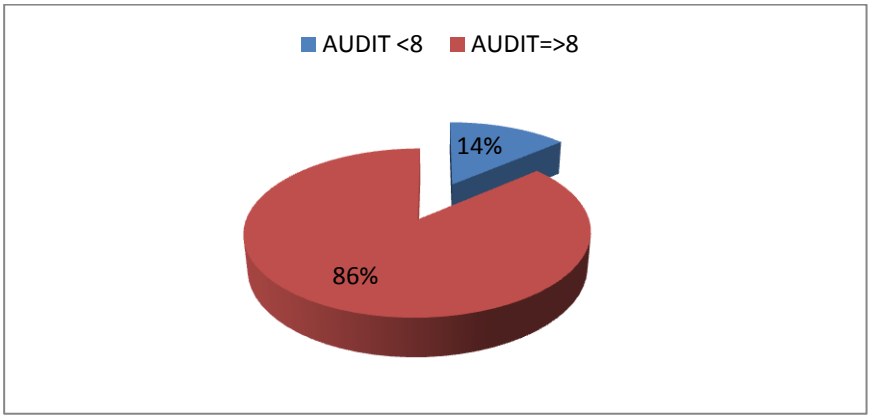
Table 33: AUDIT questionnaire on alcohol use in the year prior to prison entry

AUDIT QUESTIONS	Never n (%)	Monthly/less n(%)	2 or 4 times a month n(%)	2 or 3 times a week n(%)	4 or more times a week n(%)
How often did you have a drink contacting Alcohol?	2297(47.6)	222(4.6)	567(11.8)	824(17.1)	912(18.9)
How many drinks contacting Alcohol did you have on a typical day when you were drinking?	**1 or 2**	**3 or 4**	**5 or 6**	**7 or 9**	**Daily or almost daily**
	3308(68.6)	871(18.1)	185(3.8)	79(1.6)	379(7.9)
How often did you have six or more drinks on one occasion?	**NEVER**	**Less than monthly**	**Monthly**	**Weekly**	**Daily / almost daily**
	3156(65.5)	442(9.2)	432(9.0)	474(9.8)	318(6.6)
How often during that year did you find that you were not able to stop drinking once you had started	**NEVER**	**Less than monthly**	**Monthly**	**Weekly**	**Daily / almost daily**
	3171(65.8)	601(12.5)	350(7.3)	393(8.2)	307(6.4)
How often during that year did you fail to do what was normally expected of you because of drinking?	**NEVER**	**Less than monthly**	**Monthly**	**Weekly**	**Daily / almost daily**
	3265(67.7)	496(10.3)	402(8.3)	444(9.2)	215(4.5)
How often during that year did you need a first drink in the morning to get yourself going after a heavy drinking session?	**NEVER**	**Less than monthly**	**Monthly**	**Weekly**	**Daily / almost daily**
	3741(77.6)	393(8.2)	183(3.8)	317(6.6)	188(3.9)
How often during that year did you have a feeling of guilt or remorse after drinking?	**NEVER**	**Less than monthly**	**Monthly**	**Weekly**	**Daily / almost daily**
	2956(61.3)	381(7.9)	717(14.9)	446(9.2)	322(6.7)
How often during that year were you unable to remember what happened the night before because you had been drinking?	**NEVER**	**Less than monthly**	**Monthly**	**Weekly**	**Daily / almost daily**
	3218(66.7)	285(5.9)	553(11.5)	526(10.9)	240(5.0)
Did you or was someone else injured as a result of your drinking?	**No**	**Yes, but not in that year**	**Yes, during that year**		
	3408(70.7)	655(13.6)	759(15.7)		
Was a relative or a friend or a doctor or other health worker concerned about your drinking or suggested you cut down?	**No**	**Yes, but not in that year**	**Yes, during that year**		
	2745(56.9)	1002(20.8)	1075(22.3)		

Harmful drinking

In those who reported drinking, 86% had AUDIT scores above 8, indicating harmful drinking patterns. Mean AUDIT scores among both UTPs and CTPs was comparable at 17.0 indicating harmful patterns of alcohol consumption in both groups.

Figure 18: Harmful use of alcohol in the year prior to imprisonment (n=2461)



Age at initiation and recent use

UTPs had a significantly lower age at initiation of alcohol and more frequent recent alcohol use.

Table 34: Age of initiation and current alcohol use

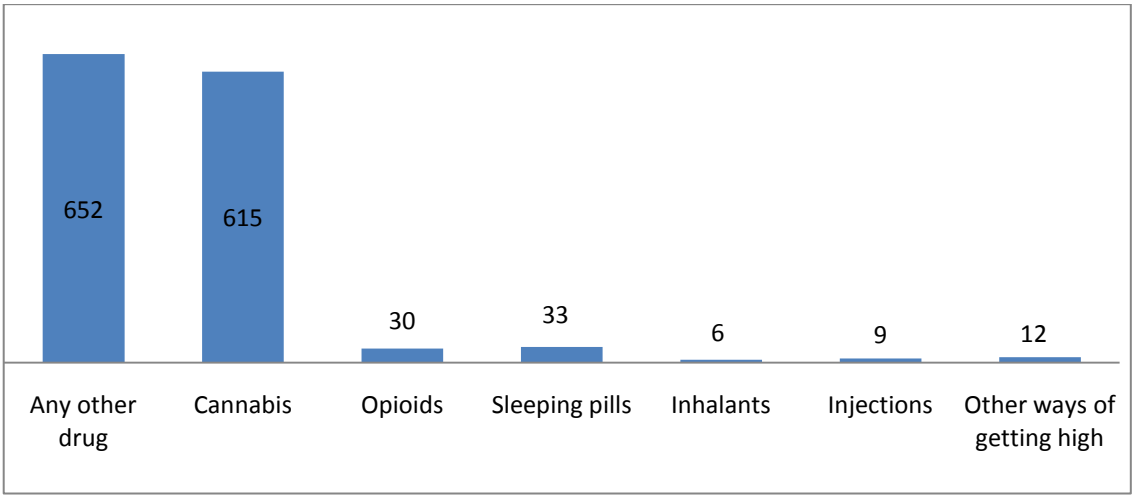
LIFESTYLE QUESTIONAIRE	(UTP /CTP) (n)	Mean	Std	t	df	sig
At what age did you first have a drink containing alcohol?	**U**(2030)	19.4	4.7	8.39	2561	0.00
	C(533)	21.4	5.6			
In the last one week, on how many days have you had a drink containing alcohol?	**U**(457)	0.8	1.6	2.47	609	0.014
	C(154)	0.5	1.2			

Undertrial prisoners were significantly more likely to have ever used smoking or chewing tobacco, ever consumed alcohol or any other drug in their lifetime.

Use of other drugs

Six hundred and fifty two (13%) of prisoners self reported ever use of any other drug apart from alcohol and tobacco. Of them, 98.7% reported use in the year prior to imprisonment.

Figure 19: Self report of ever (lifetime) use of any other drug (n)



Among those who reported prior drug use, the most commonly used drug was 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 Report of substance use by new entrants

New entrants into the prison were asked self report of their ever use of tobacco, alcohol and other drug use in the last month prior to entry into the prison. Nearly three-fourths (74.3%) reported ever use of tobacco and 71.9% had used tobacco in the previous month. Lifetime alcohol use was reported by 58% and use of alcohol in the last month reported

by 51.9%. None of the new entrants self-reported either lifetime or current use of amphetamines or barbiturates. Only one person (0.3%) each reported use of benzodiazepines and cocaine during the last month, 3 (1%) reported opioid use and 14 (4.9%) reported cannabis use.

Table 35: Tobacco and Alcohol self- report by new entrants

	Lifetime use N (%)	Current use (last month) n (%)
Tobacco	214 (74.3)	207 (71.9)
Alcohol	167 (58)	147 (51.9)

Manifestation of substance intoxication as mental illness

One afternoon, a prison staff brought a convict prisoner Mr.X, to the prison hospital. Mr X was reported to be shouting, jumping, talking irrelevantly, throwing articles, assaulting other prison inmates and destroying prison property. Prison staff recognised that he had some sort of mental illness and brought him to the hospital. Examination by the psychiatrist in the prison revealed that the Mr. X, was irritable, shouting, behaving in an authoritative manner and he was uncooperative for a formal examination. He even tried to assault the prison staff. He needed sedation with injections that day.

The next day he was absolutely alright and behaved normally. On interview with the psychiatrist, he revealed that he had smoked cannabis and also taken 'Nitravet' tablets (sleeping medications) inside the prison barrack. A few minutes after consumption, he did not know what happened. He was very embarrassed after knowing how he behaved the previous day. He repented and felt guilty. He also disclosed the fact that his first wife left him because of his drug taking behaviour and irresponsibility at home.

Following this, he was living with his second wife and had a 2 year old child. He used to indulge in robbery to maintain his drug taking behaviour. He was caught and ended up in prison. With counselling and medical treatment, he asserted that he would be sober in future.

Substance dependence

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 Ps than convicted prisoners. During the last year, 15.7% of UTPs met criteria for alcohol dependence. This is more than 3 times the prevalence of dependence in the general population (Srivastava et al., 2002).

Table 36: Substance dependence

MINI Variables for Substance use disorders	Total n (%)	UTP n (%)	CTP n(%)	Chi-square	P-value
Life time dependence on any substance	2259 (45.0)	1830(47.9)	429(35.9)	78.5	0.000
Life time Alcohol dependence syndrome	2173(43.5)	1696(44.6)	477(40.0)	7.7	0.006
Alcohol dependence currently	703 (14%)	599(15.7)	104(8.7)	36.7	0.000
Life time dependence on Cannabis	322 (6.4)	276(7.2)	46(3.8)	32.0	0.000
Life time dependence on Benzodiazepines	26 (0.5)	24(0.6)	2(0.2)	7.3	0.006

Report of recent tobacco use and CO monitoring

Of the male prisoners who underwent random sample testing for breath carbon monoxide (n=169), 42.6% had levels above 7 ppm. One in five of those tested had high levels of CO in their breath. 2824 respondents (58.5%) of male prisoners self-reported smoking in the last week. A substantial number of these could be confirmed on the random CO breath analysis. One hundred eighty (3.7%) of the resident prisoners reported alcohol use during the last week. On breath analysis of 169 male prisoners randomly screened, none was positive for breath alcohol. Thus, confidential self-reporting has helped to identify recent smoking and alcohol use. However, prisoners may not self report such use to prison authorities if there is fear of punitive action.

Table 37:Carbon Monoxide breath analysis

Carbon Monoxide breath analysis test in male prisoners	Total n(%)
1+ve (0-6 ppm)	97(57.4)
2+ve (7-11 ppm)	38(22.5)
3+ve (11+)	34(20.1)
	169(100)

Table 38:Alcohol breath analysis

Alcohol breath analysis test in male prisoners	Total n(%)
Absent	169(100)

Urine Drug Screening in Prison

As mentioned earlier, two sets of urine screening were carried out. The first was carried out as an anonymous urine screening among a random group of residential prisoners. A second screening was carried out among new entrants into the prison, and in this group, self report was also available.

Of the 721 urine samples tested among resident prisoners, 442 (61.3%) were positive for one or the other drug. Nearly one third (31%) of the samples tested positive for cannabis, 43% for benzodiazepines, 15% for cocaine, 9% for barbiturates, 6% for amphetamines and 3% for opioids. 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.

Figure 20: Positives for random anonymous urine drug screening (n=721)

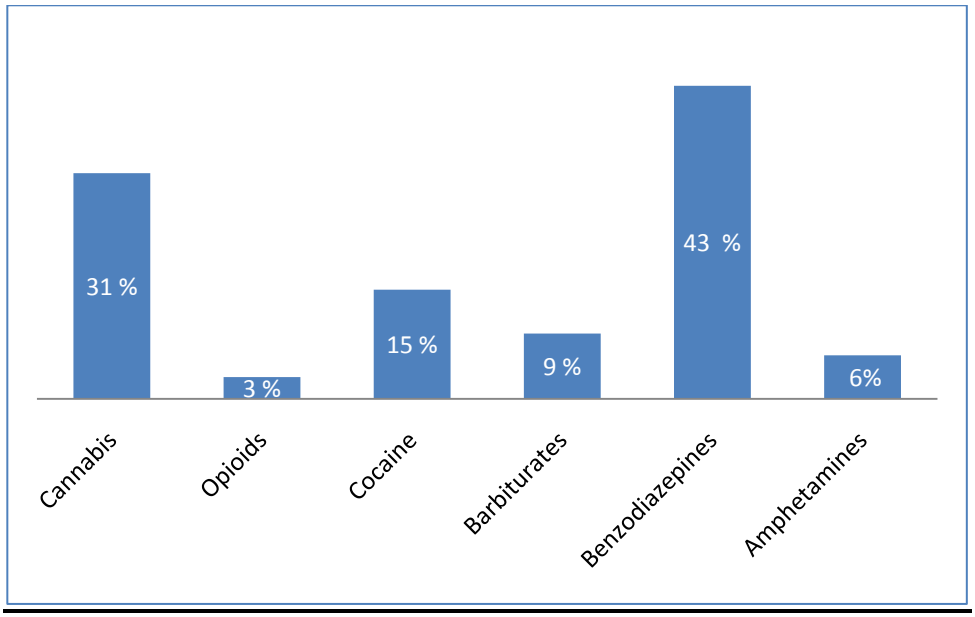


Table 39: Detection on random urine drug screening: comparison between UTP/CTP population (N= 721)

Sl.no	Drug detected in urine sample	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

Table 40: Single versus polysubstance detection on random urine screening among resident prisoners

Number of drugs detected on urine testing	FREQUENCY		Total n(%)
	UTP n= 406	CTP n=315	
No drug	127 (31.3%)	152 (48.3%)	279 (38.7)
Single drug	104 (25.6%)	111 (35.2%)	215 (29.8)
Two drugs	114 (28.1%)	38 (12.1%)	152 (21.1)
Three drugs	37 (9.1%)	12 (3.8%)	49 (6.8)
Four drugs	19 (4.7%)	2 (0.6%)	21 (2.9)
Five drugs	5 (1.2)	0 (0.0)	5 (0.7)
Total	406 (100%)	315 (100%)	721 (100%)

Nearly a third who tested positive (227/721, 31.5%) on the urine screen had two or more drugs detectable in the urine samples and were thus polydrug users. A significantly higher percentage of UTPs (43.1%) was likely to be using two or more drugs compared to CTPs(16.5%).

Enhanced identification of drug use through urine testing

While only 79(1.5%) of the resident population had reported weekly or more frequent drug use while in prison, 61.3 % tested positive on urine screening.

Urine testing made the detection of drug use more than forty times likely than on self-report.

A comparison of self-report of drug use and urine screening for new entrants

New entrants also provided a urine sample which was tested for drugs of abuse. A total of 325 new entrants into prison were screened. The urine testing was carried out within 2 days of entry into prison. In the case of new entrants, self report of current drug use was compared with the urine drug screen. A major limitation was that the time of last drug use

was not documented. Nevertheless, it is striking that a substantial number (146, 44.9%) tested positive for one or more drug. Among those who tested positive, benzodiazepines were the commonest drugs detected (28.3%), followed by cocaine (17%) and cannabis (13.2%).

Fig 21: Comparison of self report of drug use and urine screening

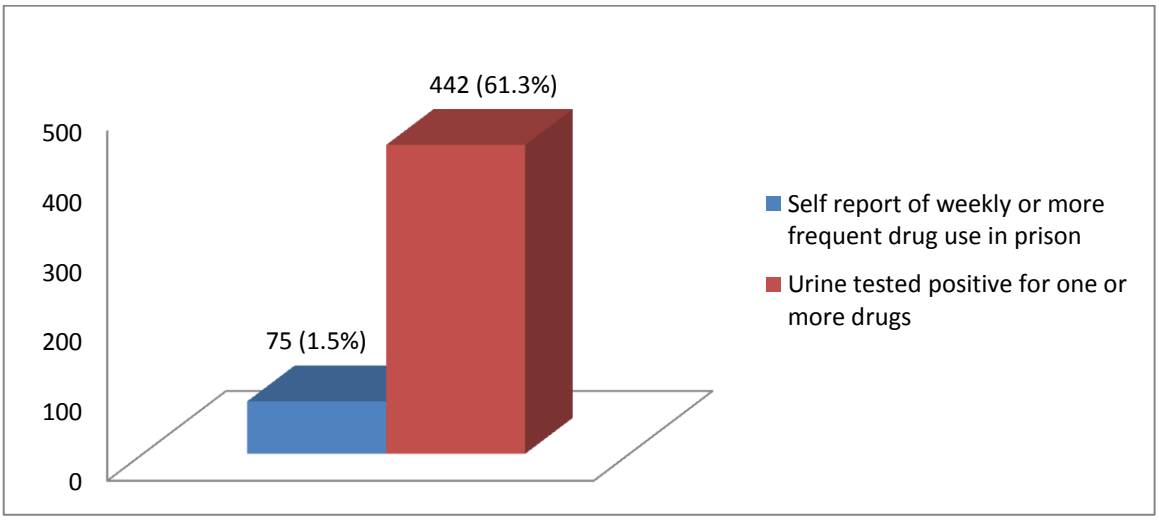


Table 41: Urine testing for drugs among new entrants (N= 325)

Substance	Self Report of current use (last month) N(%)	No of cases testing positive	% of cases
Amphetamine	0	14	4.3
Barbiturates	0	5	1.5
Benzodiazepines	1 (0.3)	92	28.3
Cocaine	1 (0.3)	49	17.0
Opioids	3 (1)	4	1.2
Cannabis	14 (4.9)	43	13.2

Mean days of test after admission = 2

One third of the new entrants who tested positive (n=146) were likely to be using two or more drugs.

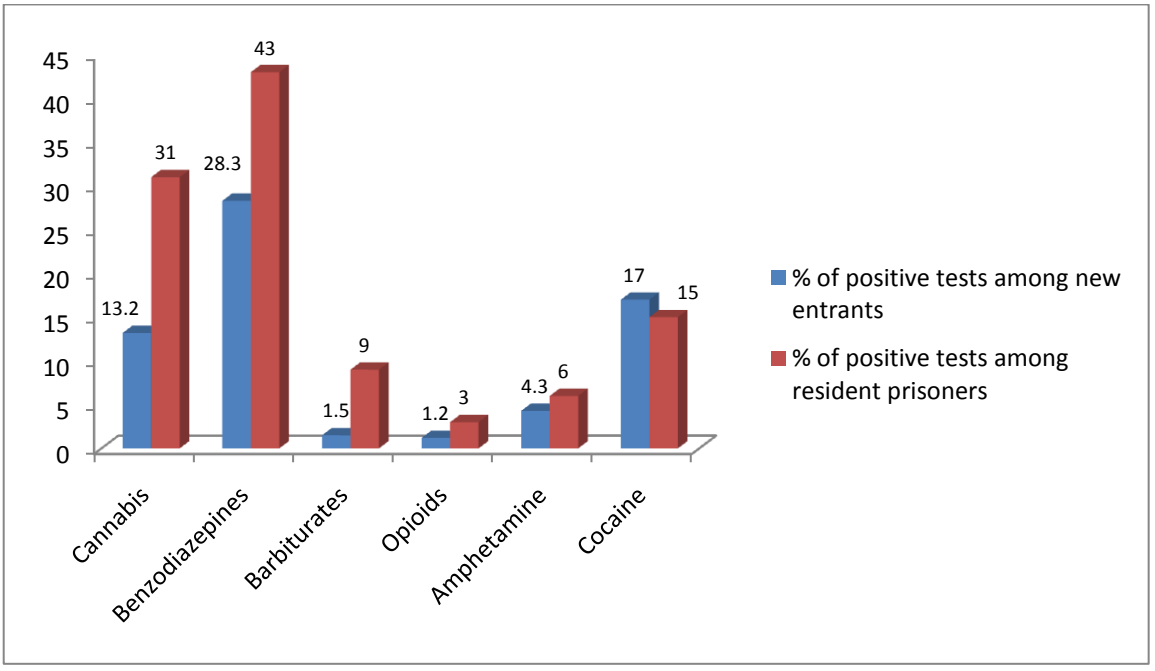
Table 42: Single and multiple drug use among new entrants (N=325)

SL no	Number of drugs detected	Frequency	Percentage (of those testing positive)
1	Single drug	98	67.1
2	Two drugs	35	24.0
3	Three drugs	11	7.5
4	Four drugs	2	1.4
	Total	146	100

Increase drug use after prison entry

Just as in the case of tobacco use, there is a definite increase in drug use after prison entry as reflected in the different rates of drug detection on urine screening between resident prisoners and new entrants.

Figure 22: Comparison of positive urine drug screens between resident prisoners and new entrants



Thus use of cannabis after prison entry has 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 after prison entry, which can be attributed to its cost.

Gambling

About one in 10 prisoners (11%) had 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.

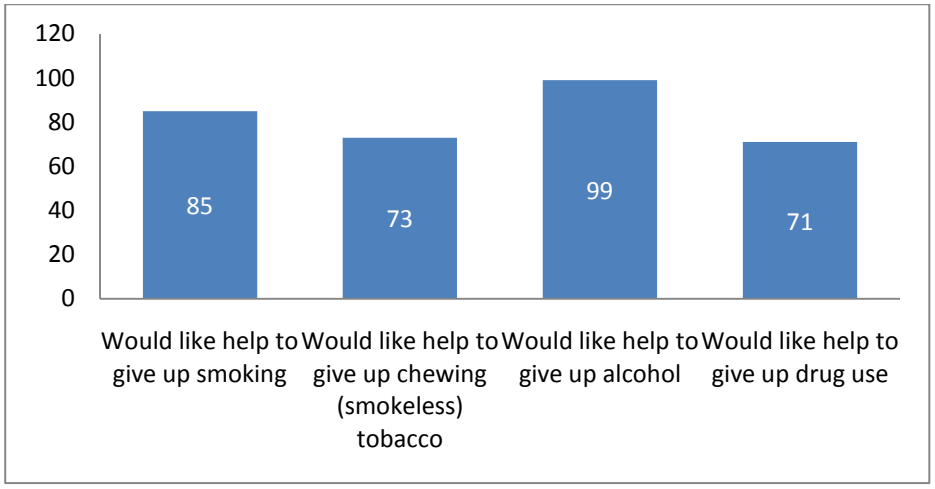
Table 43: Gambling

	Total	UTP [n(%)]	CTP [n(%)]	Chi-square	P-value
Ever any form of gambling	559 (11.1)	442 (11.5)	117 (9.8)	2.9	0.09
Ever played cards for stakes	367 (7.3)	293 (7.7)	74 (6.2)	2.9	0.048
Ever went to the races more than once or twice	36 (0.7)	30 (0.8)	6 (0.5)	1.03	0.2
Ever bought lottery tickets more than once or twice	50 (1)	39 (1.0)	11(0.9)	0.09	0.46
Ever bought online lotteries more than once or twice	47 (0.9)	38 (1.0)	9 (0.8)	0.57	0.29
Involved in any other form of betting	300 (5.6)	240 (6.3)	60 (5.0)	2.6	0.06

Perception of the need for help among prisoners who reported substance use

A majority of those who used tobacco, alcohol or other drugs expressed the need for help to give up use in the future. Sadly, such help is not provided to prisoners on a routine basis. Prisoners are not even assessed upon entry into the prison for substance use and its related problems (intoxication, dependence, withdrawal).

Figure 23: Percentage of substance users who would like help to give up use in the Future



(percentages represent valid percentages among users)

While it is abundantly clear that substance abuse is overrepresented in prison populations, such use may be present prior to prison entry, or begin or intensify in prison (change from less harmful to more harmful substances). The United Nations General Assembly Special Session on the World Drug Problems in 1998 explicitly identified prisoners as an important group for activities to reduce drug demand (United Nations, 1998).

WHO Health in Prisons Project (2003) 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. WHO Health in Prisons Project proposes that in public health relating to prisons, harm reduction describes a concept aiming to prevent or reduce negative health effects associated with certain types of behaviour (such as drug injecting) and with imprisonment and overcrowding as well as adverse effects on mental health.

Prison administrations have a responsibility to guard against (a) creating new problems and (b) exacerbating problems that already exist. Screening for drug and alcohol

problems to identify immediate needs for medical treatment upon arrival in prison is clearly an important component of service delivery.

Drugs, crime and HIV – intimate relationships

Mr. K, a 38 year old was in prison for the fifth time. He has several cases against him - a few for murder and 307 cases of robbery. In the past 19 years he has spent almost 10 years in jail.

He was born in a village near Bangalore. He has an elder sister and an elder brother. His father is a farmer and mother is a house wife. He stopped his studies at 8th standard and started working to support his family. At the age of 22 years he fell in love with a neighbour. He left his village and came to Bangalore to work. After six months he came to know that his girl friend was forced to marry someone else.

He was extremely depressed and started smoking cigarettes, beedies and drinking alcohol. He had financial problems, and to resolve them, began involvement in illegal activities such as threatening people, collecting money, theft and robbery. He used this money for alcohol and others indulgences.

One day he assaulted a stranger to extort money. The stranger collapsed and died. He came to prison for the first time. In prison, he made friends with big rowdies and underworld dons. He was also introduced to various new substances including hashish, ganja, brown sugar and sleeping tablets.

Upon acquittal, he continued using hashish, ganja, brown sugar, cannabis and under the influence, began visiting call girls and indulging in unprotected sexual activity.

Gradually, he became weak, used to get fever frequently. He went to the doctor and after following a blood test, realised he was suffering from HIV.

Even today his parents do not know that he is in prisons. They think that he is in a very good job and earning good money. Whenever he calls them they tell him that they want to see his marriage before they die. He says he feels hopeless at times.

"In future, I want to do some social service if this society allows me. Otherwise, if my opposite gang attacks me, I have no other go but to continue as a criminal and I really do not know how things will be in future" is what he has to say.

Remand prisoners (Undertrials) are in particular need of help with detoxification, assessment, advice on harm reduction, screening for hepatitis and other diseases and referral to substance use treatment in prison or in the community upon release (Brooke et al 1998). In their study, 23% of drug users requested treatment. In ours, a majority requested help. This difference can be explained by the fact that while the treatment available in our community for substance use disorders is limited and not many people are aware of the treatment options.

Meeting Mental Health Needs of Prisoners – Systemic successes and limitation

Need to network with families

Mr. Z, a 45 year old unmarried male from Bangalore had Paranoid Schizophrenia since fifteen years and was on irregular treatment from NIMHANS. Recently, he had stopped medicine and had a relapse of symptoms. He was refusing to take medicine and stopped follow-up at NIMHANS. He was physically abusive to his mother and sister because of his illness. His family members unsuccessfully tried to bring him to the hospital.

His family approached the nearest police station but could not get any help. They approached NIMHANS for help. A certificate was issued to get a reception under the Mental Health Act 1987. The family members approached the court with this certificate. The court, however, declined to issue a reception order. After two weeks, Mr.Z became extremely violent and assaulted his mother and sister. His mother sustained multiple fractures of her limbs. His sister had multiple bruises over her body. Family members had to give police complaint for his assaultive behaviour. He was charged with grievous injury and was sent to prison.

In prison, Mr. Z, was behaving abnormally, hence he was referred to prison psychiatrist. During the examination, he reported that he was under treatment from NIMHANS earlier. Hence, he was referred to NIMHANS for treatment, where he was admitted and treated in for four weeks. He improved completely, hence he was sent back to prison. He continued maintenance treatment in prison. He felt sorry for having stopped medicine and assaulting his family members.

His family members were reluctant to get him bail or even to hire a lawyer as they were afraid of him. His family members were assured by the NIMHANS treating team and prison psychiatrist that he was doing well and on regular medication. Finally, his family members agreed to bail him out. Court granted him bail. He was imprisoned for nine months for his illness related behaviour.

7. Needs of Prisoners

We asked all resident prisoners about their needs in various aspects of their prison stay and their own satisfaction with the meeting of these needs. These included the frequency of contact with their family members, the way they were treated by the staff and co-prisoners, the general upkeep of their living areas, the quantity and quality of food and other areas likely to impact their mental health. They were also asked about their satisfaction regarding avenues for entertainment and exercise. Other important areas of need assessment were access to health care as well as access to legal aid. This section discusses the various needs expressed by the prisoners. The special needs of women prisoners are discussed in a subsequent chapter.

Contact with family

A majority (74%) of convict and undertrial prisoners received personal visits from their families.

Personal visits from family

About one in four UTPs (26%) and CTPs (27%) had no contact with their families. Among those in contact, 38% of UTPs and 31% of CTPs received at least weekly or fortnightly personal visits from their families. Visits were monthly or less frequent among 36% UTPs and 40% CTPs.

Telephone contact with family

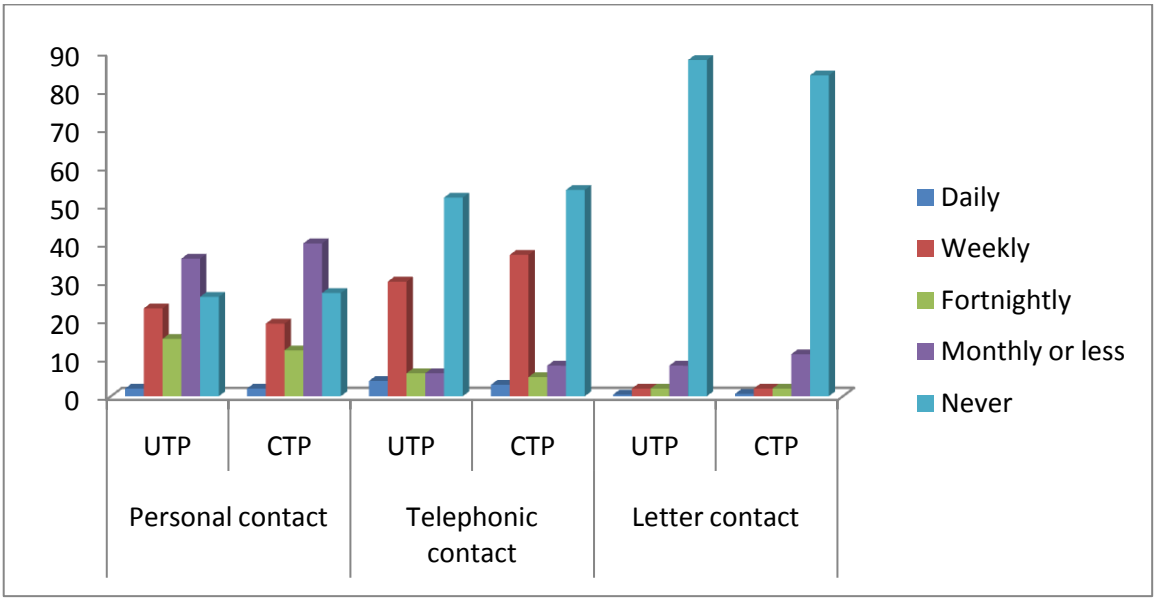
About half the resident population did not report any telephone contact with family members (52% of UTPs and 54% of CTPs). CTPs were significantly more likely to receive telephone calls compared to UTPs ($p<0.001$) and more likely to receive calls fortnightly or more frequently (45%) compared to UTPs (40%). Letters were a very rare mode of correspondence and 88% of UTPs and 84% of CTPs reported no contact through letters. However, when letters were mentioned as being modes of contact, CTPs were

significantly more likely to receive letters from their families compared to UTPs (p<0.001).

Table 44: Contact with family members after entry into prison

Contact with family members	Present or Absent	Total n(%)	UTP n(%)	CTP n(%)	X2 (p)
Do any family members visit you?	Yes	3703(74)	2826 (74)	877 (74)	**0.2 (ns)**
	No	1305(26)	988 (26)	317 (26)	
Do any family members contact you by telephone?	Yes	2387(48)	1760 (46)	627 (53)	**14.8 (<0.001)**
	No	2621(52)	2054 (54)	567 (47)	
Do any family members maintain contact with you by letter?	Yes	578(12)	400 (11)	178 (15)	**17.4 (<0.001)**
	No	4430(88)	3414 (89)	1016 (85)	

Figure 24: Frequency of contact with family members



Satisfaction with facilities for contact

About half of both UTPs and CTP's were generally satisfied with the current visiting room and system, but a fourth were not satisfied and another fourth did not respond to these questions. About half the resident prisoners did not know about any facility of pay phones existing in the prison.

Table 45: Satisfaction with arrangements for meeting families

Safety Issues	Options	Total n(%)	UTP n(%)	CTP n(%)	X2 (p)
Are you satisfied with the current system of visiting room?	Strongly dissatisfied	4(0.1)	4 (0.1)	0	2.51 (0.64)
	Dissatisfied	1315(26)	996 (26)	319 (27)	
	Do not know	1248(25)	945 (25)	303 (25)	
	Satisfied	2439(49)	1868 (49)	571 (48)	
	Strongly Satisfied	2(0.01)	1 (0.0)	1 (0.01)	
Are you satisfied with the current procedure for visitors?	Strongly dissatisfied	4(0.1)	4 (0.1)	0	1.85 (0.76)
	Dissatisfied	1070(21)	820 (22)	250 (21)	
	Do not know	1217(24)	921 (24)	296 (25)	
	Satisfied	2716(54)	2068 (54)	648 (54)	
	Strongly Satisfied	1(0.01)	1 (0.01)	0	
How do you rate the access to pay phones in this prison?	Strongly dissatisfied	21(0.4)	17 (0.4)	4 (0.3)	**15.72 (0.003)**
	Dissatisfied	156(3)	122 (3)	34 (3)	
	Do not know	2473(49)	1938 (51)	535 (45)	
	Satisfied	2357(47)	1736 (46)	621 (52)	
	Strongly Satisfied	1(0.01)	1 (0.01)	0	

Safety Issues in Prison

A majority of the resident prisoners (70%) expressed that they felt safe in the prison most of the time, and that the staff treated them with respect. Nearly one in five (18%) expressed that they were never or rarely treated with respect. A majority (88%) felt that the other inmates treated them with respect. Most did not feel discriminated on grounds of any mental distress (95%). Five percent reported having been victims of bullying by others and also reported maltreatment by the staff. There were no significant differences of opinion regarding safety issues between the UTPs and CTPs.

Violence – a common occurrence in prison

Mr B, a 22year old, reported to the prison hospital with severe bleeding from face and scalp. He had sustained a contusion over the forehead and a lacerated wound on his left cheek. On enquiry, he said that he had asked for one more serving of rice. The co-prisoner who was serving the rice became angry and impulsively attacked Mr. B with a plate.

Hygiene Issues in Prison

One third of the resident prisoners felt that the hygiene conditions in the prison were inadequate. Toilet cleanliness was felt to be unsatisfactory by 43% of residents. About one third (31%) felt that the cleanliness in the barracks was unsatisfactory. One third felt they were not in a position to change their clothes every day. More than a third expressed that they did not have access to safe drinking water (37%). Undertrial prisoners were significantly more dissatisfied with the hygiene conditions of the prison compared to convict prisoners on all parameters.

Table 46: Safety and other Issues

Safety Issues	Options	Total n(%)	UTP n(%)	CTP n(%)	X2 (p)
Do you feel safe at Central Prison, Bangalore?	Never	426(9)	328 (9)	98 (8)	3.51 (0.32)
	Rarely	315(6)	230 (6)	85 (7)	
	Often	713(14)	557 (15)	156 (13)	
	Most often	3540(70)	2687 (70)	853 (72)	
Do staff treat you with respect?	Never	421(8)	326 (9)	95 (8)	3.24 (0.36)
	Rarely	499(10)	392 (10)	107 (9)	
	Often	532(11)	411 (11)	121 (10)	
	Most often	3542(70)	2673 (70)	869 (73)	
Do other inmates treat you with respect?	Never	249(5)	187 (5)	62 (5)	2.6 (0.46)
	Rarely	184(4)	148 (4)	36 (3)	
	Often	135(3)	99 (3)	36 (3)	
	Most often	4426(88)	3368 (88)	1058 (89)	
Have you ever been discriminated on the basis of your mental illness by inmates?	Never	4767(95)	3628 (95)	1139 (96)	0.08 (0.99)
	Rarely	92(2)	71 (2)	21 (2)	
	Often	49(1)	37 (1)	12 (1)	
	Very often	86(2)	66 (2)	20 (1)	
Have you ever been a victim of maltreatment / bullying by inmates?	Never	4767(95)	3629 (95)	1138 (95)	0.46 (0.93)
	Rarely	114(2)	89 (2)	25 (2)	
	Frequently	57(1)	42 (1)	15 (1)	
	Regularly	56(1)	42 (1)	14 (1)	
Have you ever been assaulted in prison by inmates?	Never	4790(95)	3645 (96)	1145 (96)	0.72 (0.87)
	Rarely	83(2)	66 (2)	17 (1)	
	Frequently	57(1)	42 (1)	15 (1)	
	Regularly	63(1)	48 (1)	15 (1)	

Table 47: Satisfaction with environmental hygiene in prison

Personal Hygiene	Options	Total n(%)	UTP n(%)	CTP n(%)	X2 (p)
The cleanliness of your hall/dormitory is adequate	Strongly Disagree	538(11)	411 (11)	127 (11)	**21.15 (0.000)**
	Disagree	1101(22)	843 (22)	258 (22)	
	Do not know	167(3)	151 (4)	16 (1)	
	Agree	3165(63)	2378 (63)	787 (66)	
	Strongly agree	23(0.5)	19 (0.5)	4 (0.3)	
The cleanliness of the toilet area is adequate	Strongly Disagree	536(11)	409 (11)	127 (11)	**23.8 (0.000)**
	Disagree	1629(32)	1256 (33)	373 (31)	
	Do not know	167(3)	151 (4)	16 (1)	
	Agree	2639(53)	1967 (51)	672 (56)	
	Strongly agree	23(0.5)	19 (0.5)	4 (0.3)	
The cleanliness of your cell/barrack is adequate	Strongly Disagree	528(11)	404 (11)	124 (10)	**22.17 (0.000)**
	Disagree	982(20)	765 (20)	217 (18)	
	Do not know	167(3)	150 (4)	17 (1)	
	Agree	3293(66)	2464 (64)	829 (70)	
	Strongly agree	24(0.5)	19 (1)	5 (0.4)	
If I want, I can change my clothes every day	Strongly Disagree	530(11)	403 (11)	127 (11)	**20.72 (0.000)**
	Disagree	1107(22)	856 (23)	251 (21)	
	Do not know	166(3)	149 (4)	17 (1)	
	Agree	3168(63)	2375 (63)	793 (67)	
	Strongly agree	23(0.5)	19 (0.5)	4 (0.3)	
Clean and safe drinking water is available	Strongly Disagree	536(11)	409 (11)	127 (11)	**18.88 (0.001)**
	Disagree	1321(26)	1006 (27)	315 (27)	
	Do not know	166(3)	149 (4)	17 (1)	
	Agree	2947(59)	2218 (58)	729 (61)	
	Strongly agree	24(0.5)	20 (0.5)	4 (0.3)	
If I want, I can bathe every day	Strongly Disagree	530(11)	404 (11)	126 (11)	**21.97 (0.000)**
	Disagree	1121(22)	874 (23)	247 (21)	
	Do not know	169(3)	151 (4)	18 (1.5)	
	Agree	3149(63)	2353 (62)	796 (67)	
	Strongly agree	25(0.5)	20 (0.5)	5 (0.4)	

Food and serving of food in the prison

A majority of resident prisoners (73%) felt that the food was good. About one fourth (24%) felt it was bad or very bad. In addition, more than half (55%) felt that the quality of the food provided was bad or very bad.

Table 48: Satisfaction with food and serving of food

Food	Options	Total n(%)	UTP n(%)	CTP n(%)	X2 (p)
Quantity of food provided	Very Bad	714(14)	521 (14)	193 (16)	5.34 (0.25)
	Bad	480(10)	374 (10)	106 (9)	
	Ok	124(3)	93 (2)	31 (3)	
	Good	3670(73)	2809 (74)	861 (72)	
	Very Good	3(0.01)	2 (0.1)	1 (0.1)	
Quality of the food provided	Very Bad	849(17)	619 (16)	230 (19)	**10.11 (0.04)**
	Bad	1931(38)	1457 (38)	474 (40)	
	Ok	131(3)	98 (3)	33 (3)	
	Good	2076(41)	1621 (43)	455 (38)	
	Very Good	1(0.01)	1 (0.01)	0	
Choice of the menu	Very Bad	690(14)	508 (13)	182 (15)	**17.53 (0.002)**
	Bad	345(7)	237 (6)	108 (9)	
	Ok	823(16)	620 (16)	203 (17)	
	Good	3130(62)	2431 (64)	699 (59)	
	Very Good	1(0.01)	1 (0.01)	0	
Regularity of the timings of the food	Very Bad	615(12)	451 (12)	164 (14)	3.42 (0.49)
	Bad	211(4)	162 (4)	49 (4)	
	Ok	131(3)	102 (3)	29 (2)	
	Good	4031(80)	3081 (81)	950 (80)	
	Very Good	1(0.01)	1 (0.01)	0	
Way the food is served	Very Bad	604(12)	445 (12)	159 (13)	3.85 (0.43)
	Bad	257(5)	196 (5)	61 (5)	
	Ok	120(2)	96 (3)	24 (2)	
	Good	4006(80)	3059 (81)	947 (79)	
	Very Good	2(0.01)	1 (0.01)	1 (0.1)	

While two-thirds felt that there was adequate variability in the menu, 21% felt it was not varied enough. A majority (80%) felt that the food was served on time and were satisfied with the way it was served. One if five was not satisfied with the way the food was

served. While the level of satisfaction/dissatisfaction among UTPs and CTPs was comparable, dissatisfaction with the choice of menu was greater among CTPs, who are likely to have stayed for much longer periods in the prison.

Table 49: Satisfaction with health care needs

Health care	Options	Total n(%)	UTP n(%)	CTP n(%)	X2 (p)
How easy is it to get to see the Doctor at Central Prison, Bangalore?	Very difficult	99(2)	76 (2)	23 (2)	1.59 (0.81)
	Difficult	1588(32)	1210 (32)	378 (32)	
	Do not know	1136(23)	877 (23)	259 (22)	
	Easy	2064(41)	1564 (41)	500 (42)	
	Very Easy	106(2)	77 (2)	29 (2)	
How would you describe the service you get from the Doctor?	Very poor	96(2)	74 (2)	22 (2)	1.17 (0.88)
	Poor	1638(33)	1248 (33)	390 (33)	
	Do not know	1142(23)	879 (23)	263 (22)	
	Good	2010(40)	1525 (40)	485 (41)	
	Very good	107(2)	78 (2)	29 (2)	
How would you rate the quality of outpatient health care services?	Very poor	87(2)	68 (2)	19 (2)	1.38 (0.85)
	Poor	1628(32)	1242 (33)	386 (33)	
	Do not know	1155(23)	886 (23)	269 (23)	
	Good	2015(40)	1530 (40)	485 (41)	
	Very good	108(2)	78 (2)	30 (2)	
How would you rate the quality of inpatient health care services?	Very poor	86(2)	67 (2)	19 (2)	1.45 (0.84)
	Poor	976(19)	745 (20)	231 (19)	
	Do not know	1916(38)	1467 (39)	449 (38)	
	Good	1908(38)	1448 (38)	460 (39)	
	Very good	107(2)	77 (2)	30 (3)	
I feel that my healthcare needs are better met in prison than in the community	Strongly Disagree	106(2)	80 (2)	26 (2)	2.40 (0.66)
	Disagree	1756(35)	1349 (36)	407 (34)	
	Do not know	1148(23)	883 (23)	265 (22)	
	Agree	1876(37)	1415 (37)	461 (39)	
	Strongly agree	107(2)	77 (2)	30 (3)	

Health care needs

While more than one in five prisoners did not know how easy it was to see a doctor, a third (34%) felt it was not easy to consult a doctor. More than a third (35%) was not satisfied with the service they received from the doctor within the prison and were dissatisfied with the quality of outpatient health care services provided. A sizeable number (38%) were unable to comment on the overall quality of health care within the prison.

Table 50: Satisfaction with recreational facilities

Sports and Entertainment	Options	Total n(%)	UTP n(%)	CTP n(%)	X2 (p)
We are allowed to play sports /games	Strongly Disagree	45(1)	37 (1)	8 (0.7)	1.82 (0.61)
	Disagree	131(3)	104 (3)	27 (2)	
	Do not know	95(2)	71 (2)	24 (2)	
	Agree	4725(94)	3592 (94)	1133 (95)	
	Strongly agree	0	0	0	
We are allowed to go out into the open air	Strongly Disagree	22(0.4)	17 (0.4)	5 (0.4)	3.43 (0.49)
	Disagree	116(2)	95 (2.5)	21 (2)	
	Do not know	46(1)	37 (1)	9 (0.8)	
	Agree	4810(96)	3654 (96)	1156 (97)	
	Strongly agree	2(0.01)	1 (0.01)	1 (0.1)	
We are allowed to watch TV	Strongly Disagree	19(0.4)	13 (0.3)	6 (0.5)	**9.34 (0.053)**
	Disagree	97(2)	85 (2)	12 (1)	
	Do not know	47(1)	37 (1)	10 (0.8)	
	Agree	4826(96)	3665 (96)	1161 (97)	
	Strongly agree	7(0.1)	4 (0.1)	3 (0.3)	

Forty percent rated it as good and 20% rated it as poor. Nearly a quarter (23%) was not able to opine whether their health needs were better met in prison or in the community. However, 39% of both UTPs and CTPS felt that the health care in prison was better than

that in the community, perhaps a sad but real reflection of the state of health care in the community. The opinions regarding health care did not significantly differ between the two groups.

Sports and avenues for recreation

An overwhelming majority (94%) felt that they had an opportunity to play sports and games in the prison as well as go out into the open air (96%). Similarly, a majority opined that they had opportunities to watch television. The opinions of UT and CT prisoners did not significantly vary on these issues.

Rehabilitation needs

A majority (95%) had not been exposed to any form of rehabilitation or occupational activity within the prison. A majority (95%) also did not agree that such intervention

Table 51: Satisfaction with occupational activity and rehabilitation

Rehabilitation	Options	Total n(%)	UTP n(%)	CTP n(%)	X2 (p)
Do you attend any rehabilitation work /occupational therapy in Central Prison, Bangalore?	Never	4746(95)	3678 (97)	1068 (90)	**132.56 (0.000)**
	Rarely	29(0.6)	25 (0.7)	4 (0.3)	
	Frequently	12(0.2)	10 (0.3)	2 (0.2)	
	Regularly	209(4)	90 (2)	119 (10)	
Do you feel that the rehabilitation work /occupational therapy provide you with work that has a purpose?	Yes	265(5)	110 (3)	155 (13)	**184.43 (0.000)**
	No	4731(94)	3693 (97)	1038 (87)	
Do you think the work you do at Central Prison, Bangalore will help you find a job on release?	Yes	216(4)	86 (2)	130 (11)	**163.71 (0.000)**
	No	4780(95)	3717 (98)	1063 (89)	

would provide them purposeful activity or would help them to find a job after release. This result could have several interpretations. One is that the resident prisoners do not understand the importance of rehabilitation. An alternative explanation could be that such activities are not available to the majority or existing activities are not suited to the needs of a majority.

Legal Needs

With respect to legal needs, the question was not answered or not applicable (in case of already convicted prisoners). About one in four prisoners was not aware of the charge

Table 52: Satisfaction with arrangements for legal support

Legal Needs	Options	Total n(%)	UTP n(%)	CTP n(%)	X2 (p)
I am aware of the charges against me	Yes	3677(73)	2824 (74)	853 (72)	**102.67 (0.000)**
	No	1205(24)	941 (25)	264 (22)	
	Not Applicable /don't know	122(2)	46 (1)	76 (6)	
I have a lawyer at present	Yes	3884(77)	3026 (79)	858 (72)	**146.17 (0.000)**
	No	801(16)	631 (17)	170 (14)	
	Not Applicable/don't know	319(6)	154 (4)	165 (14)	
Escorts are provided regularly to take me to court	Yes	263(5)	219 (6)	44 (4)	**117.91 (0.000)**
	No	3915(78)	3083 (81)	832 (70)	
	Not Applicable/don't know	826(16)	509 (13)	317 (27)	
I am satisfied with the pace at which my case is proceeding in the court	Yes	1571(31)	1254 (33)	317 (27)	**89.98 (0.000)**
	No	2735(54)	2123 (56)	612 (51)	
	Not Applicable/don't know	698(14)	434 (11)	264 (22)	

against them, and UTPs were significantly not likely to know the charge against them. One in five UTPs either did not have a lawyer or was not aware of whether they had a lawyer. A majority of both UTPs and CTPs were dissatisfied with the regularity of escorts provided. More than half (56%) of UTPs were dissatisfied with the pace of court proceedings.

Meeting Mental Health Needs of Prisoners – Systemic successes and limitations

Need to educate and support families

Mr. Y is a 30 year unmarried, unemployed, male hailing from a middle-class-socio-economic rural background of North Karnataka. From the age of 15, his academic performance declined and he dropped out of college at 21 years. At the age of 25, he developed abnormal behaviour characterised by abusive, assaultive outbursts,, poor personal care, talking to self, laughing to self, begging for money and food, wandering behaviour, fighting with his family members and others in the village. Family tried to seek help from faith healers but there was no improvement in his condition.

One day he became violent and destroyed house hold articles, when his brother called him 'mental'. His father lodged a complaint with the police. He was an influential person in the locality. So the police arrested him on a charge of petty crime and produced him before the magistrate. He was sent to judicial custody and was also referred to NIMHANS for treatment.

On inpatient evaluation, he was found to be suffering from Schizophrenia. Appropriate medications were started. During his inpatient stay his father was contacted and the treatment discussed with him. Initially the father was reluctant, but later began to co-operate with the treating team. During the discussion, it was understood that the father was not aware of his illness and wanted his son to be in prison for some more time to 'teach him a lesson'. However, after educating him about illness and the need for medication he agreed to bail him out. Sadly, in the whole process, the patient had to be in prison for more than fifteen months before his bail was granted.

8. Women in Prison- Mental Health Problems, Substance Abuse and Needs

Women constitute a very small proportion of the general prison population worldwide, usually between 2% and 9% of a country's prison population. Only 12 prison systems worldwide report a higher percentage than that (Walmsley 2006, WHO Regional Office for Europe 2009). Unfortunately, this means that most prison arrangements are male-centred and do not pay attention to the problems and needs of women in prison. As prison systems have been primarily designed for men, who comprise more than 95% of the prison population in most countries, prison policies and procedures often do not address women's health needs. Data on the health of women in prison and the health care provided for them is inadequate, because most prison data are not gender specific (UNODC 2009).

Mental health problems among women in prisons all over the world are very high. These include many mental disorders and a high level of drug or alcohol dependence. Many women undergo sexual and physical abuse and violence before or in prison. The gender-specific health care needs and additional issues related to the women's responsibility for children and families are often neglected. Many women in prison have young children for whom they were often the primary or sole carer before they entered prison (UNODC 2009). Women in prison frequently come from deprived backgrounds, and many have experienced physical and sexual abuse, alcohol and drug dependence and inadequate health care before imprisonment (Penal Reform International, 2008). Further, women entering prison are more likely than men to have poor mental health, often associated with experiences of domestic violence and physical and sexual abuse (United Nations Office on Drugs and Crime, 2009).

In prisons in the United Kingdom, 70% of sentenced female prisoners are said to have two or more mental disorders. Psychotic disorders are estimated to be present among 14% of this population, 14-23 times the level in the general population. Data from the prison services for 2005 showed that 597 out of every 1000 women harm themselves while in prison (prisonreformtrust.UK.org).

Research indicates that women in prison have mental health problems to a much higher degree than both the general population and male prisoners (Bastick, 2005). A study conducted by the Bureau of Justice Statistics of the United States Department of Justice showed that 73% of the women in state prisons and 75% of the women in local prisons in the US have symptoms of mental disorders compared to 12% of women in the general population (Covington, 2007). In England and Wales, 90% of women in prison have a diagnosable mental disorder, substance use or both, and 9 of 10 women in prison have at least one of the following: neurosis, psychosis, personality disorder, alcohol abuse or drug dependence (WHO Regional Office for Europe, 2007a).

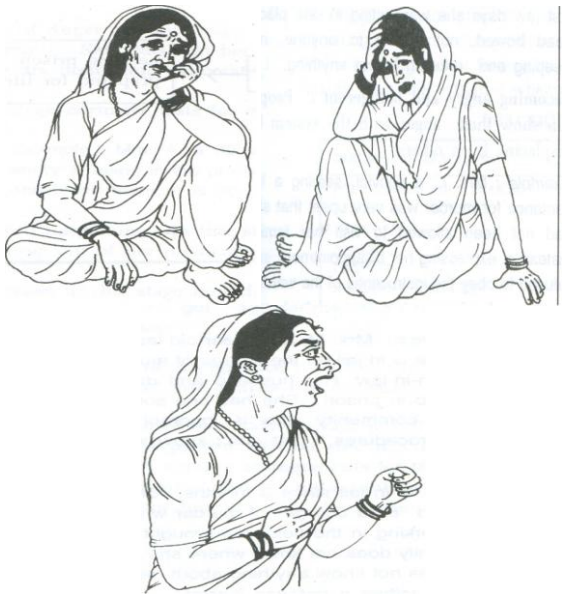
Some of the issues for women in prisons in other countries as well as in India have been highlighted in an earlier chapter.

Table 53: Common mental health problems among women in custody

NIMHANS/NCW study

Most common mental health problems among the women undertrials		Common mental health problems among convicted women	
Unhappiness	73%	Unhappiness	43%
Worthlesness	69%	Tiredness	43%
Worrying	65%	Worrying	29%
Poor sleep and appetite	65%	Poor appetite	29%
Headache	56%		

Murthy et al.,1998



Worry, helplessness, anger- most common reactions among women in prison

Women with substance use problems

Substance use among women is a growing problem in India. Twelve percent of women use tobacco, mainly in the chewing form (GATS 2010). Nearly 6% of women consume alcohol. Abuse of other drugs is also growing. A recent community based study conducted in several states of India, highlights the growing problem of other drug abuse among women (Murthy 2008). The study consisted of interviews with 1865 women using drugs and found that high illiteracy, lack of supportive relationships, high level of substance use among partners, early coercion into sexual activity, high levels of violence, greater sexual risk behaviours, higher levels of emotional distress among children and very high rates of mental distress and suicidal ideation characterised this group. For women, substance use is often considered a way of dealing with their emotional problems. Imprisonment can add a major component of distress to already distressed women.

Generally, women with substance use problems:

- have fewer resources (education, employment and income) than men;
- are more likely to be living with a partner with a substance use problem;
- have more severe problems at the beginning of treatment for substance use; and
- have higher rates of trauma related to physical and sexual abuse and concurrent mental disorders than men, especially post-traumatic stress disorder and other mood and anxiety disorders (United Nations Office on Drugs and Crime, 2004).

Bangalore Prison Mental Health Study Findings

At the time of conducting the study, there were 210 women prisoners (4%) of whom 197 were interviewed for the study.

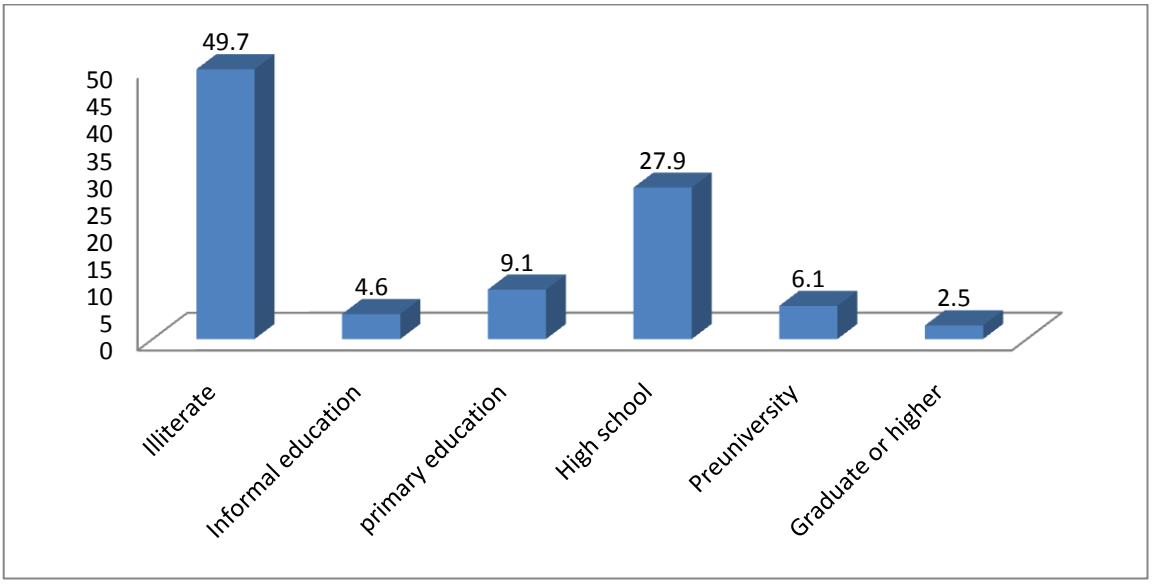
A majority of the women prisoners were undertrials (62.4%), just as in the case of men. Nearly half the women prisoners (49.7%) were illiterate, much higher compared to male prisoners (19.7%). Women prisoners were significantly older than men [mean ages 37.5 (14.4) years and 30.4(10.3) years, p=0.000], were more likely to be married (81%

compared to 44% of men, p=0.000). Both men and women have been in prison for similar durations of time.

Table 54: Sociodemographic characteristics of women prisoners

Variable		N	%
Legal status			
Undertrials		123	62.4
Convicts		74	37.6
Religion	Hindu	163	82.7
	Christians	14	7.1
	Muslims	19	9.6
	Others	5	2.5
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 months(SD)		20.3	21.3

Figure 25: Educational status of women prisoners



Nutritional status of women in prison

Among women prisoners, one in four was underweight, but a greater number were overweight or obese (26.3%) compared to males (10.9%).

Table 55. Weight classification of all the prisoners (according to Gender)

BMI	Classification*	Male n(%)	Female n(%)	Others n(%)	Total n(%)
<18.5	Underweight	1467(30.7)	49(25.3)	1(20)	1517(30.5)
18.5 -24.9	Normal weight	2798(58.5)	94(48.5)	3(60)	2895(58.1)
25.0 -29.9	Overweight	421(8.8)	33(17)	1(20)	455(9.1)
30.0-34.9	Class I obesity	70(1.5)	11(5.7)	0	81(1.6)
35.0-39.9	Class II obesity	22(0.5)	5(2.6)	0	27(0.5)
≥40.0	Class III obesity	3(0.1)	2(1)	0	5(0.1)
		4781(100)	194(100)	5(100)	4980(100)

*World Health Organization classification

Table 56: Any diagnosable mental illness or substance use condition according to gender

	Male n (%)	Female n (%)	Total	X^2	P-value
Present	3935 (81.9)	61 (32.1)	5003 (79.9)	290	**<0.001**

Nearly one third of women could be diagnosed as having a mental health or substance use problem. The higher overall prevalence in men is attributable to higher substance use among them. After excluding for substance use, the rates of any diagnosable mental illness are somewhat similar for men and women.

Table 57: Patterns of diagnosable mental disorders among women

	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

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. According to the prison psychiatrist, two women are currently diagnosed to have a psychiatric disorder.

Use of alcohol, tobacco and drugs among women in prison

More than one in ten women reported using chewing tobacco in their lifetime and 5% reported smoking. As in the general population, prevalence of smoking was much higher among males than females. However, in comparison to the prevalence of smoking among

Table 58: Use of tobacco, alcohol and other drugs

Life style Questionnaire for Drug use	Female n(%)	Male n(%)
Ever used tobacco in any form	34 (17.9)	3195 (66.4)
Ever smoked tobacco	10 (5.1)	3007 (62.5)
Ever chewed tobacco	25 (12.7)	735 (15.3)
Ever consumed alcohol	6 (3.0)	2574 (53.5)
Ever used any other drugs or any other means to get a high	1(0.5)	651(13.5)
Ever used Ganja, Charas, Bhang	0(0.0)	615(12.8)
Brown sugar, Opium, Proxyvon, Spasmoproxyvon, Morphine, Pethidine, Tidigesic.	0(0.0)	30(0.6)
Sleeping Pills, (Calmpose, Alprax, Nitrest)	0(0.0)	33(0.7)
Inhalants (Petrol, Erasex)	0(0.0)	6(0.1)
Injections (Mention the name)	0(0.0)	9(0.2)
Any other ways to get a high (Specify)	0(0.0)	12(0.2)
In the one year you were in jail, Did you use any drugs / use other ways to get a high?	0(0.0)	38(0.8)

women in the general population in Karnataka, the prevalence is higher in the prisons. The prevalence of chewing tobacco among women in prisons is also higher than among the general population of 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). With regard to gambling,

though a higher percentage of women reported having participated in online lottery, a very small number reported any other form of gambling.

Table 59: Tobacco use among adults in Karnataka (WHO SEARO/ICMR 2001)

Males		Females		Total	
n	%	n	%	n	%
7613/17773	42.8	2504/16438	15.2	10119/34211	29.6

Table 60: Prevalence of gambling behaviours among women in prison

Sl. no	Life style Questionnaire for Gambling	Female n(%)	Male n(%)
1	Played cards for stakes	3(1.5)	364(7.6)
2	Went to race more than once or twice	0(0.0)	36(0.7)
3	Bought lottery more than once or twice	0(0.0)	5(1.0)
4	Participated in online lottery more than one or twice	9(1.0)	47(0.1)
5	Involved in any other form of betting more than once or twice	2(1.0)	298(6.3)

Urine Drug Screening

Sixty women were randomly screened for urine drugs. As this was done anonymously, the findings could not be correlated with self reports. In total, 18 women (30%) tested positive for one or more drugs.

Table 61: Urine drug screening among women in prison

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

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.

Gender specific needs

In terms of safety needs, there were no significant differences between men and women. About one in ten women felt unsafe in the prison, nearly one in five women felt that the staff rarely or never treated them with respect, whereas one in ten felt the co-prisoners did not treat her with respect. Of the entire group, 4 to 5 women felt discriminated on account of their mental problems, and a similar number reported being victims of bullying. Four women reported having been assaulted by their co-prisoners.

Depression

Mrs. S was born to a fruit vendor in Bombay. She could not go to school because of financial problems. She was married to Mr. N, 12 years older to her, at the age of 17. He looked after her well for the first three years of marriage. She gave birth to 2 children. One day she came to know that her husband was having an affair with another lady. She started fighting with him over this issue. He left home and never returned. She had to really struggle hard for daily living along with her two children. She met a friend who offered her a job in Bangalore and promised to pay Rs 15,000 per month. So she left her two children with her sister and came here. Her job was to dance and satisfy other men in a hotel. One week after joining the job, the hotel was raided and she along with her 4 friends ended up in jail. Now, she feels sad, dejected and wants to commit suicide. She was counselled. Later, she got legal aid and she was released from the prison.

Table 62: Safety and other Issues (women)

Safety Issues	Options	Total n(%)	Female n(%)	Male n(%)	X2 (p)
Do you feel safe at Central Prison, Bangalore?	Never	426(9)	14 (7)	412 (9)	8.82
	Rarely	315(6)	9 (5)	305 (6)	0.18
	Often	713(14)	19 (10)	694 (15))	
	Most often	3540(70)	154 (78)	3382 (70)	
Do staff treat you with respect?	Never	421(8)	19 (10)	402 (8)	10.76
	Rarely	499(10)	15 (8)	484 (10)	0.10
	Often	532(11)	10 (5)	522 (11)	
	Most often	3542(70)	152 (77)	3385 (71)	
Do your co-prisoners treat you with respect?	Never	249(5)	11 (6)	238 (5)	4.51
	Rarely	184(4)	7 (4)	177 (3)	0.61
	Often	135(3)	1 (0)	134 (3)	
	Most often	4426(88)	177 (90)	4244 (89)	
Have you ever been discriminated on the basis of your mental illness by co-prisoners?	Never	4767(95)	190 (97)	4572 (95)	1.63
	Rarely	92(2)	2 (1)	90 (2)	0.95
	Often	49(1)	2 (1)	47 (1)	
	Very often	86(2)	2 (1)	84 (2)	
Have you ever been a victim of maltreatment / bullying by co-prisoners?	Never	4767(95)	189 (96)	4573 (95)	1.98
	Rarely	114(2)	2 (1)	112 (3)	0.92
	Frequently	57(1)	3 (2)	54 (1)	
	Regularly	56(1)	2 (1)	54 (1)	
Have you ever been assaulted in prison by co-prisoners?	Never	4790(95)	191 (98)	4594 (96)	1.71
	Rarely	83(2)	2 (1)	81 (2)	0.94
	Frequently	57(1)	2 (1)	55 (1)	
	Regularly	63(1)	1 (0)	62 (1)	

Table 63: Satisfaction with hygiene issues in prison (women)

Personal Hygiene	Options	Total n(%)	Female n(%)	Male n(%)	X2 (p)
The cleanliness of your hall/dormitory is adequate	Strongly Disagree	538(11)	9 (5)	529 (11)	**67.6**
	Disagree	1101(22)	35 (18)	1064 (22)	**0.000**
	Do not know	167(3)	4 (2)	160 (3)	
	Agree	3165(63)	146 (74)	3019 (63)	
	Strongly agree	23(0.5)	2 (1)	21 (1)	
The cleanliness of the toilet area is adequate	Strongly Disagree	536(11)	8 (5)	528 (11)	**77.8**
	Disagree	1629(32)	46 (23)	1581 (33)	**0.000**
	Do not know	167(3)	4 (2)	160 (3)	
	Agree	2639(53)	136 (69)	2503 (52)	
	Strongly agree	23(0.5)	2 (1)	21 (1)	
The cleanliness of your cell/barrack is adequate	Strongly Disagree	528(11)	8 (5)	520 (11)	**75.6**
	Disagree	982(20)	24 (11)	956 (20)	**0.000**
	Do not know	167(3)	4 (2)	160 (3)	
	Agree	3293(66)	158 (81)	3135 (65)	
	Strongly agree	24(0.5)	2 (1)	22 (1)	
If I want, I can change my clothes every day	Strongly Disagree	530(11)	8 (4)	522 (11)	**68.55**
	Disagree	1107(22)	36 (19)	1069 (22)	**0.000**
	Do not know	166(3)	4 (2)	159 (3)	
	Agree	3168(63)	146 (74)	3022 (63)	
	Strongly agree	23(0.5)	2 (1)	21 (1)	
Clean and safe drinking water is available	Strongly Disagree	536(11)	8 (4)	528 (11)	**73.82**
	Disagree	1321(26)	38 (20)	1281 (27)	**0.000**
	Do not know	166(3)	4 (2)	159 (3)	
	Agree	2947(59)	144 (73)	2803 (58)	
	Strongly agree	24(0.5)	2 (1)	22 (1)	
If I want, I can bathe every day	Strongly Disagree	530(11)	8 (4)	522 (11)	**66.81**
	Disagree	1121(22)	36 (19)	1083 (23)	**0.000**
	Do not know	169(3)	5 (2)	161 (3)	
	Agree	3149(63)	145 (74)	3004 (63)	
	Strongly agree	25(0.5)	2 (1)	23 (1)	

About one in four women was dissatisfied with the living and toilet area. In general, however, women prisoners were significantly more likely to be satisfied with the cleanliness of their living, sleeping and toilet areas compared to the men. A significantly greater number of women opined that they had the freedom to change their clothes daily,

Table 64: Satisfaction with food and serving of food

Food	Options	Total n(%)	Female n(%)	Male n(%)	X2 (p)
Quantity of food provided	Very Bad	714(14)	25 (13)	688 (14)	13.21
	Bad	480(10)	10 (6)	470 (10)	0.11
	Ok	124(3)	6 (3)	118 (2)	
	Good	3670(73)	153 (78)	3513 (74)	
	Very Good	3(0.01)	1 (0)	2 (0)	
Quality of the food provided	Very Bad	849(17)	32 (16)	816 (17)	4.14
	Bad	1931(38)	65 (33)	1864 (39)	0.85
	Ok	131(3)	4 (2)	127 (3)	
	Good	2076(41)	94 (48)	1980 (41)	
	Very Good	1(0.01)	0 (0)	1 (0)	
Choice of the menu	Very Bad	690(14)	17 (9)	673 (14)	**16.40**
	Bad	345(7)	12 (6)	331 (7)	**0.04**
	Ok	823(16)	28 (14)	795 (17)	
	Good	3130(62)	139 (71)	2988 (62)	
	Very Good	1(0.01)	0 (0)	1 (0)	
Regularity of the timings of the food	Very Bad	615(12)	17 (9)	598 (13)	**22.95**
	Bad	211(4)	5 (2)	204 (4)	**0.003**
	Ok	131(3)	2 (1)	129 (3)	
	Good	4031(80)	172 (88)	3856 (80)	
	Very Good	1(0.01)	0 (0)	1 (0)	
Way the food is served	Very Bad	604(12)	16 (8)	588 (12)	**20.21**
	Bad	257(5)	6 (3)	249 (5)	**0.010**
	Ok	120(2)	2 (1)	118 (3)	
	Good	4006(80)	172 (88)	3831 (80)	
	Very Good	2(0.01)	0 (0)	2 (0)	

have regular baths, and had access to clean, drinking water. The overcrowding in the male barracks with undertrial prisoners may explain the greater discontent among men with respect to basic living facilities. It was also noted that women participated more

Table 65: Satisfaction with health care needs (women)

Health care	Options	Total n(%)	Female n(%)	Male n(%)	X2 (p)
How easy is it to GET TO SEE the Doctor at Central Prison, Bangalore?	Very difficult	99(2)	2 (1)	97 (2)	**18.11**
	Difficult	1588(32)	39 (20)	1549 (32)	**0.020**
	Do not know	1136(23)	53 (27)	1081 (23)	
	Easy	2064(41)	97 (50)	1964 (41)	
	Very Easy	106(2)	5 (3)	101 (2)	
How would you describe the SERVICE you get from the Doctor?	Very poor	96(2)	2 (1)	94 (2)	**15.58**
	Poor	1638(33)	43 (22)	1595 (33)	**0.049**
	Do not know	1142(23)	53 (27)	1087 (23)	
	Good	2010(40)	93 (47)	1914 (40)	
	Very good	107(2)	5 (3)	102 (2)	
How would you rate the quality of outpatient health care services?	Very poor	87(2)	2 (1)	85 (2)	**19.39**
	Poor	1628(32)	39 (19)	1589 (33)	**0.013**
	Do not know	1155(23)	56 (29)	1097 (23)	
	Good	2015(40)	94 (48)	1918 (40)	
	Very good	108(2)	5 (3)	103 (2)	
How would you rate the quality of inpatient health care services?	Very poor	86(2)	2 (1)	84 (11)	11.99
	Poor	976(19)	22 (11)	954 (9)	0.15
	Do not know	1916(38)	81 (41)	1833 (38)	
	Good	1908(38)	86 (44)	1819 (38)	
	Very good	107(2)	5 (3)	102 (2)	
I feel that my healthcare needs are better met in prison than in the community	Strongly Disagree	106(2)	4 (2)	102 (2)	13.02 0.111
	Disagree	1756(35)	49 (25)	1707 (36)	
	Do not know	1148(23)	55 (28)	1091 (23)	
	Agree	1876(37)	83 (42)	1790 (37)	
	Strongly agree	107(2)	5 (3)	102 (2)	

actively in maintaining the day to day cleanliness of their living areas. Nearly one in five women felt that the quantity of food provided was insufficient, and nearly half were dissatisfied with the quality of the food. Women tended to be more satisfied with the choice of menu and regularity of the food timings compared to men. Women were generally more satisfied with the regularity of the food and the way the food was served.

In general, women felt that access to the doctor was less difficult compared to the men, and about half of them were quite satisfied with the care they received. However, one in five women still felt it was difficult to access medical services. A substantial number of women (45%) felt that their health care needs were better met in the prison than in the community.

Table 66: Satisfaction with recreational facilities

Sports and Entertainment	Options	Total n(%)	Female n(%)	Male n(%)	X2 (p)
We are allowed to play sports /games	Strongly Disagree	45(1)	5 (3)	40 (1)	**24.19**
	Disagree	131(3)	8 (4)	123 (3)	**0.002**
	Do not know	95(2)	11 (5)	84 (1)	
	Agree	4725(94)	172 (88)	4539 (95)	
	Strongly agree	0 (0)	0 (0)	0 (0)	
We are allowed to go out into the open air	Strongly Disagree	22(0.4)	4 (2)	18 (1)	**19.62**
	Disagree	116(2)	10 (6)	106 (2)	**0.012**
	Do not know	46(1)	1 (0)	45 (1)	
	Agree	4810(96)	181 (92)	4624 (96)	
	Strongly agree	2(0.01)	0 (0)	2 (0)	
We are allowed to watch TV	Strongly Disagree	19(0.4)	3 (1)	16 (0)	**22.95**
	Disagree	97(2)	9 (5)	88 (2)	**0.003**
	Do not know	47(1)	5 (3)	42 (1)	
	Agree	4826(96)	178 (91)	4643 (97)	
	Strongly agree	7(0.1)	1 (0)	6 (0)	

Sports and avenues for recreation

With regard to sports and recreation, women were significantly less satisfied than men with regard to access to sports and entertainment. They also felt more restricted and less able to go out into the open air. They were less satisfied regarding access to television compared to the men.

Rehabilitation needs

Although a majority of the women (89%) had not been exposed to any form of rehabilitation or occupational therapy, significantly more women compared to men reported attending some form of activity. A majority of both women and men felt that the work they were doing did not serve any purpose and that it would not help them find a job after release.

Table 67: Satisfaction with occupational activity and rehabilitation (women)

Rehabilitation	Options	Total n(%)	Female n(%)	Male n(%)	X2 (p)
Do you attend any rehabilitation work /occupational therapy in Central Prison, Bangalore?	Never	4746(95)	175 (89)	4566 (95)	**22.10 0.001**
	Rarely	29(0.6)	0 (0)	29 (1)	
	Frequently	12(0.2)	2 (1)	10 (0)	
	Regularly	209(4)	19 (10)	190 (4)	
Do you feel that the rehabilitation work /occupational therapy provide you with work that has a purpose?	Yes	265(5)	20 (10)	245 (5)	**10.05 0.04**
	No	4731(94)	176 (89)	4549 (95)	
Do you think the work you do at Central Prison, Bangalore will help you find a job on release?	Yes	216(4)	18 (10)	198 (6)	**11.89 0.018**
	No	4780(95)	178 (90)	4596 (94)	

Legal Needs

With respect to legal needs, the question was not answered or not applicable (in case of already convicted prisoners)

Table 68: Satisfaction with arrangements for legal support

Legal Needs	Options	Total n(%)	Female n(%)	Male n(%)	X2 (p)
I am aware of the charges against me	Yes	3677(73)	138 (70)	3536 (74)	1.94
	No	1205(24)	53 (27)	1150 (24)	0.93
	Not Applicable /don't know	122(2)	5 (3)	114 (12)	
I have a lawyer at present	Yes	3884(77)	156 (80)	3725 (78)	3.45
	No	801(16)	31 (16)	768 (16)	0.49
	Not Applicable/don 't know	319(6)	9 (4)	310 (6)	
Escorts are provided regularly to take me to court	Yes	263(5)	8 (4)	254 (5)	3.51
	No	3915(78)	154 (80)	3757 (78)	0.48
	Not Applicable/don 't know	826(16)	34 (16)	792 (17)	
I am satisfied with the pace at which my case is proceeding in the court	Yes	1571(31)	74 (38)	1495 (31)	**19.5**
	No	2735(54)	92 (47)	2640 (55)	**0.003**
	Not Applicable/don 't know	698(14)	28 (15)	6 64 (14)	

Nearly one in three women was not aware of the legal charges against her. About 20% did not have a lawyer. An overwhelming number (80%) felt that escorts were not available regularly to take them to court. Nearly half (47%) were not satisfied with the pace at which the case was proceeding in court. There were no significant differences

among women and men with respect to legal needs, but significantly more women seemed to be accepting of the slow pace at which their case was proceeding compared to the men.

Summary of the findings

Women represent 4% of the prison population in Bangalore. A majority were UTPs (62.4%), married (81.2%) and living with their families. While 47% hailed from urban areas, 43% were from rural areas and 10% from villages. One in five women in prison was a housewife. A significant number (56%) was involved in either unskilled or semi-skilled work or agriculture. They have low levels of education (mean 3.9 years) and nearly half the female prison population illiterate. One in four women prisoners (25.3%) was underweight and more than one in four (26.3%) was overweight or obese. Nearly a third (32.1%) of women in prison had a diagnosable mental disorder. These include major depressive episode (lifetime in 26.3%), phobic disorders (6.1%). Lifetime episodes of deliberate self-harm and suicidality are much lower among women than male prisoners. Lifetime tobacco use among women in Bangalore prison was higher (17.9%) than its prevalence among women in the general community (15.2%). Chewing tobacco was more prevalent than smoking tobacco. Self report of alcohol use (3%) was lower than the reported prevalence of alcohol use among women in Karnataka (5.8%). A small number of women (1%) reported participating in online lottery more than once or twice. Hardly any woman respondent reported lifetime use of any other drug. However, anonymous urine drug screen in sixty women showed that 30% tested positive for one or more drugs, primarily benzodiazepines. A small number tested positive for cocaine, opioids and amphetamines.

In the Bangalore prison, the issues that have emerged are: the needs of women to be treated with respect and dignity, for better quality of food and a greater need for open space, sports and recreation and easier access to health care, though a substantial number of women felt that the care they received in the prison was better than care in the community. This is probably a reflection of the poor accessibility to medical care in the community. Legal help and speedy trials are also important, particularly for illiterate and poor women.

Rejection by family and relapse of mental illness- the need for aftercare and alternative facilities

Mr. D and P both suffer from schizophrenia. They came to prison under IPC 302. They were treated at the prison hospital and at NIMHANS. One of them was in prison for 6 and the other for 5 years. They both were acquitted from their cases and the Court ordered them to be handed over to their relatives. During their stay in prison, none of their family members had come to visit them, despite intimations by post and telephone. They had to be in prison for more than a year even after their acquittal. They pleaded with the doctor and the prison authorities repeatedly for their release.

This stress led to Mr. P having a relapse of psychotic symptoms, which improved with adequate treatment. Later they were both certified by the treating doctor and were released from prison.

After 6 months, Mr. D returned to the prison campus and requested to meet the prison psychiatrist. He reported to the psychiatrist that none of his family members took care of him after his release. They did not even want him to even stay with them in their house. So he requested for shelter inside the prison. He had also stopped his medicines since 4 months and had early signs of relapse. The prison psychiatrist provided medicines and he was referred to NIMHANS. There is subsequently no news of him.

After one year, Mr. P, was arrested and brought to the prison for creating public nuisance. After starting medicines he recovered and reported that his family members did not allow him to stay with them. He had been wandering in the street and begging for food. He had also stopped medicines, leading to relapse. Now, he reports that he does not want to go back home.

9. Prison staff – Mental Health Problems, Substance Abuse and Needs

This chapter provides insights into the prison staff – the roles they play, their work environment, stress they face, their attitudes towards prisoners and their own needs in their professional capacities. A prison officer's job is to:

- Maintain secure custody, in a context where people are held in confinement against their will;
- Provide prisoners with care, with humanity;
- Provide prisoners with opportunities to address their offending behaviour; and
- Assist with day-to-day management in the complex organizational environment of the prison

(Price and Liebling, 1998)

Prison officers are also expected to provide prisoners with the opportunity to use their time in the prison positively, so that they will be able to resettle in the society when they are released (Coyle, 2002). Further, as the prison population becomes more and more diverse, the staff is expected to deliver a range of services and programmes. They need to be aware of the dietary intake, recreational needs, sources of stress, behaviours and health care needs of the prisoners. They need to be sensitive to the differing needs due to diversity in age, gender and the prisoners' need to interact with friends and their families. They also have to deal with violence and other behavioural problems, thereby making their job dangerous, risky and often perceived as thankless (Marquart, American Correctional Environment and Prison Officers). In addition, their personal interactions with the prisoners can directly influence the level of tension between the staff and prisoners and indirectly influence the safety, security and control within the prison (Gilbert 1997).

Stress among prison staff has been attributed to lack of training, low confidence in dealing with crisis, general working conditions, work load and staff deployment, leading to high levels of sickness-absence, which in turn exacerbates stress. Poor management practices, combined with a perceived lack of support, further aggravate stress. (Holmes and Maclness, 2003).

This stress on correctional staff is damaging over time, leading to increased medical problems, substance abuse, divorce, suicide, and death (Cheek and Miller 1983; Woodruff 1993). Additionally, job stress has been linked to decreased job satisfaction, organisational commitment, life satisfaction, and increased turnover intent and absenteeism among correctional staff (Lambert et al. 2005; Lambert et al. 2005; Slate and Vogel 1997). Due to the adverse effects on both the employees and the organisation, scholars have conducted research to identify stressors among correctional staff. Role conflict, role ambiguity, role overload, perceived danger in the job, work-family conflict, and role strain, have all been found to lead to increased job stress (Dowden and Tellier 2004). Research has also indicated that favouritism, arbitrary decision making, lack of job autonomy, lack of input into decision-making, poor instrumental communication, decreased procedural justice, lack of trust in supervisors, lack of task control, and low administrative and supervisory support lead to increased job stress for correctional staff (Dowden and Tellier 2004; Slate and Vogel 1997).

Staff in Indian prisons

Little has been written about the staff in Indian prisons. K.V.Reddy, in his article on Prisons and Human Rights summarises staff issues thus: *Central to the prison administration is the problem of demoralisation and lack of motivation of the prison staff. The conditions in which the lower echelons of the prison staff lived were in some cases worse than those of the prisoners. This was seen as an important factor contributing to the poor functioning of the prisons, apathy of the prison staff towards the plight of the prisoners, corruption and the over all deprivation of the prisoners of their basic amenities. Such substandard conditions of service providers produce a culture of frustration and dehumanisation in the service which often spills over and gets translated into aggression on prisoners. The prevailing conditions of work create an environment that discourages initiative, leadership qualities and an enlightened rights based approach.*

Assessment of Prison Staff

In addition to evaluating mental health and substance use problems of prisoners, we carried out an assessment of the prison staff. Of the total of 207 prison staff, we interviewed 201 individuals. Majority were male (92.3%). Their mean age was 37.04 (11.7) years. While about one in five had been educated only upto high school a majority had received preuniversity education or higher. A small number had completed their postgraduation (5.8%). A majority (68%) was married.

Table 69: Socio-demographic background of prison staff

Sl No	Demographic details	Options	n(%)
1	Gender	Male	191 (92)
		Female	16 (8)
2	Education	Primary	0
		High School	47 (22)
		Pre-university	63 (30)
		Degree	79 (38)
		Post graduation	12 (6)
3	Religion	Hindu	192 (93)
		Christian	12 (6)
		Muslim	3 (1)
4	Marital Status	Single	59 (29)
		Married	140 (68)
		Widow(er) / Separated	3 (1)

There were no significant differences in terms of the educational status of male and female warders.

Weight classification of prison staff

About 40% of the prison staff was outside the normal weight range, with more than a third being overweight or obese.

Table 70: Prevalence of obesity among staff

BMI	Classification*	Male n(%)	Female n(%)	Total (202) n(%)
<18.5	Underweight	4(2.2)	1(6.3)	5(2.5)
18.5 -24.9	Normal weight	112(60.2)	10(62.5)	122(60.4)
25.0 -29.9	Overweight	55(29.6)	4(25)	59(29.2)
30.0-34.9	Class I obesity	11(5.9)	1(6.3)	12(5.9)
35.0-39.9	Class II obesity	4(2.2)	0	4(2)
≥40.0	Class III obesity	0	0	0
		186(100)	16(100)	202(100)

*World Health Organization classification of obesity

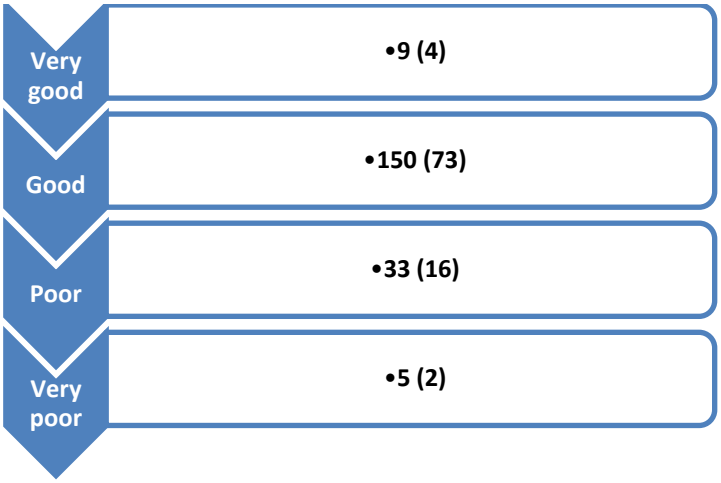
Overall physical health

While a majority (77%) rated their overall physical health as good, 18% rated it as poor or very poor. 3 persons (1%) did not provide any rating of their overall physical health. About one in ten staff reported falling sick frequently. The staff was divided in their opinion as to whether it was easy to get leave as and when necessary with 50% agreeing that it was easy and the other 50% saying it was not.

Table 71: Sickness and sick leave application among staff

Sickness	Options		
	Frequently (at least once a month or more)	Rarely (once or twice a year or less)	Never
How often do you fall sick?	19 (9)	63(30)	118(57)
Applied sick leave in the past year	20 (9)	44(21)	136(66)

Figure 26: Overall self-rating of physical health by staff



Specific physical problems among prison staff

Although a majority reported being in overall good physical health, digestive problems were commonly reported (20%), followed by joint pains and eye problems (11%) and back pain (10%). Many of these could be stress related as outlined in the subsequent section. A smaller number reported skin and dental problems (9%), diabetes and high blood pressure (8%). However, only one staff reported taking regular medication. This reflects that many of the staff are not taking treatment for their underlying physical problems.

Table 72: Health problems among staff

General medical problems	n(%)	General medical problems	n(%)
Physical disability	0	Epilepsy	1(0.5)
Heart problem	5(2)	Digestive problems	41(20)
Blood pressure	17(8)	Back pain	21(10)
Chest disease	2(1)	Rheumatic problem	22(11)
Diabetes	16(8)	Eye problems	23(11)
Mental illness	0	Skin disease	18(9)
Dental problems	18(9)		

Common symptoms of stress

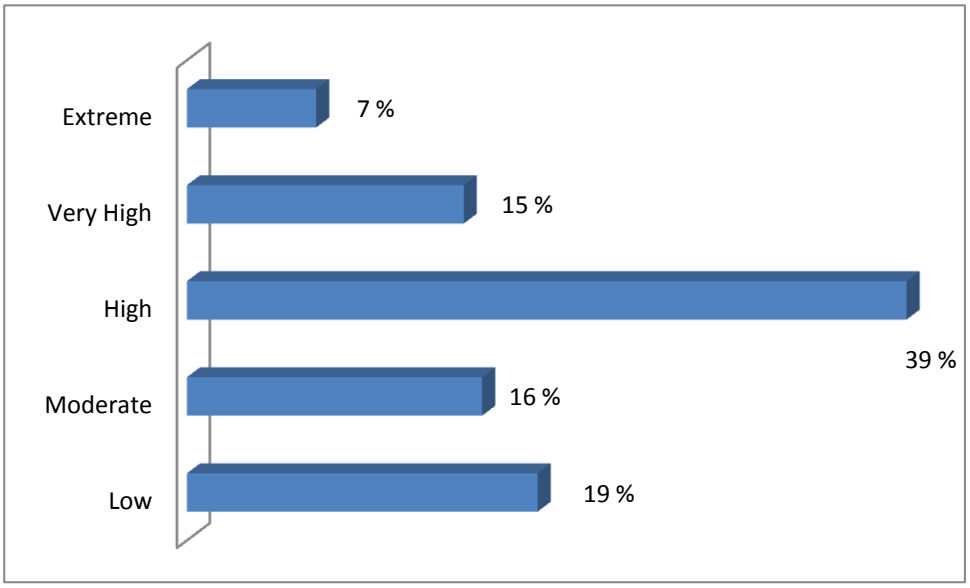
A considerable number had high perceived levels of bodily symptoms that could be attributed to stress. Such symptoms included headaches (46%), bodyache (25%), backache (18%), pain in the limbs (34%), fatigue (33%), decreased sleep (15%), inability to relax (36%), tendency to worry (39%), gas problems (15%), ulcer symptoms (97%), anxiety (32%), irritability (30%) and sadness(32%). A small number (2.5%) reported suicidal ideation.

Table 73: Symptoms and stress and distress among staff

Symptom	Perceived level of stress			
	Low (0-20%) n(%)	Moderate (21-40%) n(%)	High (41-60%) n(%)	Very High (over 60%) n(%)
Headache	104(50)	36(17)	37(18)	23 (11)
Backache	162 (78)	14 (7)	16 (8)	7 (3)
Bodyache	151(73)	24(12)	16(8)	9 (4.5)
Pain in limbs	131(63)	23(11)	35(17)	11 (5.5)
Fatigue	132(64)	30(15)	30(15)	8 (3)
Decreased sleep	167(81)	9(4)	11(5)	13 (6)
Cannot relax	126(61)	26(13)	23(11)	25 (12)
Worrying	112(54)	27(13)	33(16)	28 (13)
Gas problems	166(80)	13(6)	13(6)	8(3)
Ulcer symptoms	0	200 (97)	0	0
Tobacco use	191(92)	5(2)	1(0.5)	3 (1.5)
Alcohol or any other drug use	183(93)	2(1)	3(1)	2(1)
Anxiety	133(64)	23(11)	25(12)	19 (9)
Irritability / Anger	136(66)	25(12)	26(12)	13 (6)
Depression/sadness	133(64)	24(12)	27(13)	16 (7)
Suicidal ideas	195(94)	1(0.5)	4(2)	0

Overall perception of stress

Figure 27: Level of stress during the last year



Observations by the prison staff

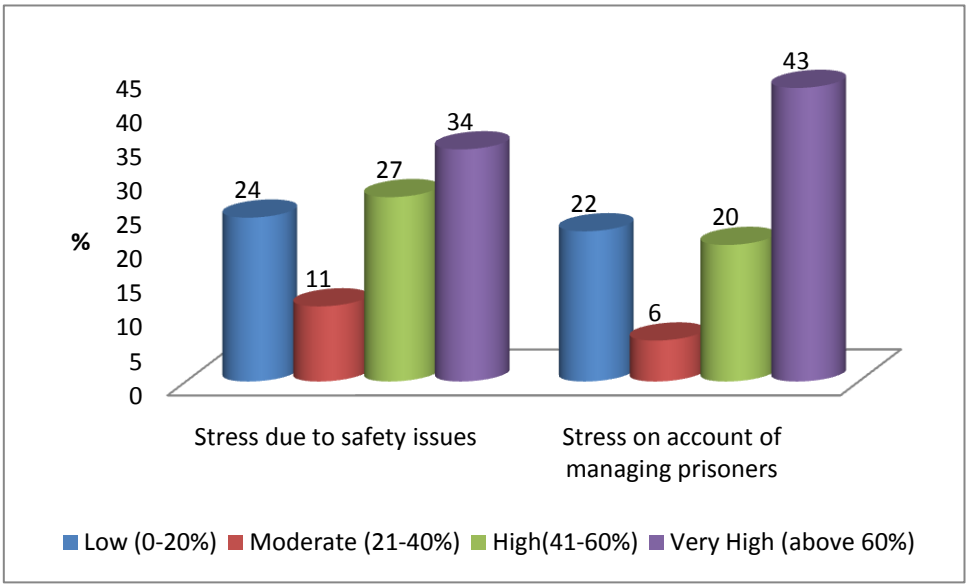
On interactions with the staff, more and more sources of stress emerge. Not only is the job viewed as thankless, it is also seen as hazardous and risky. Prisoners sometimes group together and threaten the staff, including the doctors. They sometimes make allegations the Courts and Human Rights Organisations. The staff often feels helpless. The staff are also threatened with violence, revenge if they don't comply to the 'special' needs of prisoners (these include demands for fake certificates when they want to avoid court proceedings, admission to the prison hospital without any ailment and refusing discharge despite recovery).

Only 19% of staff perceived that they were under low stress and the rest of the 81% perceive moderate to high levels of stress. While 16% perceived moderate levels of stress, 59% perceived high, very high or extremely high levels of stress.

Stress perception on account of the nature of the job

Most of the prison staff experienced stress on account of their job. Stress on account of safety issues was reported to be very high among 34% of the staff, high among a third (27%) of staff and moderate among 11%. A significant proportion also expressed very high (43%), high (20%) or moderate (6%) levels of stress in managing the prisoners.

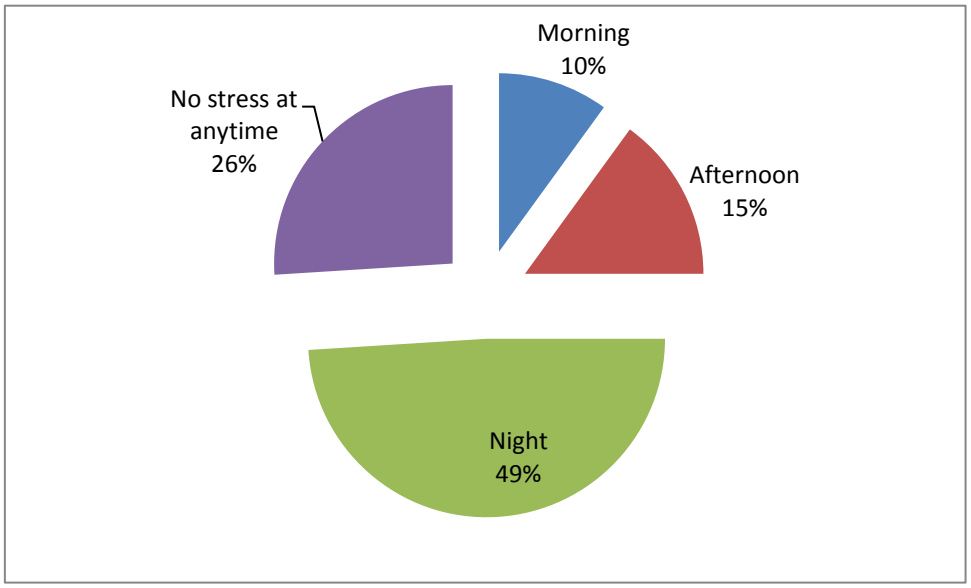
Figure 28: Major sources of stress among prison staff



Shift and relationship to stress

A majority of the staff perceived maximum stress during the night. Morning time, when the maximum number of staff is present, was perceived to be the least stressful. A majority (44%) felt that the allocation of shift duty was not done in a fair manner. When asked for the preference of shift, 56% indicated preference for the morning shift, 10% for the afternoon, 8 % for the night, while 25% indicated no specific preference for any particular shift.

Figure 29: Shift where maximum stress was reported



Other work environment sources of stress

Other common sources of stress were fear of suspension with 39% experiencing moderate to high levels of stress on this account and anticipation of transfer (23%). Only 9% of staff attributed some level of stress to co-workers.

More than a third of the staff (38%) felt that their posting was not done fairly and 20% preferred to respond that they did not know. Clearly, there is a high amount of disatisfaction with their perception of whether their postings are done fairly.

Lack of security is another worry for the prison staff. Lady staff often has to deal with disinhibited behaviour from male prisoners.

Manipulative behaviours and malingering (pretending to be ill) by prisoners occurs often and is difficult to deal with.

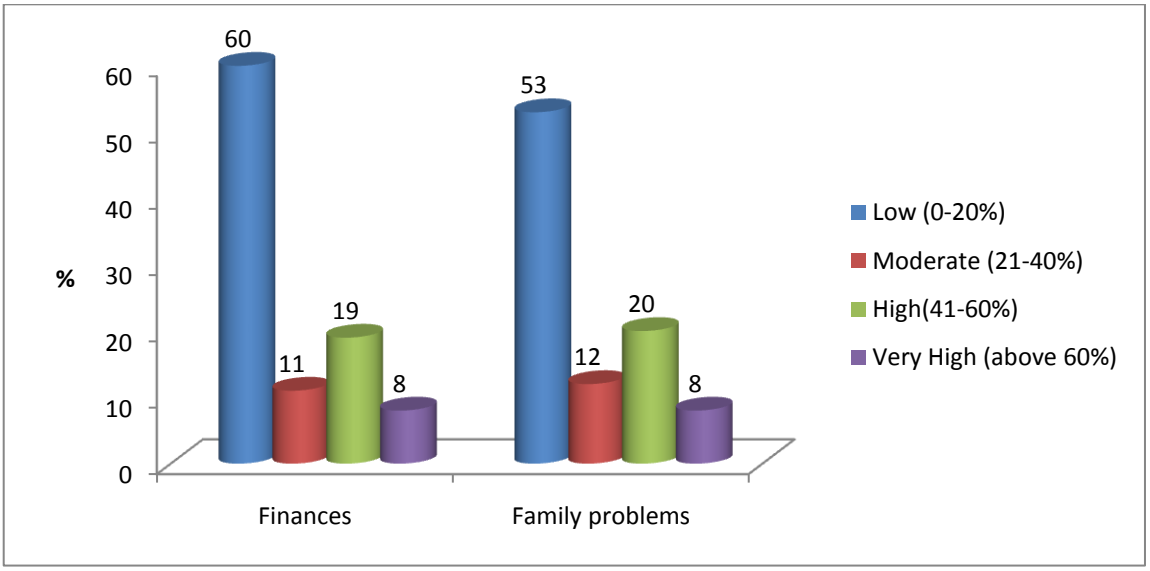
Table 74: Other sources of stress among prison staff

Source	Perceived level of stress			
	Low (0-20%) n(%)	Moderate (21-40%) n(%)	High (41-60%) n(%)	Very High (over 60%) n(%)
Stress due to co-workers	182 (88)	4 (2)	12 (6)	2 (1)
Stress due to anticipation of suspension	117 (57)	20 (10)	34 (16)	29 (13)
Stress due to anticipation of transfer	152 (73)	11 (5)	23 (11)	14 (7)

Personal sources of stress

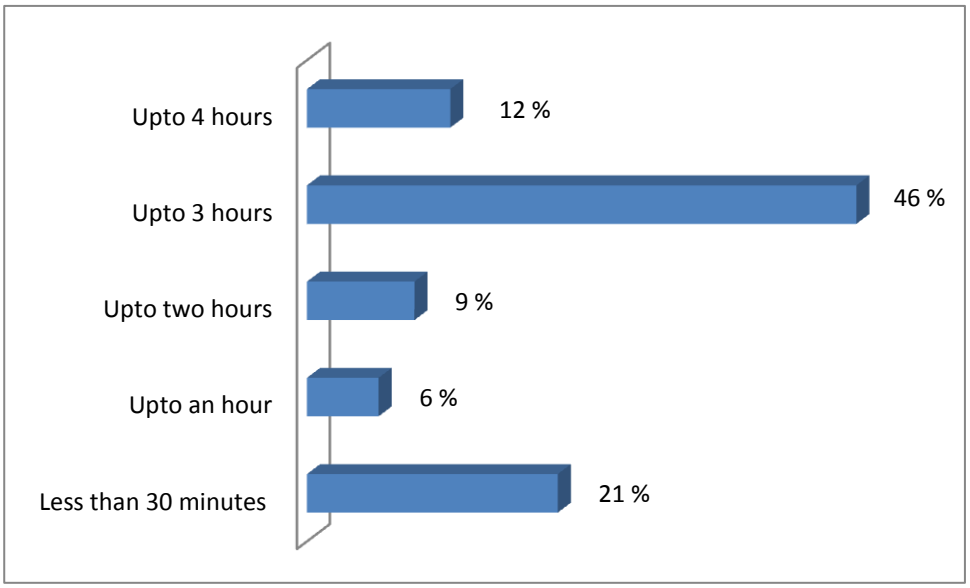
40% of the staff perceived moderate to very high levels of stress because of family issues and 38% on account of financial issues. Forty seven percent expressed dissatisfaction with their pay scales.

Figure 30: Personal sources of stress among prison staff



Prison staff reported spending very little time with their family members. A majority (82%) spent under 3 hours everday with their families. About one in five staff (21%) spent just upto 30 minutes during the entire day with their families.

Figure 31: Time spent daily with family members



Rank Order of sources of stress for prison staff

The stressors most frequently perceived as moderate or high among the staff are rank ordered in figure 31.

Thus, the greatest stress for the prison staff emerges from concerns for their personal safety and difficulties in managing the prisoners. There is always the threat of suspension should anything go wrong. Family and financial worries compound fears related to work.

Figure 32: Rank order of sources of stress among prison staff

Clear definitions of roles and responsibilities

The staff were asked if their roles and responsibilites were clearly defined so that accountability can be ensured. Nearly one in five staff (19%) felt that there was no clarity on their roles and responsiblities. A majority (62%) felt this was adequate.

Table 75: Adequacy of Staff

Our prison is understaffed	Strongly Agree	24(12)
	Agree	7(3)
	Do not know	11(5)
	Disagree	127(61)
	Strongly Disagree	31(15)

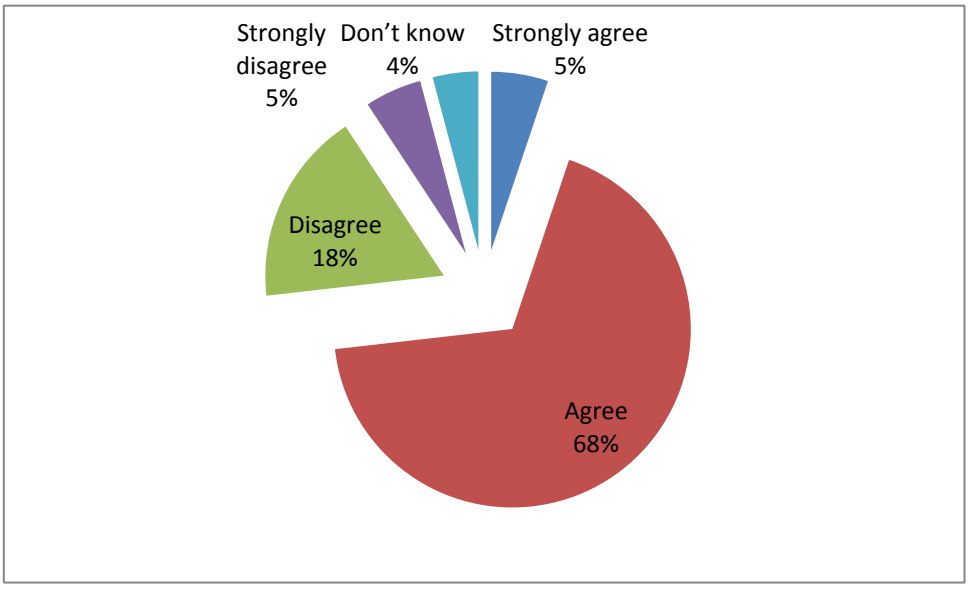
Appreciation for their work

With regard to appreciation of their work, the staff was asked to respond to the following statements:

1. *My job is appreciated in society*
2. *My superiors appreciate the work I do*

A majority (68%) agreed that their job was indeed appreciated by society. However, more than one in five staff (23%) did not feel that their work is appreciated in the larger society.

Figure 33: 'My job is appreciated in society' - Responses



A larger number of staff perceived lack of appreciation from their superiors. Thus, 40% of the prison staff felt their superiors did not appreciate their work. Lack of support and appreciation from superiors can make the work environment very demoralising. A stressful environment with lack of support for work is an ideal breeding ground for dissatisfaction, stress and psychological morbidity.

Figure 34: "My superiors appreciate the work I do"- Responses

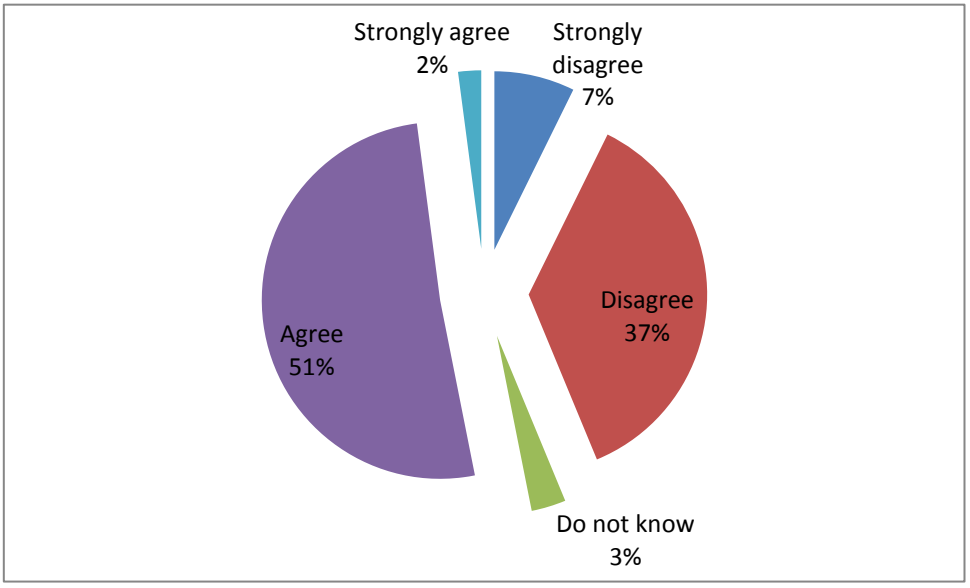
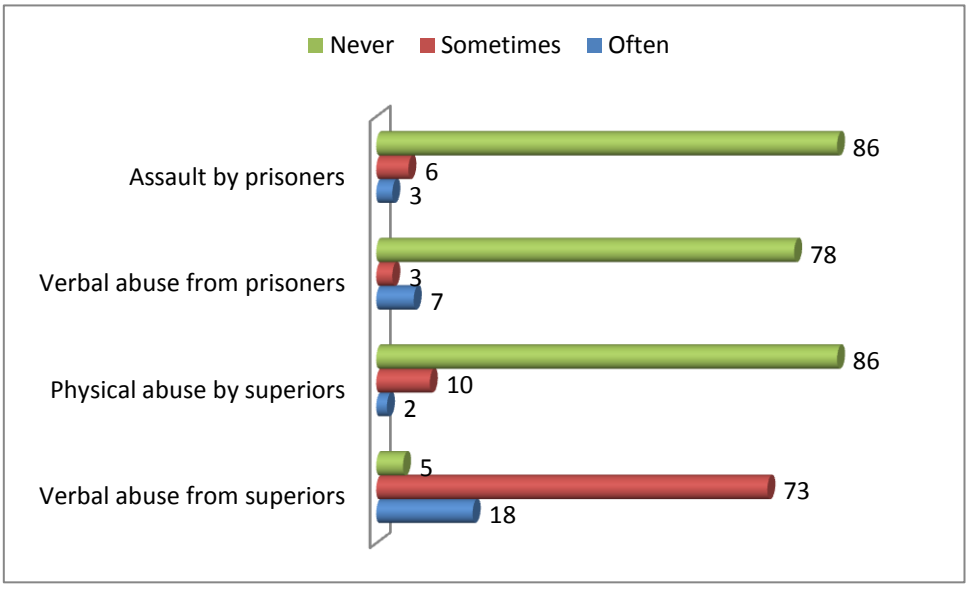


Figure 35: Verbal and physical abuse from superiors and from prisoners (figs in %)



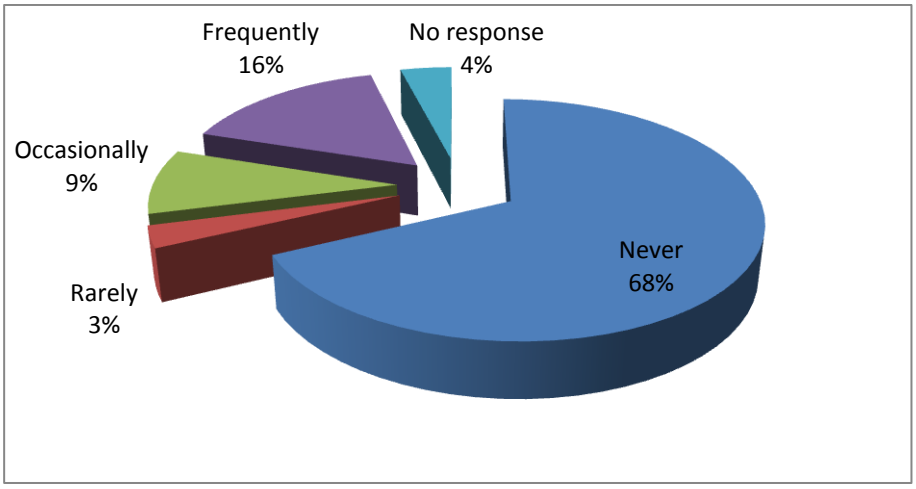
The staff was asked about the level of respect they got from their superiors and from the prisoners they were in charge of. One in five staff (20%) felt that they were not treated

with respect by their superiors. Let alone respect and appreciation for their work, the staff reported abuse from their superiors. The commonest form of abuse reported by staff was verbal abuse from superiors, with 91% reporting verbal abuse. Among those who reported such abuse, 18% reported it frequently and 73% sometimes. More than one in ten staff (12%) reported physical abuse by superiors.

Response to stress

The staff was asked whether they had considered resigning their current job because of the stress.

Figure 36: Ever considered resigning current job because of stress



While a majority (68%) had never contemplated leaving the job due to stress, 25% had contemplated resigning occasionally (once a year or more often) or frequently (monthly or more often).

Due to the perceived risky and dangerous environment in which prison staff are working, many of them present with depression, somatoform disorders and substance use. During the interviews, staff expressed that they were not at all happy with the working environment. *"The authorities are concerned about the prisoner's well being but nobody is there to care for us".*

Diagnosable psychiatric illnesses among the prison staff

The prison staff was also administered the MINI plus standard psychiatric interview for lifetime and current psychiatric illnesses.

Table 76: Diagnosable mental disorders among staff

Diagnosis	n(%)	Diagnosis	n(%)
Major depressive episode (current)	10(5)	**Conduct disorder**	1(0.5)
Major depressive episode (past)	12(6)	**Anti social personality disorder**	1(0.5)
Major depressive episode (lifetime)	22(11)	**Social phobia current**	9(4)
Substance induced mood disorder	7(3)	**Social phobia generalized**	2(1)
Suicide (low risk)	1(0.5)	**Specific phobia current**	3(1)
Deliberate self harm	1(0.5)	**Post traumatic stress disorder current**	1(0.5)
Panic disorder current	2(1)	**Alcohol dependence current**	23(11)
Agoraphobia current	1(0.5)	**Alcohol abuse current**	3(1)
Agoraphobia lifetime	1(0.5)	**Alcohol dependence lifetime**	29(14)
Generalized anxiety disorder	5(2)	**Alcohol abuse lifetime**	3(1)
Pain disorder	2(1)	**Tobacco dependence lifetime**	7(3)

Lifetime and current depression rates among prison staff were high (11% and 5% respectively). Similarly lifetime and current alcohol dependence rates were high (14% and 11% respectively). These rates are very much higher than the prevalence in the general population. Though spontaneous self report of alcohol use was very low, a significant proportion of staff met the criteria for dependence. Tobacco dependence

(lifetime) was present in 3% of the staff. In the current study, although only one person was estimated to have a suicidal risk, suicidal attempts and completed suicides are not unknown among the staff. It is well known that severe mental stress can lead to hopelessness and helplessness and culminate in suicide. Such instances have been reported in prison. High levels of stress, depression and alcohol dependence are present among prison staff. All these areas merit immediate and serious attention.

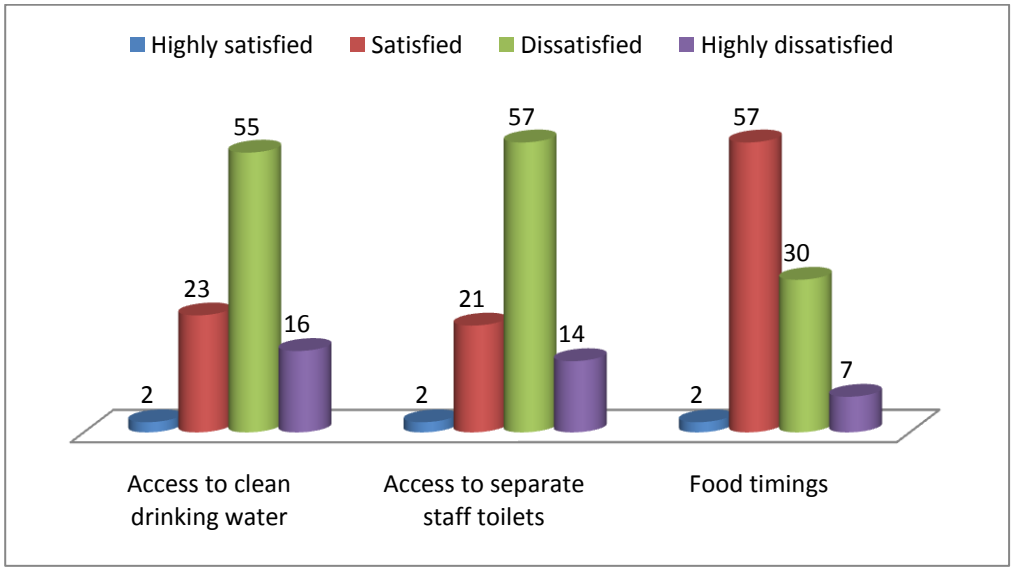
Need for training in stress management

A majority (71%) of the prison staff affirm the need for stress management training for themselves. More than half (52%) felt such programmes should be held at least once or twice per year.

Staff perception of basic amenities in prison

The staff was asked to comment on the same critical areas that prisoners had been asked to comment. These included quality of food, access to clean drinking water, and adequate access to toilets.

Figure 37: Staff satisfaction with amenities (response in %)



A significant proportion of staff expressed dissatisfaction with access to clean drinking water (71%) were dissatisfied or highly dissatisfied and access to separate staff toilets (71%) were dissatisfied or highly dissatisfied). More than a third (37%) was dissatisfied with the regularity of food timings.

Familiarity and attitude of prison staff towards persons with mental illness

Nearly half (46%) of the staff reported coming into contact with persons with mental illness frequently, and 44% said they came into contact with mentally ill persons on a rare occasion. A small number (8%) said they had never come across persons with mental illness.

A majority (73%) agreed that mental illness was common among prisoners. They were generally optimistic about treatment with 84% agreeing that mental illness is treatable. However, a significant proportion of the staff (56.5%) shares the lay misconception that persons with mental illness are highly dangerous and violent, and this needs to be corrected.

Poor knowledge of mental illness among the prison staff

Mr. P, a prisoner would suddenly attack and attempt to throttle his co-prisoners without any provocation. After a couple of such incidents, this was brought to the notice of the police in charge, who beat up Mr P badly, tied him up and left him in an isolated room. Two days later, Mr P developed swelling of legs and hands. He was referred from Gulbarga to Bangalore for further treatment.

On examination, he had cellulitis, which was treated. In Central Prison, Bangalore, he once again tried to throttle one of his co-prisoners without any provocation. This was brought to the notice of the prison psychiatrist. On mental status examination, it was found that, Mr.P had delusions and hallucinations. He was diagnosed to be suffering from schizophrenia. He improved significantly after receiving medication.

Table 77: Perceptions regarding mental illness and treatment

	Strongly disagree	Disagree	Don't know	Agree	Strongly agree
Mental illness is common in prisoners	1(0.5)	30(15)	17(8)	147(71)	5(2)
Mental illness is treatable	0	17(8)	8(4)	170(82)	5(2)
Mentally ill patients are highly dangerous and violent	9(4)	59(28)	15(7)	116(56)	1(0.5)

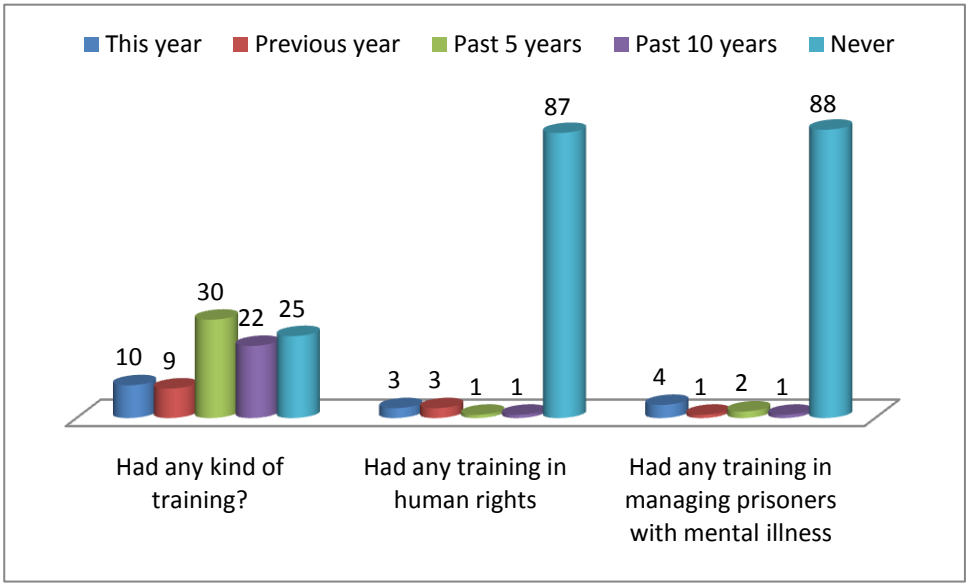
A majority of staff (174, 84%) concurred that persons with mental illness require medical treatment. Twenty one staff (10%) felt that such persons must be isolated. Only two staff (1%) felt that physical restraint and punishment were required for treatment of mental illness.

Existing Inservice Training

One in four prison staff reported having received no kind of training in their career, and more than half (52%) had received some kind of training several years ago. However, a majority of the staff (87%) had not received any training in human rights issues, or in managing prisoners with mental illness (88%).

The quality of services in prisons, particularly for mental health problems has been a concern not just in India, but from several other countries. Reed and Lyne (2000) investigated the facilities for inpatient care of mentally disordered people in prison. They inspected 13 prisons with inpatients beds in England and Wales and appraised the quality of care against published standards. They found that no doctor in charge of inpatients had completed specialist psychiatric training. Majority of nursing staff did not have mental health training. Only one prison had occupational therapy input. Most patients were unlocked for about 3.5 hours a day and none for more than nine hours a day. They concluded that the quality of services for mentally ill prisoners fell far below the standards in the National Health Services.

Figure 38: Exposure of prison staff to training (response in %)



Need for training in managing mental illness among prisoners

A majority of the staff (71%) felt the need for training in this regard. 44% of the staff felt that such training must be held once or twice every year. 11% felt it can be held much less frequently.

Summary of the Findings

The prison staff has a difficult job in carrying out day to day management tasks within the complex organisational environment of the prison. In Indian prisons, very little has been written about prison staff, and the little that has been written, suggests a major problem of demoralisation and lack of motivation among the staff. We therefore carried out an assessment of the prison staff and interviewed 201 staff. A majority of the staff in the Bangalore prison had received pre-university or higher grades of education (74%) while 22% had been educated only upto high school.

With regard to their physical health, 40% of the staff was outside the normal weight range, with more than a third being overweight or obese. Nearly one in five (18%) self

reported poor or very poor health. Common physical problems included digestive problems, joint and back pains and eye problems. Very few staff had been evaluated in detail for their physical problems and only one reported taking regular medication.

Staff had a number of bodily symptoms attributable to stress including headaches (46%), bodyache (25%) and backache (18%). Psychological symptoms of stress reported were worry (39%), inability to relax (36%), anxiety (32%), sadness (32%) and irritability (30%). Decreased sleep was reported by 15%. A majority (81%) self- reported moderate to high levels of stress. Sources of stress include concerns for personal safety and difficulties in managing the prisoners. Stress was also reported due to anticipation of transfer and fear of suspension. Shift duty also contributed to stress, with maximum stress reported during night duties. A significant number of staff perceived unfairness in posting for duties. Personal sources of stress are financial and family related. Prison staff spends very little time with their families, and 82% reported spending under 3 hours every day with their families. A significant number (40%) were dissatisfied with their salaries. Stress was aggravated by low morale stemming from lack of appreciation from superiors (40%), lack of respect (20%) and worse, reports of verbal (91%) and physical abuse (12%). One in four staff had occasionally or frequently contemplated resigning on account of stress. Prison staff showed higher lifetime and current prevalence rates of both depression and alcohol dependence.

A significant proportion of staff was dissatisfied with access to clean drinking water (71%), separate staff toilets (71%) and regularity of food timings (37%). A substantial number of them (90%) had come in contact with persons with mental illness, believed mental illness is common among prisoners (73%) and that it is treatable (84%). Although it is reassuring that the staff here are relatively more familiar with mental illness, there is a great need for education on mental illness, its prompt recognition and appropriate intervention. Of concern is the misperception that mentally ill are highly dangerous and violent (56.5%). Most staff (88%) themselves perceived the need for training in mental illness management as well as regular inservice training. A majority (87%) had not received any training in human rights issues.

What needs to be done?

Prisons are often difficult and demanding working environments for all levels of staff. 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. A prison that is responsive to, and promotes the mental health of prisoners, is more likely to be a workplace that promotes the overall morale and mental health of prison staff and should therefore be one of the central objectives of good prison management.

Training prison staff at Central Prison, Mysore

Training on mental health issues should be provided to all people involved in prisons including prison administrators, prison guards and health workers. Training should enhance staff understanding of mental disorders, raise awareness on human rights, challenge stigmatising attitudes and encourage mental health promotion for both staff and prisoners. An important element of training for all levels of prison staff should be the

recognition and prevention of suicides. In addition, prison health workers need to have more specialised skills in identifying and managing mental disorders (WHO MH fact sheet).

There is a clear need to decongest the prisons, increase the number of staff, train the staff on counselling, conflict resolution, and enhance the safety procedures and mechanisms, apart from ensuring that fit warders with self defense skills are employed in prisons. Routine screening of staff for physical and mental health issues and providing appropriate interventions can be of immense help. There needs to be better infrastructure to address the health needs of the prisoners and staff. Good health care can reduce death and disability in prison settings and result in reducing violence against the prison staff. There is a need to provide more cash allowance given their hazardous work environment.

Training volunteer prisoners in peer counselling, handling substance use problems and emotional issues

Generally speaking, prison staff are held in lower regard than other people who work in the criminal justice field, such as the police. This is often reflected in the pay of prison staff, which in many countries is very low. As a consequence it is often very difficult to recruit properly qualified staff to work in prisons. In order to attract and to retain high quality personnel it is essential those salaries should be set at a proper level and that the other conditions of employment should be the same as in comparable work elsewhere in the public service.

10. Indicators of health status in the Bangalore Prison and actionable points

In this chapter we summarise the major findings from the study with respect to mental health and substance abuse problems among prisoners, as well as their felt needs while in the prison and following release. For each indicator, there would be one or more action points, which are noted in this chapter. These will form the basis of the recommendations presented in the next chapter. While the actionable points stem from the findings of the Bangalore Prison Study, the recommendations that ensue in the next chapter will be applicable for all prisons in India.

The proportions indicated below are with respect to the prison population evaluated at the time of the study (n=5024) unless otherwise indicated.

Table 78: A SUMMARY OF INDICATORS OF HEALTH STATUS AMONG PRISONERS OF CENTRAL PRISON, BANGALORE

	Indicator	Proportion (Bangalore Prison Study)	Actionable points and Comments
1	**Demographic Indicators**		
1.1	Overcrowding	248%	Need to address issues of overcrowding to improve standards of living Need to educate prisoners on health and ill health Need to address psychological issues with respect of families
1.2	Illiteracy	20% UTP, 23.4% CTP	
1.3	Poverty (family income below Rs 3000)	33.5%UTP, 44.4% CTP	
1.4	Staying with families prior to prison entry	86%	
2	**Common self reported health problems**		
2.1	Back and neck problems	16%	Low rates of self-reported physical problems like diabetes, hypertension Relatively higher rates of psychosomatic symptoms Very low treatment rates
2.2	Arthritis	14.7%	
2.3	Digestive disorders	13%	
2.4	Skin disease	10.5%	
2.5	Self report of diabetes	3%	
2.6	Self report of high blood pressure	3.9%	

2.7	Detection of hypertension	20.5%	and treatment adherence
2.8	On regular medication for any health condition	5%	Need to educate about common health conditions
2.9	Positive Random urine testing for diabetes	4.5% new entrants 4.6%	Need to routinely screen and intervene for non communicable diseases. Screening doubles the detection of underlying diabetes
2.10	Random urine testing for proteinuria	7.3% new entrants	
2.11	Body Mass Index Underweight (below 18.5)	33.8% UTP, 19.8% CTP 25% new entrants	Need evaluation of renal dysfunction due to diverse causes
	Overweight (above 25)	33.8% UTP, 19.8% CTP 25% new entrants	Problems of both undernutrition and overnutrition exist Sedentary prison life Increased relationship between obesity and diseases like hypertension, diabetes, arthritis, mental health problems
3	**Secondary health related data**		
	(Most common hospital referrals)		Referral mainly for infections
3.1	Skin disease	40%	
3.2	Gastrointestinal problems	20%	Low rates of referral for chronic non-communicable diseases indicates need for better screening
3.3	HIV sero-positivity	3% (2008)	Higher prevalence of non-specific health problems underscores need for psychological evaluation for psychosomatic conditions High rates of HIV sero-positivity. HIV risks are

			known to increase in populations with high substance use and other adversities
4	**Deaths in prison and recorded causes**		
4.1	Annual deaths *Recorded causes*	38 in 2008. Annual prevalence 7.3 deaths per 1000	Deaths in prison twice that of the general population
4.2	HIV	26%	Need for systematic screening for both
4.3	Cardiac causes	23%	communicable and non-communicable diseases
4.4	Cancer	17%	High rates of suicide
4.5	Suicide	11%	Existing rates of detection of drug abuse very low
4.6	Tuberculosis	9%	
4.7	Drug abuse related	3%	
5	**Mental health conditions identified**		
5.1	Self-reported mental health condition	2%	High discordance between self-reported and diagnosed levels of mental health problems Very high rates of mental health and substance use problems Need to educate and counsel prisoners regarding psychological issues
5.2	Any mental health or substance use condition detected by study	76.9%	
5.3	Diagnosable mental health condition (apart from substance use)	27.6	
5.4	Major depressive episode (lifetime)	13%	
5.5	Major depressive episode (current)	10%	
5.6	Somatisation	1.7%	
5.7	Pain disorder (current)	5.4%	
5.8	Conduct disorder in childhood	13%	
5.9	Anti-social personality disorder	13.1%	
5.10	Diagnosis of Psychosis (Prison psychiatrist)	2.2%	
6	**Suicidal attempt and self injurious behaviour**		
6.1	Suicidal attempt (lifetime)	1.7% UTP, 1.1% CTP	It is important to identify and reduce risk among vulnerable prisoners 11% of deaths in prison have been identified as completed suicides Among those expressing suicidal ideation, mean
6.2	Deliberate self harm lifetime	2.9% UTP, 1.5% CTP	
6.3	Deliberate self harm in prison	1.5% UTP, 0.8% CTP	
6.4	Mean suicidal risk score (among those who expressed suicidal ideation)	11.5-UTPs,10.6- CTPs	

			suicidal risk scores indicate moderate suicidal risk
7	**Alcohol use**		
7.1	Ever used alcohol	51.5% 58% new entrants 3% women	High levels of ever use of alcohol among male prisoners
7.2	AUDIT scores above 8 (one year prior to prison entry)	86% of those who ever used	Harmful patterns of alcohol use in a majority as well as high rates of alcohol dependence prior to prison entry indicating the need for treatment and rehabilitation
7.3	Mean AUDIT score	17	
7.4	Lifetime Alcohol Dependence	43.5%	
7.5	Current Alcohol Dependence (one year prior to prison entry)	14%	
7.6	Self-reported use of alcohol in the last week in prison	3.7%	Use of alcohol occurs even inside the prison
8	**Tobacco Use**		
8.1	Self-reported lifetime use of any tobacco use	67.3%	High rates of lifetime tobacco use among prisoners
8.2	Self-report of any tobacco use in the year prior to prison entry	18.3 years UTP 20.4 years CTP	
8.3	Age of smoking initiation	19 years UTP 20.2 years CTP	Majority of new prison entrants are tobacco users
8.4	Age of chewing initiation	71.9%	Tobacco smoking increases enormously following prison entry
8.5	Use of any tobacco in the month prior to imprisonment among new male entrants	Increased from 9.2 sticks to 34.3 sticks per day UTP	
8.6	Change in tobacco smoking after prison entry	Increased from 11.4 sticks to 44.9 sticks per day CTP Chewing increased from 8.3 sachets to 20.9 sachets per day UTP	Chewing tobacco also increases significantly following prison entry High rates of breath CO at high levels indicates active smoking exposure likely to cause harm both to the smoker and to the others in prison (through passive smoking)
8.7	Change in tobacco chewing after prison entry	Chewing increased from 8.7 sachets to 10.8 sachets per day CTP	
8.8	Breath CO monitoring among male prisoners in the CP	42.6% had high CO levels (above 7 ppm) indicating recent smoking exposure	

9	**Any other drug use**		
9.1	Any other drug use lifetime (self-report)	13.8% UTP 10.5% CTP	High rates of self-reported lifetime drug use
9.2	Anonymous urine drug screen (n=721)	61.3% positive for drugs	Anonymous drug screening reveals much higher levels of drug use within the prison
	Cannabis positive	32% UTP 29.2% CTP 13.2 % new entrants	
	Opioid positive	3% UTP 3.8% CTP	
	Cocaine positive	16.3% UTP 13.3% CTP 17% new entrants	
	Barbiturate positive	15% UTP 1.3% CTP	
	Benzodiazepine positive	57.4 % UTP 24.4% CTP 28.3% new entrants	
	Amphetamine positive	9.9% UTP 6.1% CTP	
10	**Gambling**		
10.1	Gambling lifetime (self report)	11%	There are anecdotal reports of gambling within the prison
11	**Expressed need for help with addiction (% of users)**		
11.1	Help for smoking cessation	85%	A majority of the prisoners are willing to take help for tobacco, alcohol and other drug dependence. Many of them have entered the prison with a substance use problem, and have continued use in prison. Some have developed the problem after prison entry
11.2	Help for chewing tobacco cessation	73%	
11.3	Help for alcohol cessation	99%	
11.4	Help for other drug use cessation	71%	

12	**Health care delivery in the prison (prison population at the time of study- 5200)**		
12.1	Doctors	*4*	The health system delivery currently existing in the prison is extremely inadequate. The doctors and nurses are very few, and other health professionals are non-existent Inpatient facilities in the prison are grossly inadequate Referral systems for adequate medical and psychiatric care need to be strengthened
12.2	Staff nurse	*1*	
12.3	Inpatient beds	*100*	
12.4	Occupancy at time of study	*250 (150% overcrowding)*	
12.5	Doctor:prisoner ratio	1:1300	
12.6	Other health professionals like counsellors/health workers	*Nil*	

Expressed needs of resident prisoners

13	**Dissatisfaction with**		
13.1	Visiting room arrangements	26.1%	Improve visiting facilities
13.2	Current visiting system	21%	
13.3	Cleanliness of living area	33%	Pay attention to living conditions, reduce overcrowding,
13.4	Cleanliness of toilet	44%	
13.5	Access to clean and safe drinking water	38%	
13.6	Quantity of food provided	25%	Improve food quality and service
13.7	Quality of food provided	59%	
	Other difficulties		
13.8	Find difficulty in bathing daily	33%	Encouraging personal hygiene is important to prevent spread of diseases
13.9	Do not feel treated with respect from the staff	17%	Ensure staff training and sensitisation
13.10	Find it difficult to see the doctor in the prison	34% (22% do not know)	Increase access to health care

13.11	Do not attend any rehabilitation or occupational therapy	90.3%	Urgent need for appropriate rehabilitation and occupational therapy
13.12	Perceive that rehabilitation/occupational therapy will provide work with a purpose	13%	Need to educate the prisoners about the importance of work and design vocational training to suit post-release needs
13.13	Not aware against the legal charges against self	22%	Legal literacy and support is an urgent need for the prisoners
13.14	Do not have a lawyer	14%	
13.15	Do not get escorts regularly to attend court proceedings	70%	Legal procedures, particularly for minor offences need to be simplified
13.16	Unhappy with pace of legal proceedings	51%	

Prison Staff – Health Morbidity and Needs (n=201)

14	**Indicator**	**Proportion**	**Actionable points/comments**
14.1	Overweight (BMI >25)	29.2%	Need to address lifestyle issues of prison staff
14.2	Poor physical health (self rated)	18%	A substantial number of prison staff perceives being in poor physical health
14.3	Common physical health problems (self reported)		
	Digestive problems	20%	Very few are on regular medication for underlying physical health problems
	Joint pains	11%	
	Eye problems	11%	
	Backpain	10%	None of them self-report any mental problems/illness
	Dental problems	9%	
	Diabetes	8%	
	High blood pressure	8%	
14.4	On regular medication for underlying physical health problems	1 (0.5%)	

14.5	Self reported mental problems/illness	0	Although none of them report mental health problems, they have high levels of psychological stress as revealed below. Many of them also suffer from physical, physiological and psychological symptoms of stress
	Symptoms associated with moderate to very high stress (elicited during interview)		
	Ulcer symptoms	97%	
	Headache	46%	
	Worry	39%	
	Aches and pains	34%	
	Inability to relax	36%	
	Anxiety	32%	
	Depression/sadness	32%	
	Fatigue	33%	
	Decreased sleep	15%	
	Anger/irritability	30%	
	Backache	18%	
14.6	Moderate to high levels of overall stress	81%	A majority of staff experience stress particularly on account of the nature of their job and their safety concerns as well as family problems. Lack of support from superiors aggravates the stress. Abuse from superiors is unacceptable There is an urgent need to address staff stress as well as the issues contributing to this
	Attributed to:		
	Safety concerns	82%	
	Difficulties in managing prisoners	69%	
	Family problems	40%	
	Fear of suspension	39%	
	Financial problems	38%	
	Fear of transfer	23%	
	Considered resigning from job because of work stress	28%	
14.7	Self-esteem at work		Morale among the staff needs to be heightened
	Do not feel job is appreciated by society	23%	
	Do not feel superiors appreciate them	40%	
	Do not feel superiors respect them	20%	
	Report verbal abuse from superiors	91%	
	Report physical abuse by superiors	12%	
14.8	Commonly diagnosed psychiatric illness among staff (through interview)		Staff need education about mental health problems both from the point of view of identifying these among prisoners as well as among themselves
	Major depressive episode lifetime	11%	
	Major depressive episode current	5%	
	Alcohol dependence lifetime	14%	
	Alcohol dependence current	11%	

11. Recommendations

" *The degree of civilisation in a society can be judged by entering its prisons"*

Fyodor Dostoevsky, 1821-1881

Proper identification and management of mental illnesses in prison and improvement of mental and physical well being are critical for both the process of rehabilitation in prison, as well as for maintaining a facilitatory prison environment that promotes a corrective experience. Health promotion in prisons also has several other benefits (WHO 2008) which include:

to the prison:

- improved security
- safer environment
- improved staff–prisoner relations
- improved industrial relations
- easier recruitment and retention of staff
- lower sickness absence/ill-health retirement rates
- reduced assaults and other incidents
- greater efficiency
- greater cost-effectiveness;

to the prisoner:

- increased emotional and physical wellbeing;
- increased ability to confront offending behaviour;
- increased confidence and social skills;
- ability to use time well and plan realistically for the future;
- social inclusion and improved rehabilitation prospects;
- reduction in the likelihood of developing mental disorder, or in the degree of mental disorder experienced;

to the staff:

- improved job satisfaction
- higher morale
- lower levels of tension and stress
- consequent improvements in mental and physical health;

to the family:

- better relationships between family members
- safer environment for children to grow up
- lower risk of developing mental ill health in family members;

In order to promote mental well-being and effective treatment of mental health problems, an assessment of ground realities is critical. The Bangalore Central Prison provides a window view into the health and related problems prisoners in many parts of India face. There are several lessons to be learnt from the findings of the study that are relevant all over the country. However, it must be emphasized at the beginning of this section that the Bangalore Central Prison is one of the relatively better prisons in the country. Several improvements have occurred from time to time, which may not be the case in many other prisons in the country. Nevertheless, these findings form the basis of larger recommendations to address the health needs, particularly mental health needs of prisoners.

Health care as a basic right

Although prisoners are necessarily denied some basic rights such as freedom of movement, they retain all other human rights, including the right to health and to be treated with dignity (WHO 2007). All health, including mental health and substance use services must have as their basis, the promotion of and respect for human rights. The recommendations outlined below indicate what needs to be done and suggests the steps that need to be taken at programmatic and policy levels, to ensure this action. The reforms suggested here are confined to reforms in the broad context of health particularly mental health.

1. Proper evaluation and assessment upon prison entry:

1.1. Every prisoner needs to have a systematic evaluation at the time of entry into the prison. The minimum health data as prescribed by the National Human Rights Commission must be documented for each prisoner. A brief substance use history and mental state history and evaluation must be incorporated into the health screening

1.2. Any prisoner reporting a substance use problem must be assessed for intoxication, withdrawal, and for any serious physical or psychiatric complications and referral made to the medical officer.

1.3. A breath alcohol examination and urine screen for active substance use upon prison entry will facilitate referral of prisoners with active use for a more detailed assessment.

1.4. Prisoners with a past or current history of any mental problems must be evaluated in detail for any necessary intervention.

1.5. At the time of entry, all prisoners should undergo a detailed physical examination

1.6. Prisons are public places, where by law (Cigarettes and Other Tobacco Products Act 2003) smoking is banned. All prisoners should be explained regarding prison policies and offered treatment for nicotine dependence.

2. General care in prison

2.1. The cleanliness in the environment, proper toilet facilities and personal cleanliness are very important for physical and mental well-being. All the necessary resources to ensure such cleanliness must be provided.

2.2. Basic needs such as potable water, adequate food, access to open air, exercise and entertainment must be ensured for all prisoners. Women prisoners, especially when they are few in number, are likely to be confined in smaller spaces. Their needs must be kept in mind.

3. Improving mental health services in prison

3.1. Prompt and proper identification of persons with mental health problems. This involves training of the prison staff and availability of counsellors.

3.2. Identification of persons with serious mental illness and proper treatment and follow-up for this group.

3.3. Ensuring the availability of psychiatric medication in the prison to facilitate prompt treatment (Antipsychotic medication, antidepressant medication, anxiolytic medication, mood stabilizers, anticonvulsant medication, etc).

3.4. Availability of psycho-social interventions for prisoners with a range of mental health problems.

3.5. Protocols for dealing with prisoners with suicidal risk, with behavioural problems and crises related to mental illnesses as well as to prison life.

3.6. Suitable rehabilitation services for prisoners with mental illness.

3.7. Specific attention to the aftercare needs of prisoners with mental illness including providing medication after release, education of family members, steps to ensure treatment compliance and follow-up, vocational arrangements, and for those without families, arrangements for shelter.

4. Dealing with the psychological stress of prison life

4.1. Counselling for stress needs to be provided to all prisoners in both individual and group settings.

4.2. Prisoners must be encouraged to proactively seek help for any emotional problems, substance use problems or physical health problems.

4.3. Training the prison staff in simple counselling skills.

4.4. Empowering some of the sensitive, motivated convicted prisoners to be effective peer counsellors.

4.5. One to one counselling upon entry, during periods of crises and upon need or request.

4.6. Address the issues that commonly lead to psychological stress, including living conditions.

5. Addressing substance use problems

5.1. Identification of substance use problems through questionnaires, behavioural observation and urine drug screening.

5.2. Detoxification services and making suitable pharmacotherapy available for detoxification.

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

5.4. Specific interventions to be made available include the following:

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

5.4.2. Alcohol – benzodiazepines for detoxification, vitamin supplementation for associated nutritional problems, counselling and long-term medication.

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

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

> In addition to reducing HIV transmission among 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).

6. Improve health and mental health resources in the prison

6.1. There is a need to increase resources and funding especially for prison health programmes.

6.2. The prison department should have greater autonomy for improving health care resources within the prison. Prison budgets are generally low and

prison authorities should either be given the funding or given the autonomy to develop partnerships with both government, non-governmental and private sectors to run such programmes.

6.3. There is a need for urgent human resource enhancement. All large prisons must ensure the presence of at least:

6.3.1 1 doctor for every 500 patients. In addition, every prison must have one each of the following specialists providing care – physician, psychiatrist, dermatologist, gynaecologist and surgeon.

6.3.2 2 nurses for every 500 prisoners

6.3.3 4 counsellors for every 500 prisoners. These trained counsellors (with a degree in any social sciences/any recognized degree with counselling experience (medical counselling/legal counselling/ psychosocial counselling/rehabilitation/education) can carry out the following tasks

- Assessment
- Counselling
- Self referred
- Case referred by prison staff/hospital staff for psychological assessment and counselling
- Crisis intervention (family crisis, bail rejection, verdict pronouncement, interpersonal difficulties, life events, serious physical or psychiatric illness)
- Legal counselling
- Pre-discharge counselling
- Rehabilitation
- Substance use counselling
- Train prison staff and peer counsellors
- Ensure that all services are available round the clock

6.3.4. In patient beds – there should be a 20 bed facility for every 500 prisoners.

6.3.5. The current health system in the prison runs on the support of the

Health Department, and is thus highly influenced by the vagaries of this system. One consideration could be the creation of a prison health corps along the lines of the army health corps which can take care of the health including mental health needs in all custodial settings in the country. This may help to develop adequate and better quality of services that having the same seconded by the state health departments.

7. Prison staff training and needs

7.1. Improve staff teamwork
7.2. Improve interdepartmental cooperation
7.3. Improve morale
7.4. Reduce conflict
7.5. Improve staff communication and conflict resolution skills
7.6. Make prison staff aware of mental illness –identification and referral
7.7. Identify motivated prison staff to act as local counsellor and provide training for such roles
7.8. Regular training of personnel not directly manning the prison but concerned with prisoners on mental health issues. This includes the judiciary, lawyers and police particularly from the rights viewpoint.
7.9. Address physical and mental health needs of prison staff, improved work conditions, remunerations and support.

8. Address other health problems in prison

8.1. All prisoners must have access to health care. This involves the availability of necessary human resources and facilities to provide adequate care.
8.2. All prisoners must be educated about common physical and mental problems. This includes but is not limited to skin infections, cardiac and respiratory disorders, tuberculosis, HIV, other sexually transmitted illnesses, diabetes, stress related symptoms, anxiety, depression, and affected persons must be encouraged to seek help for such symptoms.

8.3. All national programmes must be implemented in prisons. This would facilitate prompt identification and treatment of many illnesses that are prevalent among prisoners. As prisoners come from the community, all illnesses present in the community are likely to be overrepresented in the prison.

8.4. Periodic screenings in the barrack for physical problems, communicable and non communicable diseases (particularly for TB and other respiratory problems, heart disease, high risk behaviours)

Health problems in prison, such as TB, are the result of a complex interaction between poverty, imprisonment and disease. Our response needs to look at the problem as a whole. Interventions, such as universal access to the DOTS strategy, must be implemented urgently, but also be put in the broader perspective of the factors that promote and perpetuate disease in prison. These include reducing overcrowding through penal reform, promoting the respect, protection of and fulfilment of fundamental human rights and co-ordinating health systems to ensure continuity and equivalence of care. In achieving these goals, we must build partnerships with professionals from other disciplines.

9. VCTCs in every prison offering HIV and STI treatment as well as education on preventing high risk behaviours.

10. Address other needs of prisoners

10.1. Legal needs

10.2. Interaction from families

10.3. Vocational training and pre-release counselling

These factors can be the primary responsibility of the prison counsellors, with the assistance of prison staff and peer counsellors.

The prison authorities can also liaise with local schools and colleges of social work, law and other institutions to ensure a greater availability of human resource to provide basic information and counselling for the prisoners.

There are some good but isolated examples of HIV prevention programmes in prisons in Mumbai, Andhra and a few other places that should be expanded to prisons all over the country. These include IEC programmes, voluntary counselling and testing, access to HIV and STI treatment, treatment of opportunistic infections, improving access to drug dependence treatments and harm reduction strategies including condom distribution programmes.

11. Documentation

11.1. Computerised data base and tracking system for all prisoners

11.2. Surveillance of health conditions on a regular basis with adequate emphasis on confidentiality and proper information regarding these procedures to the prisoners

11.3. Health records for prisoners with basic health information, pre-existing health problems, health problems that develop during imprisonment, details of evaluation and treatment, hospitalization details, health status and advice at release

11.4. This information must be given to the prisoner to facilitate continuing health care after release.

12. Ensure continuity of health care after prison release

12.1. Continuity of health care after release is extremely important. All prisoners must be provided appropriate advice on health care after release. This will include advice prior to release on issues related to health and well-being, arranging care and support in the community, and facilitating re-entry and re-integration into the community, all of which are major challenges.

13. Addressing Systemic needs

13.1. Improve general prison conditions to meet the standards of the United Nations Office of the High Commissioner for Human Rights' Minimum standard rules for the treatment of prisoners.

13.2. Set up a prison working group for improving health care in prisons in India.

13.3. Reduce the prison population through interventions such as non-custodial sentencing, legal reforms and alternatives to imprisonment for minor offences. A range of alternatives have been developed in many countries including warnings, supervision and support, restrictions of liberty in the community, community service work, treatment order and mediation.

13.4. The Board of Visitors to be activated/constituted to be responsible for:

13.3.1. Ensuring that care is providing to all persons with mental illness in the prison
13.3.2. Free legal aid is provided to persons with mental illness
13.3.3. Ensuring speedy trial
13.3.4. Ensuring aftercare for persons with mental illness released from prison.

13.5 Regular training in mental health issues to the judiciary, lawyers and police particularly from the rights viewpoint

13.6 Linkages to the DMHP and all national health programmes

13.7 Each state must have at least one specialized forensic psychiatric facility with multidisciplinary staff and linkages to the local psychiatric hospital/medical college. This should have rehabilitation facilities and de-addiction facilities

13.8 Hastening the process of trial can reduce overcrowding, the mental anguish of prolonged incarceration and a sense of denial of justice. Towards this, tele-trial proceedings whenever possible needs to be set up and strengthened.

13.9 System of Escorts to take prisoners for court proceedings needs urgent attention – Independent escorts for prisoners for production in court, medical emergencies, transfer from one prison to another, any other requirements is recommended.

13.10 The number of escorts required should be formalized as per the individual prison requirements by the respective state governments

14.0 Serious consideration must be given to institute a National Institute of Correctional Services, under which umbrella health related prevention, intervention and research activities in correctional settings can also be undertaken.

In conclusion, mental health is a positive sense of well-being and is very important for personal fulfilment as well as to improve the ability to overcome pain, disappointment and adversity. The impact of mental illness, substance use, mental health problems arising from physical illness and life situations all disturb such well-being. This undermines the individual's self-confidence and concern for self and others. These issues are particularly important in a context like the prison, where the focus is on providing corrective experiences and opportunities for self-development. This cannot occur without an improvement in mental health. Providing a supportive and understanding environment which places a premium on mental health and well-being will benefit all the constituents- the prisoners, the carers and the larger society.

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APPENDIX

के.एस. मणि
महासचिव
K.S. MONEY
Secretary General

राष्ट्रीय मानव अधिकार आयोग
फरीदकोट हाऊस, कॉपरनिकस मार्ग
नई दिल्ली- 110 001 भारत
National Human Rights Commission
Faridkot House, Copernicus Marg,
New Delhi - 110 001 INDIA

D.O. No. 4/7/2010-PRP&P

17th May, 2010

Dear Mr. Prasad,

Please refer to the Commission's letter No. 4/3/99-PRP&P dated 11.02.1999 regarding medical examination of prison inmates.

Concerned with death of prisoners in various jails due to spread of contagious diseases like Tuberculosis, the Commission had vide letter dated 11.02.1999, referred to above, advocated their medical examination at the time of entry to the jail as well as periodically thereafter as per proforma enclosed as Appendix-I. This was intended to facilitate provision of timely and effective medical treatment to the prisoners with medical problems.

It has been observed that a large number of prisoners die of Tuberculosis in the jail and HIV patients are quite vulnerable to Tuberculosis. It is, therefore, imperative that thorough medical examination should be conducted of all the prisoners at the time of their admission in jail in order to find out whether the prisoner is suffering from Tuberculosis, lung disease or HIV, or any other disease.

Keeping these considerations in mind, the Commission has made some modifications to the proforma earlier prescribed for the medical examination incorporating tests for Tuberculosis. The revised proforma is enclosed as Appendix-II.

You are requested to circulate the revised proforma to all the prison administrators in your State/ UT in order to ensure that medical examinations of all the prison inmates is carried out in accordance with the revised proforma, at the time of their entry into prison and at regular intervals.

With kind regards,

Yours sincerely,

(K S Money)

Shri S V Prasad,
Chief Secretary,
Government of Andhra Pradesh,
Secretariat,
Hyderabad-500 022.

O/C and all other Chief Secretary/ Administrator of the State/UTs as per list attach

18 MAY 2010

फोन : 91-11-23384856, फैक्स : 91-11-23384962 /23384863
Phone : 91-11-23384856, Fax : 91-11-23384962 /23384863, E-mail : sgnhrc@nic.in, Website : www.nhrc.nic.in

Chapter 13

NHRC Recommendation: General Medical Examination Proforma

PROFORMA FOR HEALTH SCREENING OF PRISONERS ON ADMISSION TO JAIL

Case No. .....

Name .....Age.....Sex.....Thumb impression.....

Father's/ Husband's Name.....Occupation.....

Date and time of admission in the prison.....

Identification marks.....

1. Previous History of illness:

(a) Are you suffering from any disease if so, the name of the disease: Yes/No

(b) Are you now taking medicines for the same? Yes/No

(c) Are you suffering from cough that has lasted for 3 weeks or more? Yes/No

2. History of drug abuse, if any:

Any information the prisoner may volunteer:

3. Physical Examination:

Height.....cms Weight.....Kg. Last menstrual period.....

(a) Pallor: Yes/No (b) Lymph Node enlargement: Yes/No

(c) Clubbing: Yes/ No (d) Cyanosis : Yes/ No

(e) Icterus : Yes/ No (f) Injury, if any.....

4. Pathological Tests/ X-ray for TB

5. Blood test for Hepatitis/ STD including HIV (with the informed consent of the prisoner whenever required by Law).

6. Any other.....

7. Systemic Examination

(i) Nervous system

(ii) Cardio Vascular System

(iii) Respiratory system

(iv) Eye, ENT

(v) Abdomen (Gastro Intestinal System (GIT) and other organs)

(vi) Teeth and gum

(vii) Urinary system.

P.T.O.

The medical examination and investigations were conducted with the consent of the prisoner after explaining to him/her that it was necessary for diagnosis and treatment.

Date of commencement of medical investigation.....

Date of completion of medical investigation.....

Signature and Seal of Medical Officer

NIMHANS MENTAL HEALTH SCREENING

QUESTIONNAIRE

Chapter 14

NIMHANS Mental Health Screening Questionnaire

1. Are you suffering from any mental illness? Yes/No
   If yes, please name or describe the condition.

2. Are you now taking any medicines for the same? Yes/No
   (If yes, please provide details)

3. Have you ever consulted a psychiatrist/got hospitalised for mental illness? Yes/No
   (If yes, please provide details)

4. Did you ever try to end your life? Yes/No
   (If yes, please provide details about the most recent attempt)

5. Did you ever try to purposely injure yourself? Yes/No
   (for e.g. cutting yourself, inflicting burns
   (If yes, please provide details about the recent self injurious behaviour)

6. Have you ever felt sad / depressed / unusually tired most of the days for at least 2 weeks?
   (If yes, please provide details) Yes/No

7. Have you ever felt useless, worthless, sinful or guilty often for at least two weeks?
   (If yes, please provide details) Yes/No

8. Have you ever felt so irritable that you found yourself shouting at people or fighting (physical/verbal) with people or getting into an argument easily? Yes/No
   (If yes, please provide details)

9. Do people around you say that you are very short tempered/ moody/ impulsive? Yes/No
   (If yes, please provide details with examples)

10. Are people around you trust worthy? Do they try to harm you or do things intentionally to harm you? Yes/No
    (If yes, please provide details)

11. Do people around you keep constant watch on you or follow you or talk about you?
    (If yes, please provide details) Yes/No

12. Are you suffering from epilepsy? Yes/No
    (If yes, please provide details about the illness and medicine in take)

(Please read following questions aloud, so that the respondent understands the questions. Ask for clarification, explanation and details for each 'yes' response. Document each response as well as the details)

NIMHANS Mental Health Screening Questionnaire

13. Are you consuming any of these substances on a weekly or daily basis

Sl No	Substances	Yes/No	Have you had any harm from use? Yes/No
1	Tobacco		
2	Alcohol		
3	Benzodiazepines (sleeping medicines)		
4	Cannabis (Ganja, bhang, hashish, marijuana)		
5	Opioids (Morphine, heroin, fortwin, cough syrup, pain killers)		
6	Inhalants (whitener, petrol)		
7	Cocaine		
8	Lysergic acid diethylamide (LSD)		
8	Methamphetamine (Ecstasy)		
10	Ketamine		
11	Any other drugs?		

14. Would you like to take treatment for the drugs that you are consuming?

15. Are you ready to undergo urine screening for substance use?
    If investigation is done, please provide the report results here……..

16. Orientation
    What is today's date, week, month?
    Name this place, city, state?
    Who is this person? (point to a familiar person)

Disoriented…… 'YES' or 'No'

Action taken if 'yes' to any response .....

Date …… Medical officer signature…….

(Please read following questions aloud, so that the respondent understands the questions. Ask for clarification, explanation and details for each 'yes' response. Document each response as well as the details)


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