

Opinion & Debate

Forensic Psychiatry — Is their a role of psychiatric services in Pakistani prisons?

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The sub-speciality which deals with the interface of law and Psychiatry is known as Forensic Psychiatry. A forensic psychiatrist treats the mentally disordered within the criminal justice system. The type of mental disorders seen can range from anti-social personality disorder, psychotic illnesses, bipolar affective disorder, sexual offenders, and learning disability to co-morbid substance misuse. The type of offending behaviour also varies and can include shop-lifting, arson, theft, domestic violence, verbal threats, physical assaults, sexual offending, man slaughter and homicide. Unfortunately the sub-speciality of Forensic Psychiatry is almost non-existent in Pakistan.¹ But is there evidence to suggest that such a service is required?

Prisons came into existence for mainly four reasons; deterrence, retribution, incapacitation and rehabilitation.² Before we embark on the issue of the feasibility of forensic units, there is one question that needs to be answered. Whether people with mental disorders can be violent compared to the general population? In the context of some studies done in the 1970's like the Baxstrom case, the risks of violence were considered either the same as or lower than the general population.^{3,4} More recent studies have shown a different picture. The MacArthur foundation risk assessment study⁵ showed that the risk increased significantly with co-morbid substance misuse and concluded that the prevalence of community violence by people discharged from acute psychiatric facilities varies considerably according to diagnosis and, particularly, co-occurring substance abuse diagnosis or symptoms. Similarly the NIMH CATIE study⁶ also showed prevalence of any violence amongst Schizophrenic patients as 19% with 4% reporting serious violence. The study also demonstrated that positive psychotic symptoms increased the risk of minor and serious violence whereas negative psychotic symptoms lowered this risk. Walsh et al⁷ explained that younger age, learning difficulties, past history of violence and substance misuse were all factors contributing to increased risk of violence in those with a co-morbid psychotic illness. It is also important to note that the mere presence of mental disorder is not a risk but active symptoms are important.

Studies suggest that there is increasing psychiatric morbidity amongst prisoners. About 10% men on remand

and 14% women prisoners had signs of a psychotic illness. While 59% men and 76% women on remand had signs of a neurotic illness.⁸ The risk of suicide also increases in prisons.⁷ There are also confounding factors within the prison environment which can exacerbate mental disorders.^{7,8} There is accumulating evidence that the effects of psychosis on risk of violence are much greater for women than for men.⁹ Men are more likely to have been under the influence of alcohol or using street drugs and less likely to have been adhering to prescribed psychotropic medication, prior to committing violence. Women are more likely to target family members and to be violent at home.^{9,10}

There are no official figures of the number of mentally disordered prisoners in Pakistan but anecdotes from mental health professionals working there suggests that psychiatric morbidity in prisons has been steadily increasing. There are many factors which may contribute to this but violent laws and delayed justice can be the front runners. There is also a critical problem of overcrowding in Pakistani prisons. The government statistics¹¹ in 1996 showed a distressing 74,483 persons in prison nationwide against a total capacity of 34,014. This problem was most severe in Punjab, which compared a prison population of 47,835 people to a capacity of 17,271. These prisoners also face regular physical, emotional, sexual and psychological abuse.¹⁷ The brutality of the law enforcement agencies in handling alleged offenders has also been observed. One study of juvenile prisoners¹² concluded that 59.7% had been subjected to major torture (severe beatings, electric shocks, hanging, cheera, cuts, and burns) and 18.9% to minor torture (slapping, verbal abuse, food deprivation, solitary confinement, and being forced to maintain uncomfortable body positions), while in police custody.

There is generally a lot of stigma attached to Psychiatry and mentally ill patients in Pakistan. Thus forensic patients could face dual stigma in our society. They would be subjected to disdain attitude by the community because of having a serious mental illness and deemed guilty because of their history of having committed a criminal offence. Even without this, persons with the psychiatric disabilities, have been socially isolated from community residents. Moreover, expectation of rejection by individuals with mental illnesses are inversely related to

psychological integration, or the sense of community belonging.^{13,14}

In the UK, hospitals which deal with the mentally disordered in conjunction with the criminal justice system are known as forensic or secure units. They are divided into low, medium and high secure units and patients are placed into them according to their index offence (crime committed), level of risk and patient needs. These units/hospitals are not different from a normal psychiatry unit apart from the level of security. They offer biological treatments as well as psychological therapies, occupational therapy and rehabilitative services.

In Pakistan there needs to be structural changes.¹⁵ We have come a long way from people being chained in "mad houses" to being accepted as patients and identifying their illnesses as biological rather than theological in origin. But there is still a lot to do. In the public sector there were around 2000 beds in three asylum-like hospitals based at Hyderabad, Lahore and Peshawar in 1947 compared to 2940 now.¹ Some sparse medical care is provided to prisoners in health units within the prison but they do not cater to the specific needs of psychiatry.

The legal system offers no real relief and such patients get lost owing to ineffective laws and inefficient law makers. There is a pathological delay in the time frame till a case is resolved. This is attributed to over-populated prisons and the failure of police to complete investigations within the time periods prescribed by law, the restrictive application of bail laws, the frequent adjournment of hearings, understaffed and underutilized parole and probation departments, and a dearth of free legal representation.¹⁶ This defect in the criminal justice system can be associated with the increased incidence and further exacerbation of mental disorders within our prisons. Pakistan is also one of the few countries in the world which has three parallel legal systems, the criminal courts, the tribal courts and the anti-terrorism courts, which further complicates the picture.

There is a need to abolish these asylum type hospitals and set up small hostel - like accommodations in every district.¹⁵ These hostels can then be linked to the department of psychiatry at teaching hospitals, helping to divert the direction of institutions to community. This would help to train a new breed of mental health workers, who can be part of teams which could then be further developed to work as in-reach services into the prisons. Consultant psychiatrists can be identified who would be responsible for covering different geographical areas within cities, towns and villages. These teams would function under the guidance of these consultants. They can run weekly clinics in prison and report back to the consultant as part of a

multidisciplinary team meeting. If they encounter more complex cases, then an appointment with the consultant should be set up to see them in the prison setting.

Integrated mental health and criminal justice service systems from the UK can be developed by incorporating probation officers¹³ (an officer of a court who supervises offenders placed on probation) as team members. This promotes effective communication and has proved strategically important in preventing unnecessary incarceration, by using legal leverage to promote treatment adherence. A similar model can be adopted in Pakistan with certain changes to suit local needs.

Such changes would require great efforts and support from the medical community (particularly psychiatrists) in Pakistan. There is always a 'clear and present danger' of such projects being left in doldrums by lack of political will and government procrastination. It can also be difficult to overcome such hurdles, due to the constantly evolving political system. But regardless of our environment, there have been multiple success stories of courage in different aspects of life in our country. Can we learn lessons from them?

Would it be useful if psychiatrists in Pakistan were encouraged to attend short courses on mental health specific to prison population and Law? Can we address the shortage of forensic psychiatrists by providing special incentives to psychiatrists who would like to attain academic qualifications in law as well? Is there further scope to develop the criminal sections of the Mental Health Ordinance, 2001? Will it be useful to also encourage lawyers to develop special interest in mental disorders and related laws? How constructive will it be to run workshops for the lawyers? It is imperative now, that we begin to develop such services in Pakistan, where the magnitude of mental disorders in prisons are unknown. This will not only help the patients but also decrease offending by this patient group.

Last but not the least; we should promote awareness that, the government should not let prisons become a breeding ground for mental disorders. Indeed Article 14 (1) of the Constitution of Pakistan reads that: "The dignity of man... shall be inviolable."¹⁷

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