JUSTICE PROJECT PAKISTAN

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MANUAL ON MENTAL HEALTH

FOR PRISON MENTAL HEALTH PROFESSIONALS

Mental Health Awareness Handbook:
For Prison Health Professionals

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Justice Project Pakistan is a non-profit legal action firm representing the most vulnerable Pakistanis facing the harshest punishments at home and abroad.

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Introduction

“The federal government (for Islamabad capital territory) and all the provincial governments shall immediately launch training programs and short certificate courses on forensic mental health assessment for psychiatrists, clinical psychologists, social workers, lawyers, prison staff, police personnel, court staff, prosecutors and the judges of trial courts.”

Mst. Safia Bano vs Home Department, Government of Punjab (2021 PLD 488 Supreme Court)

Mental health issues are far more common in the global prison population of 10 million, than the general population. According to a systematic review of the prevalence of severe mental illness and substance use disorders in prisoners in low-income and middle-income countries, published in The Lancet in 2019,

“prevalence of non-affective psychosis was on average 16 times higher, major depression and illicit drug use disorder prevalence were both six times higher, and prevalence of alcohol use disorders was double that of the general population.”

Another study in the Lancet.,

“Prisoners are at increased risk of all-cause mortality, suicide, self-harm, violence, and victimisation. Imprisoned individuals often have a low socioeconomic background, belong to minority groups, and have histories of childhood victimisation and substance abuse, which make them vulnerable to psychiatric disorders.”

While in prison, poor living conditions, physical assault and psychological abuse can further contribute to mental health disorders.

In Pakistan, the difficulties faced by people with mental illnesses are compounded by the structural and systematic problems of an under-resourced and overstretched criminal justice system. The challenges faced within the criminal justice system, including the widespread use of torture to obtain confessions, and the lack of access to competent counsel, fall most heavily on Pakistan's most vulnerable.

33 criminal offences are punishable by death in Pakistan. Failure to uphold the rights of defendants with mental illnesses has resulted in the execution of mentally ill individuals in the past, which is against both Islamic and International Law. Furthermore, in February 2021 in the case of Mst. Safia Bano v Home Department, Govt. of Punjab, the Supreme Court Of Pakistan has made a landmark decision to safeguard the rights of mentally ill individuals accused of a crime.

All professionals in the criminal justice system have a duty to ensure that vulnerable defendants are treated fairly and in accordance with domestic law and international obligations.

This manual aims to provide the knowledge, skills and attitudinal updates required to assist health professionals working in the criminal justice system to protect those with mental illness.

Drafted by a team of mental health and law professionals, under the auspices of Justice Project Pakistan, this handbook can be used by all professionals who are likely to come across mentally ill individuals accused of crime; are serving a sentence while suffering from mental illness, or develop a mental illness at any stage of their incarceration.

This handbook is to be used in conjunction with the toolkit for prison mental health officials.

CHAPTER 1

Mental Health and Mental Illness

The World Health Organisation (WHO) defines health as:

"A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." [2]

Mental health is related to "successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is the springboard of thinking and learning, emotional growth, resilience and self-esteem." [3]

Mental disorder refers to all mental health conditions associated with impaired mental functioning, including mental illnesses, personality disorders, substance misuse disorders and cognitive impairments. All mental disorders can affect a person's thinking, judgment, mood and behaviour. Mental disorder can affect anyone, irrespective of age, gender, social standing, religion or race/ethnicity. Importantly, marginalised groups in society, including the incarcerated, experience higher rates of mental disorder when compared to their mainstream counterparts [1]

Contrary to a widely-held misconception, there are tests available for nearly all mental illnesses. These include objective neurodiagnostic psychometric tests, laboratory tests and brain imaging scans. X-rays, Computerised Tomography (CT) Scan Studies, Magnetic Resonance Imaging (MRI) Scans, Positron Emission Tomography (PET) scans. These tests are used around the world, including Pakistan, to support clinical diagnosis of mental illnesses. All of this indicates that not only are mental illnesses "physical", they are deeply interconnected with the rest of our bodies and vice versa.[5]

The International Classification of Disease (ICD) by the World Health Organisation

(WHO) provides a standard list of conditions considered diseases. This is the international gold standard for reporting diseases and health conditions. ICD-10, lists Mental and Behavioural disorders in Chapter V with physical disorders in other chapters. [6]

There are rigorously researched and validated international standards for the clinical diagnosis and management of mental disorders. These standards are regularly reviewed and vetted by international institutions, including the World Health Organisation, The National Institute Of Clinical Excellence, United Kingdom, The American Psychiatric Association, World Association Of Psychiatry and many others.Clinical methods used for diagnosis of mental illness include neurodiagnostic psychometric tests, laboratory tests, radiological and other scans. These are researched, updated, reviewed, and published in peer reviewed journals of the highest scientific standing. These include the New England Journal Of Medicine, The Lancet, The Journal Of American Psychiatric Association, British Journal Of Psychiatry, Acta Psychiatric Scandinavia And The Journal Of Pakistan Psychiatric Society. There are international scientific journals specifically dedicated to issues related to forensic aspects of mental health such as International Journal Of Forensic Mental Health, International Journal Of Law And Psychiatry, And Journal Of Forensic Psychiatry And Psychology.

Myths and misconceptions about mental illnesses: “Is mental illness real, like physical illness?”

Mental illnesses are, unfortunately, viewed with suspicion and doubt in legal circles. They are not seen as diseases similar to the heart or kidney but abstract conditions that are more “in the air”. They are considered spiritual or psychological conditions that people experience transiently as a result of tensions and stresses of life. Culturally, they are seen as outcomes of black magic, “evil eye”, and possession by evil spirits and jinns. Many see them as a curse, a punishment or nature’s way of settling scores with the afflicted ‘sinner’. Shrouded in mystery, confused by religious, poetic, dramatic and religious explanations, mental illnesses are commonly seen in most societies as “not real diseases”.

In Pakistan’s criminal justice system, mental illnesses are commonly misunderstood, and thus, raise suspicion of fraud. Many individuals in the legal system believe that mentally illness can be easily identified by asking a few questions in court settings to determine if they are ‘sane’ or ‘insane’. They may also conflate severe mental disorders of thought and emotions with intellectual

disability. One of the most dangerous misconceptions amongst practitioners of law is the notion that feigning mental illness is easy and can be done to circumvent the law. They believe that mental illnesses can be faked and there are no specific assessment methods, diagnostic tests, and no scientific means to establish the diagnosis of mental illness. The honourable judges tend to undertake “evaluation” of the presence of mental illness in their respective courts and decide for themselves, if a person is mentally ill or not. They believe that criminals may wrongly use mental illness as a defense and thus hoodwink the judicial system. This leads to spurious judgments about a defendant’s mental health and may result in harsher sentencing and overall treatment, in order to “sort out” the individual. The diagnosis of mental illness is a highly technical and a specialized pursuit. Like all other medical disorders, diagnosis and management of mental illnesses can only be carried out by psychiatrists, with the help of fellow mental health professionals.

The following section highlights some of the most common myths and misconceptions surrounding mental health issues, and their treatment. The objective is to address the knowledge gap between the legal and medical professions.

Myth: Mental illness is not really illness, mental illnesses are caused by magic and evil spirits

Reality: Mental illnesses are caused by structural and chemical changes in various structures of the body, especially the brain, and are just as much a “curse” as any other illness or adverse life event. The reasons for this are genetic, biochemical, behavioral and environmental. The International Classification of Disease by The World Health Organisation has a chapter on mental, behavioural and neurodevelopmental disorders, as well as chapters on diseases affecting other parts of the body. [6]

Myth: Psychiatric patients are dangerous and violent towards other people

Reality: The large spectrum of patients with mental illnesses are non-violent and not dangerous to other people. People living with a severe mental illness and receiving effective treatment are no more violent than anyone else in the community. Individuals suffering from schizophrenia are more likely to harm themselves than to harm others. [7]

Myth: Psychiatric patients are “fraudulent, malingerers, hysterical” and are behaving abnormally to fulfill ulterior motives

Reality: Extensive research has shown that those who were labeled “fraud” “fake” “attention seekers” were in fact misdiagnosed due to lack of understanding regarding illness. Follow up studies conducted ten and fifteen years after people were labeled frauds, revealed very high rates of death and disease in the group, as they were suffering from various illnesses that had not yet been diagnosed. The nature of psychiatric disorders is such that people are unable to cope with their daily routines, experience a lack of motivation, and start to behave differently. They, therefore, appear to the untrained eye to be malingering or “seeking attention”. The real reason for this is the brain experiencing neurochemical or structural changes. As all bodily functions are controlled by the brain, patients with psychiatric illnesses also experience changes in their appetite, sleep and sex lives for extended periods of time. [5]

Myth: Psychiatric treatments are lifelong, addictive, put you to sleep and render you incapable of living your life

Reality: The main aim of treatment in psychiatry is, in fact, to ensure patients are able to return to their daily routine and live their lives as fully as possible. Psychiatric treatment includes many different kinds of treatments including medication and therapy. Medication is not addictive if used according to prescription and therapy is conducted for a set number of sessions. Only a certain category of medication is addictive. Since sleep is disturbed in many psychiatric illnesses, certain medications induce sleep in order to aid recovery.[8]

Myth: Psychological factors do not cause any other diseases

Reality: All diseases are caused by an interplay of biopsychosocial factors. In fact, mental illnesses such as depression may predispose one to developing infections, heart disease, diabetes and even cancer. Individuals suffering from any physical illness are more likely to develop mental illness e.g having diabetes doubles the risk of developing a depressive illness. Patients with depression and diabetes have a high number of cardiovascular risk factors and 50% increased risk of mortality. [8]

Myth: Spiritual interventions, homeopathy and “gharelu totkas” can be used in place of medication prescribed by the psychiatrist.

Reality: Medications and psychotherapy should be used in conjunction with spiritual interventions and neither should replace the other. Both medication and psychotherapy used in the treatment of psychiatric issues have been researched extensively and found to be effective. According to the National Health Service of the UK “There is no good-quality evidence that homeopathy is effective as a treatment for any health condition.” The largest to-date analysis of all data on homeopathic treatments, conducted by the National Health And Research Council Of Australia has concluded that they are ineffective in the treatment of any clinical conditions in humans.

Myth: Psychiatrists give “electric shock treatment” to all patients

Reality: Electroconvulsive therapy is used for the treatment of serious issues in very specific disorders. It is a well-researched, safe, painless and effective treatment used under anaesthesia. [5]

Myth: “Once a psychiatric patient always a psychiatric patient”

Reality: Not all mental illnesses are like heart disease, diabetes or hypertension (all of which require lifelong treatment. Almost all mental illnesses have symptoms that are manageable, and very few, severe illnesses require lifelong treatment. [5][8]

Case Study: Kanizan Bibi

Kanizan Bibi was born into a very poor family, and her mother died shortly after her birth. She was a young girl when she began work as a housemaid to help make ends meet. In 1989, her employer's wife and children were found murdered, for which Kanizan and her employer were subsequently arrested and convicted. According to her family, the real culprits, who were engaged in a longstanding land dispute with Kanizan's employer, had filed a false police report accusing Kanizan. She was sentenced to death by Additional Sessions Judge, Toba Tek Singh in 1991, and her subsequent appeals in the Lahore High Court and the Supreme Court were dismissed.

Kanizan Bibi suffers from schizophrenia and has spent more than 30 years in prison. She was first shifted from Lahore Central Jail (Kot Lakhpat) to Punjab Institute of Mental Health (PIMH) in 2006, and then again in 2018. She was constantly being treated for her mental illness. During the course of her incarceration, her medical condition has deteriorated so much that she has not spoken a word in decades.

In April 2018, the Supreme Court took suo moto notice of her case. During the hearing, then chief justice Saqib Nisar observed that it was "beyond sense or reason that we execute mentally ill individuals". The court then ordered to shift Kanizan Bibi back to PIMH and provide her the best possible treatment and care. It also ordered the constitution of a board to evaluate her mental health.

On 10.02.2021, the Supreme Court of Pakistan passed a landmark judgement in the case tilted Safia Bano v Home Dept. (2021 PLD 488 Supreme Court) that enforces the rights of mentally ill defendants in the criminal justice system. Adjudicated by a five-member bench, the court decided three appeals pertaining to mentally ill condemned prisoners, including Kanizan Bibi, who spent 30 years on death row while exhibiting acute symptoms of mental illness. The court was pleased to commute her sentence. She continues to undergo treatment in PIMH as a patient.

CHAPTER 2

Classification of Mental Illness

“ …we are of the view that a limited definition of the terms ‘mental disorder’ or ‘mental illness’ should be avoided, and the Provincial Legislatures may, in order to better appreciate the evolving nature of medical science, consider to appropriately amend the relevant provisions of mental health laws to cater for medically recognized mental and behavioral disorders as notified by WHO through its latest edition of ICD.”

Mst. Safia Bano v Home Department, Government of Punjab (2021 PLD 488 Supreme Court)

The World Health Organisation (WHO) provides a standard classification of disease known as the International Classification of Disease (ICD). Chapter 06 of the ICD, 11th edition* is dedicated to psychiatric disorders / mental health conditions. The chapter is titled ‘mental, behavioural or neurodevelopmental disorders’.

ICD 11, defines psychiatric disorders as:

“syndromes characterized by clinically significant disturbance in an individual‘s cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes that underlie mental and behavioural functioning. These disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational, or other important areas of functioning”. [24]

The Diagnostics and Statistical Manual 5 (DSM-), by the American Psychiatric Association, defines mental disorder as follows:

"A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviour (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above."

ICD-11 Chapter 6 has 161 categories recognized as diseases of psychiatric origin. These categories are enlisted under twenty blocks. Some of the blocks relevant to forensic mental health are:

- **Neurodevelopmental Disorders**
- **Schizophrenia, Schizotypal And Delusional Disorders**
- **Catatonia**
- **Mood [Affective] Disorders**

- Anxiety Or Related Fear Disorders
- Obsessive Compulsive Disorders
- Disorders Associated With Stress
- Dissociative Disorders
- Mental And Behavioural Disorders Due To Psychoactive Substance Use
- Behavioural Syndromes Associated With Physiological Disturbances And Physical Factors
- Impulse Control Disorders
- Disruptive Behaviour Or Dissocial Disorders
- F69 Disorders Of Adult Personality And Behaviour
- Disorders Associated With Stress
- Dissociative Disorders
- Mental And Behavioural Disorders Due To Psychoactive Substance Use
- Behavioural Syndromes Associated With Physiological Disturbances And Physical Factors
- Impulse Control Disorders

The Mental Health Ordinance 2001

Pakistan's domestic law also recognises and defines the concept of mental disorder. Section 2 of The Mental Health Ordinance 2001 defines the following relevant terms:

Mental Disorder

Mental illness, including mental impairment, severe personality disorder, severe mental impairment and any other disorder or disability of mind.

Mental Impairment

A state of arrested or incomplete development of mind (not amounting to severe impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

Severe Mental Impairment

A state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

Severe Personality Disorder

A persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

What Causes a Mental Disorder?

Mental illness is caused by an interplay of biological, psychological and social factors. This includes genetics, changes in brain chemistry, physical health, substance misuse, as well as factors such as personality, traumatic experiences and the environment and social structure of the individual. [5] Individuals cannot choose to have a mental disorder, nor is any individual immune to them. Due to its biopsychosocial basis, mental illness cannot be overcome or cured through 'will power' any more than a physical illness.

The process of criminal justice can aggravate, predispose, and precipitate mental disorders. Prolonged incarceration, spending time in police custody, as well as time-consuming legal proceedings can cause extraordinary stress to the physical and mental health of most people, as can going to court and prison (or execution).

As mentioned earlier, all mental illness is more prevalent in prison populations than the general population. Death by suicide is also more common in prisoners than the general population. [1] Prisoners with mental health issues are more likely to be convicted.

Imprisonment/prison conditions causes or exacerbates mental ill-health:

1. Impact of Imprisonment:

The stress of going through legal proceedings, the social stigma of being labelled a criminal and lack of meaningful activity while in prison are some of the factors that can cause or contribute to mental illness amongst prisoners. Reduced contact with family members, especially in mothers separated from their children is also a risk factor for mental illness. Mental health is also impacted by the availability, or lack of, drugs in prisons.

2. Conditions of Detention:

Almost all prisons in Pakistan are overcrowded with prisoners. Difficult conditions of detention can greatly contribute to a mental illness, as do factors such as limited privacy and the stress of being under constant observation. Solitary confinement as a form of punishment for behaviour that may have resulted from mental illness, is in itself a risk factor for mental illness. Poor physical health and lack of appropriate treatment are also risk factors.

3. Mistreatment in Detention:

People's mental health can also be impacted by mistreatment inside prison, such as violence, including sexual violence, bullying and harassment, stigma, discrimination and dehumanisation by staff.

4. Drug Use and Mental Health:

Drug use or drug withdrawal may mirror some of the symptoms of a mental illness or can exacerbate symptoms. Use of substances may be signs of a mental illness and people with such illnesses may be more likely to use drugs, in some cases to reduce the symptoms of a mental illness.

Sudden or significant changes cause or exacerbate mental health conditions:

A sudden or significant change in a person's life may contribute to a mental illness. These include experiencing traumatic events, receiving a prison sentence, outcomes from court hearings, resulting family breakdown or the death of a family member.

Case Study: Khizer Hayat

Khizar Hayat, a mentally ill death row prisoner, passed away on March 22, 2019, at Jinnah Hospital Lahore after being critically ill. He had spent 16 years on death row. Before his imprisonment, Khizar Hayat worked as a police officer in a village where he lived with his wife and children. Those who knew him described him as a kind man, but ‘very slow’ and easily manipulated. In the months leading up to the incident that would determine the rest of his life, Khizar had fallen under the influence of a local ‘pir’ — a spiritual healer who fraudulently convinced Khizar to sign over his lands and property to him. Under his influence, Khizar was eventually implicated for fatally shooting his friend and fellow police officer, Ghulam Ghous.

Khizar was sentenced to death in 2003. He was first diagnosed with ‘treatment-resistant’ paranoid schizophrenia by jail authorities in 2008. His mental health record consistently referred to his delusions, psychosis, and his mental illness, and showed that he had been prescribed powerful anti-psychotic medication. Khizar pleaded not guilty during his trial, but his lawyer failed to introduce any evidence or call a single witness in his client’s defence. He was eventually sentenced to death in 2003 and, after spending 16 years on death row, passed away on March 22, 2019 in Jinnah Hospital Lahore after being critically ill. Despite documentary evidence of Khizar’s mental illness, the courts repeatedly dismissed his appeals.

In January 2019, after Khizar’s fourth death warrant was suspended by the Supreme Court, his case was referred to a larger bench of the Supreme Court but he passed away before his case could be heard.

CHAPTER 3

Diagnosis of Mental Illness

Mental health conditions can be difficult to identify because some individuals suffering from mental disorders may never complain, or even know that they have an illness. It requires the presence of insight or adequate mental faculties to appreciate a change in functioning or impairment or distress. Some or all of these functions may be impaired in a person with a mental disorder. Many mentally ill individuals may never have seen a health professional, and therefore, may not have any medical record. When individuals are aware of their mental health problems, they may not disclose this to others, due to fear of being judged or labelled “crazy”.

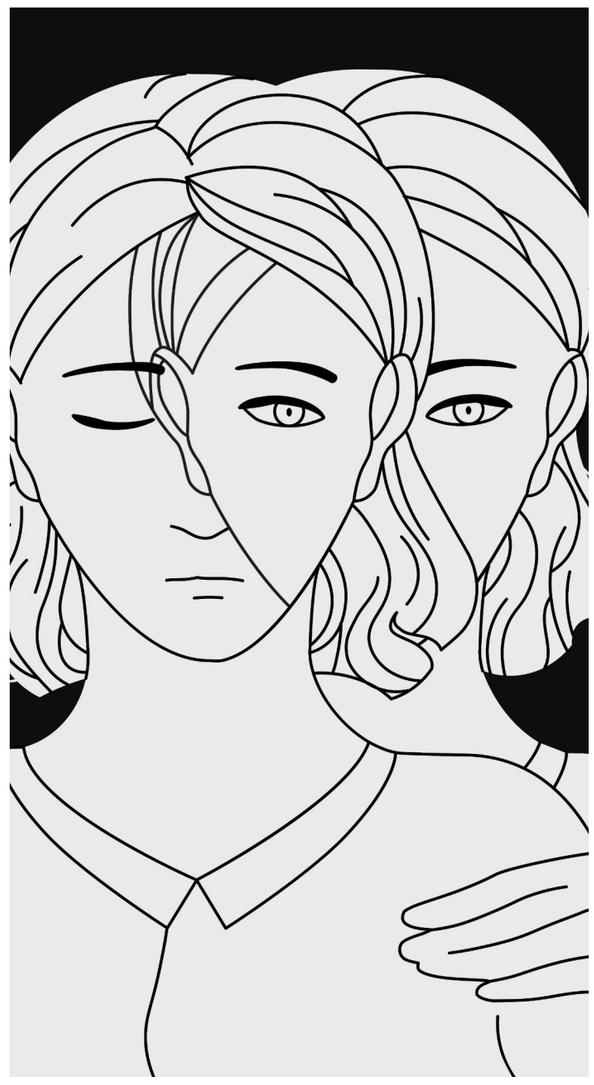
Identification of mental disorders is also made difficult on account of myths and misconceptions, and lack of awareness about them. Negative and inaccurate descriptions in films and media, can create the general impression that it is easy to fake mental illness. This is why mental illness or its symptoms tend to generate a hostile reaction amongst the police, prison, and law professionals.

Normal higher mental functions include consciousness, intellect, judgement and insight. The presence of disturbances of mental functions such as consciousness, thinking, intellect, judgement and insight, must raise the suspicion or possibility of mental disorder and impairment of mental functions influencing mens rea, capacity, culpability, fitness to plead or take part in legal proceedings. The term legal insanity is however outdated, stigmatising, and not recommended for use. Mental disorders and mental illnesses are acceptable terms.

The following are descriptions of normal higher brain functions, an understanding of which is essential in order to appreciate abnormalities. All these functions are influenced by other higher mental functions like, mood, affect, spiritual states, sensations and cues from within the body, as well as the metabolic, chemical, and hormonal states of the body.

Consciousness

This is a function of a dedicated part of the brain named the reticular activating system. A person is conscious if they are fully aware of one's self. They are able to separate their own self from the surroundings, are oriented to what time it is, where they are and separate those they know from those they do not. Humans use their five sensations of body, touch, smell, vision, taste, and hearing to send signals to the various centres of the brain, where they are assembled and given meaning based on degree of alertness, emotions, and memory. The anatomy, physiology, as well as the biochemical and electrical changes in these areas can be studied clinically as well as by labs, and scans.



Judgement

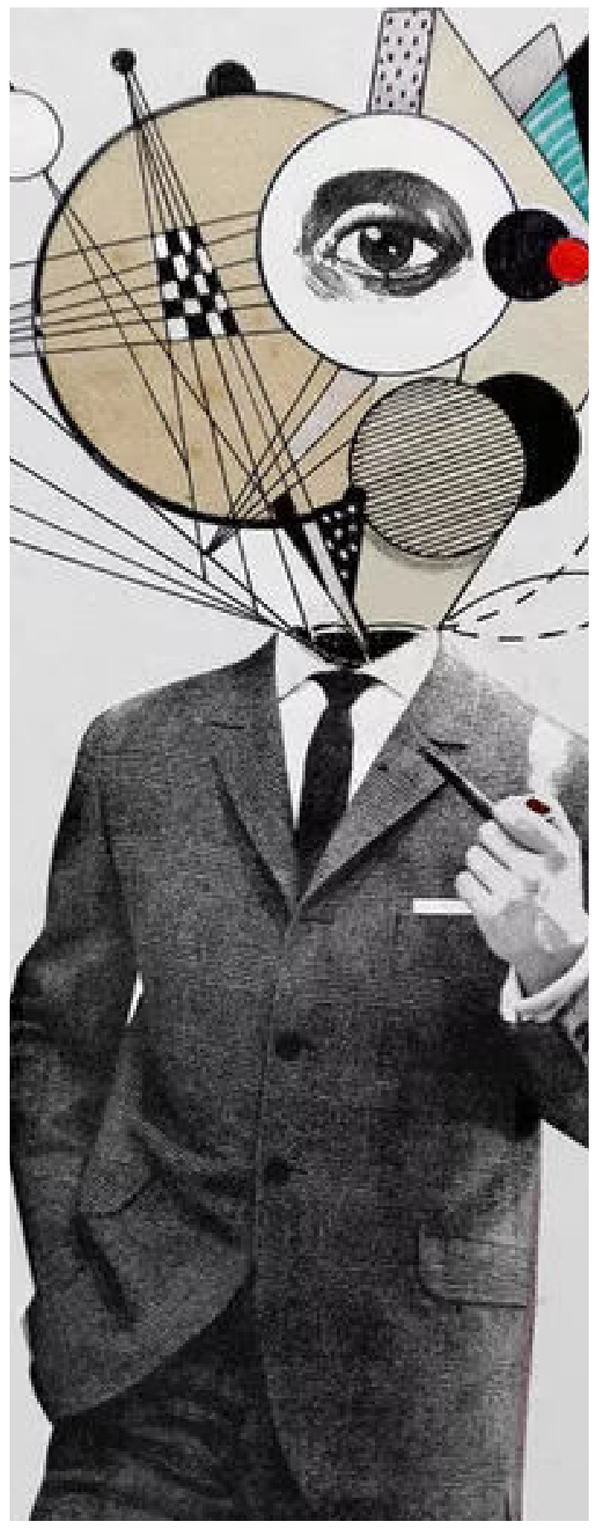
Judgment refers to a person's capacity to make appropriate decisions, and act upon them keeping in mind the potential harm and benefits, particularly in social situations.

Insight

Insight is also a higher mental function through which a person attains understanding of problems, reviews their causes, and arrives at tenable solutions

Thinking

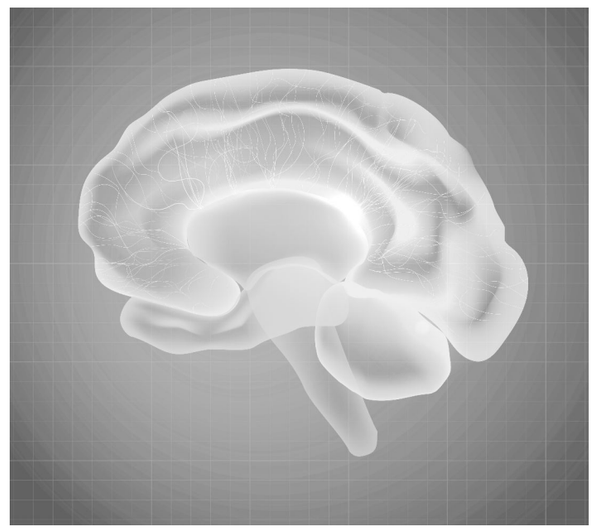
Thinking is a product of the frontal lobe of the brain. This function of the brain helps to make a mental representation of the world, self, past, and future formed through an interplay of environmental cues, perceptual cortices, and memory. Thinking helps in cognition or a synthesis of external and internal stimuli to conduct an appraisal of a situation. A disorder of thinking can therefore serve as an impediment in making correct appraisals, and respond logically, rationally, and on the basis of evidence / data / reality. A person with healthy thinking has an aim- oriented flow of ideas, which are associated with each other meaningfully, leading to formation of reality oriented conclusions. The function of thinking can be best assessed from speech (oral or written), but thinking patterns can also be ascertained from non-verbal cues, expressions, and behaviours. A disorder of thinking can therefore cause inability to separate right from wrong as seen in the eyes of law.



Intellect

Intellect is one of the higher mental functions through which a person can draw objective and abstract meanings. Intellect is needed to understand the nature and use of things, understand actions and their consequences and solve problems. This allows us to have ethical considerations. Humanity, pacifism, aesthetics, kindness, vulgarity, cruelty, and similar abstract concepts are products of intellect. This faculty is to be distinguished from the capacity to attach feelings to things, or undertake willful actions, as

both can take place with minimal intellectual capacity. This is often referred to as intelligence and measured as IQ or the problem-solving ability of a person. A person with an impaired intellect (intellectual disability) may have difficulties distinguishing right from wrong and appreciating the consequences of their actions.



Clinical Assessments

Diagnosis of mental illness is made through:

- **Detailed History Taking**
- **Formal Structured Mental State Examinations**
- **Detailed Neurological Testing**
- **Examinations of Brain Function and the Rest of the Body**

The clinical assessments are time honoured, exhaustive, and thorough. Clinical examinations are then supported by laboratory tests or brain imaging. Diagnosis of mental illness and management is, therefore, to be undertaken by a trained mental health professional such as a psychiatrist.

Indications of Mental Illness

Medical professionals and support staff in prison should, however, have an understanding of whom to refer to specialist services. Certain indications, mentioned below, when persisting over a period of 2-4 weeks may necessitate a referral to a mental health specialist.

Substance misuse can occur with other mental illness, cause other mental illness or occur because of mental illness. Any individuals imprisoned due to substance use charges must, therefore, be observed for these indications.

Individuals on death row, awaiting sentencing for many years while imprisoned or

those being detained for an offense that is especially bizarre or severe may exhibit some indications as a result of mental illness. (Refer to page 06 of toolkit)

Some indications that a person has a mental illness include:

- **Self-Neglect**
- **Unprovoked, Unexpected Anger, And Violence**
- **Strange And Bizarre Strongly Held Beliefs (Delusions)**
- **Seeing Or Hearing Things That Those Around Cannot Perceive (Hallucinations)**
- **Prolonged Depression Or Irritability**
- **Feelings Of Extreme Highs And Lows, Or Fluctuations Of Mood**
- **Dramatic Or Consistent Changes In Eating Or Sleeping Habits**
- **Strong Feelings Of Anger**
- **Inability To Cope With Daily Problems And Activities**
- **Numerous Unexplained Physical Symptoms**
- **Self-Harm, Suicidal Thoughts / Attempts**
- **Excessive Fears, Worries And Anxieties**
- **Social Withdrawal**

Medical Observation Criteria

Where there are any doubts about a defendant's mental health, the first, and perhaps most important step is to place them under medical observation promptly. This will help to ensure that reliable medical evidence of the defendant's state of mind is obtained. Most mental disorders require observation over a period of time for a correct diagnosis. For example, the ICD-11 requires that certain symptoms must be present for one month to make a diagnosis of schizophrenia.

In Pakistan, where there is any suspicion that a defendant has a mental disorder or disability, there is a duty on the judge to hold an inquiry into his mental health. As it can be difficult to determine whether a person has a mental disorder, courts should use trained mental health professionals to arrive at the appropriate conclusion. Defence lawyers should also be alert to the possibility that the defendant has a mental disorder and take appropriate steps.

According to the Supreme Court judgement titled *Mst Safia Bano vs The Home Department, Govt. of Punjab, Feb 2021*

"…the Court must get the accused examined by a Medical Board, to be notified by the Provincial Government, consisting of qualified medical experts in the field of mental health, to examine the accused person and opine whether accused is capable or otherwise to understand the proceedings of trial and make his/her defence. The report/opinion of the Medical Board must not be a mere diagnosis of a mental illness or absence thereof. It must be a detailed and structured report with specific reference to psychopathology (if any) in the mental functions of consciousness, intellect, thinking, mood, emotions, perceptions, cognition, judgment and insight. The head of the Medical Board shall then be examined as Court witness and such examination shall be reduced in writing." (Pg 31, Para 54).functions of consciousness, intellect, thinking, mood, emotions, perceptions, cognition, judgment and insight. The head of the Medical Board shall then be examined as Court witness and such examination shall be reduced in writing." (Page 31, Paragraph 54).

Relationship between ‘legal insanity’, crime, and specific mental illnesses

Some mental illnesses and mental functions have demonstrable, diagnosable, and extensively researched overlaps with criminal offences.The presence of disturbances of mental functions such as consciousness, thinking, intellect, judgement and insight,must raise the suspicion of ‘legal insanity’ or possibility of mental disorder and impairment of mental functions influencing mens rea, capacity, culpability, fitness to plead or take part in legal proceedings. The term legal insanity is however outdated, stigmatising, and not recommended for use. Mental disorders and mental illnesses are acceptable terms for use.

An individual’s mental illness should be taken into account in the criminal justice process because:

- **It may affect their legal responsibility for an offence, which in turn may be relevant in determining the eventual sentence or acquittal.**
- **It may hinder their meaningful participation in the legal process.For example, people with mental illness may not have had the necessary mens rea for the alleged offence, or their ability to understand the consequences of their actions may have been impaired.**
- **People with mental illnesses may also be at a greater risk of making false confessions if they have a diminished ability to accurately perceive reality.**

Case Study: Imdad *A*li

Imdad Ali, began exhibiting symptoms of schizophrenia in 1998. In 2002, he was sentenced to death by the Lahore High Court for murder. He remained on death row for 20 years, and spent almost four of those years in solitary confinement, which is not permitted under Pakistani law.

He was first diagnosed with psychosis in 2009 by a Medical Officer and then with paranoid schizophrenia in 2012. Several medical reports confirmed over the years that he was suffering from psychotic symptoms. His illness was exacerbated by overcrowded conditions of death cells and the damaging effects of solitary confinement.

A review petition challenging his Supreme Court dismissal order was submitted, and on 14 November 2016, the Supreme Court stayed his execution, ordering the formation of a medical board to assess the state of Imdad's mental illness. The board confirmed that Imdad was mentally ill.

In April 2018, the Supreme Court took suo motu notice of another mentally ill prisoner, Kanizan Bibi, and clubbed Imdad's case with hers. Ordering fresh medical examinations of both the prisoners, the apex court stated that this case will set a precedent for all mentally ill prisoners on death row.

On 10.02.2021, the Supreme Court of Pakistan passed a landmark judgement that enforces the rights of mentally ill defendants in the criminal justice system. Judgement in the case of Safia Bano v Home Dept. (2021 PLD 488 Supreme Court), authored by Justice Manzoor Ahmad Malik, and adjudicated by a five-member bench commuted Imdad ali's death sentence who spent 18 years on death row while exhibiting acute symptoms of mental illness. Imdad continues to undergo treatment in PIMH as a non-criminal mental patient.

CHAPTER 4

Mental Illnesses Associated with The Legal System

This section provides an overview of the main mental disorders that are likely to be relevant to the criminal justice process. [9] It is important to note that although all mental disorders are separate illnesses, individuals may experience overlapping symptoms. Two or more mental (as well as physical) disorders may exist simultaneously. The table describes the various categories of illness as described in the ICD-10.

ICD - 11 Code Group	Grouping
06	Mental And Behavioural Disorders
6A0(X)**	Neurodevelopmental Disorders
6A5(X), 6A6(X)	Schizophrenia / Primary Psychotic Disorders
6A7(X), 6A8(X), 6B0(X)	Mood Disorders
6B1(X)	Anxiety And Fear-Related Disorders
6B2(X)	Obssessive-Compulsive Or Related Disorders
6B3(X)	Stress Disorders
6B4(X)	Dissociative Disorders
6B5(X)	Physical Disorders
6B6(X)	Feeding Or Eating Disorders
6B7(X)	Elimination Disorders
6B8(X), 6B9(X), 6C0(X)-6C9(X), 6D0(X)-6D7(X)	Disorders Due To Substance Abuse / Addiction
6D8(X)	Impulse Control Disorders
6D9(X)	Disruptive / Dissocial Disorders

**The ICD-11 will officially come into effect on 1 January 2022*

The following is a description of the common symptoms and signs of mental illness.

Psychosis

The commonest form of mental illness that has overlap with criminal offences are those covered under the umbrella of psychosis. The term refers to an individual having abnormal beliefs (delusions) as well as sensations without any outside stimuli (hallucinations).

Delusions and Hallucinations

Delusions are bizarre beliefs that are not only false and improbable in reality but persist even after adequate evidence is presented to the individual against the belief. For example, a labourer, claiming to be president, when shown that another person is president in newspapers or television continues to believe that he is president with no evidence to support this claim, could be suffering from psychosis.

A hallucination is ‘perception without stimulus’. A typical example is that of a person who is sitting alone in a quiet setting yet is seen conversing claiming that he is responding to sounds and voices that only he or she can hear.
Delusions and hallucinations are typically seen in people with severe mental illness as psychotic features. Their specific presence suggests possible pathology in functions of mind such as consciousness, thinking, emotions, perceptions, and cognitions.

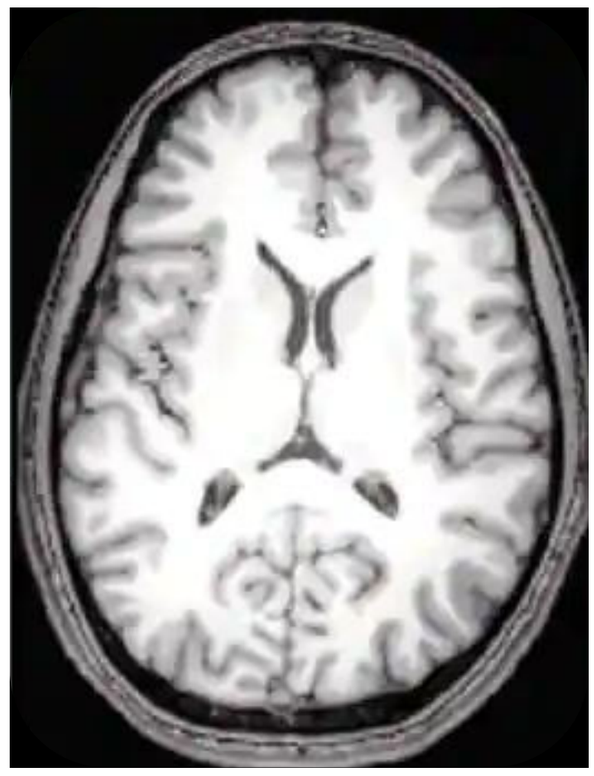
The mental illnesses that may cause patients to develop psychosis include:

+ Schizophrenia And Related Disorder
+ Intellectual Disability
+ Mood Disorder
+ Organic Mental Disorders

Schizophrenia and Related Disorders

A central feature of schizophrenia, a psychotic illness, is that the individual experiences a reality that is particular to them and is not shared with the people around them. This means that individuals suffering from schizophrenia may have belief systems that are not based on objective reality.

They may also have experiences such as hallucinations (having a sensory experience without any stimulus) i.e. Hearing voices that are not heard by those around them. Another feature of these hallucinations may be “command hallucinations”. The individual may hear voices commanding them to perform certain acts. They may also lose control over their own bodies (somatic passivity) and are forced to move them without their own will or volition. Psychotic disorders may take the form of pathological jealousy as a particularly dangerous form of psychosis that was identified in 12% of ‘insane’ male and 3% of ‘insane’ women murderers in a study[5]. Schizophreniform features may appear in puerperium, or under the effect of chronic alcohol and drug abuse or as acute syndromes with psychostimulant and psychedelic drug abuse.



MRI Scan of a Normal Brain

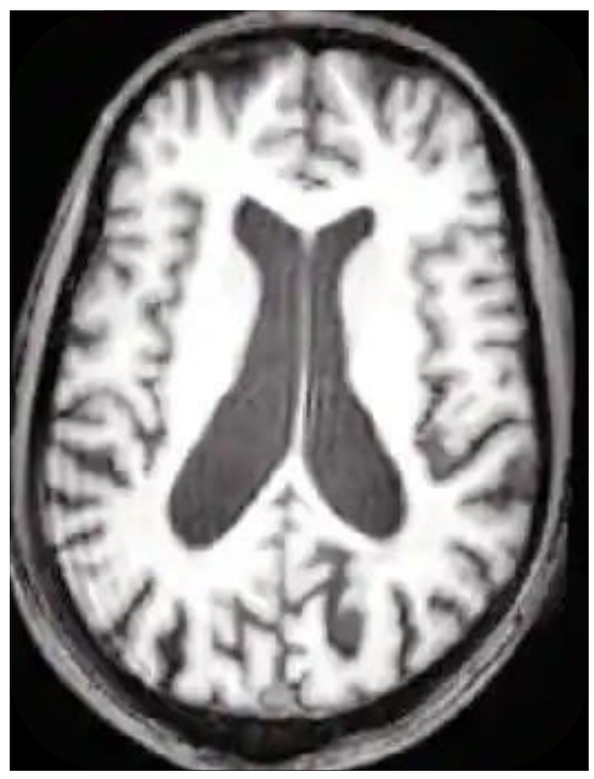


Fig 2. MRI Scan of a Schizophrenic Brain

Violent crimes are committed by only a minority of individuals with serious mental illness and the main factor in this is comorbid substance misuse[5]. Infact, patients suffering from mental illness, particularly “schizophrenia are more at risk of being victims of violence.” (Dean et al). [5]

More importantly but contrary to a commonly held misconception, schizophrenia cannot be easily faked, and has clear signs and symptoms delineated in the ICD. Certain types of schizophrenia also result in changes in brain structure as evidenced by brain imaging.

Intellectual Disability

Individuals with intellectual disability (aka mental retardation/learning disability) have an IQ lower than 70, as well as ‘impairments of general mental abilities that impact adaptive functioning in everyday life and include communication and social skills, personal independence, and school/work functioning’.[5]

85% of individuals with an intellectual disability (id) fall into the mild category. These individuals have reasonable language and social skills, ability to read and write and are able to do semi-skilled work. These individuals are more likely to commit crimes as they do not fully understand the implications of their actions and because they are more impulsive and vulnerable to exploitation by others. They are also more likely to get caught committing a crime. Under the effect of their intellectual disability they may also give false confessions.

Objective and highly sensitive and specific neurodiagnostic psychometric tests of intellectual disability are currently available internationally and in Pakistan. Many types of intellectual disabilities also have valid, specific and sensitive, laboratory tests, brain imaging tests, and genetic tests that are widely available for diagnosis.[5]

Mood Disorders

The two main types of mood disorders are mania and depressive disorders. These can occur with or without psychosis. They are both more likely to be associated with suicide and homicide, as well as other criminal offences[5].

Individuals with mood disorders may also make false confessions to crimes they did not commit as a result of abnormal guilt and lack of self-worth (under the effect of depressive illness) and inflated and unfounded self-worth, and feelings of grandeur, lack of vulnerability, and exaltation (in mania).

Mood disorders can be diagnosed through detailed history taking, clinical assessment and objective psychological tests. Patients of mood disorders also show biochemical changes demonstrable in lab tests, hormonal changes, changes in CT scans, MRI scans and pet scans (see annexe).

Stress Related Disorders

Dissociative Disorders

Dissociative disorders where symptoms like those seen in psychosis may temporarily appear in the form of fits, possession states (where the patient starts to behave as if possessed by a jin / bhoot / churail / evil spirit etc). In all such states, the patient is not fully conscious, can hear and see things but does not respond meaningfully to questions, or demands of those around him or her. Dissociative disorders occur as a result of severe stress with which an individual feels unable to cope. This happens when an individual has no healthy or productive way of expressing themselves.

Post-traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is a condition that results from challenges to an individual's life, property, honour or dignity observing acts of terror, or living through natural and man-made disasters. Up to one third of survivors of disasters and two third of victims of rape, arson, dacoities, and physical and sexual violence may go on to develop PTSD. These cases are on the rise in Pakistan on account of its extraordinary exposure to natural and human disasters in the last two decades. PTSD may result in substance abuse, alcoholism and emotional dysregulation, leading to deliberate self-harm, para suicide/attempted suicide, fits, and dissociative episodes resulting in violence, petty crimes, and road traffic accidents. PTSD may also be a factor when women exposed to prolonged torture exhibit an act of violence as retaliation. It has been used successfully as a defence for homicide in the US.

Anxiety Disorders

This is a group of disorders in which individuals suffer from excessive, persistent anxiety about everyday events and problems which results impairment of an individual's functionality and affects their appetite, sleep and weight. Panic disorder is a specific kind of anxiety disorder in which an individual experiences panic attacks due to the body's "fight or flight" response getting triggered without any threat. In this an individual's heart may race, they may experience difficulty breathing and subjectively feel as if they are about to die.

Individuals who have suffered stressful life events such parents dying in childhood, war or rape may be more likely to suffer from anxiety disorders.

Organic Mental Disorders

This includes disorders such as delirium and dementia. These are neuropsychiatric illnesses with structural pathological changes with behavioural manifestations. Organic mental disorders may result in cognitive impairment and impaired consciousness. Both disorders may result in violence either as a result of impaired consciousness or judgement due to abnormal beliefs. The causes for delirium and dementia may become apparent through laboratory testing and brain imaging, although in some cases the diagnosis may have to be based on exclusion and clinical judgement.

Organic mental disorders also include traumatic brain injuries. Injuries to the frontal lobe of the brain may result in impulsive, disinhibited and violent behaviour as well as personality change. Evidence of coarse brain injury may be apparent on brain imaging (although diffuse, axonal brain injury may not be apparent in conventional scans).

Physical Disorders

Physical disorders such as infections, imbalances of chemicals and hormones in the body, high fever in heat stroke, longstanding sleep and sensory deprivation. This may be more likely to occur in prisoners spending prolonged times in isolation as punishment, or those awaiting the death penalty. In all such situations, the symptoms improve with treatment of the underlying cause.

Epilepsy

Epilepsy is a neuropsychiatric disorder where abnormal electrical discharges in the brain result in changes in consciousness and automatic movements of the body. “epileptic automatisms may, very rarely, be associated with violent behaviour and subsequent criminal proceedings”[*]. Epilepsy was the condition used in the defence of the famous Jack Ruby case, who murdered Lee Oswald, the accused assassin of John F Kennedy, in 1967.

Mental or Behavioural Disorders associated with Pregnancy, Childbirth or the Puerperium, with/without Psychotic Symptoms

Pregnancy, childbirth and puerperium are times of major shifts in the physiology of a female body. The postpartum period in particular is a period of high risk for relapse of pre-existing mental illness. There is also a risk in 1.5/1000 live births of developing psychosis. This risk increases with each subsequent pregnancy if one psychotic episode has occurred. Under the influence of psychosis, a

person may develop delusions and hallucinations regarding their infant and as a consequence may harm or even murder them.

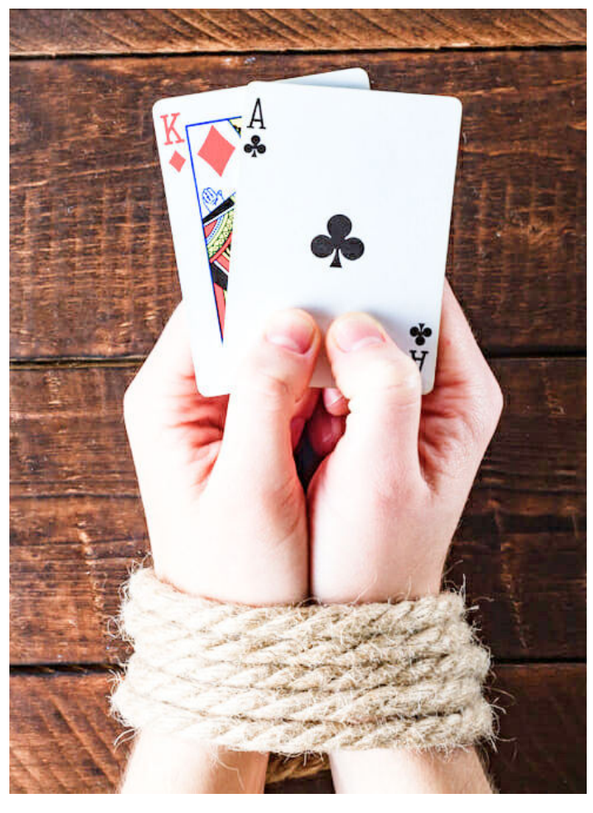
Mental and Behavioural Disorder due to Psychoactive Substance Use

Substance *A*buse

There is a close relationship between substance abuse and crime. The mental health ordinance of Pakistan 2001 allows for substance dependence to be used as a defence only when it is secondary to another psychiatric disorder. If the defendant was known to be acutely intoxicated at the time of the offense then they lack the mens rea to commit the crime, although they may be aware of the risks of substance abuse, they may be physically dependant on the substance and, therefore, a “diminished responsibility” defence may be considered in their case. Substance misuse can be caused by mental illness, complicate the symptoms of mental illness or lead to mental illness. Substance misuse and dependency are recognised as mental illnesses in The International Classification of Disease by the World Health Organisation.

Habit and Impulse Disorders

Pathological Gambling



Gambling is pathological when it is a regular indulgence by an individual and continues despite their lack of finances to support their habit. “brain imaging studies of pathological gamblers show abnormalities in mesolimbic reward pathways similar to those in drug dependence (Goudriaan et al., 2004).” This means that individuals suffering from this condition have uncontrollable impulses to indulge in gambling.

Other Impulse Disorders

Other pathological impulse disorders include pathological fire setting, and pathological stealing. Pathological stealing or kleptomania involves the impulses to steal things that have no value or that are not needed for use. Pathological fire setting involves setting fires on purpose leading to damage. It is preceded by tension and arousal and a feeling of pleasure when the fire is set.

Severe Personality Disorders

The dsm-5 defines a personality disorder as “an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.'' personality disorders are characterised by:

+ **Dysfunctional Aspects of the Self (Identity, Self-Worth, the Accuracy of Self-View, Self-Direction); and/or**

+ **Interpersonal Dysfunction (e.g., Ability to Develop and Maintain Close and Mutually Satisfying Relationships, Ability To Understand Others’ Perspectives and to Manage Conflict in Relationships)**

These characteristics are usually present for extended periods of time (2+ years) exhibiting behaviour that is maladaptive, manifesting in patterns of cognitive, emotional experience and expressions across a range of personal and social situations. Personality disorders are diagnosed by “assessing the severity of the symptoms against those of a normal population, rather than against what is normal for that individual”.

Personality disorders differ from ordinary personality traits due to their lack of flexibility and the effects they have on the individual. It is only when personality traits are inflexible and maladaptive and cause significant

functional impairment or subjective distress" that they are considered to constitute personality disorders.

The dsm-5 includes 10 different personality disorders, which it divides into three clusters based on similarities between the affected individuals. Cluster a refers to the following three disorders, which often result in the affected individuals appear odd or eccentric:

CLUSTER A

Paranoid Personality Disorder

is a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent.

Schizoid Personality Disorder

is a pattern of detachment from social relationships and a restricted range of emotional expression.

Schizotypal Personality Disorder

is a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behaviour.

Cluster b refers to the following four disorders, which often result in the affected individuals appearing dramatic, emotional or erratic:

CLUSTER B

***A*ntisocial Personality Disorder**

is a pattern of disregard for, and violation of, the rights of others.

Borderline Personality Disorder

is a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity.

Histrionic Personality Disorder

is a pattern of excessive emotionality

Narcissistic Personality Disorder

is a pattern of grandiosity, need for admiration, and lack of empathy.

Cluster c refers to the following three disorders, which often result in the affected individuals appearing anxious or fearful:

CLUSTER C

Avoidant Personality Disorder

is a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.

Dependent Personality Disorder

is a pattern of submissive and clinging behaviour related to an excessive need to be taken care of.

Obsessive-Compulsive Personality Disorder

is a pattern of preoccupation with orderliness, perfectionism, and control.

One notable omission from this list is “psychopathic personality disorder”. Psychopathy is not currently included as a separate diagnostic category in the DSM or ICD classifications. Despite this fact, it is often described as a type of personality disorder, which is associated with many social and behavioural problems.

While definitions of psychopathy vary, one of the most influential clinical descriptions was provided by Cleckley. He considered that psychopathy can best be described in terms of a specific pattern of interpersonal, affective, and behavioural characteristics, which Cooke has summarised as follows:

Within the interpersonal domain, psychopaths are egocentric, grandiose, manipulative, dominant, forceful, and cold. Within the affective domain, psychopaths are shallow and emotionally labile; they are unable to form long-lasting bonds; they lack empathy, genuine guilt, or remorse. Within the behavioural domain, psychopaths are impulsive and sensation-seeking; they violate social norms by failing to fulfil their obligations, by acting irresponsibly, and by becoming involved in criminal activities.

Hare has developed a rating scale for the assessment of psychopathy (the hare psychopathy checklist, revised (pcl-r)).

The icd-11 categorises personality disorders based on their severity:

Mild Personality Disorder:

All general diagnostic requirements for personality disorder are met. Disturbances affect some areas of personality functioning but not others (e.g., problems with self-direction in the absence of problems with stability and coherence of identity or self-worth), and may not be apparent in some contexts. There are problems in many interpersonal relationships and/or in performance of expected occupational and social roles, but some relationships are maintained and/or some roles carried out. Specific manifestations of personality disturbances are generally of mild severity. Mild personality disorder is typically not associated with substantial harm to self or others, but may be associated with substantial distress or impairment in personal, family, social, educational, occupational or other important areas of functioning that is either limited to circumscribed areas (e.g., romantic relationships; employment) or present in more areas but milder.

Moderate Personality Disorder:

All general diagnostic requirements for personality disorder are met. Disturbances affect multiple areas of personality functioning (e.g., identity or sense of self, ability to form intimate relationships, ability to control impulses and modulate behaviour). However, some areas of personality functioning may be relatively less affected. There are marked problems in most interpersonal relationships and the performance of most expected social and occupational roles are compromised to some degree. Relationships are likely to be characterized by conflict, avoidance, withdrawal, or extreme dependency (e.g., few friendships maintained, persistent conflict in work relationships and consequent occupational problems, romantic relationships characterized by serious disruption or inappropriate submissiveness). Specific manifestations of personality disturbance are generally of moderate severity. Moderate personality disorder is sometimes associated with harm to self or others, and is associated with the marked impairment in personal, family, social, educational, occupational or other important areas of functioning, although functioning in circumscribed areas may be maintained.

Severe Personality Disorder:

All general diagnostic requirements for personality disorder are met. There are severe disturbances in the functioning of the self (e.g., sense of self may be so unstable that individuals report not having a sense of who they are or so rigid that they refuse to participate in any but an extremely narrow range of situations; may be characterized by self-contempt or be grandiose or highly eccentric). Problems in interpersonal functioning seriously affect virtually all relationships and the ability and willingness to perform expected social and occupational roles is absent or severely compromised. Specific manifestations of personality disturbance are severe and affect most, if not all, areas of personality functioning. Severe personality disorder is often associated with harm to self or others and is associated with severe impairment in all or nearly all areas of life, including personal, family, social, educational, occupational, and other important areas of functioning.

Malingering/Feigning Mental Disorders

A concern in the criminal justice system is that prisoners may feign (or “malinger”) psychiatric or cognitive impairment in order to avoid the death penalty or harsher punishments.

Mental health professionals are aware of this risk. In fact, malingering has been identified by the dsm-5 as “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives.” In this case, the incentive may be a more lenient sentence, or avoiding prison in favour of a medical facility. The tests designed to evaluate prisoners account for feigning/malingering. Feigning mental illness when being evaluated by an experienced mental health professional is, thus, extremely difficult.

In addition, while concerns surrounding malingering are not unfounded, there are equally serious consequences for misclassifying malingering when an individual possesses a genuine mental disorder. Doing so may result in the execution of a mentally disordered prisoner, or the unjust imposition of a harsher penalty than is warranted in the circumstances.

The risk of malingering can be reduced by takings steps to ensure that mental health experts present evidence that is reliable and valid.

Dealing with Malingering and Deception

In prisoners exhibiting medical symptoms whether psychiatric or physical, prison officials as well as health professionals may jump to the conclusion that the prisoner is “faking it” or malingering. While this may be the case, malingering is to be considered as the last differential diagnosis, not the first. The estimated prevalence of malingering in prison settings is approximately 10-20 percent. Therefore, there will be prisoners who exhibit symptoms of psychosis but without the presence of any of the psychotic disorders listed above.

In all such situations a well-trained health professional, lawyer, or judge must consider the presence of following disorders before a formal decision on the cause of these symptoms being malingering is made. Objective psychological tests are an important tool.

Symptoms

We must remember that the symptoms similar to those seen in psychosis may also occur in following conditions:

Ganser Syndrome

Ganser Syndrome is a dissociative disorder seen in prisoners. A patient of Ganser syndrome gives approximate answers (wrong or nonsensical but not irrelevant), e.g. asked how many legs a cow has, Ganser patients will reply "5", and answers to plain arithmetic questions will likewise be wrong, but only slightly off the mark (e.g., 2 + 2 = 3). They may be seen wandering around aimlessly, may appear to have lost all memory, or appear to be in a state of changed consciousness, or claim seeing things and hearing voices (as done by patients of psychosis). All forms of dissociative disorders including Ganser syndrome are psychiatric disorders and demand evaluation and management by a mental health professional. They are not to be considered as malingering. In the past these patients were labelled as ‘Hysteria’. This term is no more valid, is considered negative / derogatory, and has, therefore, been abandoned.

Factitious Disorders

Factitious disorders is an illness in which patients give themselves symptoms of physical or mental illness. Their motivation for doing this is gaining medical attention. They may deliberately harm themselves, cause physical injuries, or even undergo surgical procedures for the sole purpose of medical interventions and

without gaining any other benefits from these damages. Such patients are seriously ill and require immediate referral and management by mental health professionals.

Malingering

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, defines malingering as the intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external gain. In malingering individuals feign / pose to be patients with mental illnesses or physical illnesses to gain an advantage or a benefit e.g. removal from prison to a hospital setting, or reduction in their sentences, specialist care in another country, access to family, special food and clothing or shift to a better class in the prison. They do so in their full consciousness, with a clear (detailed and an extensive) plan to deceive the legal and medical authorities to gain an advantage or benefit that will not get otherwise. These individuals are not mentally or physically sick. Labelling an individual as a malingerer should always be done with the help of a team of mental health professionals, after ruling out other causes, some of which are stated above.

Features	Psychosis	Malingering
Appearance	General Self Neglect, Poor Hygiene, Talking To Self, Irrespective Of The Setting And Whether Others Are Watching Or Not	Evidence Of Self Neglect Only In Visible Parts Of The Dress Or Body, Self Hygiene Mostly Preserved, Mimicking Psychotic Behavior Often Only When Others Are Watching / Prison Staff Is Expected To Take Notice
General Behaviour	May Appear Calm And Unaware Of Surroundings, Stares Meaninglessly, Smiles Inappropriately, May Maintain Odd And Uncomfortable Postures For Hours At End Irrespective Of Extreme Weather Conditions Shows No Urge To Attack Or Harm Others When Left Alone, May Get Violent Only When Others Try To Approach Or Interfere Or Probe	Exhibits Dramatic Laughters And Weeping Spells, Chooses Timings And Conditions When Others Are Around And The Setting And Weather Is Not Uncomfortable Or Extreme. Approaches Others To Undertake Violence, Shouting And Crying Even Nobody Is Bothering Or Interfering

Features	Psychosis	Malingering
Talk / Speech	May Talk Normally And Give Coherent And Correct Responses Initially (Particularly Closed Ended Questions Like What Is Your Name, Where Are You, What Is Your Address Or Prisoner Number Etc), But Then Speech Becomes Incoherent As The Conversation Progresses Particularly When Asked Open Ended Questions	Starts By Giving Inappropriate And Wrong Answers Even To Closed Ended Questions Seeking Simple Personal Data. Most Of The Speech Is To Exhibit Naïve Or 'Mad'
Daily Routines	Appetite Is Either Almost Nothing, Or Too Much, With Little Or No Concern For Manners, Timings, Settings; Sleeps And Stays Awake At Odd Hours, Often Staying Awake At Night; Sometimes Staying Awake For Days At End; Drink No Water Or Too Much Water, Spilling It. All This Is Done Without A Fixed Pattern Or Routine Or Concern For Others	Will Refuse To Eat, Or Make Demands For Special Foods, Spills Food And Water To Cause Inconvenience For Others, Particularly The Prison Support Staff, Creating Dramatic Scenes At Lunch Or Supper Hours When Everybody Is Watching, Follow Fixed Patterns Of Sleep And Wakefulness, Causing Minimal Or No Inconvenience To Self.
Link With Court		No Link Oddities Exaggerated And Increased In Intensity Just Before The Proceedings Or In The Court Or Prison Visits

	Dissociative Disorder	Malingering
	Individuals Are Willing To Engage	Individuals Are Uncooperative And Aloof
	Do Not Usually Object To Being Assessed By A Health Professional	Avoid Assessment

	Dissociative Disorder	Malingering
	Willingly Take Treatment If Given Adequate Informational Care	Refuse Treatment
	Willing To Engage In Activities	Refuse Opportunities To Engage In Activities Even When They Do Not Involve Their Symptoms
	Provide Detailed Descriptions Of Their Illness And The Events That Lead Up To Them	More Likely To Give History That Is Not Descriptive And Has Gaps And Inaccuracies
	Management Involves Ruling Out Physical And Psychiatric Causes Of Symptoms	Management Involves Identifying The Underlying Conflict Leading To The Symptoms

Case Report

The following case reports and the table will help in separating one condition from the other, but the basic principle is that a diagnosis of any of these conditions should never be made by a single individual. It should be based on detailed observations, formal recordings of behaviour (written, photographic or video-based), as well as accounts collected from fellow prisoners, prison personnel, those who serve food, or cameras installed, nursing staff, and mental health professionals.

Prison and law authorities must never rush or jump to make the diagnosis of malingering and remember that it is one of the toughest tasks even in the hands of professionals. Many studies have shown that those who malingered an illness, may develop the same illness or other serious mental and physical disorders later in life.

Mr X under trial for a white collar crime has been remanded in prison. He was a senior banker, but is being kept amongst regular prisoners. He has frequently complained about the harsh weather conditions and discomforts he is experiencing.

One day he is seen standing in front of the wall facing it and talking to himself. When approached by a guard, he starts to laugh excessively for few minutes, and then starts crying. He gives irrelevant answers to questions. Specimen of his conversation with guard is as follows:

G: Kia hua saab, kis se baatein ker rahay hein?

X: Asmani makhluq se baat ker raha hun, koi meray qareeb naa aye.

G: Aap ko kia hua hai?

X: Mein haqeeqat jaan gaya hoon, sab ko seedha ker doon ga, mujh se duur raho verna apni asmaani taqat se sab ko jala doon ga….jao apnay baron ko bulao……iss se pehlay ke mein sub kuch tabah ker doon.

After this conversation he turns around and tears his clothing, and tries to strangulate himself with a piece of cloth.

The fellow prisoners report that he took his breakfast and tea as routine, slept well last night, but was restless for the last couple of hours before the incident. Once shifted to the prison hospital Mr X continued to talk with the same content for a day. However when it was decided that he will be returned to the cell next day, his condition returned at night and he broke utensils and started o jump on his bed. On the next morning he became mute, refused breakfast, and again went to the wall and started to talk to himself facing the ward.

The jail authorities engaged mental health professionals from the local hospital. They took detailed accounts of Mr X's behavior since arrival, interviewed fellow prisoners, guards, and the prison hospital staff. They also conducted several interviews with Mr X, involved his family members to collect information about his physical and mental health and any history of illnesses in the family.

After three days it was decided by the mental health team that Mr X was malingering to claim a shift to a psychiatric facility outside the prison with

ready access to his family and better living conditions. The mental health team in-charge discussed with the jail authorities and guided Mr X that his request for shift to a better class in the prison can be taken up by his lawyer. It was highlighted to him that in the meantime, he would continue in his current setting after discharge from hospital. The guard and fellow prisoners were informed not to respond or take notice of Mr X's earlier behavior if it recurred. The guard was instructed to stay in close vicinity and patiently wait till Mr X returned to regular behavior, ensuring with the help of colleagues to save him from any behavior to damage clothing or harm himself, but not to return him to the hospital.

Mr X continued to exhibit similar episodes for two days, and then stopped. He was shifted to class B after a week, once the court orders were received on the subject. Mr X was not given any medication, was not punished or ridiculed for his behavior, was not rushed to the hospital at any stage. The jail authorities did, however, make an effort to listen to his grudges patiently, helped him to ventilate his anger, but ensured that no extra advantages were granted to him while he exhibited the behavior of being a mentally ill patient.

Suicide

Suicide is a psychiatric emergency. It is defined as a deliberate act taken by an individual leading to their own death. There are very few data avilable on suicide in Pakistan, within prison settings or the general population. International data suggests, however, that suicides are more common in prison populations. This indicates that incarceration/imprisonment itself is a risk factor for suicidality. Some of the myths that surround suicide are stated below with factual corrections:

Myth: Those who talk about suicide do not commit it. “Jo garajtay hain woh barastay nahi”

Fact: In a US study, suicidal ideas have been expressed by more than two-thirds of those who die by suicide, and clear suicidal intent by more than one-third. Often the warning had been given to more than one person. Over 40% of people who committed suicide had consulted their doctor in the preceding weeks (Pirkis and Burgess, 1998).

Myth: Talking about suicide will give someone the idea of committing suicide

Fact: Considering suicide is not something any individual does lightly. When one is having these thoughts, they may feel a sense of relief when asked about them. This may be a life saving conversation.

Myth: If someone has made an unsuccessful attempt at suicide, they “dont have the guts” to do it properly and will not actually commit suicide

Fact: The rate of suicide in the year following an episode of deliberate self-harm (DSH) is some 60–100 times that of the general population (Hawton et al., 2003a).

Myth: Suicide only happens in young people

Fact: The highest rates of suicide in both men and women are in the elderly.

Myth: Those who harm themselves by cutting their wrists or burning themselves will not commit suicide

Fact: For every suicide it is estimated that more than 30 non-fatal episodes of self-harm occur.

Myth: Suicide is unrelated to physical illness

Fact: The risk of suicide is higher in individuals with chronic, debilitating physical illnesses.

Myth: Once an individual is discharged from an inpatient psychiatric facility they are fine and will not commit suicide

Fact: The rate of suicide is also raised in the period following discharge from inpatient psychiatric care.

Myth: Suicide is just a behaviour, it is unrelated to any mental illness

Fact: Depression, substance misuse, and other mental health problems are more common in people who deliberately harm themselves.

Health professionals must conduct a suicide risk assessment on any individuals that are showing a change in their activities of daily living and their biological functions (sleep and appetite) for a period of two weeks. If a prisoner has made an attempt at self-harm or violence this assessment as well as the forensic mental health screening questionnaire should be conducted immediately. The following questions must be asked when making an assessment for risk of suicide in an individual. This assessment should then be augmented with gathering data on the current status of the prisoner's sentence, what their offence was, where they are serving their sentence and whether they receive any social visits (see table on risk factors).

* Harrison P, Cowen P, Burns T, Fazel M. Shorter Oxford textbook of psychiatry. Oxford university press; 2017 Oct 12.

* Zhong S, Senior M, Yu R, Perry A, Hawton K, Shaw J, Fazel S. Risk factors for suicide in prisons: a systematic review and meta-analysis. The Lancet Public Health. 2021 Feb 10.

Suicide Risk *A*ssessment

Q. What are your plans for the future? Have you thought about ending your life?

Q. Have you made a plan?

Q. What is stopping you from carrying out this plan?

Q. Have you attempted to commit suicide in the past?

Q. Have you tried to harm yourself in any way (by cutting wrists, or taking overdoses of medications) in the past?

Q. Have you been diagnosed with a mental illness in the past?

Q. Are you currently or have you in the past abused street drugs?

Q. How has your physical health been?

Q. Has anyone close to you committed suicide?

Q. Does anyone in the family have a mental illness?

* Mavrogiorgou, P., Brüne, M., & Juckel, G. (2011). The management of psychiatric emergencies. Deutsches Arzteblatt international, 108(13), 222–230. https://doi.org/10.3238/arztebl.2011.0222

Factors Associated with Suicide

Clinical Factors

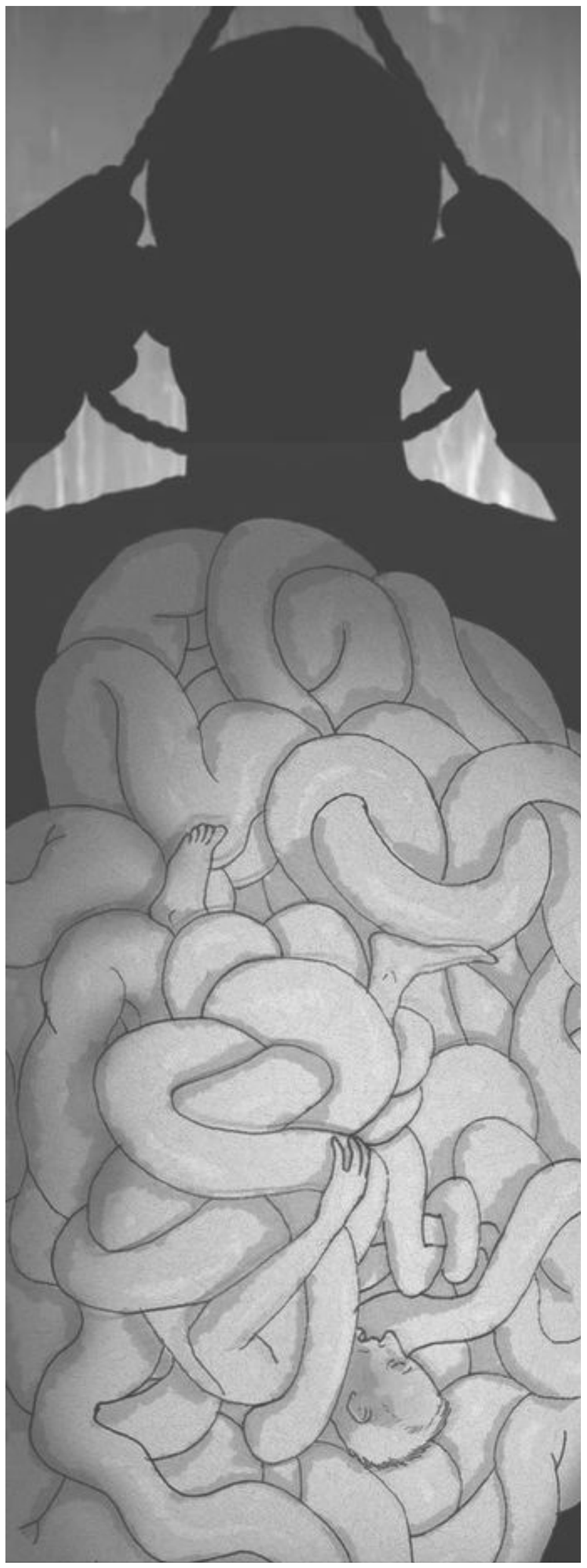
- Suicidal Ideation During The Current Period In Prison
- History Of Attempted Suicide
- Current Psychiatric Diagnosis

Institutional Factors

- Occupation Of A Single Cell
- Having No Social Visits

Criminological Factors

- Being Convicted of a Violent Offence, particularly Homicide
- Serving A Life Sentence
- Remand Status



Risk Factors for Suicidality

1. Recent Suicidal Ideation

2. Prison Settings

3. Mental Illness

- Depression
- Addiction
- Schizophrenia
- Bipolar Disorder

4. Prior Suicidality

- Expressions Of Suicidal Intent
- Prior Suicide Attempts (Especially In The Recent Past)

5. In Younger Persons

- Developmental And Relationship Difficulties
- Problems In The Family, School, Or Job Training
- Problems With Illicit Drugs

5. In Older Persons

- Loneliness, Widowhood / Widowerhood
- Painful Chronic Disease Impairing Quality Of Life

6. Traumatic Experiences

- Loss Of A Partner, Severely Hurt Feelings
- Loss Of Social, Cultural, Or Political Context
- Identity Crises, Disturbances Of Adaptation
- Long-Term Joblessness, Lack Of Prospects
- Criminality, Traffic Offenses (With Injury Or Mortal Harm To Another Person)
- Physical Illness Severely Impairing Quality Of Life

CHAPTER 5

Mental health and mens rea

Effects of Mental Illness on Criminal Offences

"…it is clarified that not every mental illness shall automatically qualify for an exemption from carrying out the death sentence. This exemption will be applicable only in that case where a Medical Board consisting of mental health professionals, certifies after a thorough examination and evaluation that the condemned prisoner no longer has the higher mental functions to appreciate the rationale and reasons behind the sentence of death awarded to him/her. To determine whether a condemned prisoner suf ers from such a mental illness, the Federal Government (for Islamabad Capital Territory) and each Provincial Government shall constitute and notify, a Medical Board comprising of qualified Psychiatrists and Psychologists from public sector hospitals."

Mst. Safia Bano v Home Department, Government of Punjab (2021 PLD 488 Supreme Court)

The key issue in determining the culpability of an individual is whether the accused had the mental capacity to form the intention (mens rea), or whether mental disorder might have affected that capacity.

"Individuals with mental illness are especially vulnerable in the legal system as they may not want their condition to be recognised as well as actively hide it. They may be unable to understand their rights. They may also feel overwhelmed by police presence, upset at being detained and attempt to run away (thus, appearing guilty). They may only say what they think police want to hear even if it is not true. They may be "unfit to plead" and unable to assist their defence lawyer and may appear to show no remorse. All these factors contribute to their sentencing, therefore, being harsher."

The mentally ill or intellectually disabled are less morally culpable when their impairment is a cause or explanation for their criminal actions. People who are less morally culpable are:

- **Less Able to Appreciate the Consequences of their Actions**
- **More Likely to Act on Impulse Instead of Premeditation**
- **Less Able to be Deterred by Threats of Punishment**
- **Less Able to Control and Conform their Behaviour to the Requirements of the Law**
- **More Likely to be a Follower and not a Leader of Criminal Activity**
- **The Degree of Moral Culpability Determines the Severity of Punishment for All Crimes.**

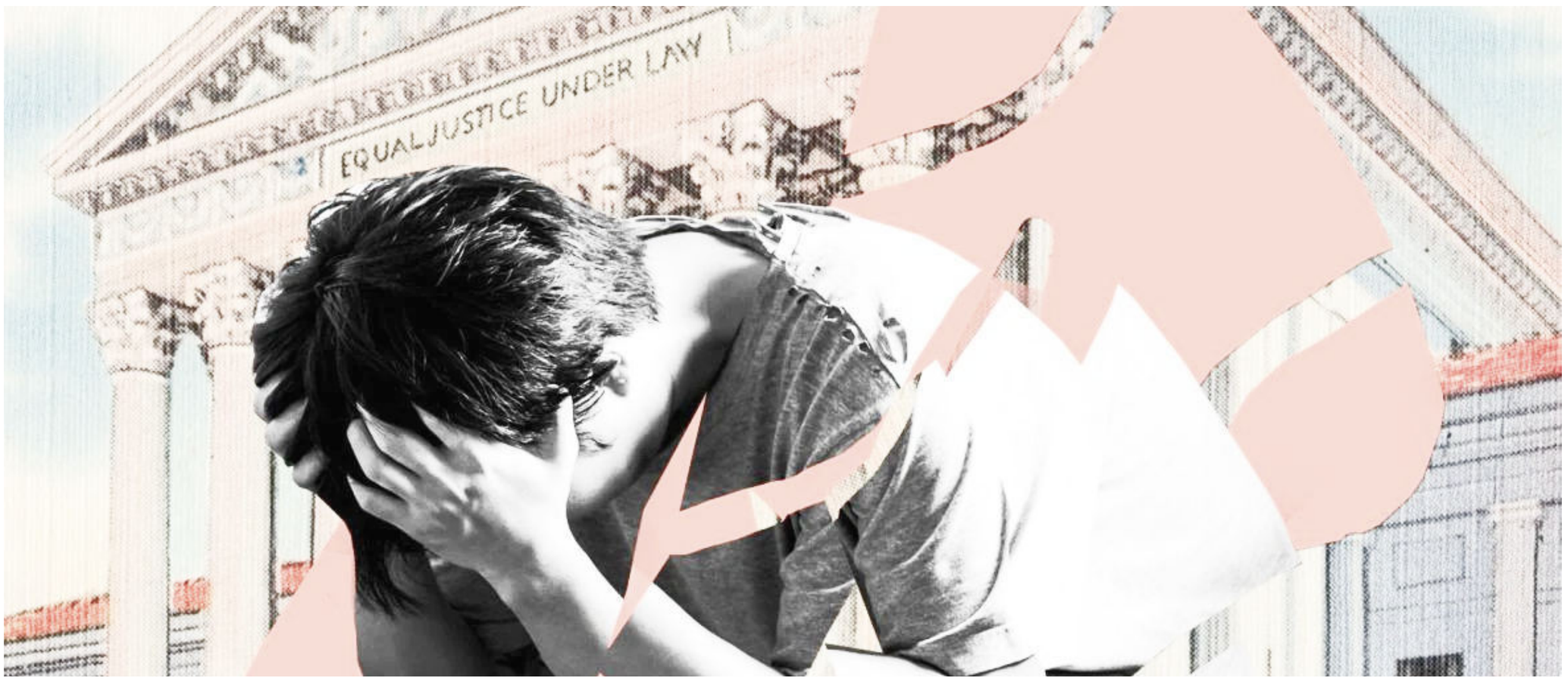
Meta-analysis of 62 psychiatric surveys of prisoners revealed that one in seven prisoners had a treatable psychiatric illness.

* Robin M. Maher, Esq The unique challenges and vulnerabilities of persons with mental illness and intellectual disability

Relevance of Mental Disorders to Legal Processes or Psychiatric Defences

There are several ways in which a defendant's mental disorder may be relevant to the criminal justice system:

- **If The Defendant Has A Mental Disorder At The Time Of The Trial, They May Not Be Fit To Plead**
- **If The Defendant Had A Mental Disorder At The Time Of The Offence, They May Be Found Not Guilty By Reason Of Insanity**
- **If The Defendant Is Convicted Of An Offence And Subsequently Develops A Mental Illness, This May Provide A Basis To Mitigate Their Sentence**
- **If The Defendant Is Mentally Impaired But Convicted For A Crime, He May Be Transferred To A Forensic Mental Health Facility**
- **If The Defendant Had A Mental Disorder At The Time Of Offending Or Has A Mental Disorder When Execution Is Scheduled To Take Place, He May Not Be Competent To Be Executed**



Capacity

All forms of psychoses are characterised by a lack of insight into the nature of their illness and acts of commission and omission made that may have resulted in harm to self or others. Individuals suffering from psychosis also lack the capacity to make reasonable, common sense judgments in situations of potential harm to their own self or to those of others. A person with psychosis may, therefore, destroy property, steal, injure, kill or perform an act, appearing to be a crime, in the eyes of law. This, however, would be an act without any intent, plan, consequence, or advantage to the patient (termed mens rea in law) suffering under the burden of psychosis.

- Understand
- Retain
- Weigh
- Communicate

Fitness to Plead

A defendant is unfit for trial if it is established on the balance of probabilities that he or she is incapable, by reason of a mental or physical condition, of participating effectively in a trial.

It is advantageous if the defendant has the ability to:

- Understand The Nature Of The Charge
- Understand The Requirement To Tender A Plea To The Charge And The Effect Of Such A Plea
- Understand The Purpose Of, And Follow The Course Of The Trial
- Understand The Evidence That May Be Given Against The Person
- Instruct And Otherwise Communicate With The Defendant's Legal Representative

Chapter 34 of the code of criminal procedure provides vigorous protection to defendants suffering from a mental disorder at the time of trial. See chapter iii(a) below for an overview of the provisions of this chapter.

In Abdul Wahid v the state, the supreme court of Pakistan confirmed that the court must comply with the provisions of chapter 34, which require it to hold an inquiry or a trial if it has "reason to believe" that the defendant is of "unsound mind" and is incapable of making his defence.

The Insanity Defence

It is a well-established principle of Pakistani law that "mens rea or a guilty mind is an essential ingredient of a criminal offence." If a person had a mental disorder at the time of committing an offence, they may not have had the requisite mens rea and so may have been acquitted on the basis of the insanity defence.

The insanity defence recognised in Australia, Canada, England, wales, Hong Kong, India, the republic of Ireland, new Zealand, Norway and most American states is governed by the M'Naghten case, which held that if "at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know what he was doing what was wrong", then a person cannot be held criminally liable.

This defence has been incorporated into section 84 of the Pakistan penal code, which states:

Act of unsound mind: nothing is an offence which is done by a person who, at the time of doing it, by reason of unsoundness of mind, is incapable of knowing the nature of the act, or that he is doing what is either wrong or contrary to the law.

Thus, an individual cannot be held criminally liable if they are suffering from a disease of the mind and as a result of it is prevented from understanding the nature of the criminal act. Pakistan's definition of mental disorders is notably broader than the historical M'Naghten test, it is outlined in the mental health ordinance 2001. It defines the parameters of mental disorders as including "mental illness, including mental impairment, severe personality disorder, severe mental impairment and any other disorder or disability of mine," - while excluding from the scope of the definition "promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs."

Sentencing Mitigation

Mental illness should be fully taken into account and given proper weight at the sentencing stage. The sufferance of mental illness by an offender is highly pertinent and should be reflected in the sentence he receives. "the greater the contribution of the psychiatric illness, the more the moral culpability will be lessened.

However, mental illnesses can often prevent mitigating factors from being properly put to the court for consideration. Symptoms which are common within certain disorders - such as paranoia, disorganised thoughts and lack of insight - can provide great challenges in obtaining medical evidence when a defendant denies suffering from any such disorders. This presents great danger, particularly in capital cases where the defendants' lives are at stake. It is therefore vital to identify mental

illnesses before the sentencing stage. Research has suggested that even terms of imprisonment "often aggravate these individuals" symptoms, in particular, if they are placed in solitary confinement.

Competency to be Executed

International law prohibits the execution of mentally ill condemned prisoners, where the illness was present at the time of the commission of the offence or where it is present at the time of execution (see below). Execution of mentally disordered prisoners is also prohibited under Pakistan's domestic law.

Aside from the inhumanity of executing a mentally ill condemned prisoner, doing so serves no penological purpose or justification.According to justice William Wayne, "if we reject the moral necessity to distinguish between those who willingly do evil and those who do dreadful acts on account of unbalanced minds, we will do injury to these people."

Mental Health Service Provision in Prison Settings

"We hold that words "Civil Surgeon" and "medical of icer" used in Chapter XXXIV Cr.P.C. and Prison Rules be substituted by the relevant Legislature with "Medical Board". The Medical Board shall comprise of qualified and experienced Psychologists and Psychiatrists. The concerned governments are directed to take immediate steps to do the needful."

Mst. Safia Bano v Home Department, Government of Punjab (2021 PLD 488 Supreme Court)

Mental Health Evaluation Principles

It is important for approved psychiatrists and practitioners to understand and adopt certain key mental health principles while treating and assessing mentally disordered patients. These are:

Non-Discrimination	**Participation**
Equality	**Respect for Carers**
Respect for Diversity	**Least Restrictive Alternative**
Reciprocity	**Benefit**
Informal Care	**Child Welfare**

Psychiatric Services Pursuant to the Mental Health Ordinance and the Mental Health *Act*

Psychiatric services pursuant to the mental health ordinance and the mental health act as per the Supreme Court of Pakistan's judgement on Mst. Safia Bano vs The Home Department:

1. The Federal Government (for Islamabad Capital Territory) and each Provincial Government, shall immediately constitute and notify a Medical Board comprising of three qualified and experienced Psychiatrists and two Psychologists from public sector hospitals for examination and evaluation of the condemned prisoners who are on death row and are suffering from mental illness to ensure that such mentally ill condemned prisoners who no longer have the higher mental functions to appreciate the rationale and reasons behind the sentence of death awarded to them are not executed.

2. The Federal Government (for Islamabad Capital Territory) and all the Provincial Governments shall immediately constitute and notify a Medical Board consisting of two qualified and experienced Psychiatrists and one Psychologist from public sector hospitals at Islamabad (in case of Federal Government) and at each Divisional Headquarter of the Provinces for examination, assessment and rehabilitation of the prisoners i.e. under-trial and convicts, if referred by the jail authorities. The said Medical Board shall also be authorized to examine those accused persons who are referred by the trial Court(s) for examination under the provisions of sections 464 and 465 Cr.P.C.

3. The Federal Government (for Islamabad Capital Territory) and all the Provincial Governments shall immediately launch training programs and short certificate courses on forensic mental health assessment for psychiatrists, clinical psychologists, social workers, police and prison personnel.

4. The Federal Judicial Academy, Islamabad and all the Provincial Judicial Academies shall also arrange courses for trial Court judges, prosecutors, lawyers and court staff on mental illness including forensic mental health assessment."

The health staff of a prison consists of the Medical Officer, the Psychologist and the Junior Psychologist, Medical Professionals such as Consultant Psychiatrists or Registrars in Psychiatry at the District Headquarters Hospital, and can include other visiting medical professionals who render their services to prisoners from time to time.

The duties and obligations of the Medical Officer can be found in Chapter 40 of the Pakistan Prison Rules 1978. Moreover, the duties of the Psychologist and Junior Psychologist can be found in the memo of the Inspectorate of Prisons, Punjab, Lahore, dated 03.04.2019. The other medical professionals mentioned above must also refer to the Pakistan Prison Rules 1978, as well as their training and modern best practices to identify and ensure a high standard of care for prisoners. After initial assessment by a prison psychologist to generate documentation of a prisoner's history mental state, an orientation manual regarding the psychosocial support available in the prison may be provided to prisoners.

Solitary Confinement

There is ample research that shows the negative health impacts of solitary confinement, including death and suicide. Solitary confinement can be as distressing as physical torture and can result in anxiety, depression, panic attacks, hallucinations, deteriorating eyesight, headaches, sleep problems, and weight loss among other conditions.

As part of the international community, Pakistan also abides by the Mandela Rules, according to which solitary confinement should be for as short a time as possible and should not last more than 15 days. Prisoners should be placed in solitary confinement only in exceptional cases and as a last resort.

If there is no other option but to put a prisoner in solitary confinement, it is important to closely monitor them and keep a watchful eye on their symptoms and condition.

Intial Assessment

Psychologist to be provided with basic information and relevant record of new inmate

All offenders to be screened and a mental status examination carried out by junior psychologist within 24 hours

If the offender would be identified with some deviant tendency, he/she will undergo detailed assessment

Psychological profile to be prepared by junior psychologist in consultation with medical officer and clinical psychologist

Disoriented offender will be cross assessed by the clinical psychologist and referred to medical officer for further evaluation

What To Do?

Do Establish Rapport With Prisoners And Form Professional Therapeutic Relationships

Do Listen To Prisoners During Periods Of High Stress

Do Help Prisoners To Solve Their Own Problems Using Socratic Reasoning

Do Encourage Prisoners To Share If They Receive Shocking Or Traumatic News

Do Understand The Negative Impact Of Stressful Detention Conditions, Physical Restraints Especially Solitary Confinement

What Not To Do?

Do Not Isolate, Ignore Or Have Personal Relationships With Prisoners

Do Not Give Advice On How They Should Conduct Themselves

Do Not Tell Prisoners How To Solve Their Problems

Do Not Share Prisoners Problems With Other Inmates Or Gossip About Them

Do Discuss The Negative Impact Of Physical Restraints, Physical Disciplinary Measures Solitary Confinement With Prison Administrative Staff Using Evidence From Research Done On Prison Populations

Who is an Approved Psychiatrist?

Pursuant to the Mental Health Ordinance, 2001 and The Sindh Mental Health Act, 2013, an approved psychiatrist means a medical practitioner possessing a recognized postgraduate qualification and registered with Pakistan Medical And Dental Council and also approved by the authority.

Forensic Psychiatric Services (As advised by the Supreme Court)

(1) Special security forensic psychiatric facilities shall be developed by the Government to house mentally disordered prisoners, mentally disordered offenders, as may be prescribed.

2) Admission, transfer or removal of patients concerned with criminal proceedings in such facilities shall be under the administrative control of the Inspector General of Prisons.

3) The Board of Visitors shall have an access to such persons admitted in forensic psychiatric facility in accordance with the provisions of this Ordinance.

Forensic Mental Health Report

In all such matters where a suspicion of mental illness is raised from the accused side or any quarter or if the defence takes a plea on grounds of mental illness, it is mandatory for the court to seek assistance of mental health professionals (duly nominated by the provincial government for this purpose). The court must ask for a formal forensic mental health report (FMHR), the same way that forensic chemical examiner reports or post mortem / autopsy reports are sought. Such a report should be prepared after a thorough evaluation of a board of mental health professionals comprising minimally of one psychiatrist / neuropsychiatrist, one clinical psychologist, one social worker with experience of working with mental health issues related to the legal system, prisoners / offenders. The report so compiled

The report so compiled must not be a mere diagnosis of a mental illness or absence of it. It must be a detailed and a structured report that answers the specific questions and concerns raised by the court, clearly listing the influence of biological / physical, psychological and social factors, as well as a clinical, psychometric, and wherever needed diagnostic radiological, electrophysiological, and scans based assessment. The specific psychopathology (if any) in the mental functions of consciousness, intellect, thinking, emotions, perceptions, cognitions, judgment and insight will be included in the report. The experts will then be available for examination by the court, as well as defence and prosecution counsels.

The major concern of judiciary and law makers is the possibility of criminals malingering or feigning mental illness to exploit the system and, thus, escape punishment. The way to reduce malingering is by ensuring that the expert report about a defendant's mental health is valid and reliable and has a proper evidential basis. This will help ensure that any conclusions about the presence of a mental disorder have been properly drawn and are not just a matter of the experts' subjective opinion.

Suggested Format

A certificate signed by members of the board compiling a FMHR that states 'our opinion on the mental state of the defendant / accused is based upon proper evaluation, facts and reasoning and thus can be relied upon in determining the accused as regards his or her fitness to plead, and or appropriate sentence'.

It must minimally include:

- **Each Expert's Name and Place of Employment**
- **A Statement of Each Expert's Qualifications and Experience**
- **Whether Any Particular Matter Falls Outside the Expert's Specialised Knowledge**
- **In Respect of Each Opinion Expressed in the Report, the Facts on which the Opinion is Based and the Reasons for the Opinion**

- **Any Qualification Of An Opinion Expressed In The Report Without Which The Report Would Or Might Be Incomplete Or Misleading**
- **Any Limitation Or Uncertainty Affecting The Reliability Of The Opinions In The Report**
- **Any Concern Which The Expert Has About The Reliability Of Facts Reported By The Subject, On Which The Expert Has Relied, Together With The Basis Of That Concern**
- **Any Examinations, Tests Or Other Investigations On Which The Expert Has Relied**
- **Any Limitation Or Uncertainty Affecting The Reliability Of Such Examination, Test Or Investigation**
- **A Declaration That The Expert Has Made All The Inquiries And Considered All The Issues Which The Expert Believes Are Desirable And Appropriate, And That No Matter Of Significance Which The Expert Regards As Relevant Have, To The Knowledge Of The Expert, Been Withheld.**

None of the expert members should simply rely on diagnostic labels or simply record opinions or conclusions. For a report to be considered appropriate, and trustworthy, it must engage in detailed and research-based discussion, rather than merely making unqualified assertions.

The members of the board should then fill the following form with consensus, due diligence and discussion after interviewing the individual, and all other social resources who have been in contact with the defendant such as family members, associates, fellow detainees, prison staff, health staff etc.

CHAPTER 6

Relevant Legal Instruments

Safeguards and Procedures Under Domestic Law

There are two sets of domestic laws that deal with prisoners who have mental illness: Mental Health Ordinance, 2001; and Pakistan Prison Rules. In addition, a recent Supreme Court judgment issued on 10th February, 2021, will also guide the treatment of mentally ill prisoners going forward. There are many international agreements and standards detailing with the rights and treatment of people with mental illnesses, for example: International Covenant on Civil and Political Rights (ICCPR), The International Covenant on Economic, Social and Cultural Rights (ICESCR) and Convention on the Rights of Persons with Disabilities. However, the two most relevant are the UN Minimum Standard Rules for the Treatment of Prisoners (Nelson Mandela Rules) and the United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (the Bangkok Rules).

See flowcharts on the next page.

Mental Health Ordinance

Section 54 and 55 of the Punjab Mental Health Ordinance, 2001, also deal specifically with prisoners who have mental illness.

Section 54 requires the Inspector General of Prisons, or any person he empowers, to visit the prisoner once at least every six months to ascertain the prisoner's state of mind.

Section 55 of the Ordinance requires special security forensic psychiatric facilities to be developed by the Government to house prisoners and offenders with mental illness. This section also requires admission, transfer or removal of prisoners in such facilities to be under the administrative control of the Inspector General of Prisons

Prison Rules 1978 (Pakistan)
Chapter XVIII

Mental Patient Criminal

Rule 434: Definition of a Mental Patient

Criminal mental patients are those who are accused of having committed, or have been found to have committed, a crime.

Rule 440: Classification of Criminal Mental Patients

A criminal mental patient is further classified into 4 classes:

1. An accused person, whose soundness of mind is doubted by the Magistrate, is sent to prison for medical observation per s.464 Cr.C.P.
2. An accused person, by reason of unsound mind and incapable of making his defence, and who is consequently detained under s.466 Cr.C.P., pending orders of the Government
3. A person who is held to have committed an act that constituted an offence (but for the unsound of his mind) has been acquitted on the ground of insanity, and is detained under s.471 Cr.C.P. pending orders of the Government
4. A convicted prisoner who becomes a mental patient in prison

Rule 442: Confinement of Criminal Mental Patient

When a criminal mental patient is found to be dangerous, noisy or filthy in his habits, the patient shall be confined in a cell and kept under strict and continuous supervision.

Mental patients not found to be dangerous, noisy or filthy in his habits, may be detained in the prison hospital or in a ward set apart for this purpose.

Rule 441: Procedure when Certain Mental Patients are Committed to Prison

If a person belonging to class ii. (rule 440) is committed to prison, the Superintendent shall apply to District Coordination Officer for an order for his transfer to a mental hospital in anticipation of the receipt of orders from Government.

If a person belonging to class i. or class ii. (rule 440) is detained in a prison for more than a month, the fact shall be reported to the Inspector-General.

Rule 452: Mental Patients to be Visited by Inspector-General

The Inspector General of Prisons shall be a visitor ex-officio of all the mental hospitals within his jurisdiction (s.28 Act IV of 1912 Replaced by Mental Health Ordinance 2001)

When any person is confined under ss. 466 or 471 of CPC, they may be visited to ascertain their state of mind.

Must be visited at least once every six months, by the Inspector General if person confined in prison, or visitors if person confined in mental hospital

Rule 454: Officer Empowered to act as Inspector-General

The Provincial Government may empower the officer in charge of the prison (in which the person is confined under ss.461 or 471) to discharge all or any of the functions of the Inspector General under s.473 or s.474 CPC.

Rule 453: Procedure when Prisoner Reported Capable of Making Defence

If:

Person confined under s.466 Cr.P.C.; AND

Inspector General or visitors in mental hospital certify in their opinion that;
The person is capable of making their defence, the person shall be taken before the Magistrate or Court and be dealt with under s.486 Cr.P.C.

Prison Rules 1978 (Pakistan)
Chapter XVIII

Mental Patient – Criminal Suspected Feigning Insanity

Rule 443: Prisoner Suspected of Feigning Insanity

If a convicted person is acting as if he was insane, the convicted prisoner shall be put under observation by the Superintendent and their symptoms shall be closely scrutinised by the Medical Officer to preclude the possibility of a criminal feigning insanity.

Rule 433: Definition of a Mental Patient

A mental patient is defined as an idiot or person of unsound mind

Rule 442: Confinement of Criminal Mental Patient

When a criminal mental patient is found to be dangerous, noisy or filthy in his habits, the patient shall be confined in a cell and kept under strict and continuous supervision.

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Mental patients not found to be dangerous, noisy or filthy in his habits, may be detained in the prison hospital or in a ward set apart for this purpose.

Rule 437: Non-Criminal Mental Patient

These patients shall be detained in a mental hospital.

If there is no mental hospital, they shall be detained in a civil hospital or dispensary – wherein the District Officer deems it suitable accommodation for the custody of a mental patient.

In other cases, these patients shall be a district prison.

Rule 438: Detention of Non-Criminal Patients. Procedure when Period Expires

These patients shall be detained in a mental hospital.

If there is no mental hospital, they shall be detained in a civil hospital or dispensary – wherein the District Officer deems it suitable accommodation for the custody of a mental patient.

In other cases, these patients shall be a district prison.

Rule 444: Procedure if Criminal Appears of Unsound Mind

If it appears to the Superintendent that a convicted prisoner is of unsound mind, they will place the patient under observation of the Medical Officer for 10 days.

After 10 days, the Medical Officer shall report the result.
If found unsound: a report regarding his case shall be submitted to the Inspector-General to obtain orders from the Government for his transfer to a mental hospital

The following documents shall accompany the report:

- Descriptive roll of the prisoner
- The prisoner's descriptive roll in form of No.9 Medical Hospital Manual
- Medical Certificate prescribed in the Mental Health Ordinance 2001

Rule 445: Transfer of Mental Patient to Mental Hospital

When the Superintendent receives the order from the government, the mental patient shall be transferred to a mental hospital with the following documents:

- Government order directing the transfer
- The prisoner's descriptive roll in form of No.9 Medical Hospital Manual
- Medical Certificate prescribed in the Mental Health Ordinance 2001
- Warrant of imprisonment
- Remission sheet
- History ticket and private property
- Copy of the Court's judgement of the mental patient's case

If the Court's judgement does not contain full particulars of the offence committed, the following should accompany the mental patient:

- Copy of the Police Report on the arrest; OR
- Copy of the Police Roznamcha
- Any Government property accompanying the mental patient should be returned to the dispatching prison.

Rule 446: Conditions before a Transfer can be made

A criminal mental patient shall not be transferred from a prison to a mental hospital unless:

- The Medical Officer certifies immediately before the transfer that
- the patient is physically fit to take the journey; AND
- It has been ascertained that the Medical Superintendent of the Mental Hospital is prepared to receive the patient

Rule 447: Transfer in Anticipation of Sanction in Urgent Cases

In urgent cases where the patient is:

- Noisy;
- Filthy; OR
- Dangerous;

In anticipation of Government sanction, the Superintendent may, if it considers it necessary AND with the previous consent of the Medical Superintendent of the mental hospital conserved, transfer the prisoner to the mental hospital.

The prescribed documents shall be sent with the patient, and a copy of the Government order shall be forwarded as soon as it is received.

Rule 449: Time Spent in Prison to Count Towards Sentence

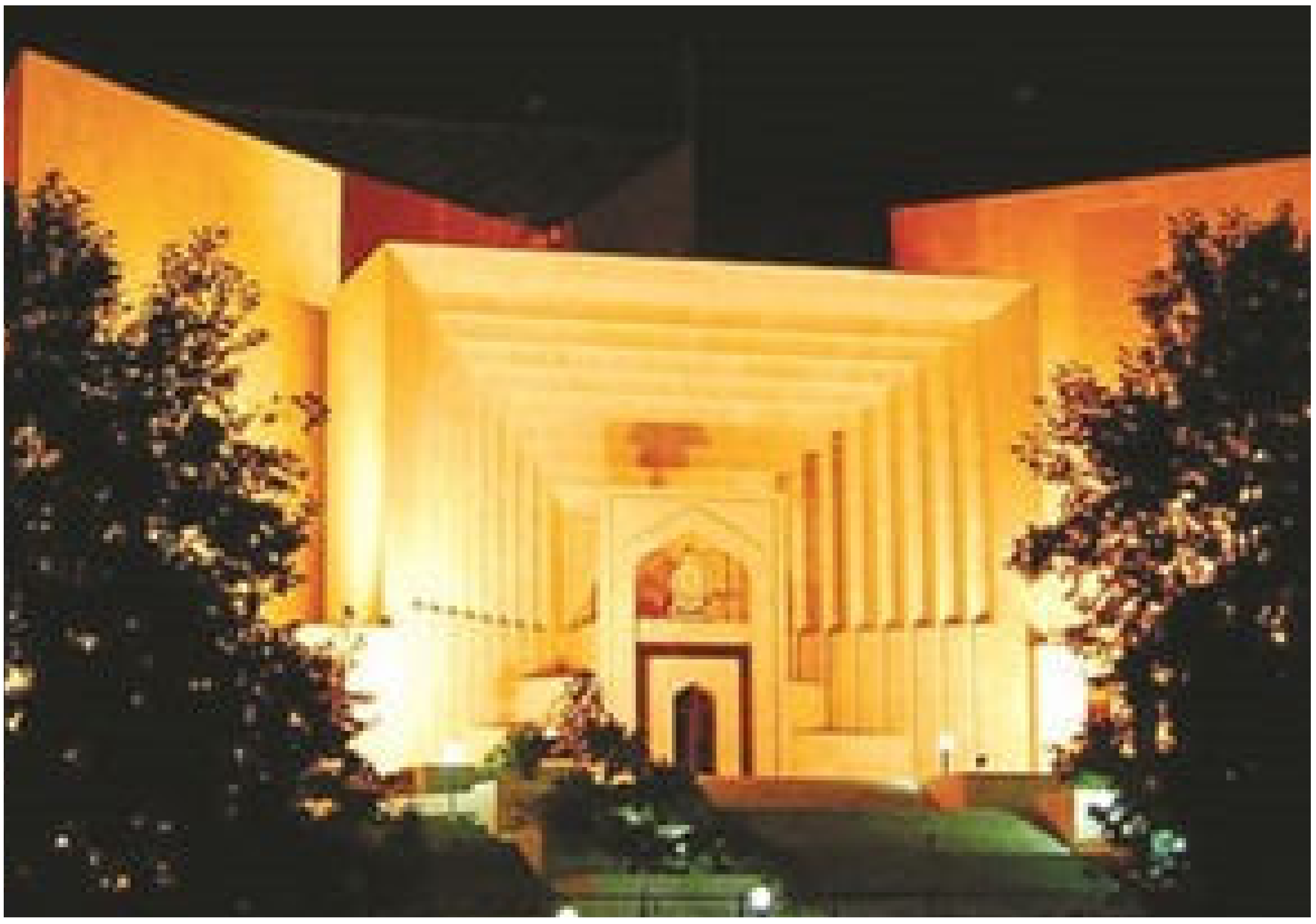
When an insane prisoner becomes of sound mind, and an order to return to prison has been issued, the time spent in the mental hospital shall be reckoned as a sentence undergone.

Rule 451: Treatment of Patients Returned to Prison

When a recovered mental patient is returned to prison, he shall be assigned some suitable work and such liberty as the Medical Officer consider safe.

Mst. Safia Bano vs Home Department, Government of Punjab (2021 PLD 488 Supreme Court)

In a landmark judgment of the Supreme Court in the case of Mst. Safia Bano vs Home Department, Government of Punjab, issued on 10th February 2021, the Supreme Court of Pakistan ruled that enforcing the death penalty for prisoners living with a serious mental illness “will not meet the ends of justice”. The judgment reads “... if a condemned prisoner, due to mental illness, is found to be unable to comprehend the rationale and reason behind his/her punishment, then carrying out the death sentence will not meet the ends of justice”. Not all mentally ill prisoners will be considered exempt from the application of the death penalty. “This exemption will be applicable in cases where a Medical Board that the condemned prisoner no longer has the higher mental functions to appreciate the rationale and reasons behind the sentence of death awarded to him/her.” Of equal importance, this judgment is also a milestone since it directed the Federal Government and all the Provincial Governments to immediately establish/ create high security forensic mental health facilities in the teaching and training institutions of mental health for assessment, treatment and rehabilitation of under trial prisoners and convicts who have developed mental ailments during their incarceration. This is the first time



that a direction has ever been passed to set up forensic facilities by a superior court. This is also in accordance with the Mental Health Ordinance, 2001 which requires such facilities to be set up as they are essential for the understanding of complex mental disorders. The Court has further directed the Federal Government and all the Provincial Governments to immediately launch training programs and short certificate courses on forensic mental health assessment for psychiatrists, clinical psychologists, social workers, police and prison personnel. Furthermore, the Federal Judicial Academy, Islamabad and all the Provincial Judicial Academies shall also arrange courses for trial Court judges, prosecutors, lawyers and court staff on mental illness including forensic mental health assessment.

Key International Instruments and Standards

There are many international agreements that deal with treatment of prisoners and persons with mental illness. As a member of the international community, Pakistan is obligated to abide by these agreements. These include:

- **Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.**
- **Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment.**
- **Basic Principles for the Treatment of Prisoners**
- **Convention on the rights of persons with disability**
- **United Nations Rules for the Protection of Juveniles Deprived of their Liberty**
- **UN Principles of Medical Ethics Relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment**

+ **Convention Against Torture And Other Cruel, Inhuman Or Degrading Treatment Or Punishment**

+ **International Covenant On Economic, Social And Cultural Rights (1966)**

+ **International Covenant On Civil And Political Rights (1966)**

For our purpose the two most relevant ones are the Mandela Rules and The Bangkok Rules on Women in Detention.

The Mandela Rules are a set of 122 agreed on standards by the international community regarding the treatment of prisoners. The Rules provide direction on aspects of prison management, from admission to the prohibition of torture and limits on solitary confinement and use of restraints and force.

The Bangkok Rules, or formally, *"The United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders"*, comprise 70 rules focusing on the treatment of female prisoners.

Basic Principles

Standard Minimum Rules for the Treatment of Prisoners. These rules are now known as the Mandela Rules.

- The Bangkok Rules, formally known as "The United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders", comprise 70 rules focusing on the treatment of female prisoners.

- All prisoners have a human right to the highest attainable standard of physical and mental health. *(International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 12)*

- States have an obligation to provide adequate treatment and care for the mental health of all prisoners, and to mitigate the effects of imprisonment on mental well-being. *(Mandela Rules 24, 25 and 33)*

- Mental healthcare and support must be provided at the same level of care as in the community. *(UN Principles of Medical Ethics, Principle 1; Mandela Rule 24)*

- Prisons should retain a sufficient number of specialists on their staff, including psychiatrists and psychologists. *(Mandela Rule 25)*

- Prisoners with mental ill-health must be treated with humanity and respect for their inherent dignity. *(Mandela Rule 1)*

- Gender-specific provision of mental healthcare should be provided to women prisoners. *(Bangkok Rule 10)*

- All prisoners have the right to protection from exploitation and abuse, including torture and ill-treatment. *(CRPD, Article 16; Convention against Torture, Article 2; Mandela Rule 1)*

- Prisoners with mental health conditions have the right to equal recognition before the law. *(CRPD, Article 12)*

- All prisoners must be protected from discrimination, including on the grounds of their mental health status. *(Mandela Rule 2).*

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