MENTAL HEALTHCARE & CRIMINAL JUSTICE IN PAKISTAN

April 2019

A DIALOGUE REPORT

This report is based on the proceedings of a consultative dialogue convened in Islamabad by the National Academy for Prison Administrators with support from the International Committee of Red Cross, and in collaboration with Justice Project Pakistan

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Background

The involvement of mentally disordered offenders in the criminal justice system is currently a major public health concern all over the world. Like the rest of the world, the number of people with mental disorders in detention facilities is known to be steadily increasing in Pakistan. This creates a significant burden on an over-crowded and under-resourced correctional system and causes serious medical and ethical concerns for detainees with mental disorders.

Like other low-income and middle-income countries, Pakistan too has ignored the rights of people with mental disorders in detention facilities for long enough. A paradigm shift is essential in justice custodial services. For this reason, a consultative dialogue was held in Islamabad on 27th April 2019. This was convened by National Academy for Prison Administrators (NAPA) with support from International Committee of Red Cross (ICRC) and in collaboration with Justice Project Pakistan. The objective was to engage relevant stakeholders including policy makers, prison authorities, members of the judiciary, mental health professionals, health authorities, legal experts, human right activists, journalists etc. to initiate a conversation about mental healthcare needs in prison population.

Some areas for focused discussions included the challenges of managing detainees with mental disorders inside the prisons; gaps in existing mental healthcare in prisons; legal deliberations on issues of mental incapacity; limitations of forensic assessments and reports and the implementation of mental health legislation.

It was recognised that the challenges are tremendous because there is a severe dearth of existing mental health services in the country and the prison system has its own limitations, both in terms of resources and capacity. The participants agreed that the collective aim of all stakeholders should be to help promote recovery of mentally ill in the detention facilities by transforming present judicial processes and prison environments into truly reformative opportunities. To achieve this, the existing gaps were identified and some recommendations were proposed which can expedite justice without violating the rights of this highly vulnerable population. This report is based on the proceedings of this consultative dialogue.

SECTION 1 MENTAL HEALTH AND PRISONS

It is well established that prisons are the wrong place for people with mental illness and are poor settings for mental health treatment. The adverse conditions in prisons, including overcrowding, a lack of resources, and human rights abuses (both physical and psychological) worsen mental wellbeing and mental disorders. Most mentally ill prisoners would be better served outside the prison system, and most prisons would be cheaper and easier to manage without such a sick population. Effective mental health services in primary care settings and adequate psychiatric hospital capacity might prevent the unwell from being involved in criminal offences in the first place. For those unwell people who are currently in prisons, awaiting trials or serving sentences, it is important to provide essential mental healthcare within the prisons.

1.1 What are the goals of providing mental healthcare inside prisons?

The specific goals of providing mental healthcare in detention facilities is to ensure treatment for those who are suffering from mental disorders and to assist the courts where detainees' mental capacity is in question.

But at the interface of these detention facilities and community, the broader objectives of mental healthcare should include protecting people with mental disorders from becoming victims of crime, preventing them from becoming/relapsing offenders or intervening in the vicious circle from victim to perpetrator.

The overall benefit of treating mental illness within the prison system are many folds:

a) It provides ethical and humane treatment of prisoners who suffer from treatable illnesses.
b) It provides a safer and secure working environment for prisons. Untreated mental illness can have a negative impact on the overall milieu of the prison system. For example, a psychotic or manic prisoner may become agitated and aggressive towards other inmates and/or prison staff.
c) Identification and treatment of mental illness can result in diversion of persons to more appropriate treatment settings rather than being incarcerated in a prison.
d) Due to a lack of community-based mental healthcare, prisons end up functioning as de facto psychiatric treatment facilities. The benefit of providing treatment in prisons is that it reduces over all prevalence of untreated psychiatric morbidity in the population.

1.2 What is the association between mental disorders and prisons?

A mental illness is a belief, behaviour, or pattern of thoughts that results in significant distress and impairment of one's functioning. Mental disorders encompass mental illnesses, personality disorders and learning disability (commonly known as mental retardation).

Common categories of mental disorders that are known to be highly prevalent in prisons include:

- Learning disability
- Substance use disorders
- Common mental illness (e.g., Depressive disorders)
- Severe mental illness (e.g., Schizophrenia)
- Risk of self-harm & suicide
- Personality disorders (Anti-social personality disorders, commonly referred as psychopathy)
- Neuro-psychiatric disorders (disorders that cause cognitive impairment e.g., delirium, dementia)

Multiple studies around the world have clearly shown that mental disorders are very common among people detained in prison systems. The estimates of prevalence of mental disorders have varied between 50%-90% of prisoners. Based on a systemic review[1], one in seven prisoners had major depression or psychosis. There is also a high rate of substance use disorders (10-48%)[2].

Some studies have been conducted in Pakistani prisons but in view of limitations of research methodology (e.g., small sample size), the results cannot be generalised.

It is well established that prison environment can often be very intimidating or frightening. Mental illnesses can also develop as a result of the increased risk of violence and victimization in prisons. Some of the known challenges in the prison system that adversely affect mental health of the prisoners include over-crowding, human rights violations, poor resources. Limited healthcare resources include a severe shortage of medical staff, unavailability of medicines, poor access to general hospitals etc. Individuals with mental illness often have multiple medical comorbidities that may worsen their mental illness and even lead to situations that may place them at risk of harming self and others.

One of the basic challenges that one faces while treating mental health during the prison system is a lack of education amongst correctional staff. It is well understood that the correctional environment is one in which safety is paramount and is important to maintain proper conduct to ensure safety of other prisoners as well as correctional staff members. Unfortunately, situations may arise in which a prisoner with untreated mental health related issues may act in a manner which would result in them facing disciplinary actions such as segregation. However, such isolation may actually worsen their overall mental health which can result in an increase of the precipitating behavior. It is

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[1]Fazel S, Seewald K. Severe mental illness in 33 588 prisoners worldwide: systematic review and meta-regression analysis. Br J Psychiatry. 2012; 200:364–73.

[2]Fazel S, Bains P, Doll H. Substance abuse and dependence in prisoners: a systematic review. Addict. 2006; 101:181–91.

important that prisoners with mental health related issues be appropriately identified, treated, and housed to ensure a safe and secure prison environment.

Prison-based treatments often focus on stabilizing and managing acute medical and mental health related issues. For example, a patient who is floridly psychotic or manic may receive antipsychotic medication however, the individual who has a long-standing history of depression, or a stress disorder may go untreated. With time this may result in deterioration of a person's mental health who was previously well-controlled in the community. When untreated, these common mental disorders may increase the rate of self-injurious and suicidal behaviours. Also, these individuals may be more prone to have difficulties adhering to prison rules and regulations.

1.3 What is forensic psychiatry?

Forensic psychiatry is a sub-specialty that encompasses the interface between psychiatry and the law. Forensic Psychiatrists have special training in the area of mental health within the criminal justice system. They have special training in evaluating persons for fitness to stand trial, determination of mental state at the time of the offense, mitigating and/or aggravating evidence during the sentence phase, as well competency to be executed. In addition to this a forensic psychiatrist can assist with civil law matters such as the ability to sign a contract, child custody, medical malpractice, and the development of a will. The specialized training helps in the assessment of safety, security, and recidivism. A forensic psychiatrist can also help evaluate and assist an individual who is somehow involved with the legal system and help provide psychiatric insight into their behaviours and actions through detailed expert reports and/or court testimony. It is important to understand that a forensic psychiatrist will offer independent and objective information to assist the criminal justice system and is not one who is to act as an advocate for the person being evaluated.

However, the role of mental health providers in the prisons is much different. This is, sometimes, known as correctional psychiatry. The primary objective is to assist prison authorities in:

- Prevention of mental disorders
- Early identification of detainees suffering from mental disorders
- Assessment of risk (harm to self and others)
- Treatment of mental disorders
- Referral and transfer to psychiatric facility, where specialist care is needed.

SECTION 2 THE CASE: PAKISTAN

2.1 Prison services

There are four kinds of prisons in the provinces:[3]

a) **Central Prisons:** Each division in a province is required to have a Central Prison, which can accommodate more than 1,000 prisoners, irrespective of the length of sentence. The provincial government has discretionary authority to re-designate any Special Prison or District Prison as a Central Prison.[4]
b) **District Prisons**: Other than Central prisons or Special prisons, all prisons are designated as District Prisons,[5] which, in turn, are divided into three classes: first class, capable of accommodating 500 prisoners or more, sentenced up to five years; second class, capable of accommodating between 300 and 500, sentenced up to three years; and third class, capable of accommodating less than 300, sentenced up to one year.[6]
c) **Special prisons**: These include women's prisons, open prisons, borstal institutions[7] and juvenile training centers. The provincial government can establish a special prison at a time and place of choosing or can declare any existing prison a special prison.[8] Another example of special prisons are the high security prisons established for terrorist suspects and convicts.[9]
d) **Sub-jails**: These are smaller facilities where criminal suspects may be detained on remand. A provincial government can declare any place "by general or special order" to be a "subsidiary jail."[10]

Prison management in Pakistan is a provincial subject.[11] The Home Departments are in charge of the administration of prisons in all four provinces, as well as the AJK and GB regions.[12] Under the supervision of their respective Home Secretaries, the Inspector General (IG) Prisons are each in charge of their provincial/administrative territory's prison administration.[13] While there are some

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[3] Prison Rules 1978, R. 4.

[4] Prison Rules 1978, R. 5.

[5] Prison Rules 1978, R. 7.

[6] Prison Rules 1978, R. 8.

[7] Borstals are custodial institutions for juvenile offenders.

[8] Prison Rules 1978, R. 6.

[9] The News International, High security jail in Mardan turned into central prison, 27 July 2017 https://article.wn.com/view/2017/07/27/High_security_jail_in_Mardan_turned_into_central_prison/ (last accessed on December 22, 2017).

[10] Prisons Act 1894, S. 3 (1)(c).

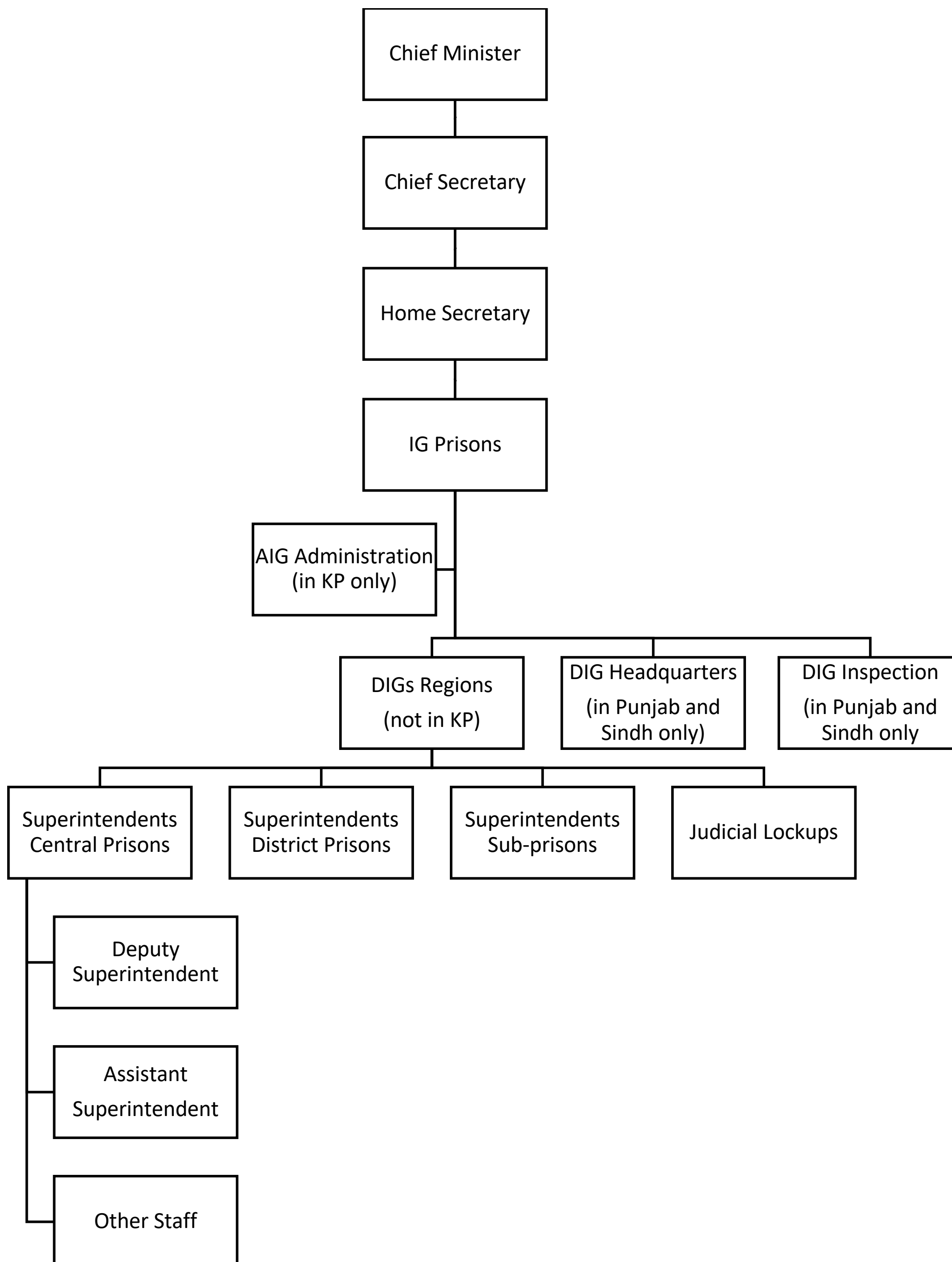
[11] See Constitution of Pakistan, Article 142 read with Federal Legislative List in Fourth Schedule, and the Rules of Business 1973.

[12] *See* Punjab Government Rules of Business 2011, Second Schedule, Home Department, Item 19. Sindh Government Rules of Business 1986, Second Schedule, Prisons Department. The Balochistan Government Rules of Business 2012, First Schedule, Section B, Home Department, Item 6. North-West Frontier Province Government Rules of Business 1985, Second Schedule, Home and Tribal Affairs Department, Item 11. Gilgit-Baltistan Government Rules of Business 2009, Second Schedule, Home and Prisons Department. Azad Government of the State of Jammu and Kashmir Rules of Business 1985, Second Schedule, Home Department, Section B – Prisons.

[13] *See* Section 5 of Prisons Act 1894. There are minor variations in the Prisons Act 1894 as adopted by the provinces respectively, but each province has the post of Inspector General, in Punjab, known as the 'Director of Prisons' under section 5 of the Prisons Act 1894.

slight differences in the prison administrations of the four provinces, generally, each IG Prisons is assisted by some staff at the headquarters as well as a Deputy Inspector General (DIG) Prisons for regions incorporating more than one district.[14] The DIGs of the region, in turn, supervise the Superintendents of all Central Prisons in the districts under his jurisdiction as well as the Superintendents of the District Prisons, Sub-jails, and Judicial Lockups (see Illustration 1 below).[15]

Illustration 1**:** Organizational Structure of Prisons in each Province/Administrative Territory



[14] *For example, see* Section 11(2) and Section 14 of the Prisons Act 1894 as adopted in Khyber Pakhtunkhwa.
[15] *See* Section 888 and 889 of Pakistan Prison Rules 1978.

Based on official data shared by prison authorities, as of October 1, 2017, there were 112 prisons in Pakistan: 26 Central Prisons, 60 District Prisons, 12 sub-jails, four prisons for women, seven prisons for juveniles, two High Security Prisons or 'Special Prisons', and one Open Prison.

Table 1**:** Breakdown of Different Types of Prisons in the Country

	Punjab	**Sindh**	**KP**	**Baluchistan**	**GB**	**AJK**	**Total by type of prison**
Central Prison	9	5	5	5	0	2	26
District Prison	25	11	9	6	5	4	60
Sub-jail/Judicial Lockup	2	0	8	0	1	1	12
Women Prison	1	3	0	0	0	0	4
Juveniles prison	2	5	0	0	0	0	7
High Security / Special Prison	1	1	0	0	0	0	2
Open Prison	0	1	0	0	0	0	1
Total	40	26	22	11	6	7	112

- There is no prison in Islamabad Capital Territory (ICT) and in FATA region.
- In general, all other provinces/administrative territories have Central Prison(s) and District Prisons. According to Rule 5 of the Pakistan Prison Rules,[16] there should be each division of a province. However, every division does not necessarily have a central prison.[17]
- The prison setups differ from one province to another. Punjab and Sindh have special prisons for women and for juveniles, such as Borstal Institutions or Youth Offenders Industrial School (YOIS), whereas, similar prisons for these categories of detainees do not exist in other provinces/autonomous territories, notably KP, Baluchistan, GB and AJK.
- Baluchistan and Sindh do not have sub-jails or judicial lock-ups.

For a detailed list of prisons in Pakistan, see Annex 3.

[16] All provinces have adopted Pakistan Prison Rules 1978. The name of the Rules have not been changed, except in Khyber Pakhtunkhwa where they are known as the 'NWFP Prison Rules 1985'. Amendments at provincial level are made in the Rules via notifications, e.g. the Punjab government made amendments in 1985 via Order of the Governor of Punjab No. No.3/23-SO (Prs:)II/HD/81 and Order of the Governor of Punjab No.3/23-SOPrs. II-HD/81. Similarly, the Rules were amended in KP via Notification No. 4/44-SO(Prisons)HD/2004. As major changes have not been made to the Prison Rules in these provincial variations, here onwards, the Prison Rules as applicable to all provinces will be referred to as Pakistan Prison Rules 1978.

[17] Comments made by a senior-level prisons official of the Government of KP during consultations with prison officials on Rule 745 of the Prison Rules at NACTA on December 15, 2017.

2.2 Mental healthcare services

According to present estimates, 20% of Pakistan's population may be suffering from mental disorders. This is a figure that includes children and adolescents. The irony is that while affordable treatment is available, up to 90% of patients do not receive it[1].

Pakistan does not have a national mental health policy. There is no budget allocated to mental health services. There is a severe dearth of psychiatric services with less than 500 psychiatrists in the country, most of whom are based in urban centres. The in-patient facilities (psychiatric beds) are mostly limited to tertiary hospitals. The outpatient facilities are limited to tertiary and district hospitals but not all districts have a psychiatrist. Also, there is a severe dearth of properly trained clinical psychologists[2]. There is no integration of mental health into the primary care. The subject of Psychiatry is 'optional' in undergraduate medical examination, there is no mandatory examination. There is no training for the primary care physicians to recognise and treat mental disorders[2].

All over the world, the rights of the mentally ill are protected through mental health legislation. In Pakistan, the Mental Health Ordinance, 2001 (MHO) replaced the Lunacy act 1912. Even a Federal authority was formed but even after years, it was never implemented. After the 18th Amendment, the provinces are still struggling to formulate effectual mental health legislation. Sindh, Punjab and KPK mental health acts were passed in 2013, 2014 and 2017 respectively but no satisfactory progress has been made towards implementing these legislations.

In the present Mental Health Acts, there are two relevant chapters:

- Chapter IX *(Inspection of mentally disordered prisoners)* outlines the procedure where by a Board of visitors should inspect every prisoner suffering from a mental disorder, inspect records and documents relating to the patients, prepare a report and review him every six months.
- Chapter X *(Forensic psychiatric services)* which states that secure forensic psychiatric facilities shall be developed by the Government; and that 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.

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1. World Health Report. 2001. World Health organisation. https://www.who.int/whr/2001/media_centre/press_release/en/
2. Mental health reforms. 3 December 2018. Dawn. https://www.dawn.com/news/1449130/mental-health-reforms

2.3 Legal framework for protection of mentally ill defendants

In Pakistani law, three stages have been identified at which a judge can give consideration to a defendant's mental illness;[18]

a) Fitness to plead at the trial

The law provides vigorous protection to defendant's suffering from mental illness at the time of trial in Code of Criminal Procedure (CrCP).

In *Abdul Wahid v The State*[19] the Supreme Court confirmed that the provisions of Chapter 34 are obligatory and require the court to hold an inquiry or a trial, if it has 'reason to believe' that the accused is of 'unsound mind' and incapable of making his defense.

If the court has reason to believe the defendant may be of unsound mind, the court must:

- Hold an inquiry into the facts of such unsoundness of mind;
- Order the accused to be examined by the civil surgeon of the district or by such other medical officer as the provincial government may direct;
- Examine the medical officer as a witness;
- Take into consideration a broad range of independent factors such as psychiatric assessment, social history and mental health records at the prison.[20]

Case law and 464 CrPC confirm that the court must conduct this 'trial within a trial' when even a slight suspicion is raised that the accused may not be of sound mind. The courts are bound to make enquiry into the accused's mental health where they have reason to believe that he is of unsound mind. They must ensure that the accused is examined by the civil surgeon of the district or such other medical officer as the provincial government direct.[21] Where a Trial Court order was contrary to the doctor's certificate and the Trial Court had not examined the doctor, it was held that the order was contrary to ss. 464-466 CrPC and should be set aside on the ground that the doctor must be examined and cross examined before the Court.[22]

If the defendant is deemed to be of unsound mind and incapable of making his defence;

- The trial should be postponed.[23] During the adjournment, the Court has discretionary powers to either grant bail in accordance with section 466(1) CrPC or commit the defendant in safe custody.[24]

[18] (n1) 19

[19] [1994 SCMR 1517]

[20] Ibid

[21] See also PLD 1980 Pesh. 103

[22] [PLD 1985 Kar 549. See also 1996 PCrLJ 1366 (DB

[23] 1997 SCMR 239.

[24] In relation to granting bail, sufficient security must be given that the defendant will be properly taken care of and shall be prevented from injuring himself or any other person and for his appearance before a Magistrate or court or such officer as the magistrate of court appoints, when required. In *Asghar Ali v The State* [1992 PCrLJ 2083] the Court stated that the bond should provide for the surety: to take care of the defendant; to take care of the defendant to prevent him from doing injury tohimself; to take care of the defendant to prevent him from

- As a preliminary step inquiry into the soundness of mind of accused and his consequent incapacity to stand trial has to be made in accordance with s. 465 CrPC. before taking any evidence of any charge.
- Both the prosecution and defence ought to be associated with full opportunity for leading evidence in support of their versions.[25] Burden of proof is on the defendant, but failure of the defence counsel to raise a plea of insanity at trial does not disentitle the accused to be treated in accordance with the law.

Provisions of this section are mandatory, hence the omission to decide the preliminary issue will vitiate the whole trial, and a re-trial of the accused may be ordered.

b) Not guilty by reason of insanity

'Not guilty by reason of insanity' is a complete defence available to an accused suffering from mental illness in Pakistani law. Section 84 of the Penal Code of Pakistan dictates that a mentally ill person cannot be found criminally responsible for an offence:
"Act of unsound mind: Nothing is an offence which is done by a person who, at the tie 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."

Mens rea or a guilty mind is an essential ingredient of a criminal offence[26]. Criminal intention is the basis for criminality, which is to be proved by the prosecution by placing on record the evidence that the accused knew that what they were doing was illegal or that it was done with dishonesty and in a deceitful manner.[27] Under the Pakistan Penal Code, not constructive but actual intention is required.[28] Where the psychological evaluation falls within the scope of 'legal insanity', there can be no guilty mind, no intent in the commission of the offence.

Some mental health conditions can be very difficult to detect without either medical expertise or a longstanding relationship with a person. Lawyers and the judiciary are not expected to have either of these. It is therefore extremely important that the opinion of medical experts is sought when evaluating the mental health of an accused. However, it should be borne in mind that even some Pakistani mental health experts maybe unfamiliar with the concepts of forensic psychiatry.

In order to establish the defence of legal insanity, three of the four conditions of section 84 P.P.C. must be satisfied:

1. Commission of an offence (in other words, if the prosecution fails to prove that the prisoner committed the act, then the mental state does not matter – he is not guilty);
2. Unsoundness of mind (this should be read in the broad context of mental disorder as defined by [the MHO 2001 or] provincial mental health acts);

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doing injury to any other person; to produce him before the magistrate or court of such officer the magistrate or court appoints in this behalf.

[25] 1997 SCMR 239

[26] PLD 1967 SC 1

[27] 2000 P.Cr.L.J. 1105 (b)

[28] 1995 P.Cr.L.J 1807 (b)

3. Incapability of knowing the nature of the act/offence; or
4. Distinction between right and wrong (again a disjunctive concept – does he know the act is wrong, or contrary to law?).[29]

Under current Pakistani law, total mental insanity is recognized as a valid defence; the defence of irresistible impulse or diminished responsibility is recognized as at least a partial defence and a mitigating factor, depending on the facts of the case.[30]

The British Royal Commission report on the death penalty, 1953 recognized that 'in India and Pakistan, the court may regard diminished responsibility as a reason for passing a sentence of life imprisonment instead of the death sentence'.[31]

The defense of 'diminished responsibility' has been explained as "..even if a man charged with murder is not insane, still our law does recognize... that, if he was suffering from some infirmity or aberration of mind or impairment of intellect to such an extent as not to be fully accountable for his actions, the result is to reduce the quality of his offence in a case like this from murder to culpable homicide.[32]

No capital punishment scheme imposes an automatic sentence of death; the sentencer must take into account the 'diverse frailties of humankind'.[33] The law clearly permits the introduction of a broad range of mitigating circumstances, to help persuade the courts to award a lesser sentence. The court will be justified in awarding the lesser penalty when satisfied with the presence of mitigating circumstances.[34]

Furthermore, Intellectual Disability; a permanent condition that is usually present from birth and is not an illness or disease affects *mens rea* as well. It can mean that a person is *less criminally responsible* for his actions either because he did not intend the crime or because he was unable to conform his behavior to the law. Their mental impairments mean they cannot meaningfully appreciate the effect of their actions, nor do they intend for certain criminal acts to occur. Just like the child, they are less criminally responsible and should be punished less severely.

Age is analogous to mental infirmity as a case of diminished responsibility. Where there are two accused, the younger should not be sentenced to death as there is a possibility that he might have acted under the influence of the elder.[35] If it can be argued that youth reduces responsibility, through making the accused vulnerable to outside influence, then mental infirmity should also be read as a mitigating factor, for the same reason.

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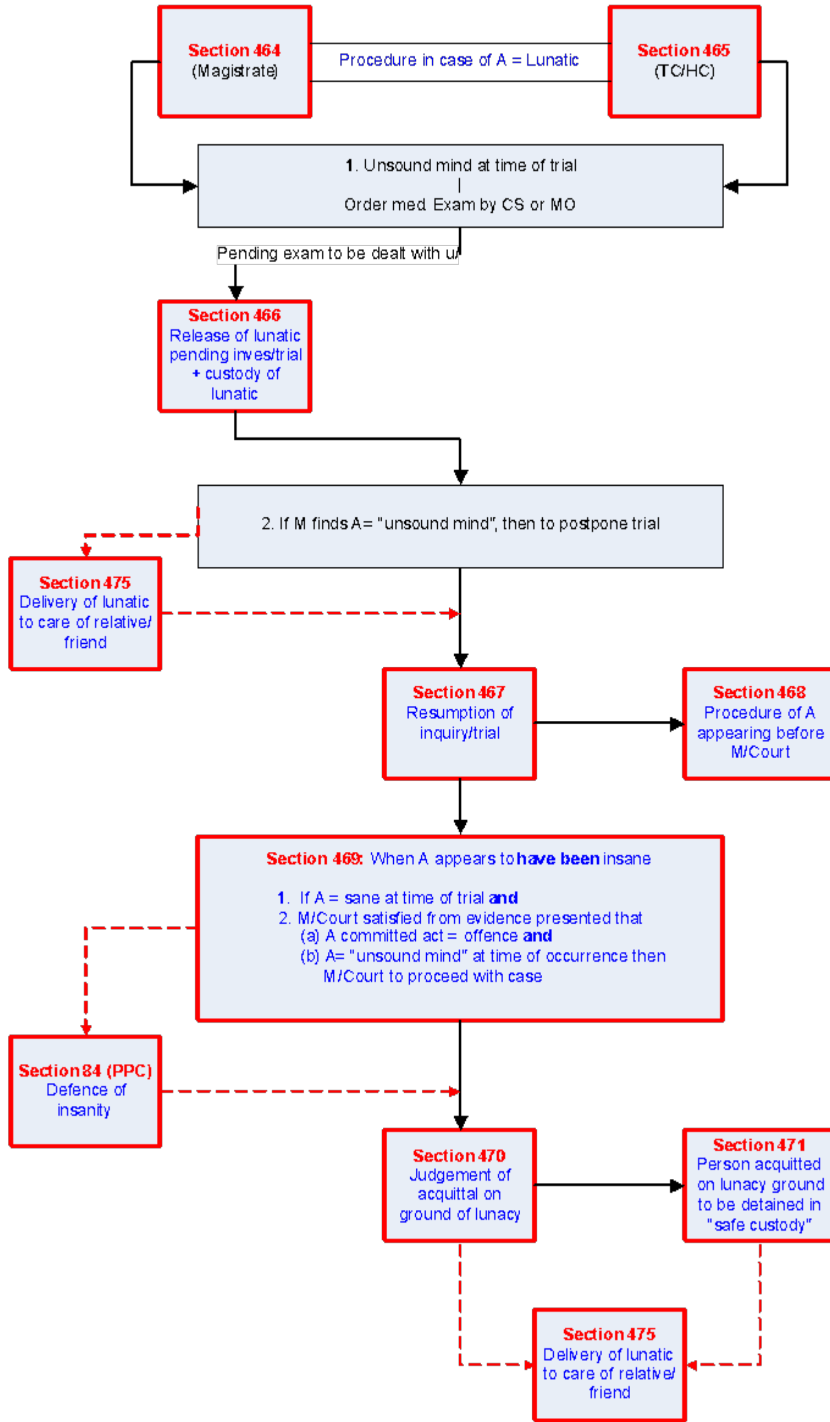
[29] *Mehrban v. The State [PLD 2002 SC 92].*
[30] *[PLD 2000 Journal 201]*
[31] Francois Lareau, *Selected Bibliography on Diminished Responsibility*, at 66 (2003), citing Report of the Royal Commission on Capital Punishment in Great Britain, 1949-1953, at 413, para. 13.
[32] *R. v. Braithwaite*, 1945 J.C. 55.
[33] *Woodson v. North Carolina*, 428 U.S. 280, 304 (1976) (any of the "diverse frailties of humankind" constitute mitigating factors which must be considered as a matter of law in deciding punishment); *Lockett v. Ohio*, 438 U.S. 586 (1978) (sentence must consider "any aspect of the defendant's character or record . . . that the defendant proffers as a basis for a sentence less than death").
[34] *[PLD 2006 SC 109]*

c) Competency to be executed

Even though the law does not have an explicit provision prohibiting the act of execution on a mentally ill prisoner; it provides us with safeguards. Under the provisions of Pakistan Prison Rules 1978, rule 444 and 445, the Superintendent shall obtain a report for a prisoner that may be suffering from a mental disorder and should submit the case of the Inspector-General for obtaining orders of the Government for removal to a mental health facility. However, if the case is deemed to be urgent as a result of the mental disorder, the Superintendent under Rule 447 can transfer the defendant in the absence of a Government order. A prisoner must be healthy to be executed under these provisions.

The execution of mentally ill condemned prisoners is prohibited in International law as well. It is stated that execution of a mentally ill prisoner is prohibited irrespective of whether the illness was present at the time of commission of the offence or is present at the time of execution.
Aside from the complete 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." [36]

[36] Andrea Yates case, U.S. District Judge William Wayne Justice during an address to psychiatrists and others at the University of Texas-Houston Medical School; https://www.chron.com/news/houston-texas/amp/Judge-defends-mentally-ill-in-speech-2122274.php


Section 464
(Magistrate)
Procedure in case of A = Lunatic
Section 465
(TC/HC)
1. Unsound mind at time of trial
Order med. Exam by CS or MO
Pending exam to be dealt with u/
Section 466
Release of lunatic pending inves/trial + custody of lunatic
2. If M finds A= "unsound mind", then to postpone trial
Section 475
Delivery of lunatic to care of relative/ friend
Section 467
Resumption of inquiry/trial
Section 468
Procedure of A appearing before M/Court
Section 469: When A appears to have been insane
1. If A = sane at time of trial and
2. M/Court satisfied from evidence presented that
(a) A committed act = offence and
(b) A= "unsound mind" at time of occurrence then M/Court to proceed with case
Section 84 (PPC)
Defence of insanity
Section 470
Judgement of acquittal on ground of lunacy
Section 471
Person acquitted on lunacy ground to be detained in "safe custody"
Section 475
Delivery of lunatic to care of relative/ friend

SECTION 3 GAPS IN EXISTING SERVICES

3.1 Prison services

a) The role of prisons

The purpose of Pakistani prisons is custody, control, care and correction (4Cs). At the prisons, the distinct power dynamics for 'custody' and 'control' are overwhelmingly conflicted with the need for 'care' and 'correction' that is central for mental healthcare, thus making these prisons poor settings for psychiatric treatment. The main responsibility of the staff is operations, safety, and security of the prison environment. They do not have any formal training to address the care needs of detainees with mental health problems in the most humane and least restrictive way possible.

b) Identifying prisoners with mental illness

It is well known that many people with mental disorders come in contact with healthcare or are diagnosed for the first time when they come to a prison setting. Although there is a formal mechanism to categorise prisoners according to their criminal record (first offender or repeated offender), there is no formal mechanism to identify or suspect those with mental disorders. The more experienced or sensitive a warden is, higher is the possibility to detect mental disorder. This is only based on observations of grossly disturbed behaviour, and it is highly likely that many are missed. In all probabilities, mental disorders are more likely to be recognised when unwell detainees commit another offence in the prison. This practice of informal identification varies across the country and there are no standard criteria or formal training of the staff to accurately identify or triage them according to their care needs. As a result, many are never assessed by a mental health professional.
According to the presentations made during the meeting, there are about 1100 prisoners identified as mentally ill in Sindh, which is 8% of the total prison population. And in KPK, 383/ 10,000 prisoners have been identified as suffering from mental disorders through a screening process, of which 10-20% of cases are suffering from severe mental disorders. Quite clearly, these figures are far less than the projected estimates.

c) Lack of data collection

Most prisons do not have effective information management systems and there are no central databases at provincial level. The medical records within prisons are usually poorly kept with sparse information hand written in registers. According to the experience of JPP, most times there are no more than ten lines written in the medical records of prisoners over years. The National Commission on Human Rights published a report in 2018, which suggested that medical records were maintained in only 10-15 prisons in KPK.

d) Limited healthcare resources

There is a severe dearth of healthcare staff in Pakistani prisons. The best doctor to prisoner ration is about 1:1000 (there are 3-5 doctors in Central Jail Karachi and 5 doctors in Malir Jail, each with a

prisoner population of 5000). The doctors work in shifts but where there's only one doctor, he remains on call for 24 hours.
The doctors working in the prison system have no training in detecting or treating mental disorders. Many of them are not even familiar with the pharmacology of the medicines used to treat mental disorders (Psychotropic).

There is also a dearth of funding and technical resources. For example, the laboratory facilities are severely limited even for regular blood screening in Baluchistan.

e) Juvenile offenders

The most vulnerable segment in prison system are the juvenile offenders, particularly youthful offenders (under 15 years of age). According to NACTA, 95% juvenile prisoners are under trial
Since May 2018, there is a new law to deal with juvenile offenders – Juvenile Justice System Act (JJSA). This act states that youthful offenders should be sent to reformatory schools and rehabilitation centres. The rehabilitation should include opportunities for educational, vocational and psychosocial development. At the moment, there is a severe dearth of these reformatory schools. In most prisons, juvenile offenders are not classified or housed separately.

f) High risk practices

Since prisoners with mental disorders are not identified, they are constantly exposed to coercive practices, harassment and violence common in prison environments. These are likely to cause harm and worsen mental disorders. Some unfavourable examples are:

Isolation
Solitary confinement is a commonly used practice in prisons. It is known that prisoners suffering from severe mental disorders are also subjected to segregation with a view to manage behavioural difficulties or risk of harm to others or self. Sometimes, the period of isolation extends much beyond a few days. According to JPP, it is a 'legal black hole', where not just the symptoms worsen but it becomes very difficult to reintegrate them.

Exposure to drugs
Substances of abuse are commonly available in most prisons. These can also lead to behavioural difficulties including aggression. These can cause drug use disorders and worsen other mental disorders. Sometimes, the security staff are also involved in trading these drugs inside the prisons.

Exposure to violence and hardened criminals
Prison populations are often grouped based on their gender, charges, and needs. It is important to appropriately classify and house mentally ill prisoners to protect this vulnerable group of individuals. Prisoners who suffer from mental illness and/or intellectual disability may be more easily be indoctrinated into violent extremism.

3.2 Mental healthcare services

Pakistan does not have forensic psychiatry services — a specialized branch of psychiatry that provides assessment and treatment of offenders with mental illness in prisons, secure hospitals and the community. Such psychiatric expertise is routinely required to provide psychiatric services to prisons and to assist criminal justice proceedings to ascertain capacity related to mental disability.

a) Psychiatric services in prisons

There are no psychiatrists employed by the prison authorities in any province. In most central prisons, a separate 'ward' is designated for patients with mental disorders. The psychiatric services are provided by the tertiary-care psychiatric facility in the area. These services comprise of a visit by a psychiatrist who is usually a postgraduate student of psychiatry. The frequency of the visit may vary from every fortnight to once a month. The number of patients seen at each visit also varies but can be as high as 40-50 prisoners per visit. Therefore, the duration of each consultation may also vary (5-15minutes). There is poor documentation of these assessments and management plans. Also, there is poor continuity of care as the visiting psychiatrist may often change.

In case of a severely unwell patient, he is transferred to the psychiatric facility at the tertiary care hospital. Since the security is the responsibility of the referring prison, so these transfers are neither logistically feasible, nor encouraged. In Baluchistan, mentally ill prisoners are referred to Hyderabad as there is no inpatient psychiatric facility for prisoners in the province.

At the district level, usually there is only one psychiatrist available but, in some cases, there might not be any. Either way, the regular clinical services to the jails are not a priority.

Although some jails have employed psychologists but these are mostly women who are unable to deal with male prisoners; they are not adequately trained and their role is not clearly defined.

The psychiatric 'ward' has its own limitations. Most jails lack even a small private space to interview a patient, let alone expect a therapeutic environment. The health records are poorly maintained, there are no reliable informants (security staff or family), so assessments are completed without vital information. There is a severe dearth of essential psychiatric medicines or availability of trained staff to dispense the medicines responsibly. Therefore, compliance is a serious problem.

In the case of Khizar Hayat, a prisoner on death row, who suffered from long-standing psychotic illness, was assessed by more than eleven psychiatrists at Kot Lakhpat Jail over a period of years and yet he was never adequately assessed or treated.

b) Training of psychiatrists

The role of psychiatrists can be clearly divided between that of clinical services for the prisons and that as forensic psychiatrists to prepare independent court reports. The limitations of clinical services to the prisoners have already been discussed above.

Unfortunately, psychiatrists in Pakistan have limited training to conduct forensic assessments; to prepare reports for the court; or to assist the courts as expert witnesses. The minimum requirement (by the College of Physicians and Surgeons of Pakistan) for training psychiatrists is to assess ten forensic patients as part of their postgraduate training programme. But these cases are not always supervised and there is little guidance on writing forensic reports for the courts. The psychiatrists often lack expertise in understanding the roles and various functions of the legal system, as well as their role in addressing psycho-legal questions to assist fact-finders in making legal decisions.

As forensic experts, psychiatrists should offer independent assessments, striving for objectivity to assist the legal processes. However, the psychiatrists are employed in provincial health service; are accountable by the government regulations, work in poorly resourced environments where even transport arrangements to the prisons/courts is a big hassle; and are deprived of legal or administrative protection. Weighing these consequences, they are always reluctant to 'get involved', avoid conflict and remain defensive.

c) Court reports

The courts do not always seek psychiatric opinion. Sometimes, forensic psychiatry assessments are requested directly by the courts or via an application by the defense counsel. The courts do not always communicate the purpose of seeking a psychiatric opinion.

The courts may also make a referral to the medical superintendent of an institution, which is then either forwarded to the psychiatry department for formal assessment or the hospital administration constitutes a 'board' which comprise of senior health professionals (some of whom might not even be qualified to assess mental states).

The assessment process varies across the country. In case of assessments done by the faculty of psychiatry, a postgraduate resident takes a thorough history of the patient. It is not always possible to take a corroborative history from the family or a close friend. The case is presented to a team of mental health professionals who examine the patient with a basic understanding to 'dispose' the case at the earliest, avoiding any dissent. Unfortunately, most of these assessments are hurried, lack depth and precision.

In either case, the reports are forwarded to the medical superintendent of the institution, who then replies back to the court with the findings of the committee. These reports are brief, comprise of medical jargon (usually focusing on clinical diagnosis) and usually missing the essential testament of capacity (fitness) for trial or sentence.

Not surprisingly, the judges who have no training to interpret the context of psychiatric morbidity anyway, are unable to interpret these unmeaning psychiatric reports, and conveniently disqualify mental impairment thus depriving patients of their basic rights.

3.3 The justice system

a) Training of judiciary

The judges have no formal training in understanding mental disorders or the disability associated with these disorders that could impair mental capacity in criminal proceedings.

Some key gaps include:
Why does mental health matter in criminal cases? (Culpability, mens rea)
How can psychiatrist assist courts to assess mental capacity in criminal proceedings?
What are the signs of mental illness in prisoners? How can courts respond?
What should judges do when accused shows signs? (CrPC Guidelines, Chapter 18 in Prison Rules)
When should judges take help from specialists? (exclude malingering, establish capacity/fitness)
When to redirect judgements towards treatment and rehabilitation?
How to break the cycle of re-offending by addressing psycho-social determinants of criminal behaviour?
Why defendants with these impairments must receive special consideration and legal protection to ensure fairness and accuracy.

b) **Criminal and Prison Law**

There are safeguards in our law to protect the rights of mentally disordered prisoners at different stages of criminal proceedings: at the point of arrest, trial and detention.
Unfortunately, these are not always implemented because criminal justice stakeholders:
- are not fully aware
- lack understanding of jurisprudence/procedure
- not familiar with the nature of mental disorders and associated disability.
- are influenced by stigma and discrimination

Some gaps are as follows:

1. The prison acts need to be updated as these do not comply with international standards of human rights. Sometimes, the prison rules are clearly stated but are not implemented. For example, according to Prison Rule 18, the point of entry to the prison a detailed medical check-up (which includes mental state examination) is mandatory, but it is not being followed. Similarly, Rule 444, Chapter 18 of the Prison manual, describes the procedure of shifting the prisoner from jail to outside mental health facility when a prisoner is known to suffer from a severe mental disorder that cannot be treated in the prison. Again, this is hardly practiced.

2. The problems with psychiatric assessments for court reports (according to Chapter 34 of CrPC) for under trial prisoners has already been highlighted above. If the person is not fit to stand trial, the procedure says that the person can be released on bail or sent to a mental health facility (under prison or mental health authority). His condition should be checked periodically to see if he regains competency. If not, they might continue to need proper long-term mental healthcare. In Pakistan there does not seem to be a statutory procedure or body that oversees the ongoing

assessment of risk and the balance of freedoms of such individuals. Also, there are only limited facilities for long term care (one in Lahore and one in Hyderabad), but no secure forensic facilities exist.

3. Sentenced offenders with a mental disorder may be transferred to a medical facility for treatment for part of, or the remainder of, their sentence under Part VI (Removal of Prisoners), section 30, of the Prisoners Act 1990. It is the responsibility of the provincial government to direct this. This should be implemented when needed. In JPP's experience to support mentally ill prisoners over years, Kanizan Bibi is the only one who was transferred for psychiatric treatment, but that too was brief, and she remains without treatment to this day.

4. Regarding fitness to stand trial, it is evident that the Pakistani legislation does not contain discrete fitness indicators. Currently, the terminologies 'unsound mind' and 'incapable of making a defence' are used in the proviso which convey similar meaning but this could be further explained by defining specific fitness indicators.

5. Even if a patient is declared unfit for judicial proceedings, there is no formal mechanism to ensure treatment in the community so the cycle of offending might just continue.

6. There is a pathological delay in the time frame till a case is resolved. This gap in the criminal justice system can be associated with the increased incidence and further increase of mental disorders within our prisons. Cases (trials) often take 15-20 years in court.

7. Lastly, the police force is also not formally trained to recognise mental disorders and often arrest people who should be directed to mental healthcare services.

SECTION 4 WAYS FORWARD

4.1 Principles of intervention for mental healthcare[1]

1. The prison management should promote mental health and protect human rights by providing prisoners food and sanitation; protection from discrimination and violence; and opportunities to engage in exercise, occupational activities, and healthy social interaction.

2. Mental disorders can cause disability which may impair an individual's capacity for criminal responsibility, fitness to stand trial or serve a sentence. The legal system must protect those with mental disorders.

3. Prison is the wrong place for many patients with mental illness, since the criminal justice system emphasizes deterrence and punishment over treatment and care.

4. Prison environments and policies should be reviewed to promote positive mental health and prevent mental disorders.

5. All prisoners should have access to general health services that include access to assessment, treatment, and the referral of individuals with mental disorders, including substance abuse.

6. For people with mental disorders who have been charged with committing minor offences, the introduction of mechanisms to divert them towards mental health services before they reach prison will help to ensure that they receive the treatment they need and also contribute to prevent prison overpopulation.

7. The imprisonment of people with mental disorders, due to lack of public mental health service alternatives, should be strictly prohibited by law.

8. Mental health services for prisoners may include: training prison staff to provide basic mental health training, training health providers to recognise and offer basic management of common mental health disorders, and establishing regular visits to prison by a mental health team.

9. Rules should facilitate the transfer of prisoners to psychiatric facilities at all stages of the criminal proceedings (arrest, prosecution, trial, imprisonment).

10. In accordance with the principles of de-institutionalisation, special psychiatric prison hospitals are strongly discouraged.

11. All stakeholders should collaborate to plan an inter-sectoral response for mental healthcare in prisons.
12. National mental health policy/plans and Prison Acts should encompass the mental health needs of the prison population.

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[1]Mental health & Prisons: Information sheet. October 2005.WHO & ICRC. http://www.euro.who.int/__data/assets/pdf_file/0007/98989/WHO_ICRC_InfoSht_MNH_Prisons.pdf

4.2 Best practices: Examples from the provinces

It was encouraging that the prison authorities are becoming more aware of mental healthcare needs in all provinces. Some examples are as follows:

Khyber Pakhtunkhwa

a) In KPK, some jails have regular psychiatric services and some have full time psychologists.

b) A Prison Information Management System is being developed in KPK. There are plans that by May 2022, all jails will be connected digitally to a central system.

c) In Peshawar, a separate hospital is under construction which will also have a secure facility for transferring prisoners for treatment.

d) The prison department has signed a Memorandum of Understanding (MOU) with the technical vocational education and training sector (TVET) authorities to arrange for comprehensive classes for juvenile offenders in prisons. The areas highlighted for training include plumbing, computer skills, beautician skills, sewing etc.

e) Also a survey has been carried out to address the problem of overcrowding, and it is expected that 400 prisoners will be released soon.

f) In Swabi, an open jail for mentally ill prisoners is being established.

Sindh

a) The province has introduced a new 'Sindh Prisons and Correctional Facilities Act, 2019' which proposes the constitution of a policy board for introducing reforms in jails.

b) There is a facility for youthful offenders in Karachi (under home department not prisons)

c) There is a doctor for 50-60 prisoners in a women's jail. If there is a health issue, the patient is seen by the doctor within 24 hours.

Punjab

This year, Punjab has employed 40 psychologists for the prisons.

4.3 RECOMMENDATIONS

4.3.1 Prison services

a) Promote positive mental health

There is dire need to overhaul and institute a cultural change in prison environments. Some key areas for improving the general atmosphere and well-being of prisoners include:

- Overcrowding
- Basic amnesties like sanitation, food
- Meaningful occupation including physical, recreational and educational activities
- Prevention of discrimination and violence
- Promotion of social networks, including contact with the outside world such as families
- Effective communication between authorities and detainees

b) Screening/identification of prisoners with mental disorders

The prison must formally screen for mental illness at reception, at regular intervals (6-12 months) and at other critical times. Some strategies include:

- Use of a screening instrument
- A mandatory medical check-up for all prisoner within 24 hours of entry into a prison system (Pakistan Prison Rules: 18). Medical officers should be trained to detect common mental disorders (by taking history and conducting a mental state examination). The findings should be clearly documented in a pro forma or register.
- The security staff and wardens should also be trained to recognise signs and symptoms of mental disorders.

c) Categorising of prisoners with mental disorders

Prison populations are often grouped according to their gender, charges, and needs. It is equally important to identify prisoners with mental disorders to protect this vulnerable group of individuals. Prisoners who suffer from mental illness and/or intellectual disability may be more easily be indoctrinated into violent extremism.

d) Drug free environment

There should be zero tolerance of access to, or availability of, any substance of abuse within prisons.

e) Protocols for managing difficult behaviour

Prisoners with mental illness are often inappropriately kept in isolation due to their behaviour. However, studies have clearly shown that the segregation of such individuals can result in a worsening of their mental illness. Appropriate housing and treatment of mentally ill prisoners will

help ensure that the prison is an overall more safe and secure place. The prison staff should be trained to assess risk (e.g. for dangerousness and self-harm) and should have clearly defined protocols for intervening with difficult or violent behaviour by those suffering from mental disorders.

f) **Data collection**

There is a dire need for collecting information to study a representative national sample from prisons across all provinces on the prevalence of mental disorders and associated risk factors.

g) Juvenile prisoners

The most vulnerable prisoners are juveniles, particularly youthful offenders (those under 15) Rules state that youthful offenders should be sent to reformatory schools and rehabilitated.

h) Others

Police: Pakistan's police force requires more training in triaging offenders and detainees who may have a mental disorder and the police need to know how to divert such offenders to psychiatric facilities.

Probation: Probation and parole departments should be made effective. People charged with petty crimes/minor violations shouldn't have to come to prisons**.** These departments are working in Punjab but not in other provinces.

4.3.2 Mental healthcare services

4.3.2.1 Mental healthcare within prisons

a) Build capacity of prison staff (security and healthcare)

There is a severe dearth of doctors and other healthcare staff in the prisons. This must be addressed. All healthcare staff should be trained to recognise and manage common mental disorders. They should also have clear guidelines to refer people with severe mental disorders to the visiting psychiatrist. This could be achieved by implementing mhGAP training guidelines recommended by the WHO, designed to train healthcare staff to recognize priority mental disorders.

Mental health training should also be provided to all people involved in prisons including prison administrators and security staff. Such training should enhance staff understanding of mental disorders, raise awareness of human rights, challenge stigmatizing attitudes and encourage the promotion of mental health for both staff and prisoners. A special emphasis should be placed on selecting and training the correction staff in this regard.

In addition, psychologists working in the prison system should also be trained to deal with mental health challenges at prisons.

It is important to note that there is a high drop-out rate for health staff employed by the prison system as there are few incentives or personal development opportunities for these practitioners. This needs to change.

b) Link with specialist service

Each prison must have a formal referral link to a specialist service. A psychiatrist should visit a prison at regular intervals. Special emphasis should be placed on documenting findings, the working diagnosis and a clear treatment plan for each patient assessed during these visits. It would be helpful if the visiting psychiatrist fills in a comprehensive form to ensure reliable documentation.

Those who require more specialist care can be temporarily transferred to psychiatric wards of general hospitals, or existing mental hospitals, where appropriate security can be provided.

c) Access to information and treatment

Prisoners and their families should receive information and education on the nature of mental disorders and the interventions required.

Prisons should ensure that psychotropic (psychiatric) medication is available and psychosocial support can be provided for the treatment of mental disorders.

4.3.2.2 Psychiatric services

a) Implement mental health legislation

Mental health legislations at the provincial levels must be updated (right based) and implemented. The legislation should ensure:

I. The promotion of positive mental health and prevention of mental disorders by safe guarding the basic rights of prisoners such as: acceptable living conditions, adequate food, access to open air, opportunities to engage in meaningful activity, and contact with the family. The prison conditions must conform to international human rights standards.

II. The right to quality treatment and care, confidentiality, protection from discrimination and violence, and protection from torture and other cruel, inhuman and degrading treatment (including abusive use of seclusion, restraints and medication).

III. The implementation of independent inspection mechanisms such as mental health visiting boards for prisons and other mental health facilities to monitor conditions for people with mental disorders.

IV. Procedural protections within the criminal justice system regarding the accused's right to fitness to stand trial, serve sentence etc, equivalent to those granted to other prisoners.

V. The establishment of adequate specialist psychiatric services for people in detention in all provinces.

b) Develop forensic psychiatry

The specialty of forensic psychiatry needs to be promoted. The training of psychiatrists needs urgent attention to improve expertise for conducting psychiatric assessments and writing forensic reports for the courts.

The departments of psychiatry must be fully equipped to offer regular services at the prisons; offer facilities to transfer detainees suffering from severe mental disorders; and sustain follow up care in the community once the detainees are released.

4.3.3 The justice system

4.3.3.1 Training the judiciary

The training of judiciary needs to be reviewed so as to encourage the following practices:

a) To incorporate the concept of 'therapeutic jurisprudence' to understand the links between social adversity and rates of crime, with a view to address the root causes of offending behaviour through actively involving social agencies.

b) To recognise mental disability and be able to assess the capacity of the offenders (in the context of mental disorders) for criminal responsibility, and the fitness to plead or serve a sentence.

c) To ensure opportunities and services for the treatment and rehabilitation of individuals with mental disorders through legal processes, including the implementation of mental health legislation.

d) To protect the rights of people with mental disorders and help the criminal justice system and community at large to overcome associated stigma.

4.3.3.2 Amendments and implementation of existing Law/procedures

a) Improve the procedures for constitution of medical boards; protocols for evaluations and forensic reporting, and interpretation of these reports by the courts, etc.

b) Increase judiciary's understanding of mental illness and intellectual disability in view of obligations under ICCPR and CAT.

c) Ensure implementation of Prison Rules, especially procedures concerning the conviction of a prisoner of unsound mind, and addressing the gaps in those procedures.

d) Make requisite amendments to the Prison Act & Rules to bring them in line with the international standards of human rights.

e) Review relevant legislation regarding fitness to stand trial to explain specific fitness indicators. This might improve understanding of present terms like 'unsound mind' and 'incapable of making a defence'.

f) Implement Rule 444, Chapter 18 of the Prison manual, which describes the procedures of shifting prisoners from jail to outside mental health facilities when they are known to suffer from a severe mental disorder that cannot be treated in the prison.

g) Ensure effective implementation of Chapter 34 CrPc, and all the relevant sections, concerning instances when the accused shows signs of a mental illness, including how the prison authorities and judges should consult psychiatrists to take their expert opinions. For this the current

procedure must be reviewed and the gaps highlighted in section 2.3.2 and 2.3.3 must be addressed.

h) Sentenced offenders with a mental disorder may be transferred to a medical facility for treatment for part of, or the remainder of, their sentence under Part VI (Removal of Prisoners), section 30, of the Prisoners Act 1990. It is the responsibility of the provincial government to direct this. This should be implemented when needed. For those needing long-term mental healthcare, facilities must be created in each province.

i) The new Juveniles Justice System Act (JJSA) must be implemented.

j) Amend the procedure of submitting mercy petitions to disclose the prisoners with mental disorders. The current procedure for submitting a Mercy Petition, as a last recourse that these individuals may file, is scarcely helpful and does not enable the prisoner to effectively present his case for clemency. Therefore, we recommend providing the condemned prisoners an accessible and comprehensible Mercy Petition form. This should guide him/her to make his case for mercy in a more personalized manner; should encourage him/her to present factors that would bolster the case for mercy including all the mitigating facts and supporting documents. The opportunity to document mental disorder and intellectual disability should be a vital addition to the mercy petition form.

Annexures

Annex 1 Panel discussants

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Annex 2 Proceedings of the consultative dialogue on mental healthcare in detention facilities

1. Panel discussions with Jail Superintendents: Good practices & gaps in existing prison system
   https://youtu.be/S8b4s8e25rs

2. Panel discussions with Inspector Generals Prisons: Currant challenges & way forward
   https://youtu.be/Z5aJBtBKn34

3. Need for mental healthcare in detention facilities by Dr Asma Humayun, Consultant Psychiatrist
   https://youtu.be/ESr8sLGYzsQ

4. Mental Health & Mens Rea in Pakistan's Criminal Justice System by Barrister Sarah Belal, Justice Project Pakistan
   https://youtu.be/uJe0qoj9jNs

5. Prevalence of mental disorders in detention facilities by Prof Murad M Khan, Aga Khan University
   https://youtu.be/Zm2gi2nULu4

6. Mental healthcare needs of detained women/children by Valerie Khan, Women's & Children rights activist
   https://youtu.be/XGwxxVKKfcw

7. Mental healthcare in prison is a human rights issue by Jibran Nasir, Lawyer & Human rights activist
   https://youtu.be/IbgPObqVRFI

8. Need for training the judiciary by Zainab Mahsood, Justice Project Pakistan
   https://youtu.be/_BqpSpJ03jE

9. Slipping through the cracks: Defending mentally ill prisoners in Pakistan by Sohail Yafat, Justice Project Pakistan
   https://youtu.be/d1EdETxAKjs

Annex 3 List of prisons

Province and No. of Prisons	Central Prisons (C.P.)	District Prisons (D.P.)	Sub-jails and Lock-ups	Special Prisons
Punjab (Total 40 prisons) **9 Central Prisons** **25 District Prisons** **2 Sub-jails** **4 Special Prisons**	1. C.P. Lahore 2. C.P. Gujranwala 3. C.P. Sahiwal 4. C.P. Multan 5. C.P. Bahawalpur 6. C.P. Dera Ghazi Khan 7. C.P. Rawalpindi 8. C.P. Faisalabad 9. C.P. Mianwali	1. D.P. Lahore 2. D.P. Sheikhupura 3. D.P. Kasur 4. D.P. Sialkot 5. D.P. Multan; 6. D.P. Rajanpur 7. D.P. Vehari 8. D.P. Rahim Yar Khan 9. D.P. Bahawalnagar 10. D.P. Muzaffar Garh 11. D.P. Attock 12. D.P. Jhelum 13. D.P. Mandi Bahauddin 14. D.P. Gujrat 15. D.P. Faisalabad 16. D.P. Jhang 17. D.P. Toba Tek Singh 18. D.P. Sargodha 19. D.P. Shahpur 20. D.P. Narowal 21. D.P. Layyah 22. D.P. Okara 23; D.P. Pakpattan 24: D.P. Hafizabad 25: D.P. Bhakkar.	1. Sub Jail Chakwal 2. Sub Jail Shujabad	1. Borstal Institution and Juvenile Jail Bahawalpur 2. Borstal Institution and Juvenile Jail Faisalabad 3. Women Jail Multan 4. High Security Prison Sahiwal
Sindh (Total 26 prisons) **5 Central Prisons** **11 District Prisons** **10 Special Prisons**	1. C.P. Karachi 2. C.P. Hyderabad 3. C.P. Sukkur 4. C.P. Larkana 5. C.P. Khairpur	1. D.P. Malir Karachi 2. D.P. Badin 3. D.P. Mirpurkhas 4. D.P. Shaheed Benazirabad 5. D.P. Sanghar 6. D.P. Dadu 7. D.P. Sukkur 8. D.P. Shikarpur 9. D.P. Naushahroferoze 10. D.P. Ghotki 11. D.P. Jacobabad		1. Y.O.I.S. Karachi 2. Y.O.I.S. Hyderabad 3. Y.O.I.S. Dadu 4. Y.O.I.S. Sukkur 5. Y.O.I.S. Larkana 6. Women Prison Karachi 7. Women Prison Hyderabad. 8. Women Prison Larkana. 9. Special Prison Nara Hyderabad 10. Open Prison Badin

Khyber Pakhtunkhwa (Total 22 prisons) **5 Central Prisons** **9 District Prisons** **8 Sub-jails and lock-ups**	1. C.P. Peshawar 2. C.P. Haripur 3. C.P. Bannu 4. C.P. DI Khan 5. C.P. Mardan	1. D.P. Mansehra 2. D.P. Kohat 3. D.P. Timargara 4. D.P. Abbottabad 5. D.P. Chitral 6. D.P. Swat 7. D.P. Lakki Marwat 8. D.P. Daggar 9. D.P. Karak	1. Sub Jail Upper Dir 2. Sub Jail Dassu Kohistan 3. Sub Jail Battagram 4. Sub Jail Charsadda 5. Judicial Lockup Malakand 6. Judicial Lockup Nowshera 7. Judicial Lockup Tank 8. Judicial Lockup Swabi	HSP Mardan was converted to Central Prison
Baluchistan (Total 11 prisons) **5 Central Prisons** **6 District Prisons**	1. C.P. Mach 2. C.P. Khuzdar 3. C.P. Gadani 4. C.P. Mastung 5. C.P. Zhob	1. D.P. Quetta 2. D.P. Sibi 3. D.P. Turbat 4. D.P. Dera Murad Jamali 5. D.P. Loralai 6. D.P. Nushki		
Gilgit Balitistan (Total 6 prisons) **5 District Prisons** **1 Sub-jail**		1. D.P. Gilgit; 2. D.P. Ghizer; 3. D.P. Skardu; 4. D.P. Astore; 5. D.P. Chilas.	1. Sub-jail Jutial	
Azad Jammu Kashmir (Total 7 prisons) **2 Central Prisons** **4 District Prisons** **1 Sub-jail**	1. C.P. Mirpur 2. C.P. Muzaffarabad	1. D.P. Bagh 2. D.P. Kotli 3. D.P. Phallandri 4. D.P. Rawlakot	1. Sub-jail Bhimbher	