PRISON INMATES: HEALTH AND MEDICAL CARE

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ABSTRACT:

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

- **Martin Luther King**

Speaking before the Second National Convention of the Medical Committee for Human Rights in Chicago. Does Health care really weigh only for non-prisoners. If so what about rest 1/3rd of population who resides in Prison.

This report describes health care services and treatment received by prisoners and jail inmates with health problems, including doctor's visits, use of prescription medication, and other types of treatment. It also explains reasons why inmates with health problems were not receiving care and describes inmate satisfaction with health services received while incarcerated. Data for this report were derived from the 2011–2012 National Inmate Survey. Highlights of this report include: 1) In 2011-12, an estimated 40% of state and federal prisoners and jail inmates reported having a current chronic medical condition while about half reported ever having a chronic medical condition. 2) Twenty-one percent of prisoners and 14% of jail inmates reported ever having tuberculosis, hepatitis B or C, or other STDs (excluding HIV or AIDS). 3) Both prisoners and jail inmates were more likely than the general population to report ever having a chronic condition or infectious disease. The same finding held true for each specific condition or infectious disease. 4) Among prisoners and jail inmates, females were more likely than males to report ever having a chronic condition. 5) High blood pressure was the most common chronic condition reported by prisoners (30%) and jail inmates (26%). 6) About 66% of prisoners and 40% of jail inmates with a chronic condition at the time of interview reported taking prescription medication.

And, 7) more than half of prisoners (56%) and jail inmates (51%) said that they were either very satisfied or somewhat satisfied with the health care services received since admission.

INTRODUCTION:

Prison population consists of an over representation of members of the most marginalized groups in society, people with poor health and chronic untreated conditions. This population is an underserved section of the society. Often their health problems are neglected. They carry a much greater burden of illness than other members of the society; They harbour diseases that are determined both by the environment out of which they come and by the prison in which they live. “Prison” means any jail or place used permanently or temporarily under the general or special orders of the state government for the detention of prisoners and includes all lands and buildings appurtenant thereto, but does not include any place for the confinement of prisoners who are exclusively in the custody of the police or any place declared to be a subsidiary jail. It is not a place where someone would like to live. Whatever are the reasons behind incarceration? Whether it is seen as a punishment or as a mode of rehabilitation? The normal life of the inmate is restricted, freedom of movement is curtailed, and private space is limited. Many of the prisons over the globe are overburdened; The population confined behind bars in the US in 2008 was in excess of 1.6 million In India too, the situation is no better. There are about 1276 prisons in the country with an authorized accommodation of 2,77,304; However, the total number of jail inmates is nearing 4 lacs indicating severe overcrowding in prisons. There are problems of drug abuse, alcoholism, trauma, homicide, suicide, violence,
Neuropsychiatric diseases, epilepsy, stress manifestations, HIV infection and AIDS, sexually transmitted diseases, tuberculosis, skin infections, and so on. In the walls of the jails, the lack of adequate health facilities amounts to society inflicting punishment twice, once by incarceration and a second time by illness. The second punishment has potential to get inflicted on the family of prisoners.

For example, in case a prisoner in US prison, his undetected tuberculosis got ultimately transmitted to his wife and two children one of whom died. Reforming the delivery of prison health care is one of the most important aspects of improving human rights compliance. Therefore, knowing the burden and types of morbidities among them will help policy planners and administrators in taking actions to minimize the disease burden in this group and also to help in reintegration of prisoners into main stream of society following their discharge from prison. Therefore, present study was conducted with the aim of studying the health status of persons from a section of our society, who were condemned by law and are behind the high walls.

GENERAL PRINCIPLES GOVERNING HEALTH CARE

Prison authorities should ensure that: A qualified health care professional is designated the responsible health authority for each facility, to oversee and direct the provision of health care in that facility; prisoners are provided necessary health care, including preventive, routine, urgent, and emergency care . Such care is consistent with community health care standards, including standards relating to privacy. special health care protocols are used,

when appropriate, for female prisoners, prisoners who have physical or mental disabilities, and prisoners who are under the age of eighteen or geriatric; and health care that is necessary during the period of imprisonment is provided regardless of a prisoner's ability to pay, the size of the correctional facility, or the duration of the prisoner's incarceration.

Duties of Medical Officer.[1]—Subject to the general control of the Superintendent, the Medical Officer shall be in charge of health, hygiene and the medical and sanitary administration of the prisoners in prison and he shall perform such duties as may be prescribed.

Prisoners should not be charged fees for necessary health care. Dental care should be provided to treat prisoners' dental pain, eliminate dental pathology, and preserve and restore prisoners' ability to chew. Routine preventive dental care and education about oral health care should be provided to those prisoners whose confinement may exceed one year. Prisoners should be provided timely access to appropriately trained and licensed health care staff in a safe and sanitary setting designed and equipped for diagnosis or treatment.

Health care should be based on the clinical judgments of qualified health care professionals, not on non-medical considerations such as cost and convenience. Clinical decisions should be the sole province of the responsible health care professionals, and should not be countermanded by non-medical staff. Work assignments, housing placements, and diets for each prisoner should be consistent with any health care treatment plan developed for that prisoner. Prisoners should be provided basic educational materials relating to disease prevention, good health, hygiene, and proper usage of medication.

The US Department of State (USSD) reported in its 2013 Human Rights Report for India that 'Prison conditions were frequently life threatening and did not meet international Standards. Prisons were severely overcrowded and food, medical care, sanitation, and environmental conditions often remained inadequate. Potable water was only occasionally available. Prisons and detention centers remained understaffed and lacked sufficient infrastructure. Prisoners were physically mistreated[2].

SANITATION AND HYGIENE

A total of 144 toilets, give a toilet to prisoner ratio of nearly 1:11 for the average population of 1600. While the overall situation is satisfactory in the convict blocks, the actual number of toilets available in the under –trial prisoner blocks is very small. Block No. 8 accommodating 91 UTPs has only 4 toilets. Block II holding 140 UTPs has only 6 toilets. Barracks constituting the blocks have been provided with attached toilets also which can also be used for bathing purposes. Cells have been provided with toilets for emergency use only. Availability of 32 bath rooms gives a bath room to prisoner ratio of 1:50. Bathing facilities provided in the open are adequate and inmates expressed satisfaction.

[1]Section 23 of ACT 9 OF 2010 [THE KERALA PRISONS AND CORRECTIONAL SERVICES (MANAGEMENT) ACT, 2010]
[2]U.S. Department of State, Country Report on Human Rights Practices for 2013: India, 27 February 2014

The supply of water from the Municipal Corporation is dependable and adequate for drinking, bathing and washing purposes. Water is stored in two overhead tanks, one spacious underground tank and one ground level tank outside the jail. Inside the jail, 26 ground level water tanks have been provided Besides 4 wells available for pumping the water for bathing purposes when municipal supply is interrupted. One water tank is exclusively available for laundry purposes.

CLOTHING AND BEDDING

Prisoners sleep on the ground and have been provided with gross mats and jamukalam' (ground -sheets). These items are found to be in short supply in the District/Sub Jails of Kozhikode. Prisoners are receiving other items of clothes as per the prescribed scale and no complaints were received on this count. Although women prisoners are being provided sanitary napkins as per actual needs, the item has not been formally included in their entitlement.

DIET

Rice, vegetables, wheat and meat are allowed in the diet. Special diet is allowed for sick prisoners. Special meals are provided to A class and B class prisoners. The superintendent and the medical officer shall exercise utmost vigilance in the supervision of food supplied and all items supplied for consumption are to be inspected daily. It is also the duty of the inspecting officer to see that the full ration is given. Quality is to be ensured and any defect in the quality is brought to the notice of the Superintendent. If the food is not of the quality and quantity a prisoner can complain the matter to the Head Warder. He receives the complaint and the matter will be reported to the Superintendent with his observation. Final decision comes from the Superintendent. The Deputy Jailor or Assistant Jailor weighs all items of food supplied for consumption daily. He or she shall be responsible for ensuring proper quantity of the food. The diet of individual prisoner may be modified on the recommendations of the medical officer. As shown in table 4.1, The morning meal will be given immediately after unlocking and mid-day meal will be given at 12:15 PM. Evening meal will be given on the completion of the day's work. The prisoner will also be provided every morning a cup of black coffee or black tea (bed coffee). The prisoner will be given feasts on the following festival days every year :Vishu, Onam, Ramzan, Bakrid, Christmas, and Easter. Every prisoner will be provided with a plate and a glass for taking food.

PRISONER HEALTH CARE NEEDS

Prison authorities should implement a system that allows each prisoner, regardless of security classification, to communicate health care needs in a timely and confidential manner to qualified health care professionals, who should evaluate the situation and assess its urgency. Provision should be made for prisoners who face literacy, language, or other communication barriers to be able to communicate their health needs. No correctional staff member should impede or unreasonably delay a prisoner's access to health care staff or treatment.

A prisoner suffering from a serious or potentially life-threatening illness or injury, or from significant pain, should be referred immediately to a qualified medical professional in accordance with written guidelines.

Complaints of dental pain should be referred to a qualified dental professional, and necessary treatment begun promptly. When appropriate, health care complaints should be evaluated and treated by specialists. A prisoner who requires care not available in the correctional facility should be transferred to a hospital or other appropriate place for care.

In my study over the commission report[3] of Trivandrum central jail it was noted that the medical facilities available at the Jail hospital which has a spacious accommodation. The hospital is Sanctioned one Medical Officer, one Pharmacist, one Lab. Tech. And two Nursing Assistants. But the post of nursing assistant is vacant over 10 years.

The hospital is not sufficiently equipped to carry out the initial medical examination for all the inmates on admission as per the guidelines issued by the NHRC. And this serious matter is not receiving due attention by the government.

CONTINUITY OF CARE

A prison authority should ensure each prisoner's continuity of care, including with respect to medication, upon entry into the correctional system, during confinement and transportation, during and after transfer between facilities, and upon release. A prisoner's health care records and medication should travel with the prisoner in the event of a transfer between facilities, including facilities operated by different agencies.

Prisoners who are determined to be lawfully taking prescription drugs or receiving health care treatment when they enter a correctional facility directly from the community, or when they are transferred between correctional facilities-including facilities operated by different agencies-should be maintained on that course of medication or treatment or its equivalent until a qualified health care professional directs otherwise upon individualized consideration.

CONTROL AND DISTRIBUTION OF PRESCRIPTION DRUGS

A prison authorities should store all prescription drugs safely and under the control and supervision of the physician in charge of the facility's health care program. Prescription drugs should be distributed in a timely and confidential manner. Ordinarily, only health care staff should administer prescription drugs, except that health care staff should be permitted to authorize prisoners to hold and administer their own asthma inhalers, and to implement other reasonable "keep on person" drug policies. In an emergency, or when necessary in a facility in which health care staff are available only part-time, medically trained correctional staff should be permitted to administer prescription drugs at the direction of qualified health care professionals. In no instance should a prisoner administer prescription drugs to another prisoner.

[3] commission report of shrichamanlal, special rapporteur to jails in kerala

Supply of medicines through a centralized system as per the indent placed by the Medical Officer was reported to be satisfactory. Local purchase restricted to the maximum of Rs.500 per day is also authorized. The ceiling has recently been raised to Rs.1000 per day. The system of referral of emergency cases to the Medical College Hospital is working very well Kerala.

QUALIFIED HEALTH CARE STAFF

Each correctional agency should employ or contract with a sufficient number of qualified medical, dental, and mental health professionals at each correctional facility to render preventive, routine, urgent, and emergency health care in a timely manner consistent with accepted health care practice and standards.

Health care providers in a non-federal correctional facility should be fully licensed in the state in which the facility is located; health care providers in a federal correctional facility should be fully licensed in the United States. No health care provider should be permitted to practice in a correctional facility beyond the scope permissible for that individual provider outside of a correctional facility, given the provider's particular qualifications and licensing. Regardless of any training a prisoner may have had, no prisoner should be allowed to provide health care evaluation or treatment to any other prisoner. There shall be a prison hospital in every Central Prison or Open Prison, administered by Medical Officers and para-medical staff for admission and treatment of sick prisoners. The hospital shall have inpatient facility and facility for clinical tests.

ADEQUATE FACILITIES, EQUIPMENT, AND RESOURCES

Health care areas in a correctional facility should be safe and sanitary, should include appropriately private areas for examination and treatment, and should be designed so that prisoners can hold confidential discussions with health care personnel.

A correctional facility should have equipment necessary for routine health care and emergencies, and an adequately supplied pharmacy. Specialized equipment may be required in larger facilities and those serving prisoners with special medical needs. Smaller facilities should be permitted to provide for prisoners' health care needs by transferring them to other facilities or health care providers, but should have equipment that is reasonably necessary in light of its preexisting transfer arrangements.

Hospitals and infirmaries operated by or within correctional facilities should meet the licensing standards applicable to similar, non-prison hospitals or infirmaries. Vehicles used to transport prisoners to and from medical facilities should be adequately equipped with emergency medical equipment and provisions for prisoners with special needs.

HEALTH CARE RECORDS AND CONFIDENTIALITY

Prisoners' health care records should be compiled, maintained, and retained in accordance with accepted health care practice and standards and not include criminal or disciplinary records unless a qualified health care professional finds such records relevant to the prisoner's health care evaluation or treatment. To be maintained

in a confidential and secure manner, separately from non-health-care files; accompany a prisoner to every facility to which the prisoner is transferred; and be available to the prisoner who is the subject of the records, absent an individualized finding of good cause.

Medical Board to submit report in certain cases.:

(1) Whenever a Medical Board constituted by the Government by notification in the Gazette for this purpose, considers that any prisoner is seriously ill and that his illness has not been caused or aggravated by the prisoner himself and that his illness, whether Caused by imprisonment or not. will be so aggravated by further imprisonment as to render his early death certain and that the prisoner will have a fair chance of recovery if released, it shall record a certificate accordingly, forward the same, through the Superintendent of the prison, to the Director General together with a full statement of the medical case and of the reasons which led the Medical Board to the observation in the certificate. While forwarding the certificate and statement, the Superintendent shall furnish the nominal roll of the prisoner showing the amount of remission earned and any remarks relevant to the case. The Director General shall forward the report to Government for appropriate orders with his remarks regarding the release of the prisoner

Information about a prisoner's health condition should not be disclosed to other prisoners. No prisoner should have access to any other prisoner's health care records, Information about a prisoner's health condition should be shared with correctional staff only when necessary and permitted by law, and only to the extent required for:

- (i) the health and safety of the prisoner or of other persons;
- (ii) the administration and maintenance of the facility or agency;
- (iii) quality improvement relating to health care; or
- (iv) law enforcement purposes.

Health care personnel or prison authorities should provide information about a prisoner's health condition to that prisoner's family or other persons designated by the prisoner if the prisoner consents to such disclosure or, unless the prisoner has previously withheld consent, if the prisoner's condition renders the prisoner unable to consent or if the prisoner has died.

PREGNANT PRISONERS AND NEW MOTHERS

A pregnant prisoner should receive necessary prenatal and postpartum care and treatment, including an adequate diet, clothing, appropriate accommodations relating to bed assignment and housing area temperature, and childbirth and infant care education. Any restraints used on a pregnant prisoner or one who has recently delivered a baby should be medically appropriate; prison authorities should consult with health care staff to ensure that restraints do not compromise the pregnancy or the prisoner's health.

A prisoner in labor should be taken to an appropriate medical facility without delay. A prisoner should not be restrained while she is in labor, including during transport, except in extraordinary circumstances after an individualized finding that security requires restraint, in which event correctional and health care staff should cooperate to use the least restrictive restraints necessary for security, which should not interfere with the prisoner's labor.

Governmental authorities should facilitate access to abortion services for a prisoner who decides to exercise her right to an abortion, as that right is defined by state and federal law, through prompt scheduling of the procedure upon request and through the provision of transportation to a facility providing such services. Governmental authorities should ensure that no birth certificate states that a child was born in a correctional facility. Governmental and prison authorities should strive to meet the legitimate needs of prisoner mothers and their infants, including a prisoner's desire to breastfeed her child. Governmental authorities should ordinarily allow a prisoner who gives birth while in a correctional facility or who already has an infant at the time she is admitted to a correctional facility to keep the infant with her for a reasonable time, preferably on extended furlough or in an appropriate community facility or, if that is not practicable or reasonable, in a nursery at a correctional facility that is staffed by qualified persons. Governmental authorities should provide appropriate health care to children in such facilities. A prisoner should be informed of the consequences for the prisoner's parental rights of any arrangements contemplated. When a prisoner and infant are separated, the prisoner should be provided with counseling and other mental health support.

SERVICES FOR PRISONERS WITH MENTAL DISABILITIES

A prison authority should provide appropriate and individualized mental health care treatment and habilitation services to prisoners with mental illness, mental retardation, or other cognitive impairments. Correctional officials should implement a protocol for identifying and managing prisoners whose behavior is indicative of mental illness, mental retardation, or other cognitive impairments.

A prison authority should provide prisoners diagnosed with mental illness, mental retardation, or other cognitive impairments appropriate housing assignments and programming opportunities in accordance with their diagnoses, vulnerabilities, functional impairments, and treatment or habilitation plans When appropriate for purposes of evaluation or treatment, prison authorities should be permitted to separate from the general population prisoners diagnosed with mental illness, mental retardation, or other cognitive impairments who have difficulty conforming to the expectations of behavior for general population prisoners.

However, prisoners diagnosed with serious mental illness should not be housed in settings that may exacerbate their mental illness or suicide risk, particularly in settings involving sensory deprivation or isolation.

PRISONERS WITH CHRONIC OR COMMUNICABLE DISEASES

Correctional officials should provide for the voluntary medically appropriate testing of all prisoners for widespread chronic and serious communicable diseases and for appropriate treatment, without restricting the

availability of treatment based on criteria not directly related to the prisoner's health. Prison authorities should not discriminate against a prisoner in housing, programs, or other activities or services because the prisoner has a chronic or communicable disease, including HIV or AIDS, unless the best available objective evidence indicates that participation of the prisoner poses a direct threat to the health or safety of others. When medically necessary, prison authorities should be permitted to place a prisoner with a readily transmissible contagious disease in appropriate medical isolation or to restrict such a prisoner in other ways to prevent contagion of others. Any accommodation made to address the special needs or risks of a prisoner with a communicable disease should not unnecessarily reveal that prisoner's health condition.

A report in a daily newspaper, 75 inmates of the Tiruchi Central Prisons were taken ill with complaints of acute diarrhea on Sunday. Two of them tested positive for cholera. Food poisoning and water contamination were suspected to be the causes of the illness. Health and prison authorities initiated precautionary measures in the prison, which has 2,500 inmates. Fifteen prisoners were admitted to the K.A.P. Viswanatham Government Medical College Hospital here after being brought to the hospital over the past 48 hours. Sixteen others are undergoing treatment in the prison hospital, while 43 others have been treated as outpatients. Prison authorities said the incidence came to light on Saturday morning when some prisoners complained of diarrhea.

Sexually transmitted and blood-borne infections amongst the inmates of a district jail in Northern India. Two hundred and forty male and 9 female jail inmates confined for various crimes in a district jail near Delhi were screened for sexually transmitted and blood-borne diseases including HIV, syphilis and hepatitis B and C viral infections, skin diseases etc. The inmates were aged 15-50 years with a mean of 24.8+/-0.11. Their alleged criminal background, period of stay in the jail, drug addiction, education, birth place, marital status, sexual activity, and clinical complaints were recorded by an anonymous questionnaire. Serum samples were tested for antibodies against HIV (1+2), hepatitis C (HCV), Treponemapallidum and for hepatitis B surface antigen (HBsAg). Sputum examination was done for acid-fast bacilli. Out of the 240 men, 115 were married and 125 unmarried. One hundred and eighty-four (76.6%) men gave history of penetrative sex. Of the 184, 53 (28.8%) were homosexuals or bisexuals and 131 (71.2%) had sex with women only. Sixty of the 131 (45.8%) were faithful to their partners while 124 gave a history of having multiple sexual partners and 100 of them (80.6%) had unprotected sex. Eighty-three of these 100 also had had sex with commercial sex workers (CSWs). One hundred and twenty-six were addicted for alcohol, 44 for smack/charas and 8 had a history of intravenous drug abuse. One hundred and seventy-four were not aware of AIDS. On examination 28 of the 240 (11.6%) had active hepatitis with or without a history of jaundice in the last 2 years, 25 (10.4%) active pulmonary tuberculosis (TB) and 11 (4.6%) had syphilitic ulcers on the penis. Four-fifths of the teenagers confined to a particular barrack had moderate to severe scabies. Three males (1.3%) were found to be Western blot confirmed HIV-1 positive while 28 (11.1%) men and 2 (22.2%) women were positive for HBsAg. Twelve (5.0%) men but no women, were found to be positive for anti-HCV antibodies. Out of the 3 HIV-positive persons, one was an intravenous drug user (IVDU), second was a drug addict and frequent CSW visitor while the third was a homosexual. This pilot study

gives an indication that sexually transmitted and blood-borne infections are highly prevalent in jail premises and pose a threat of rapid spread of these infections through IVDU and homosexuality.

PRISONERS WITH GENDER IDENTITY DISORDER

A prisoner diagnosed with gender identity disorder should be offered appropriate treatment. At a minimum, a prisoner who has begun or completed the medical process of gender reassignment prior to admission to a correctional facility should be offered treatment necessary to maintain the prisoner at the stage of transition reached at the time of admission, unless a qualified health care professional determines that such treatment is medically inadvisable for the prisoner.

THE RIGHT TO TREATMENT WITH HUMANITY WHILE IN DETENTION:

Everyone deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the human person. Sexual orientation and gender identity are integral to each person's dignity.

States shall:

A. Ensure that placement in detention avoids further marginalizing persons on the basis of sexual orientation or gender identity or subjecting them to risk of violence, ill-treatment or physical, mental or sexual abuse;

B. Provide adequate access to medical care and counseling appropriate to the needs of those in custody, recognizing any particular needs of persons on the basis of their sexual orientation or gender identity, including with regard to reproductive health, access to HIV/AIDS information and therapy and access to hormonal or other therapy as well as to gender-reassignment treatments where desired;

C. Ensure, to the extent possible, that all prisoners participate in decisions regarding the place of detention appropriate to their sexual orientation and gender identity

D. Put protective measures in place for all prisoners vulnerable to violence or abuse on the basis of their sexual orientation, gender identity or gender expression and ensure, so far as is reasonably practicable, that such protective measures involve no greater restriction of their rights than is experienced by the general prison population;

E. Ensure that conjugal visits, where permitted, are granted on an equal basis to all prisoners and detainees, regardless of the gender of their partner;

F. Provide for the independent monitoring of detention facilities by the State as well as by non-governmental organization's including organizations working in the spheres of sexual orientation and gender identity;

G. Undertake programs of training and awareness for prison personnel and all other officials in the public and private sector who are engaged in detention facilities, regarding international human rights standards and principles of equality and nondiscrimination, including in relation to sexual orientation and gender identity.

VOLUNTARY AND INFORMED CONSENT TO TREATMENT

Correctional officials should implement a policy to require voluntary and informed consent prior to a prisoner's health care examination, testing, or treatment. A prisoner who lacks the capacity to make decisions consenting or withholding consent to care should have a surrogate decision-maker designated according to applicable law, A competent prisoner who refuses food should not be force-fed except pursuant to a court order. Prisoners should be informed of the health care options available to them. If a prisoner refuses health care examination, testing, or treatment, a qualified health care professional should discuss the matter with the prisoner and document in the prisoner's health care record both the discussion and the refusal; the health care professional should attempt to obtain the prisoner's signature attesting to the refusal. Any claim that a prisoner is refusing treatment for a serious medical or mental health condition should be investigated by a qualified health care professional to ensure that the refusal is informed and voluntary, and not the result of miscommunication or misunderstanding. If a prisoner refuses care in such a situation, health care staff should take steps to involve other trusted individuals, such as clergy or the prisoner's family members, to communicate to the prisoner the importance of the decision. A prisoner who refuses testing or treatment for a serious communicable disease should be housed in a medically appropriate setting until a qualified health care professional can ascertain whether the prisoner is contagious.

Involuntary testing or treatment should be permitted only if:

(i) there is a significant risk of the spread of disease;
(ii) no less intrusive alternative is available;
(iii) involuntary testing or treatment would accord with applicable law for a non-prisoner.

INVOLUNTARY MENTAL HEALTH TREATMENT AND TRANSFER

Involuntary mental health treatment of a prisoner should be permitted only if the prisoner is suffering from a serious mental illness, non-treatment poses a significant risk of serious harm to the prisoner or others, and no less intrusive alternative is reasonably available. Prior to long-term involuntary transfer of a prisoner with a serious mental illness to a dedicated mental health facility, the prisoner should be afforded, at a minimum, the following procedural protections:

- (i) At least [3 days] in advance of the hearing, written, and effective notice of the fact that involuntary transfer is being proposed, the basis for the transfer, and the prisoner's rights under this Standard;
- (ii) Decision-making by a judicial or administrative hearing officer independent of the correctional agency, or by an independent committee that does not include any health care professional responsible for treating or referring the prisoner for transfer or any other correctional staff but does include at least one qualified mental health professional;

- (iii) A hearing at which the prisoner may be heard in person and, absent an individualized determination of good cause, present testimony of available witnesses, including the prisoner's treating mental health professional, and documentary and physical evidence;
- (iv) Absent an individualized determination of good cause, opportunity for the prisoner to confront and cross-examine witnesses or, if good cause to limit such confrontation is found, to propound questions to be relayed to the witnesses;
- (v) An interpreter, if necessary for the prisoner to understand or participate in the proceedings;
- (vi) Counsel, or some other advocate with appropriate mental health care training;
- (vii) A written statement setting forth in detail the evidence relied on and the reasons for a decision to transfer;
- (viii) An opportunity for the prisoner to appeal to a mental health care review panel or to a judicial officer; and
- (ix) A de novo hearing held every [6 months], with the same procedural protections as here provided, to decide if involuntary placement in the mental health facility remains necessary.

In an emergency situation requiring the immediate involuntary transfer of a prisoner with serious mental illness to a dedicated mental health facility because of a serious and imminent risk to the safety of the prisoner or others, the chief executive of a correctional facility should be authorized to order such a transfer, but the procedural protections set out in subdivision (b) of this Standard should be provided within [7 days] after the transfer.

Prior to involuntary mental health treatment of a prisoner with a serious mental illness, the prisoner should be afforded, at a minimum, the procedural protections specified in subdivision (b) of this Standard for involuntary mental health transfers, except that:

- (i) decision-making in the first instance and on appeal should be by a judicial or administrative hearing officer independent of the correctional agency, or by an neutral committee that includes at least one qualified mental health professional and that may include appropriate correctional agency staff, but does not include any health care professional responsible for treating or referring the prisoner for transfer;
- (ii) the notice should set forth the mental health staff's diagnosis and basis for the proposed treatment, a description of the proposed treatment—including, where relevant, the medication name and dosage—and the less-intrusive alternatives considered and rejected; and
- (iii) The de novo hearing held every [6 months] should decide whether to continue or modify any involuntary treatment, and in reaching that decision should consider, in addition to other relevant evidence, evidence of side effects.

In an emergency situation requiring the immediate involuntary medication of a prisoner with serious mental illness, an exception to the procedural requirements described in subdivision (d) of this Standard should be permitted, provided that the medication is administered by a qualified health care professional and that it is discontinued within 72 hours unless the requirements in subdivision (d) of this Standard are met. Notwithstanding a finding pursuant to subdivision (d) of this Standard that involuntary treatment is appropriate, mental health care staff should continue attempting to elicit the prisoner's consent to treatment.

Conclusion:

In the health status of inmates, one third of the prison population having normal health status but majority of them is unhealthy. India showed that 90% inmates had one or more morbid conditions. The reasons for major morbidity in prisoners, is inadequate chlorination of water, inadequate water supply, taking bath occasionally because of non-availability of hot water, unhygienic condition lack of nutrient food and proper diet for ill persons in prison. The population of the prisoner's harbours diseases that are determined both by the environment from which they come and in prison in which they live. If the inmates are not treated adequately in jails they will return to the community further burdening the existing health care facilities of the country.

References

1 SC Order in Re - Inhuman Conditions in 1382 Prisons dated 5th February 2016. W.P.(C) No.406 of 2013

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3 SC Order in Re - Inhuman Conditions in 1382 Prisons dated 5th February 2016. W.P.(C) No.406 of 2013

4 SC Order in Re - Inhuman Conditions in 1382 Prisons dated 2th May 2017. W.P.(C) No.406 of 2013

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Rule 21.15(iii), Model Prison Manual, 2016.

36 Rule 21.09 (xxiii), Model Prison Manual, 2016.

37 Rule 6.54, Model Prison Manual, 2016.

25 Law Commission of India, Women in Custody (135th Report 1989) para 2.28

26 SC Judgement in Shri Dilip K. Basu vs State of West Bengal & Ors dated 24th July 2015. W.P.(Cr) No. 539 of 1986

[19] UNHRC Report of the Special Rapporteur on the right to mental health (2017) 13-14, A/HRC/35/21 <https://documents-dds- ny.un.org/doc/UNDOC/GEN/G17/076/04/PDF/G1707604.pdf?OpenElement> accessed 26 May 2018; Committee on Economic, Social and Cultural Rights, 'General Comment No. 14: The Right to the Highest Attainable Standard of Health' (Art. 12) (11 August 2000) E/C.12/2000/4 <http://www.refworld.org/pdfid/4538838d0.pdf> accessed at 5 June 2018; UNHRC Report on the Health systems and the right to the highest attainable standard of health, (2008) A/HRC/7/11 <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G08/105/03/PDF/G0810503.pdf?OpenElement> accessed 26 May 2018