INTERNATIONAL JOURNAL OF PHARMACEUTICAL SCIENCES
[ISSN: 0975-4725; CODEN(USA): IJPS00]
Journal Homepage: https://www.ijpsjournal.com

OPEN ACCESS

Review Article

Psychotropic Polypharmacy In Indian Prisons: Clinical Risks, Behavioural Consequences And Medico-Legal Accountability

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ARTICLE INFO

Published: 10 Aug. 2026
Keywords:
Psychotropic Polypharmacy; Prison Psychiatry; Forensic Psychopharmacology; Behavioural Evidence; Custodial Death; Forensic Toxicology.
DOI:
10.5281/zenodo.21872977

ABSTRACT

Psychotropic medication is indispensable in prison mental-health care, yet prescribing occurs amid restricted autonomy, institutional control, security imperatives, fragmented records, substance dependence and responsibility for preventable harm. A custodial prescription is more than a therapeutic instruction: it may affect cognition, alertness, motor control, emotional expression, impulse regulation, interview performance, disciplinary behaviour, suicide risk and the interpretation of injury or death. This narrative review examines psychotropic prescribing and polypharmacy in Indian prisons as a clinical, pharmaceutical, behavioural and medico-legal problem. It considers literature on prison prescribing, antipsychotics, antidepressants, anxiolytics, hypnotics, mood stabilisers, medication continuity, adverse reactions, withdrawal, diversion, informed consent, self-harm, custodial death and forensic toxicology, alongside Indian prison and mental-health frameworks. Evidence indicates that psychotropic use may be higher in prisons than in community populations, with prisoners receiving multiple drugs for complex, poorly documented or off-label indications. Polypharmacy is not inherently irrational, but risk rises when medication reconciliation is incomplete, prescribers are uncoordinated, emergency sedation is added, monitoring is delayed or treatment continues without review. Aggression, confusion, emotional blunting, restlessness, slowed speech, withdrawal or apparent non-cooperation cannot alone establish criminal temperament, relapse or malingering; they may reflect illness, therapeutic effect, adverse reaction, interaction, intoxication, non-adherence or abrupt discontinuation. Prescription records do not prove ingestion, absorption or continuous exposure. The proposed Custodial Psychopharmacology Accountability Framework addresses clinical indication, prescription integrity, administration integrity, monitoring integrity, behavioural interpretation and medico-legal reconstruction.

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Relevant conflicts of interest/financial disclosures: The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Behavioural deterioration, self-harm, collapse or death should not be attributed solely to personality, criminality or mental illness until medication exposure, administration, interaction, adverse effect and withdrawal are systematically reconstructed.

INTRODUCTION

A prisoner who becomes confused, aggressive, unsteady, emotionally blunted or unresponsive may be described as violent, manipulative, mentally ill, intoxicated or deliberately non-compliant. Each description may be possible, but none is established merely by observing the behaviour. The same presentation may arise from untreated psychosis, severe anxiety, traumatic distress, medication-induced sedation, akathisia, orthostatic hypotension, anticholinergic toxicity, withdrawal, substance use, sleep deprivation, head injury or a combination of factors.

The custodial environment adds a further difficulty. Once behaviour is interpreted as an issue of order, discipline or security, a potentially medical event may be removed from clinical attention. A prisoner who paces continuously may be punished for disturbance even though the behaviour reflects medication-induced akathisia. A prisoner who cannot remain awake may be accused of laziness or intoxication when several prescribed sedating medicines have interacted. A prisoner who refuses medication may be labelled defiant without determining whether the refusal arises from adverse effects, fear, paranoia, inadequate explanation or a capacitous treatment decision.

International prison-health standards treat health care in custody as a responsibility of the State. Prisoners are entitled to professionally appropriate care and should receive standards of treatment broadly comparable to those available outside detention. Clinical decisions should be made by appropriately qualified health-care professionals rather than being driven primarily by administrative convenience or disciplinary pressure.

These principles are particularly significant for psychotropic medication. Prisoners cannot ordinarily leave the institution to seek another doctor, purchase an alternative medicine, verify a prescription independently or correct an interruption in treatment. They depend upon the institution for assessment, prescribing, dispensing, administration, monitoring, referral and emergency intervention.

India's prison system is administered primarily by the States and Union Territories. The Ministry of Home Affairs nevertheless issues model legislation, manuals and advisories intended to promote consistency. The Model Prison Manual, 2016 contains provisions concerning admission assessment, health records, mental-health care and referral. The Mental Healthcare Act, 2017 establishes rights concerning access to mental-health services, capacity, dignity and treatment, including specific protections for prisoners with mental illness.

These instruments create a normative foundation, but safe psychopharmacology ultimately depends upon what occurs at the point of assessment, prescription, administration, observation and emergency response.

Psychotropic medication use in prisons is neither inherently suspicious nor inherently protective. Appropriate treatment may reduce suffering, restore reality testing, improve sleep, control disabling anxiety, prevent relapse and support meaningful participation in rehabilitation or legal proceedings. At the same time, inappropriate prescribing, poorly coordinated combinations, unrecognised interactions and abrupt discontinuation can cause avoidable harm.

Medication may also acquire non-clinical meanings in custody. It may become a coping resource, an object of trade, a means of self-harm, a source of sedation, a marker of presumed dangerousness or an informal mechanism for producing behavioural quietness.

Research from prison systems outside India demonstrates high levels of psychotropic prescribing, particularly among women. Some studies have reported rates substantially exceeding those observed in community populations. The literature has also identified prescriptions with unclear indications, prolonged hypnotic use, frequent combination treatment and inadequate monitoring. These findings cannot be mechanically transferred to India, but they demonstrate why prison prescribing should be examined as a distinct institutional system rather than assumed to resemble ordinary outpatient care.

The central proposition of this review is that psychotropic medication in custody is simultaneously a therapeutic intervention, a pharmaceutical exposure, a behavioural variable and a medico-legal record of institutional responsibility.

The paper asks how psychotropic prescribing, polypharmacy, administration, adverse effects, withdrawal and behavioural change should be documented and interpreted in Indian prisons so that treatment is protected without obscuring accountability.

The objective is not to provide prescribing instructions, dosage schedules or individual clinical recommendations. It is to develop a forensic-clinical framework for understanding what medication records establish, what they do not establish and how medication-related evidence should be reconstructed following behavioural deterioration, injury, self-harm or custodial death.

Methodology

This article is a structured narrative review. Searches were undertaken in PubMed and official institutional repositories for English-language materials relating to prison psychotropic prescribing, psychotropic polypharmacy, antipsychotic polypharmacy, medication safety, adverse drug reactions, medication continuity, withdrawal, diversion, coercion, informed consent, self-harm, suicide, custodial death and forensic toxicology.

Citation chaining was used to identify foundational prison-health and psychopharmacology literature. Priority was given to prison-based observational studies, qualitative studies involving prisoners or health-care personnel, clinical intervention studies, pharmacological safety studies and official legal or health-care standards.

Indian sources included the Mental Healthcare Act, 2017, the Model Prison Manual, 2016, Ministry of Home Affairs prison advisories and National Human Rights Commission material concerning medical examination and custodial death.

India does not presently possess a publicly accessible national psychotropic-prescribing dataset comparable to certain overseas prison surveys. International evidence was therefore used to identify mechanisms and governance risks rather than to estimate the prevalence of psychotropic medication use in Indian prisons.

The review was organised around four functional questions:

- What therapeutic and adverse effects are forensically relevant in custody?
- How can prison processes distort prescription, administration and monitoring?

- How should medication-related behavioural changes be differentiated from illness or misconduct?
- What records are necessary to reconstruct serious adverse events?

No human participants or identifiable case records were examined. Institutional ethics approval was therefore not required.

The Indian Legal and Institutional Context

Prison administration in India is a State subject, and the legal and operational details differ among jurisdictions. The Ministry of Home Affairs provides model instruments rather than a single directly operative national prison code. The Model Prison Manual, 2016 nevertheless supplies an important reference point for admission procedures, medical examination, hospital management, mental-health care, case documentation and referral.

The Mental Healthcare Act, 2017 is more than an institutional-admission statute. It recognises a right to access mental-health care and treatment of acceptable quality without discrimination. It also adopts a functional approach to capacity. The relevant question is whether a person can understand information, appreciate reasonably foreseeable consequences and communicate a decision. The Act specifically addresses prisoners with mental illness and permits treatment within appropriate prison health facilities or transfer to a mental-health establishment where necessary. These provisions have three major implications for psychotropic medication in custody.

1. Imprisonment does not eliminate the prisoner's status as a patient. Security restrictions may affect the storage, distribution or supervision of medication, but they do not transform a clinically unnecessary intervention into legitimate treatment.
2. Consent cannot be inferred merely from the absence of physical resistance. Custody places the patient in a relationship of pronounced dependence. A prisoner may believe that refusal will affect discipline, classification, privileges, transfer, bail perception or relations with staff. A signature remains relevant, but meaningful consent requires information, comprehension, voluntariness and an opportunity to ask questions.
3. Where capacity is impaired or emergency intervention is required, the justification should be clinical and recorded. "Difficult behaviour" is not itself a diagnosis. The record should identify the symptoms observed, the immediate risks, the alternatives considered, the legal or clinical basis of intervention, the medicine administered, the monitoring undertaken and the review arranged.

International prison-health principles further require that clinical decisions be taken by responsible health-care professionals and should not be overridden for non-medical reasons. This protects prisoners from inappropriate medication, but it also protects clinicians from pressure to prescribe merely because a particular prisoner is inconvenient, distressed, sleepless, demanding or difficult to supervise.

Clinical independence therefore serves both patient welfare and institutional integrity.

Psychotropic Medication in the Custodial Environment

Psychotropic medication is a broad category encompassing medicines that alter mood, thought, perception, arousal, attention or behaviour.

In prison practice, relevant classes include:

- antipsychotics;
- antidepressants;

- anxiolytics;
- hypnotics;
- mood stabilisers;
- anticonvulsants used for psychiatric purposes;
- medicines used in substance-dependence treatment;
- medicines administered during acute behavioural emergencies.

Each class has therapeutic value, but each also produces effects that may acquire forensic significance in custody.

Antipsychotic Medication

Antipsychotics may be essential for schizophrenia-spectrum disorders, mania, severe mood disorders and certain acute behavioural states.

Their forensically relevant adverse effects include:

- sedation;
- cognitive slowing;
- orthostatic hypotension;
- akathisia;
- dystonia;
- drug-induced parkinsonism;
- metabolic disturbance;
- cardiac conduction effects;
- anticholinergic symptoms;
- serious haematological or gastrointestinal complications with particular agents.

These effects can be misread in custody. Akathisia may appear as purposeless pacing, agitation or defiance. Drug-induced parkinsonism may resemble depression, fear, neurological disease or intentional slowness. Emotional flattening may be interpreted as absence of remorse. Sedation may be described as laziness, intoxication or refusal to participate. Orthostatic symptoms may lead to a fall initially treated as clumsiness or fabrication.

Prison prescribing studies have demonstrated substantial antipsychotic exposure and frequent combination therapy. These findings do not establish that combination treatment is inappropriate in each case. They demonstrate the need for documented indication, review and monitoring.

Antidepressants

Antidepressants may be used for depressive disorders, anxiety disorders, trauma-related symptoms, obsessive-compulsive disorder, neuropathic pain or other recognised indications.

Relevant adverse effects vary by class and may include:

- gastrointestinal disturbance;
- sleep disruption;
- somnolence;
- agitation;
- sexual dysfunction;
- bleeding risk in combination with other medicines;
- hyponatraemia;
- cardiac effects;
- discontinuation symptoms.

Early activation, restlessness or increased anxiety may be behaviourally significant, particularly in a newly admitted prisoner already experiencing acute stress. Conversely, sedation or emotional blunting may reduce the person's ability to communicate distress. The existence of an antidepressant prescription must not be treated as proof that depression is controlled. Nor should abrupt deterioration be assumed to represent progression of the underlying disorder without examining adherence and recent treatment changes.

Anxiolytics and Hypnotics

Benzodiazepines and related hypnotics can reduce acute anxiety, insomnia, agitation, muscle spasm or withdrawal symptoms. They also present risks of:

- sedation;
- falls;
- cognitive impairment;
- disinhibition;
- amnesia;
- tolerance;
- dependence;
- diversion;
- respiratory depression when combined with other depressants.

Their effects may be intensified by alcohol, opioids, sedating antihistamines, antipsychotics or other central nervous system depressants.

In custody, a medicine's desirability on an informal prison market can distort clinical interaction. A genuine patient may be presumed to be drug-seeking because other prisoners misuse the same medicine. Conversely, a plausible symptom report may be used to obtain a tradable drug. Safe practice therefore requires neither automatic disbelief nor automatic continuation. It requires verification, diagnosis, risk assessment and consideration of suitable alternatives where clinically appropriate.

Mood Stabilisers and Anticonvulsants

Lithium, valproate, carbamazepine, lamotrigine and other agents may be used for bipolar illness, epilepsy, affective instability or related indications.

Safe use may require:

- laboratory monitoring;
- review of renal or hepatic function;
- attention to hydration;
- assessment of drug interactions;
- monitoring of blood counts;
- monitoring of serum concentrations where clinically indicated.

Prison conditions can interfere with these safeguards through transfer, delayed laboratory access, acute illness, fasting, dehydration or incomplete communication between institutions. A medication may also have more than one indication. The presence of an anticonvulsant does not by itself establish epilepsy. Similarly, the presence of an antipsychotic does not establish psychosis. Diagnostic inference from a medication list is hazardous because psychotropics are often prescribed across diagnostic categories.

Medicines Used in Substance-Dependence Treatment

Prison admission may abruptly interrupt alcohol, opioid, benzodiazepine or other substance use. Medication-assisted treatment and structured withdrawal management can be lifesaving. At the same time, substances may remain accessible within prisons, and prescribed medicines may interact with illicit exposure.

Indian research has identified substance use during imprisonment and rapid return to use after release. Other studies have recognised operational barriers affecting the delivery of substance-use interventions in Indian prisons. Medication decisions must therefore incorporate substance history rather than treating psychiatric prescribing as a separate clinical silo.

Table 1: Psychotropic Classes and Forensically Relevant Effects

Drug Class	Principal Clinical Purposes	Forensically Relevant Adverse Effects	Discontinuation Concerns	Custodial Interpretation Issues
Antipsychotics	Psychosis, mania and severe behavioural disturbance	Sedation, akathisia, dystonia, parkinsonism, orthostatic hypotension, metabolic and cardiac effects	Rebound insomnia, agitation, dyskinesia and relapse	Restlessness may be labelled indiscipline; emotional flattening may be mistaken for absence of remorse
Antidepressants	Depression, anxiety, trauma-related symptoms, obsessive symptoms and selected pain conditions	Activation, somnolence, gastrointestinal effects, hyponatraemia, bleeding interactions and sexual dysfunction	Anxiety, dizziness, insomnia, sensory symptoms and affective disturbance	Withdrawal may be mistaken for relapse or manipulation
Benzodiazepines	Acute anxiety, withdrawal, seizures and selected emergencies	Sedation, amnesia, disinhibition, impaired balance and respiratory risk with other depressants	Anxiety, insomnia, autonomic symptoms and seizures in high-risk circumstances	Demand may reflect genuine dependence, misuse, fear of withdrawal or diversion
Hypnotics	Short-term treatment of insomnia	Sedation, complex behaviour, cognitive impairment and falls	Rebound insomnia and anxiety	Sleep complaints may reflect trauma, withdrawal or environmental disturbance
Mood stabilisers	Bipolar disorder and mood instability	Tremor, sedation and renal, hepatic, metabolic or haematological effects	Mood destabilisation and relapse	Monitoring failure may remain unnoticed until behavioural or physical deterioration
Anticonvulsants used psychiatrically	Epilepsy, mood stabilisation and selected pain disorders	Sedation, dizziness, cognitive slowing and interaction effects	Seizure or symptom recurrence	A medication list does not independently establish the indication
Opioid-substitution medicines	Opioid dependence	Sedation, interaction-related respiratory risk and diversion	Withdrawal and relapse	Security concerns may result in undertreatment; insufficient supervision may permit diversion

Anticholinergic medicines	Treatment of selected movement adverse effects	Confusion, blurred vision, urinary retention, constipation and tachycardia	Re-emergence of movement symptoms	Confusion may be misclassified as psychosis or non-cooperation

Polypharmacy as a Systems Problem

Psychotropic polypharmacy generally refers to the concurrent use of more than one psychotropic medicine. Antipsychotic polypharmacy is narrower and ordinarily means the simultaneous prescription of two or more antipsychotics.

Neither definition establishes irrationality.

Combination therapy may be clinically justified during:

- cross-titration;
- treatment resistance;
- management of comorbidity;
- stabilisation of an acute episode;
- carefully supervised transition between medicines.

The forensic concern arises when the record cannot explain why the combination exists.

Polypharmacy in prison may develop through several routes:

- continuation of community prescriptions without complete verification;
- continuation of previous prison prescriptions after repeated transfers;
- several prescribers addressing separate symptoms;
- emergency medication added to regular therapy;
- treatment of one drug's adverse effects with another drug;
- interaction between psychiatric and non-psychiatric medicines;
- temporary combinations becoming permanent by default;
- fragmented electronic and paper records;
- reluctance to alter a regimen in a high-risk prisoner;
- institutional preference for behavioural quietness.

Correctional research has suggested that structured treatment algorithms can reduce unnecessary polypharmacy. This supports the proposition that at least some combination prescribing reflects system variation rather than unavoidable clinical complexity.

Prison health-care personnel have identified numerous barriers to safe prescribing, including:

- institutional structure;
- weak clinical governance;
- workforce limitations;
- incomplete information systems;
- medical comorbidity;
- polypharmacy;
- tradability of medication;
- diversion;
- prison culture.

Studies examining prison-specific medication-safety indicators have also identified prolonged hypnotic use, inadequate antipsychotic monitoring and potentially harmful drug interactions. The number of prescribed medicines should therefore operate as a trigger for review rather than as a verdict. A two-drug combination may be rational and well monitored. A single medicine may be

irrationally prescribed, poorly administered or dangerous in context.

A proper review should address:

- the indication for every medicine;
- the date and rationale of commencement;
- the expected duration;
- evidence of benefit;
- adverse effects;
- duplicate pharmacological actions;
- interactions;
- laboratory or physical monitoring;
- adherence;
- diversion;
- the plan for reduction, continuation or specialist review.

The problem becomes particularly serious when a symptom generated by one medicine is treated as a new illness.

Akathisia may be interpreted as anxiety and treated with an additional sedative. Sedation may be treated as depression or lack of motivation. Anticholinergic effects may generate further prescriptions. This prescribing cascade can make the original causal sequence increasingly difficult to reconstruct.

Prison transfer is a particularly vulnerable point. A person may arrive late in the day without verified records, medication or contact details for the previous prescriber. Staff must balance the risk of abruptly stopping treatment against the risk of continuing a falsely reported, outdated or diverted prescription. Studies involving prisoners and staff have documented anxiety, clinical deterioration and loss of trust following delays or unilateral medication changes at reception. A safe reception process should produce a provisional medication reconstruction rather than a simple decision to continue or stop treatment.

The record should distinguish:

- medication reported by the prisoner;
- medication physically carried into custody;
- medication confirmed by prescription records;
- medication confirmed as recently dispensed;
- medication documented as actually administered;
- medication clinically assessed as necessary;
- medication temporarily withheld and the reason;
- monitoring arranged for interruption or withdrawal.

Medication, Behaviour and False Attribution

Behaviour is evidence of a person's state, but it does not identify its own cause. This principle is especially important in prisons, where observations are frequently recorded by personnel whose primary responsibility is security rather than diagnosis.

Aggression may arise from:

- psychosis;
- mania;
- fear;
- trauma;
- pain;
- intoxication;
- withdrawal;
- akathisia;
- neurological illness;
- interpersonal conflict.

Slowed speech may result from:

- depression;
- sedation;
- intellectual disability;
- language difficulty;
- head injury;

- deliberate caution.

Emotional blunting may reflect:

- a negative symptom of schizophrenia;
- severe depression;
- antipsychotic effect;
- dissociation;
- traumatic coping;
- excessive sedation.

Refusal to communicate may indicate:

- paranoia;
- shame;
- distrust;
- cognitive impairment;
- legal advice;
- intentional non-cooperation.

The correct question is not, "What kind of prisoner behaves this way?" The correct question is, "What competing explanations are compatible with the behaviour, and what evidence distinguishes them?"

Qualitative prison research shows that psychotropic medicines are perceived both as treatment and as a means of coping with insomnia and institutional distress. Staff have also recognised their role in maintaining order while expressing concern about excessive reliance upon medication where psychological or social support is limited.

Table 2: Behavioural Finding and Differential Interpretation

Observed Finding	Possible Psychiatric Explanation	Possible Medication Explanation	Possible Withdrawal Or Interruption Explanation	Evidence Required
Agitation or pacing	Mania, psychosis, anxiety or trauma	Akathisia, activation or paradoxical disinhibition	Benzodiazepine, antidepressant or antipsychotic withdrawal	Timing, medication changes, physical examination and mental-state assessment
Slowed speech	Depression, negative symptoms or cognitive disorder	Sedation, anticholinergic burden or motor adverse effect	Sleep deprivation after withdrawal	Dose-administration times, neurological signs and alertness
Confusion	Delirium, psychosis or neurological illness	Anticholinergic effect, interaction or excessive sedation	Substance or medicine withdrawal	Vital signs, glucose, toxicology, medication chart and medical evaluation
Restlessness	Anxiety, mania or situational distress	Akathisia or activating antidepressant effect	Rebound anxiety	Temporal association and movement assessment
Excessive sleepiness	Depression, sleep debt or illness	Sedative combination, antihistamine, antipsychotic or benzodiazepine effect	Post-withdrawal exhaustion	Administration record, respiratory status, timing and co-exposure
Emotional flattening	Negative symptoms,	Antipsychotic effect or excessive sedation	Rebound dysphoria	Baseline behaviour, clinical interview and medication timeline

	depression or trauma			
Aggression	Psychosis, mania, fear or personality factors	Disinhibition, akathisia or delirium	Alcohol, sedative or opioid withdrawal	History, examination, observation and toxicology
Refusal to engage	Paranoia, depression or trauma	Cognitive slowing or sedation	Anxiety or dysphoria after interruption	Capacity assessment, private interview and language support
Tremor	Anxiety, withdrawal or neurological disease	Lithium, valproate or antipsychotic-related effect	Alcohol or benzodiazepine withdrawal	Neurological examination and drug level where indicated
Collapse	Medical illness, seizure or self-harm	Hypotension, arrhythmia, excessive sedation or interaction	Withdrawal seizure	Emergency records, toxicology, ECG and laboratory findings

The table is not a diagnostic algorithm. Several explanations may coexist. Its purpose is to prevent premature closure, whereby the first disciplinary or psychiatric label displaces further investigation. A behavioural report should record observations rather than conclusions.

"The prisoner repeatedly walked between the door and bed for forty minutes, stated that he could not remain still and had received a medication change that morning" is more useful than "The prisoner was disruptive." Similarly, "Speech was slurred, eyes closed intermittently and support was required to stand" is more useful than "Appeared intoxicated." The distinction is medico-legally important because later experts depend upon contemporaneous descriptions. When a record contains only moral or disciplinary labels, the possibility of retrospective pharmaceutical interpretation is substantially reduced.

Sedation and the Boundary Between Treatment and Control

Sedation may be an anticipated, incidental or excessive effect of treatment. In some emergencies, medication is administered to reduce immediate danger sufficiently for assessment and care. The existence of a calming effect does not make the treatment improper. The ethical and medico-legal question is whether the intervention was clinically indicated, proportionate and monitored. Medication approaches the boundary of improper behavioural control when its primary purpose is to make a person easier to manage rather than to treat a condition or respond to an immediate clinical emergency. The distinction depends upon evidence rather than terminology.

A defensible record should answer:

- What behaviour or symptom was observed?
- What immediate harm was feared?
- What medical or psychiatric assessment was undertaken?
- What non-pharmacological measures were attempted or considered?
- Why was the selected intervention clinically appropriate?
- Was consent obtained?
- Where consent was absent, what justified proceeding?
- What monitoring followed?

- When was the need for continued treatment reviewed?

The phrase “agitated prisoner” is insufficient.

Agitation may be caused by:

- hypoxia;
- hypoglycaemia;
- delirium;
- withdrawal;
- head trauma;
- medication toxicity;
- severe pain;
- infection;
- acute psychosis.

Sedating such a patient without assessment may temporarily suppress the visible sign while worsening or obscuring the underlying emergency.

Over-sedation also creates secondary custodial risks.

A person may:

- fall;
- aspirate;
- become unable to call for help;
- fail to drink;
- miss meals;
- develop pressure injury;
- appear to be asleep during deterioration.

Where several sedating medicines are combined, staff should not assume that each medicine is safe merely because every individual dose falls within an ordinary therapeutic range. The therapeutic-control distinction should not be distorted in the opposite direction. Failure to treat severe psychosis, mania, catatonia or dangerous agitation can itself constitute neglect. The objective is not medication minimisation at any cost. It is clinically justified, monitored and reviewable treatment.

Consent and Capacity in Custody

Consent in custody exists within a structurally unequal relationship.

The prisoner depends upon the institution for:

- treatment;
- privacy;
- transport;
- communication;
- physical safety;
- access to specialists;
- continued medication.

This dependence does not make every consent invalid, but it requires greater attention to voluntariness. Research involving mentally ill prisoners has shown that many retain adequate decisional capacity. Mental illness or imprisonment should not therefore produce an automatic presumption of incapacity. Capacity should be assessed individually.

For treatment decisions, the following questions are important:

- Did the prisoner receive an explanation in a language and form that could be understood?
- Was the indication explained?
- Were material benefits and adverse effects discussed?
- Were reasonable alternatives discussed?
- Did the prisoner understand the consequences of acceptance and refusal?
- Could the prisoner communicate a stable decision?
- Was there an immediate emergency?
- Did authority pressure undermine the apparent choice?
- Was the decision documented?
- Was the decision periodically reconsidered?

Perceived coercion is clinically significant even where treatment is legally authorised.

A prisoner may comply because they believe refusal will lead to punishment, isolation, adverse reports or delayed privileges. These perceptions should be addressed openly rather than dismissed merely because no overt threat was made. Long-acting injectable medication deserves particular care because its effects cannot be immediately reversed after administration. The formulation may improve continuity and reduce missed doses, but some patients experience it as more coercive than oral treatment.

The record should therefore explain:

- the clinical reason for selecting the formulation;
- alternatives considered;
- the prisoner's views;
- the consent process;
- the monitoring and review plan.

Treatment consent must also be separated from research consent.

A prisoner may agree to clinically recommended medication but remain free to refuse participation in a study. Access to ordinary treatment, privileges or favourable institutional consideration should not be made dependent upon research participation.

Administration Integrity: Refusal, Hoarding and Diversion

A prescription establishes that a clinician authorised a medicine. It does not prove that the prisoner swallowed it, absorbed it or received it continuously. The chain from prescription to pharmacological exposure contains several stages:

Prescription → dispensing → delivery to the correct prisoner → acceptance → ingestion → absorption → biological effect

Failure at any stage can produce a discrepancy between the medication chart and actual exposure.

Prisoners may:

- refuse medication;
- conceal tablets in the mouth;
- vomit after administration;
- accumulate doses;
- exchange medicines;
- surrender medication under pressure;
- trade tablets;
- use medication for self-harm.

Staff may also:

- make documentation errors;
- administer a dose late;
- omit a dose during lockdown;
- omit treatment during court production;
- fail to transfer medication with the prisoner;
- record administration without directly confirming ingestion.

Medication diversion is not a reason to deprive all prisoners of clinically indicated treatment. It is a reason to use proportionate controls.

These may include:

- supervised administration;
- suitable formulations;
- private clinical review;
- reconciliation of unexplained treatment failure;
- careful review of medicines known to be tradable;
- pharmacy stock monitoring.

Institutional studies involving quetiapine and other psychotropics demonstrate that prescribing can change considerably after systematic review of misuse and diversion. Such findings do not justify assuming that every request for a tradable medicine is deceptive. They demonstrate the need to distinguish genuine clinical need from misuse through assessment rather than stereotype.

Medication adherence is influenced by:

- adverse effects;
- trust;
- perceived benefit;
- stigma;
- coercion;
- illness insight;
- prison routine;
- continuity of professional relationships.

A person who refuses treatment may be making a capacitous decision, responding to intolerable effects, experiencing paranoia, seeking an alternative or attempting diversion. Each possibility requires different management.

Administration records should distinguish:

- offered and accepted;
- offered and refused;
- witnessed swallowing;
- partial ingestion;
- vomiting;
- dose unavailable;
- prisoner absent due to court, hospital or transfer;
- withheld on clinical instruction;
- withheld for monitoring;
- suspected concealment or diversion;
- emergency administration.

This specificity becomes crucial following deterioration or death. A series of ticks on a chart may be administratively convenient but forensically ambiguous.

Withdrawal And Abrupt Discontinuation

Psychotropic discontinuation may produce three broad phenomena:

- recurrence of the underlying illness;
- rebound, in which the original symptom returns temporarily with greater intensity;
- withdrawal symptoms that were not previously present.

These phenomena may overlap and can be difficult to distinguish.

Abrupt interruption has been associated with clinically significant consequences across:

- antidepressants;
- benzodiazepines;
- hypnotics;
- antipsychotics;
- mood stabilisers;
- anticonvulsants;
- other psychotropics.

Possible manifestations include:

- anxiety;
- insomnia;
- irritability;
- dizziness;
- nausea;
- sensory disturbance;
- autonomic symptoms;
- tremor;
- agitation;
- perceptual change;
- mood destabilisation;
- seizures in relevant circumstances.

The pattern depends upon:

- the medicine;
- duration of use;
- dose;
- elimination profile;
- individual susceptibility;
- speed of discontinuation.

Prison reception and transfer are recurrent risk points.

A community prescription may not be immediately verifiable. A prisoner may arrive without medication. The receiving institution may use a different formulary. Court production, hospital admission, segregation or transfer may interrupt administration. Administrative transition does not neutralise physiological dependence.

When behaviour deteriorates after admission or transfer, the review should reconstruct:

- the last reliably ingested dose;
- the usual regimen;
- the time since interruption;
- the medication's elimination profile;
- substance dependence and recent use;
- sleep and food intake;
- new symptoms;
- previous withdrawal history;
- alternative medical causes.

Withdrawal should not be presumed, but it should remain in the differential diagnosis until reasonably evaluated.

Self-Harm, Suicide and Medication Access

Psychotropic medication may reduce suicide risk by treating mental illness. It may also become relevant to self-harm through adverse effects, withdrawal, accumulation or overdose. The relationship is not simple enough to support a conclusion that the presence or absence of medication caused a particular act.

Prison self-harm is associated with:

- psychiatric illness;
- substance use;
- trauma;
- previous self-harm;
- suicidal ideation;
- institutional stress;
- isolation;
- social disconnection.

Psychotropic prescribing may appear associated with self-harm because severely ill prisoners are more likely both to receive medication and to harm themselves. Such an association does not independently establish that medication caused the behaviour.

A medication-related suicide-risk assessment should consider:

- diagnosis and current mental state;
- previous attempts;
- recent admission or transfer;
- medication commencement or change;
- activation, restlessness or severe adverse effects;
- abrupt interruption;
- access to accumulated medication;
- access to other substances;
- observation level;
- cell placement;
- social isolation;
- warning statements;
- recent behavioural changes;
- follow-up after refusal or missed doses.

Supervised administration may be appropriate where there is a credible risk of accumulation, but supervision must be meaningful. Where a prisoner can retain tablets despite recorded observation, the chart may create a false appearance of safety.

Following an overdose or suspected overdose, investigators should not assume that the prescribed quantity equals the ingested quantity.

The reconstruction should compare:

- stock supplied;
- doses recorded as administered;
- doses refused;
- remaining stock;
- access by other prisoners;
- packaging or residue;
- blood concentrations;
- active metabolites;
- clinical course;
- resuscitation and treatment.

The same caution applies to allegations that medication produced suicidal behaviour.

Temporal association warrants investigation, but causation requires evaluation of:

- illness severity;
- psychosocial events;
- pharmacology;
- previous history;
- alternative explanations.

Custodial Injury and Death

A custodial death involving psychotropic medication requires investigation at three interconnected levels.

Cause of Death

What physiological process caused death?

Contribution

Did medication, interaction, withdrawal or inadequate monitoring contribute?

Accountability

Were assessment, administration, observation and emergency response reasonable?

The National Human Rights Commission requires prompt reporting and documentation of custodial deaths, including post-mortem and inquiry materials. Its guidance also recognises the importance of videography, magisterial inquiry and submission of toxicology or viscera reports where analysis remains pending.

For a medicated prisoner, the investigation should obtain:

- reception medical examination;
- complete prescription history;
- previous community records;
- previous prison records;
- medication-administration charts;
- recent changes and reasons;
- refusal records;
- missed-dose records;
- emergency medication records;
- nursing observations;
- custodial observations;
- mental-state assessments;
- vital signs;
- physical examinations;
- laboratory monitoring;
- ECG records where relevant;
- substance-use history;
- cell and property search findings;
- CCTV and movement records;
- emergency call times;
- transfer times;
- hospital records;
- post-mortem findings;
- toxicology and metabolite results;
- preserved medication packets;
- remaining stock.

The chronology should be precise. An apparently small discrepancy between the recorded administration time, observed collapse and emergency response may materially alter toxicological interpretation.

The Problem of Therapeutic, Toxic and Fatal Concentrations

Post-mortem toxicology is not a mechanical comparison between a measured concentration and a table labelled therapeutic, toxic or fatal.

Concentration ranges can overlap because death reflects the interaction of drug, person and circumstance.

Interpretation may be affected by:

- tolerance;
- age;
- body composition;
- renal disease;
- hepatic disease;
- active metabolites;
- pharmacodynamic interaction;
- post-mortem redistribution;
- specimen site;
- decomposition;
- resuscitation;
- survival time;
- incomplete administration history;
- metabolic variability.

A drug detected after death does not automatically establish poisoning. Conversely, a concentration within a published therapeutic range does not prove irrelevance. A sedating concentration may contribute to aspiration, positional compromise, a fall or failure to seek help without independently reaching a traditionally fatal range. Cardiac effects require similar caution.

Several antipsychotics and other psychotropics can affect cardiac conduction. Risk may be modified by:

- dose;
- combination therapy;
- electrolyte imbalance;
- cardiac disease;
- other medications;
- genetic susceptibility.

Population research has associated antipsychotic exposure with increased risk of sudden cardiac death, but individual causation remains a case-specific forensic question. The pathologist and toxicologist should receive the full clinical and custodial chronology. A toxicology request made without the medication list, symptoms, resuscitation history and timing may answer only a narrow analytical question.

Participation In Investigation and Trial

Psychotropic medication can either improve or impair legal participation.

Effective treatment may restore:

- attention;
- reality testing;
- emotional regulation;
- comprehension;
- ability to instruct counsel.

Excessive sedation, cognitive slowing, movement adverse effects or anticholinergic burden may diminish meaningful participation. An accused prisoner's ability to answer questions should therefore not be assessed solely by diagnosis or by the fact that medication has been prescribed.

Relevant functional capacities include:

- understanding the nature of proceedings;
- comprehending questions;

- maintaining attention;
- recalling relevant information;
- evaluating legal choices;
- communicating with counsel;
- recognising consequences;
- remaining sufficiently alert throughout an interview or hearing.

Medication timing may matter.

A prisoner interviewed shortly after a sedating dose may perform differently from the same person later in the day. This does not require routine manipulation of treatment around legal proceedings, but it supports coordination among clinicians, courts and counsel where clinically permissible.

Investigators should also avoid interpreting slowed or fragmented responses as deception without considering medication and mental state. Equally, medication cannot be used as a universal explanation for inconsistency. The expert's role is to assess compatibility and functional effect, not to determine credibility merely from a prescription.

The Custodial Psychopharmacology Accountability Framework

This review proposes a six-domain framework for evaluating psychotropic treatment in custody.

Clinical Indication

The first domain asks why the medicine was prescribed.

A valid record should identify:

- diagnosis or target symptom;
- severity;
- functional impact;
- relevant medical history;
- substance-use history;
- examination findings;
- alternatives considered;
- reason for selecting the medication;
- intended duration;
- expected benefit;
- review date.

A label such as "behavioural problem" is ordinarily inadequate.

The record should explain whether the target was:

- psychosis;
- mania;
- severe anxiety;
- withdrawal;
- insomnia;
- acute danger;
- another recognised clinical problem.

Prescription Integrity

Prescription integrity concerns whether the prescribing process was informed and coherent.

Relevant questions include:

- Was the medication history reconciled?
- Were allergies reviewed?
- Were comorbidities reviewed?
- Were interactions reviewed?
- Were duplicate psychotropics identified?
- Was the prescriber appropriately qualified?
- Was the prescription consistent with available evidence?
- Was off-label use explained?
- Was polypharmacy intended or accidental?
- Was a reduction or review plan documented?

Prescription integrity does not require uniform treatment. It requires that variation be clinically explicable.

Administration Integrity

Administration integrity asks what the prisoner actually received.

It includes:

- dispensing;
- identity verification;
- timing;
- refusal;
- witnessed ingestion;
- concealment;
- vomiting;
- missed doses;
- transfer interruptions;
- diversion;
- emergency administration;
- stock reconciliation.

A prescription without administration evidence establishes authorisation rather than exposure.

Monitoring Integrity

Monitoring integrity concerns whether foreseeable benefits and harms were observed.

Depending upon the medication, monitoring may include:

- mental-state review;
- sedation;
- level of consciousness;
- movement adverse effects;
- weight;
- metabolic monitoring;
- blood pressure;
- ECG;
- laboratory tests;
- hydration;
- bowel function;
- suicide risk;
- treatment response;
- withdrawal signs.

Prison-specific prescribing indicators demonstrate that absence of monitoring and prolonged hypnotic use can be detected through structured clinical audits. Monitoring should therefore be treated as a measurable institutional process rather than as an optional clinical courtesy.

Behavioural Interpretation

This domain requires the institution to separate observation from causal conclusion.

The analysis should consider whether conduct may reflect:

- underlying illness;
- therapeutic effect;
- adverse reaction;
- drug interaction;
- withdrawal;
- non-adherence;
- intoxication;
- pain;
- physical illness;
- trauma;
- environmental stress;
- intentional behaviour.

The purpose is not to medicalise every disciplinary event. It is to prevent medication-related and medical explanations from being excluded without examination.

Medico-Legal Reconstruction

The final domain asks whether the institution can reconstruct events after an allegation, injury or death.

A reconstructable system can show:

- who assessed the prisoner;
- what information was available;
- why treatment was selected;

- what was prescribed;
- what was administered;
- what monitoring occurred;
- what changed;
- when deterioration was first observed;
- how staff responded;
- why transfer or escalation did or did not occur.

Where records are inconsistent, unsigned, retrospectively completed or dispersed across separate systems, accountability becomes difficult even if care was clinically reasonable.

Figure 1: The Custodial Psychopharmacology Pathway

Mental-Health Or Behavioural Need

↓

Clinical Assessment

History • diagnosis • substance use • physical causes • capacity

↓

Prescription Decision

Indication • alternatives • interactions • consent • review plan

↓

Dispensing And Administration

Correct medicine • correct person • timing • refusal • ingestion • diversion

↓

Clinical And Custodial Monitoring

Response • sedation • movement effects • vital signs • laboratory tests • behaviour

↓

Outcome

Therapeutic improvement / non-response / adverse effect / withdrawal / emergency

↓

Medico-Legal Interpretation

Exposure • causation • institutional response • preventability • accountability

Potential failure points exist at every stage:

Incomplete history

↓

Unsupported or duplicate prescription

↓

Administration discrepancy

↓

Inadequate monitoring

↓

Behaviour misclassified as misconduct

↓

Delayed medical response

↓

Incomplete reconstruction after injury or death

Table 3: Minimum Records after a Serious Custodial Adverse Event

Record or Material	Principal Forensic Purpose
Reception medical assessment	Establishes baseline illness, injury, substance use and previous medication

Psychiatric assessment	Identifies indication, capacity, risk and diagnostic formulation
Prescription chart	Shows authorised medicines, changes and intended regimen
Medication-administration record	Shows recorded delivery, refusal, omission and timing
Pharmacy dispensing record	Permits reconciliation of stock and prescribed quantities
Consent or emergency-treatment record	Establishes the clinical and legal basis of intervention
Nursing observations	Documents consciousness, movement, vital signs and emerging symptoms
Custodial behaviour reports	Provides contemporaneous non-clinical observations
Suicide and self-harm assessment	Establishes identified risk and observation decisions
Incident report	Records the event, discovery and immediate response
CCTV and electronic movement data	Tests chronology and staff-response times
Hospital referral and ambulance records	Establishes escalation, transfer and treatment
Laboratory and ECG results	Assesses monitoring and physiological risk
Toxicology	Identifies medicines, substances and metabolites within analytical limitations
Post-mortem report	Determines cause of death and relevant pathological findings
Remaining medicines and packaging	Assists stock reconciliation and overdose investigation
Transfer records	Identifies interruptions and information communicated between institutions

Implementation in Indian Prisons

The proposed framework does not require every prison to operate a specialist forensic-psychiatric hospital. It requires a minimum auditable process that can function at different levels of resources.

Reception Reconciliation

Every newly admitted prisoner reporting psychotropic treatment should receive prompt medication reconciliation. Where immediate verification is unavailable, the record should describe the uncertainty and the interim risk-management plan. Particular attention should be paid to medicines whose abrupt interruption may produce:

- withdrawal;
- relapse;
- seizure risk;
- severe insomnia;
- agitation;
- mood destabilisation.

Multidisciplinary Review

Complex polypharmacy should be reviewed by a team that includes, where available:

- a psychiatrist;
- a medical officer;
- a pharmacist;
- nursing personnel.

Custodial staff may contribute behavioural observations but should not determine clinical necessity.

Pharmacy Involvement

Pharmacists can identify:

- duplication;
- interaction;

- monitoring gaps;
- prolonged hypnotic use;
- non-adherence;
- unexplained stock discrepancies;
- prescribing cascades;
- medicines requiring laboratory monitoring.

Prison-focused research has demonstrated the feasibility of pharmacist-led medication-safety indicators.

Behavioural Observation Training

Prison officers need not diagnose adverse drug reactions, but they should recognise warning signs requiring clinical review.

These include:

- sudden confusion;
- marked change in alertness;
- inability to stand;
- new tremor;
- rigidity;
- severe restlessness;
- collapse;
- breathing difficulty;
- repeated vomiting;
- abrupt behavioural change after medication;
- suspected accumulation or overdose.

Training should emphasise descriptive recording rather than psychiatric labelling.

Periodic Polypharmacy Audit

Prisons should periodically identify prisoners receiving:

- two or more antipsychotics;
- several sedating medicines;
- prolonged hypnotic medication;
- high anticholinergic burden;
- medicines requiring absent laboratory monitoring;
- repeated emergency medication;
- frequent medication refusal;
- recent major treatment changes.

Audit is not a substitute for clinical judgment. It is a mechanism for bringing high-risk records back to professional attention.

Transfer Continuity

A standard transfer summary should include:

- diagnosis;
- current medicines;
- last administered dose;
- recent refusals;
- monitoring results;
- adverse reactions;
- suicide risk;
- pending investigations.

Transfer without this information converts an administrative movement into a clinical hazard.

Independent Review of Serious Events

Where injury, collapse, suspected overdose or death occurs, review should include clinicians not directly responsible for the event wherever feasible. The purpose is not automatic blame. It is to distinguish unavoidable clinical complexity from preventable system failure.

Discussion

Psychotropic medication occupies an unusual position in prisons. It may restore autonomy by treating disabling illness, yet the process of administration may itself restrict autonomy. It may reduce aggression by treating psychosis, yet excessive sedation may create apparent order without meaningful recovery. It may prevent suicide, yet accumulated tablets may provide a

means of self-harm. It may improve legal participation, yet cognitive adverse effects may impair it. This dual character explains why simple ideological positions are inadequate. The proposition that prisons overmedicate difficult prisoners cannot be presumed true in every case. Nor can the existence of a prescription be treated as proof of appropriate treatment.

The correct approach is reconstruction.

International prescribing studies reveal recurring concerns:

- high prescribing prevalence;
- off-label or insufficiently documented indications;
- frequent combination therapy;
- medication interruption at reception;
- diversion;
- inconsistent monitoring;
- tension between care and control.

The recurrence of these problems across different prison systems suggests that they arise partly from the structure of custody itself. Restricted autonomy, security controls, rapid transfers and fragmented information create risks even where individual clinicians act in good faith. India's legal framework recognises prisoners' mental-health needs and the obligation to provide treatment. However, legal entitlement does not itself ensure pharmacological continuity or monitoring.

An institution may formally provide psychiatric services while failing to:

- verify administration;
- record refusal;
- monitor adverse effects;
- maintain continuity during transfer;
- respond appropriately to deterioration.

Accountability must therefore move from the existence of services to the integrity of the medication pathway. The proposed framework treats every stage as a separate evidentiary question. This prevents the common collapse of several propositions into one.

"The prisoner was prescribed an antipsychotic" does not establish that the prisoner had psychosis, took the medicine, benefited from it or was impaired by it. "The chart records administration" does not necessarily establish ingestion. "The concentration was therapeutic" does not necessarily establish that the medication played no contributory role. These distinctions are not technical evasions. They are necessary for accurate clinical and legal reasoning. The framework also protects against the opposite error: attributing every adverse event to medication. Psychiatric illness, illicit substances, natural disease, trauma and intentional conduct remain relevant.

Medication is one component of the causal field. Its significance depends upon timing, exposure, biological plausibility and corroborating evidence.

Limitations

This review does not estimate the prevalence of psychotropic prescribing or polypharmacy in Indian prisons. The paper discusses pharmacological classes rather than individual dosing regimens and is not a clinical prescribing guideline. Adverse effects and withdrawal phenomena vary among medicines within the same class. Individual treatment must remain the responsibility of appropriately qualified health-care professionals.

The proposed Custodial Psychopharmacology Accountability Framework's lies in organising records and questions for clinical governance, research and medico-legal review. Future work

should test its feasibility in Indian prison settings and examine whether it improves monitoring, continuity and serious-event reconstruction.

CONCLUSION

Psychotropic medication is an essential component of humane prison health care, but its custodial use cannot be understood solely as a matter between a prescription and a diagnosis. Medication passes through an institutional chain of assessment, authorisation, dispensing, administration, monitoring and behavioural interpretation. Failure at any point may convert appropriate treatment into ineffective care, unrecognised withdrawal, preventable injury or irreconstructable death. Polypharmacy is not necessarily improper. Its legitimacy depends upon:

- documented indication;
- coordination;
- interaction review;
- monitoring;
- periodic reassessment.

Similarly, behavioural disturbance is not necessarily misconduct, relapse or medication toxicity.

It is an observation that requires differential interpretation.

Indian prison-health practice should therefore preserve six forms of integrity:

- clinical indication;
- prescription integrity;
- administration integrity;
- monitoring integrity;
- behavioural interpretation;
- medico-legal reconstruction.

A prison should be capable of explaining not merely what was prescribed, but why it was prescribed, whether it was taken, what followed and how the institution responded. The governing principle is straightforward:

In custody, behavioural change, self-harm, collapse or death should never be attributed exclusively to criminality, mental illness or misconduct until prescription, administration, interaction, adverse effect and withdrawal have been reconstructed.

Acknowledgements

The author acknowledges the contributions of researchers, clinicians, pharmacists, prison-health personnel and institutions whose published work and official standards informed this review.

Funding

No external funding was received for this work.

Conflict Of Interest

The author declares no conflict of interest.

Ethical Approval

Ethical approval was not required because this article is a review of published literature and official materials and does not involve human participants, identifiable clinical records or experimental intervention.

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HOW TO CITE: Ishaan Joshi[1]*, Psychotropic Polypharmacy In Indian Prisons: Clinical Risks, Behavioural Consequences And Medico-Legal Accountability, Int. J. of Pharm. Sci., 2026, Vol 4, Issue 8, 1720-1746. https://doi.org/ 10.5281/zenodo.21872977