International Journal of
Law, Politics and Governance
ISSN: Applied | https://www.ioro.org/ijlpg

Mental Illness, Criminal Responsibility and Prison Administration: Bridging the Gap Between Law and Healthcare: A Psychological and Socio Legal Study with Reference to India

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Abstract

Mental illness occupies an uneasy position as the intersection of two systems, whose constructions have different intentions. The criminal law poses a question on whether an individual has committed a wrong act, whereas the healthcare question is how an individual can be cured and assisted to recuperate. When an individual with a severe mental illness gets into a confrontation with our legal system, these two questions collide and the location that the collision occurs the most is prison. The paper will discuss the connection between mental illness and criminal responsibility and prison management and will argue that the disparity between the law and healthcare is not only due to limited resources, but a structural aspect of the nature of the two systems. It unites three groups of evidence. The initial one is the epidemiological fact, which has been unchanged over decades and dozens of countries, a serious mental illness is many times more prevalent in the population of prison than in the overall population. Second is the legal doctrine of criminal responsibility, which dates back to the MNaghten rules of 1843 to the current Section 84 of the Indian Penal Code and its recent equivalent, Section 22 of the Bharatiya Nyaya Sanhita, based on a narrow criterion of cognition and excluding much of contemporary psychiatric knowledge. The third is the prison administrative reality, with more and more mentally crippled inmates colliding with a gross lack of trained personnel and legal structure whose assurances are not upheld in every aspect. The paper analyzes these three strands in the concepts of the therapeutic gap, the diversion, and the right to health and suggests that four changes to law, healthcare, and the test of responsibility, the channels that prevent the mentally ill to prisons and the quality of care within the prison itself must be all reformed at once.

Keywords: *mental illness; criminal responsibility; insanity defence; prison mental health; forensic psychiatry; Mental Healthcare Act; diversion; India.*

1 Introduction

The mentally ill offender presents few issues that demonstrate the pressures between law and medicine with which they can be loosely tapped. More than an idea of a responsible agent is the foundation of the criminal law: it is followed by the expression of a person who makes his choice and who can be accused and punished of it in a fair way. Medicine starts in a different aspect, where disordered thought and even mood are a condition that can be learned and alleviated along with not judged. The two frames do not intersect at all most of the time as it is the case with most people. They encounter, and frequently come into conflict, in the tiny though challenging group in which an individual who has a significant mental disorder commits or even

International Journal of Law, Politics and Governance (IJLPG)
Volume 1 | Issue 1 | 2026 | Article ID: 9642-4343-0753 | https://doi.org/10.64823/ijlpg.2601005
IORO Publications · Texas, USA · www.ioro.org

attempts to commit an offense. The law wants to know the question is; is that a person who is not responsible? The question that the healthcare would wish to know is what can be done to treat that person. The two questions are put together in the prison, where typically neither question has been answered to the advantage.

The size of the overlap will not be small. Nearly forty years of extensive epidemiological studies, obtained in dozens of countries, indicates that serious mental illness is much more prevalent within prisons than without prison. A synthesis on 131 studies and a total of almost 59,000 incarcerated individuals in 43 countries has so far concluded that the pooled prevalence of psychosis and depression among people in prison was approximately 4 and 12 to 13 per cent, respectively (Fazel et al., 2025). Prior reviews have come up with similar conclusions and have also included the fact that individuals in prison are also many times more prone to psychosis or major depression and approximately ten times more prone to develop antisocial personality disorder in comparison to the general population (Fazel and Danesh, 2002). In low and middle income nations the numbers are even greater as one of the reviews documented non affective psychosis on average being sixteen times more prevalent in prisons as compared to the general population (Baranyi et al., 2019). The custom is determined, however many there are in a particular place. Prisons contain a concentration of a mental illness which is hard to believe to be anywhere else.

This infusion is no chance. It is the observable manifestation of decisions taken at the upper echelons, in the regulations that define who should be held responsible, in the mechanisms that define who should be side-tracked to care and who should be taken into custody and in the subsequent long abdication of the state into offering mental health treatment within the community. The failure of those upstream systems causes the prison to become—the institution of last resort, taking in the individuals who the hospitals, families, and welfare services couldnot or would not contain. But of the institutions least able to aid them is the prison. It is meant to be secure and orderly rather than therapeutic and in most countries it is permanently out of the trained personnel needed in mental healthcare.

This paper identifies and discusses these three points of intersection between mental illness and the criminal justice system, the doctrine of criminal responsibility, the moment of diversion, and the administration of the prison, and questions how the wide chasm between the law and healthcare could be bridged at each. It leans towards its legal substance primarily Indian law, which is directly based on the English M'Naghten rules and most recently re-codified, and whose prison regime exemplifies a graphic instance of absence of administrative discretion. It maintains the wider international evidence in sight, as even though the details may vary the structural problem is a common one across the jurisdictions. The discussion goes on through seven other steps. Section 2 introduces the literature on the topic and provides the gap in research. Section 3 stipulates the epidemiological and administrative evidence. Section 4 discusses the conceptual framework and the method. In section 5, the doctrine of criminal responsibility is discussed. In section 6, the focus is on administration of prisons and the quality of care. The findings have been discussed in Section 7, and the conclusion in Section 8.

2 Literature Review and Research Gap

2.1 The Epidemiology of mental illness in prison

The earliest and the most well-developed branch is the epidemiological branch. Numerous studies have been conducted to determine the prevalence of psychiatric disorder among prison populations since the systematic reviews of the early 2000s and they have since found it to be elevated on a regular basis. The fact that approximately one out of every seven prisoners will be diagnosed with major depression or a psychotic

disorder has remained consistent in three decades and numerous nations with few or no indication of variability with time (Fazel & Seewald, 2012). Recent publications confirm the trend and elaborate a bit further by revealing a higher prevalence in low and middle income nations and displaying that often, it comes with serious mental illness (Fazel et al., 2025; Baranyi et al., 2019). The thing that this literature demonstrates with no doubt is that the mentally ill offender is no exceptional phenomenon but rather a significant and stable portion of the prison population and this is what makes even more impressive the failure to plan on a portion of that population.

2.2 Criminal Responsibility and the insanity defence

A second area of thought is legal and philosophical relating to the doctrine of criminal responsibility. Its current law remonstrates the House of Lords rulings of 1843 (M'Naghten rules) which assume that every person is sane until proven guilty and that a defendant is justified only when, due to a defect of reason caused by a disease of the mind, he did not know the nature or quality of the act or did not know that the act was wrong (Legal Service India, n.d.). Indian law virtually followed this cognitive test in Section 84 of the Indian Penal Code of 1860 that refers to us lacking soundness of mind, not insanity, but this test is used, and the courts have always asserted that this defence is legal insanity, and not medical insanity (Math et al., 2015). Criticism of this test among scholars is an old thing. Since it is limited to asking whether or not he/she knows, it would not regard disorders that cripple the ability to control or regulate emotion and lack of control over impulse but preserve cognition as well as demand that any judgment is all or nothing and leaves no possibility of partial or diminished responsibility.

2.3 Prison mental health and the therapeutic gap

The 3rd line of examination follows up on what occurs to the mentally ill once they are in. Prison mental health studies refer to a treatment gap between treatment need and supply, which is characterized as having a broad gap in well resourced systems and as having a significantly larger gap in poorer systems. Playing a role in India this literature records a prison population of much more than half a million, increasing number of inmates reported as mentally ill and a long standing shortage of psychiatrists and psychologist to treat them (Gowda et al., 2024). It also follows legal reaction, most notably, the Mental Healthcare Act of 2017, which is the first act to put mental healthcare access and, crucially, assign concrete obligations to the prison authorities, and it documents the ongoing gap between the acts of promise and condition on the ground.

2.4 The research gap

These three literatures hardly converse between each other. The epidemiological work is the quantification of the issue, but not even up to the court or in the cell. The legal scholarship of responsibility often discusses the prison out of scope of the doctrine of responsibility. The prison health literature explains what is going on inside but is mildly inclined to assume the introduction of the mentally ill individuals into custody as a given or how it is that law and diversion generate it. One can afford, however, an account in which the three are related, which interprets the doctrine of responsibility, the practice of diversion and the administration of the prison as elements of the same system, and which poses the question of where the division between law and healthcare is effected and where it may be reinstated. This paper tries to provide such an account though it uses India as its prime example but refers to the rest of the international evidence.

3 The Scale of the Problem: Evidence

It is a good idea to set the principal quantities in parallel before going to doctrine and administration. Table 1 collects the epidemiological data on mental illness within the context of the people in prison based on the key

international syntheses. They are to be interpreted as pooled estimates of many studies and have the traditional warning that they depend on the diagnostic measure and the context. Nonetheless, the trend is clear-cut. Prison has several times the incidence of serious mental illness, and substance use disorders are very frequently co-occurring.

Table 1. Prevalence of mental illness among people in prison, international estimates.

Indicator	Estimate	Source
Psychosis in prison	Pooled prevalence of about 4.1 per cent across 43 countries	Fazel et al. (2025)
Depression in prison	Pooled prevalence of about 12.8 per cent across 43 countries	Fazel et al. (2025)
Relative risk of psychosis	Prisoners several times more likely to have psychosis than the general population	Fazel and Danesh (2002)
Personality disorder	About 65 per cent of male and 42 per cent of female prisoners, including antisocial personality disorder	Fazel and Danesh (2002)
Low and middle-income settings	Non affective psychosis about sixteen times more common than in the general population	Baranyi et al. (2019)
Broad screening estimates	Around one in seven prisoners has major depression or a psychotic illness	Fazel and Seewald (2012)

Source. The data in this table has been taken from Fazel et al. (2025), Fazel and Danesh (2002), Baranyi et al. (2019), and Fazel and Seewald (2012).

The conditions in the Indian jail system reveal the weak reaction of the administration to such a world pattern. India boasts of one of the highest prison populations in the world, majority of whom are undertrial inmates awaiting the end of their cases and the number of individuals classified as mentally ill has been increasing even though professionals have confirmed that the real number is many more than those recorded in the books (Gowda et al., 2024). Table 2 tabulates the picture of the Indian. Administrative gap in figures is the difference between the population of inmates taken to be mentally ill and the number of mental health professionals to treat these individuals.

Table 2. Mental illness and mental health staffing in Indian prisons.

Dimension	Figure	Source
Prison population	About 573,000 people in prison in 2022, a majority of them undertrials	IndiaSpend (2025)
Recorded mental illness (2022)	About 9,084 prisoners, roughly 1.6 per cent, recorded with mental illness	IndiaSpend (2025)
Recorded mental illness (2023)	About 16,503 prisoners recorded with mental illness	IndiaSpend (2025)

Dimension	Figure	Source
Mental health staff	Only about 69 psychologists or psychiatrists sanctioned across 1,330 prisons, with about 25 in post	India Justice Report (2025)
States without a post	25 of 36 states and union territories had not sanctioned a single such post	India Justice Report (2025)
Prison suicide rate (2022)	About 20.8 per 100,000, roughly 67 per cent above the national average	IndiaSpend (2025)

Source. The data in this table has been taken from IndiaSpend (2025) and the India Justice Report (2025).

4 Conceptual Framework and Methodology

4.1 Conceptual framework

The discussion is based on four concepts, which are summarised in Table 3. The former is the difference between the legal and medical insanity, and is the core of the doctrine of responsibility. Legal insanity is a very narrow idea, established by law, and based on cognition, whereas medical insanity is the much broader clinical reality of mental illness. A large part of the trouble in this sphere lies in the fact that the two do not come into coincidence, so that one and the same may be very ill in the view of medicine and most responsible in the view of the law. The second concept is the therapeutic gap; the difference between treatment that the population should get and the treatment that it gets, the gap in prisons being wider than usual.

The third concept is diversion, the system of processes, with the help of which a mentally ill individual subject to criminal justice system is steered out of custody and instead to treatment, both pre-trial and at trial and in sentence. The key that such a question will hinge on is diversion since it determines whether an individual is to be placed in the healthcare system or into the prison system. The fourth concept is the right to health, which as of today is articulated in Indian law as the Mental Healthcare Act of 2017, that shockingly redefines treatment as a discretionary privilege rather than as an obligation on the part of the state that the latter owes to individuals even in custody. These ideas combined enable the paper go back to courtroom to the cell without forgetting the linkage between the two.

Table 3. Conceptual framework and its function in the study.

Idea	Core meaning	Function in this study
Legal versus medical insanity	Law uses a narrow cognitive test; medicine recognises a broad range of disorder	Explains why serious illness does not always excuse and why the gap arises
The therapeutic gap	The distance between mental health need and mental health provision	Names the shortfall of care inside prisons
Diversion	Directing the mentally ill away from custody and toward treatment	Identifies the point where the healthcare and prison pathways divide
The right to health	Treatment framed as an entitlement the state must provide	Sets the legal standard against which prison care is judged

4.2 Methodology

The work is theoretical and artificial. It does not imply new empirical data. It is rather a compilation of three types of material, the epidemiological syntheses on mental illness in prison, the statutory and the case law on criminal responsibility in India applied to the English background, and the coverage on the administration of Indian prisons and mental health staffing and reads them together using the above framework. This procedure is composed of three moves. The former forms the magnitude and form of the issue out of the prevalence and administrative data. The second is the doctrine of criminal responsibility which is used to identify the stage in which law and psychiatry separate. The third looks at how prisons can be administered and what legal obligations mandate this responsibility, to find the place where the right to health can be respected or violated. The analysis is provided in an analytically transferable argument but not in the form of a statistical survey. The only limitation it has is that it utilizes aggregate data and secondary data sources, meaning it is unable to reflect the change between individual prisons or states and that the data is subject to the same uncertainties as previously mentioned, in particular, that official Indian counts of mental illness are more likely to be lower than the true burden.

5 Mental Illness and Criminal Responsibility

It is on criminal responsibility that the law initially makes decisions on the treatment of mental illness, and any decisions made there determine what happens down the line. The principle of the criminal law is, that to make a person guilty, there must be not only a wrongful act but also a guilty mind, in a maxim which says that a wrongful act alone would not make a person guilty, without the concomitant guilt of the mind. When denied the power to have a guilty mind through a mental disorder, a person cannot justifiably be charged and so the law has given a defence. It is the form of that defence, however, that defines the extent of the reality of mental illness in which the law is ready to concede.

5.1 From M'Naghten to Section 84 and Section 22

The contemporary defence is the descendant of the M’Naghten rules of 1843, decided by the House of Lords following the shooting of the (then) British prime ministers private secretary by Daniel M'Naghten who was acting under a paranoid delusion. The applicable rules assume all individuals are sane, and only exonerate a defendant in cases where a flaw in his/her reason by disease of the mind rendered him/her unable to know, or unable to know, what the act was, or able to know, or unable to know, that it was wrong (Legal Service India, n.d.). This cognitive test was enacted into Section 84 of the Indian Penal Code by which Indian law stipulated that nothing is an offence committed by a person that cannot at the time of the commission of the act know the character of the act or that it is wrong or against the law. In July 2024, with the Bharatiya Nyaya Sanhita replacing an existing Penal Code, the identical defence is preserved under the new name of Section 22, a rephrasing of the test to use rather modernised terms and, most importantly, gives notice of consequences in addition to the knowledge of the nature of the action and its unlawfulness in the older version (Math et al., 2024).

5.2 The narrowness of the cognitive test

The main objection to this doctrine is, that it is extremely narrower than the medical conception of mental disorder. The test inquires only about cognition, what the accused knew and it thus absolves an individual only when sickness has impaired knowledge. Nothing it says applies to those disorders that causes the person to know the nature and the wrongness of an act but cannot resist the urge to pull the trigger such that a defendant with a serious illness may remain guilty as long as he or she was aware of what he was doing as well

as knowing that it was wrong. Indian courts have explicit indicated they are dealing with legal insanity and not medical insanity and that simply being abnormal in the head, partially delusional or compulsive behaviour of an individual with psychopathic illness does not constitute a defence (Math et al., 2015). The doctrine is also an all or nothing verdict, justifying no other term of partial responsibility than in certain other systems, of a diminished responsibility, or another, and so that what the graded reality of mental disorder must be forced to fit into is either full guilt or complete excuse, as presented by the law.

These are set against other systems to bring out the point more clearly. The rigidity of M'Naghten was in later relaxed under English law, on which the Indian provision is based, by introducing a partial defence of diminished responsibility of homicide, which qualifies murder as manslaughter in cases where an abnormality of mental functioning substantially affected the capacity of the defendant, despite the fact that the defendant also knew the act was wrong. There is no equivalent, in general, of the Indian law, and thus the entire burden of the mental disorder of a defendant rests on the one narrow arch of Section 84, which has become Section 22. The individual whose sickness was not by destroying the thinking faculty sufficiently to constitute the crime, but, on the contrary, the disease influenced the crime, is not half-recognized by the doctrine, but is, as far as concerns the question of responsibility, considered to be well. Another thing that is not a little technical issue. It determines whether the law will treat huge masses of sick individuals as patients that need treatment or criminals that need to be punished.

5.3 The burden of proof and the problem of evidence

Another challenge is found in evidence. Although the prosecution needs to prove the offence beyond any reasonable doubt, the burden of proving the defence of unsoundness of mind lies on the accused who have to prove on the balance of probabilities that they were legally insane at the specific time of the offence (Math et al., 2015). This is a high guiding-post, and hardest to ascertain where the accused is a pauper and has no former record of mental treatment, because the mind of one must be made to dance one past moment, usually many years after the event, out of what evidence may be obtained to bear on the subject. The consequence is that the defence as such, in practice, will not be successfully raised, and that a significant proportion of persons who have been conditioned to commit an offence by the presence of a serious illness face trial and are convicted and imprisoned instead of getting treatment. Thus the smallness of the doctrine is directly poured into the jail, where some who would have been taken care of in a larger or better provisioned system are sent to prison.

6 Prison Administration and the Standard of Care

When the adjudication of responsibility to go to the prison is made, then the custodial prison decides on what to do to them when they are in the prison. In this case the disconnect between law and healthcare comes at the most tangible level, in the gap between the number of inmates that require the treatment on the one hand, and the number of professionals that can offer the treatment on the other hand. The prison is anti-liberal and anti-control and mental healthcare is at most a supernumerary feature tacked onto a prison the main logic of which leads elsewhere.

6.1 The administrative gap in India

The gap is evident by the Indian figures. With a prison population of more than half a million, and on average mentally ill inmates (around 16,500) rising to about 25 the next year, the country had less than 69 available posts to psychologists and psychiatrists across the 1,330 prisons, of which only around 25 posts were filled, therefore, most states and union territories did not have a single authorised post (India Justice Report, 2025;

IndiaSpend, 2025). The aftermath is evidenced in the number of suicide. The 2022 suicide rate in Indian prisons was approximately two thirds that of the general population and suicide was the cause of the vast majority of unnatural deaths in custody in the previous years (IndiaSpend, 2025). Since such a very small number of inmates are ever adequately screened, the publicly reported prevalence of mental illness practically gives the false impression of only a fraction of the problem that has manifested itself to the resources has been able to identify.

The Indian prison has two characteristics that exacerbate the issue. This is the first, that most prisoners are in fact under-trial, serving until the case is heard, rather than after it is, in the case of a mentally ill individual many years can be spent in jail awaiting a conviction of any sort, and awaiting the form of judgment that trial would have likely motivated. The second is that prisoners are disproportionately represented in the poor and marginalised groups, the very groups with the weakest access to a psychiatric evaluation, insanity defense, and treatment upon release. Poverty, mental illness, and imprisonment thus build up on each other and the lack of care is most significant to those who have less of their own resources. Crowding and isolation, which are prevalent in such an environment are known to deteriorate mental health, so that the prison can breed the ills it is ill prepared to cure.

6.2 The legal framework and its unkept promises

India has not kept quiet on this. The Mental Healthcare Act of 2017 was a true sea change as it comprehends access to mental healthcare as a right, not a privilege, decriminalises the attempt to end your own life, and incurs certain obligations on the state, including the obligation of establising a mental health institution in the medical wing of the prison in at least one state and providing mental illness care to prisoners (Duffy & Kelly, 2019). The challenge is the distance that one is used to between the statute and the ground. On-paper facilities can have no resident doctors and the provision of care comes in conflict with the above-described shortage and availability of professionals and thus the right proclaimed by the law is partially fulfilled in reality (Gowda et al., 2024). The criminal procedure law also introduces additional mechanisms, such as the determination of an accused who is found to be of unsound mind, and dealing with those who are unable to stand trial, but these also require the judgment of psychiatric ability, which the system does not always have.

6.3 Diversion as the missing bridge

The most serious issue is that the system is dependent on the prison to detain people that it was not created to assist as the routes of directing the mentally sick to treatment are fragile or non-existent. At various stages, diversion may take place, at the initial encounter of a person in crisis by officers, when a court decides to remand or permanently refer someone to have their case heard and when a prisoner is detected to be in need of care which they cannot obtain within prison. Many jurisdictions lack the development of these pathways and much of the withdrawing of community mental health services has left the other destinations to which a mentally ill person might have been directed, open. The prison then resorts to defaulting on the institutions and it swallows by default those who no other institution can swallow. The key to bridging the gap between an expression of a right to health as legal and its practicalisation is building real diversion supported by a community service that is able to accept the diverted people.

7 Discussion

The combination of reading the evidence led to three findings. The first one is that the fact that mental illness is concentrated in the prisons is a created phenomenon, rather than a discovered one. It is the ex-post facto outcome of a meager doctrine of accountability, feeble distraction, and the abandonment of community

care, all of which direct the mentally unwell to be taken in custody instead of being given treatment. Since it is the design of the system that creates the concentration, we can in theory alleviate it by redamandering the system, a more promising answer than to accept the issue as being an immutable part of the prison environment.

The second conclusion is that there is a mismatch in agenda between law and healthcare not by under-funding alone. That doctrine of criminal responsibility poses a narrow cognitive enquiry which most of current psychiatry cannot answer as required by the law, such that an optimally-resourced court would still convicted persons whose offending was motivated by disorders not identified by the test. Money will never help bridge a rift that is ingrained in the categories that the two systems operate in. To seal it, the law itself must broaden its test, and free up to graded responsibility, rather than just to recruit more clinicians.

The third conclusion is that the right to the health, which is currently enshrined in the Indian law, is still a far-fetched one within the prison. The Mental healthcare act gives you the assurance that you will receive care but the staffing numbers tell you that this is not the case and the suicide numbers reveal the price that is paid by humanity because of the deficit. The disjunction between the statute and the cell is the area of reform that needs to focus on. The combined finding of these results leads to one conclusion. Making law and healthcare meet is not a occupational endeavor that can be done under one site. It needs the concurrent reformation of the test of responsibility, the routes of diversion, and the level of care within custody, as an improvement in one area will be nullified with failure in the other areas.

8 Conclusion and Directions for Future Research

This paper has been able to suggest that mental illness, criminal responsibility and prison administration are all one and the same issue and that the loophole between the law and healthcare is created at the points of interaction. Epidemiological data indicate that serious mental illnesses occur in prisons severally more frequently than in the community (Fazel et al., 2025). The criminal responsibility doctrine, which inherited the M'Naghten rules and was brought by the relatively minor Section 84 of the Penal Code into Section 22 of the Bharatiya Nyaya Sanhita, is based on a narrow test of cognitive functioning which excludes a significant proportion of psychiatric reality (Math et al., 2024). And the prison administration, in spite of the prospects of the Mental Healthcare Act of 2017, faces an increased number of mentally ill inmates with a scarcity of care (India Justice Report, 2025; IndiaSpend, 2025). The three failures enhance each other and none of them can be fixed separately.

Some guidelines on continual work are outlined below. The most urgent is meticulous empirical studies within the Indian prisons that quantifies the actual rate of mental illness using clinical examinations instead of administrative data, to enable the determination of the magnitude of the iceberg. The second line would assess the distance the responsibilities stated by the Mental Healthcare Act have been finished in reality and which plans have managed to provide care. A third would examine the responsibility of crimes, how this has been applied to address a question by the Indian courts about Section 84 and now with Section 22, and whether a broader test which acknowledges impaired control and reduced responsibility better addresses the question of justice. A fourth would model and experiment diversion models that would be Indian-appropriate, interconnecting police, courts, and community mental health services so that less seriously ill population comes to the prison in the first place. In every direction is the same guiding principle. An individual whose infraction is bound to mental illness is now an offender and a patient and a righteous system must respond to the two 1descriptions concurrently and cure and prosecute, and construct the bridge between law and healthcare that so commonly does not exist nowadays.

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