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ISSN: 2582-6433

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ISSN: 2582-6433

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ISSN: 2582-6433

CRIMINAL LIABILITY VS. MENTAL HEALTH: A STUDY OF INDIA JUDICIAL APPROACH POST-MENTAL HEALTHCARE ACT, 2017

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INTRODUCTION:

The intersection of criminal liability and mental health presents a complex legal challenge in India, where legal reforms often outpace implementation. The Mental Healthcare Act, 2017 introduced a rights-based, person-centric approach to mental health, aiming to improve how courts assess criminal responsibility in mentally ill offenders. While Section 84 of the IPC/Section 14 of BNS and Sections 328–339 of the CrPC/Section 369 to 378 of BNSS provide legal and procedural bases, their application remains inconsistent due to poor medical assessments, lack of trained personnel, and limited awareness. The MHCA redefines state obligations, promising equal legal capacity, access to treatment, and protection from inhumane conditions. However, its impact on criminal adjudication remains limited and under-studied. This research examines these gaps and draws on comparative models to strengthen India's mental health jurisprudence.

AIM OF THE RESEARCH:

The aim of this doctrinal research is to critically examine the Indian judiciary approach to criminal liability in individuals with mental illnesses following the passage of the Mental Healthcare Act of 2017, with a focus assessing the incorporation of rights-based principles, the implementation of procedural safeguards under Cr.P.C/BNSS, and drawing insights from international standards to strengthen legal and institutional responses. It adds to the greater discussion of mental health, legal change, and access to justice for the most vulnerable sections of society.

ISSN: 2582-6433

RESEARCH QUESTIONS:

1. How has the Indian judiciary interpreted and applied criminal liability in cases involving mentally ill offenders post the enactment of the Mental Healthcare Act, 2017?
2. Does the current judicial approach adequately incorporate the rights-based framework introduced by the MHCA, 2017, especially concerning criminal responsibility and fair trial rights?
3. Are the procedural safeguards under CrPC and BNSS followed in practice? Despite statutory recognition of mental illness, why does the criminal justice system often fail to properly identify, evaluate, and treat mentally ill and vulnerable accused persons in practice?

RESEARCH METHODOLOGY:

The researcher conducts doctrinal research after exploring primary and secondary sources such as statutes, enactments, legislations, case laws, bills, national and international conventions, acts, policies, rules, regulations, law books, journals, articles, and newspapers. The present research paper is based on the the Indian judiciary approach to criminal liability in cases involving mentally ill offenders after the enactment of the Mental Healthcare Act, 2017, with a focus on assessing the incorporation of rights-based principles, the implementation of procedural safeguards under CrPC and BNSS. The researcher of the project also made a comparative analysis of the status and application of the doctrine in various countries with the help of Indian and English Case laws.

WHO ARE "MENTAL ILLNESS" UNDER INDIAN LAW:

The term "mental illness" has a clear legal definition and implications. Section 2(s) of Mental Healthcare Act, 2017 defines *mental illness* as “A substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence[1]”

[1] Section 2(s) of Mental Health Care Act,2017

ISSN: 2582-6433

A person with mental illness is someone who:

1. Suffers from a diagnosable mental disorder, such as:
    a) Schizophrenia
    b) Bipolar disorder
    c) Severe depression
    d) Psychosis
    e) Anxiety disorders (in serious forms)
    f) Substance-induced mental disorders
    g) Other severe cognitive impairments
2. Experiences impaired judgment, perception, behaviour, or reality recognition.
3. Needs treatment or care to function in society due to the illness.

CRIMINAL LIABILITY IN PERSONS WITH MENTAL ILLNESS:

Criminal liability is the moral responsibility for committing a crime. Persons with mental illnesses may be excluded from criminal culpability under Indian law if their mental state prevents them from understanding the nature, wrongfulness, or consequences of their actions at the time of the offense.

Section 84 of the Indian Penal Code (IPC)/BNS

> *"Nothing is an offence which is done by a person who, at the time of doing it, by reason of unsoundness of mind, is incapable of knowing the nature of the act, or that he is doing what is either wrong or contrary to law*[2]*"*

The person must be of unsound mind (mentally ill) at the time of the offence. Due to this unsoundness, they must be incapable of understanding 1) the nature of the act, or 2) that it was improper, or 3) That it was illegal. This has its foundation on the M'Naghten Rule, which derives from English common law. As a result, a person suffering from mental illness may or may not be immune to criminal prosecution. Hence, A person with mental illness may or may not be exempt from criminal liability. It depends on whether the mental illness affected their cognitive ability at the time of the act. Whether there is medical and legal evidence proving their state of mind. Not all mentally ill persons are exempt. Only those who meet the legal test under Section 84 IPC can avoid liability.

[2] Section 84 of India Penal Code

ISSN: 2582-6433

HISTORICAL EVOLUTION OF MENTAL ILLNESS RIGHTS:

a) Colonial Era: Lunacy Acts (1858–1912)

The earliest laws were rooted in British colonial policies, designed primarily to control and confine individuals with mental illness rather than treat or rehabilitate them.

Lunatic Removal Act, 1851

Indian Lunatic Asylum Act, 1858

Indian Lunacy Act, 1912

These laws allowed for the institutionalization of mentally ill persons, often through police or magistrate orders, without due regard to their rights or medical needs. Its focus on Public safety and confinement, not care or recovery.

b) Post-Independence Period: Medicalization and Institutional Care

The Indian Lunacy Act, 1912 continued post-independence, labeling individuals as "lunatics" and reinforcing stigma. Institutions remained custodial, with little focus on treatment or legal personhood.

c) Mental Health Act, 1987: Beginning of Reform

This Act modernized language and introduced procedures for psychiatric care and limited rights like appeal against wrongful admission. However, it remained institutional, lacked a human rights focus, and ignored community-based care.

d) Paradigm Shift: UNCRPD and Rights-Based Advocacy

India ratified the UNCRPD in 2007, promoting dignity, equality, and autonomy for persons with mental illness. It called for legal reforms to recognize their legal capacity and human rights.

e) Mental Healthcare Act, 2017: Rights-Based Legal Framework

The MHCA 2017 replaced the 1987 Act, ensuring access to quality care, legal aid, advance directives, and protection from inhumane treatment. It emphasizes community care, decriminalizes suicide, and upholds dignity and autonomy.

THE TRIAL PROCEDURE FOR A PERSON AFFECTED BY MENTAL ILLNESS:

Section 100 of Mental Health Care Act 2017, deals with the duties of police officers in respect of persons with mental illness. Every officer in-charge of a police station shall have a duty[3]-

[3] Section 100 of MHCA 2017

ISSN: 2582-6433

- Provide protection for anyone discovered wandering who appears mentally ill and unable to care for themselves. Take into protection anyone who appears to be a danger to themselves or others because of mental illness.
- The investigator must inform the person (or their nominated representative) why they are being brought into protection, especially if the person cannot understand.
- The person must be taken to a public health centre within 24 hours for medical assessment. Under no circumstances should the person be put in a police lockup or jail.
- The medical officer must ensure the person is assessed and given appropriate care as per the Act. If the medical officer finds the person does not need admission, the police must take them home or to a government shelter if homeless.
- If the person is homeless or wandering, the police must file a **missing person FIR** and try to locate and inform their family.

Section 105 of MHCA Act 2017 deals that "If during any judicial process before any competent court, proof of mental illness is produced and is challenged by the other party, the court shall refer the same for further scrutiny to the concerned Board and the Board shall, after examination of the person alleged to have a mental illness either by itself or through a committee of experts, submit its opinion to the court[4]".

Criminal Procedure Code (CrPC) 1973 and BNSS, which deal with the procedure for trial of persons of Mental illness persons/unsound mind (Sections 328 to 339) following:

- If a Magistrate believes an accused is of unsound mind and cannot defend themselves, the court must have them medically examined.
- If unsoundness of mind is suspected during sessions trial, the court will postpone proceedings and arrange medical examination.
- If the accused is found mentally ill and incapable of defence, the trial is postponed. The person may be released on bail if treatment and care can be ensured, otherwise sent to a mental health facility.
- When the accused recovers, the trial resumes. If the accused becomes mentally ill during trial, proceedings are suspended until recovery.
- If a mentally ill person committed an offense but is unfit for trial, the court records evidence and may order appropriate care. If the court finds the accused committed the

[4] Section 105 of MHCA 2017

ISSN: 2582-6433

act but was mentally ill, it does not pass a normal sentence. Instead, it considers mental health care and public safety.

- Court may order detention in a mental health facility or release the person under supervision, depending on the case.
- The state government must ensure regular reports and care of such persons detained under Section 335. The court can order release if a detained person recovers and is no longer a danger. If a person regains sanity, they can be called back to face trial.
- The Magistrate or court may supervise and report on the condition and treatment of the mentally ill accused.

3.3 JUDICIAL APPROCH POST MENTAL HEALTH CARE ACT 2017:

In the case of ***Kanhaiya v. State of U.P.,***[5] the Allahabad High Court addressed the issue of granting bail to an accused person suffering from mental illness. The Additional Sessions Judge had earlier refused to grant bail, reasoning that continued detention was in the best interest of the accused to facilitate proper psychiatric treatment. It was noted that the medical professional at the Mental Hospital in Varanasi had confirmed that the accused was of unsound mind, prompting the court to issue a custody warrant for his treatment at that facility. The Judge concluded that there were no sufficient grounds to justify bail and rejected the application under Section 330 of the Code of Criminal Procedure through an order dated 09.11.2017.

The accused, dissatisfied with the decision, petitioned the High Court under Section 439 CrPC for regular bail. However, the Allahabad High Court dismissed the case, stating that such an application was not maintainable. The Court made it clear that bail under Section 439, which is applicable in general criminal matters, is essentially different from relief under Section 330 CrPC, which is especially applicable to persons of unsound mind. The High Court highlighted that Section 330 prioritizes the health and medical care of mentally ill accused individuals over their quick release.

Vivian Rodrick v. State of West Bengal,[6] The Hon'ble Supreme Court ruled that if an accused individual is determined to be of mentally ill person, it is fair to assume that they will be unable to defend themselves during an appeal. The Court asserted that such an individual must be granted the same legal protections as would have been applicable if the mental incapacity had

[5] Cr.Misc.Bail.Application No:3417/2018
[6] 1971 AIR 1584

ISSN: 2582-6433

existed during the trial itself. This decision reinforced the principle that even mentally ill convicts retain the right to legal remedies. The judgment emphasized the importance of fairness and procedural safeguards throughout all stages of the legal process, highlighting that mental illness must be addressed continuously—not just at the trial stage—to uphold the principles of justice and due process.

Similarly, in ***Abdul Latif v. The State of Assam***,[7] The Gauhati High Court dealt with a case where the defence of insanity was raised by an individual convicted of murdering a young child. While evaluating the accused's behaviour immediately after the incident, the Court observed that he remained indifferent, unaware of the gravity of his actions, calmly ate his meal, and slept soundly. The Court noted that such behaviour was inconsistent with that of a sane individual who had just committed such a heinous act. Based on the facts, the Court concluded that: (i) The accused was medically identified with chronic mental illness, and (ii) he was mentally disturbed at the moment of executing the act, unaware of the repercussions.

In the case of ***Gopal Nair v. State of Kerala***[8], the Hon'ble Supreme Court examined whether the death penalty was appropriate for an accused who had committed murder and had a known history of mental disturbance. Although it was conclusively established that the accused was responsible for the murder of one Gouri Amma, the Court found that he could not avail the protection under Section 84 of the Indian Penal Code, 1860, which deals with legal insanity. Nevertheless, the Court chose not to award the death sentence. It observed that while the accused's condition did not meet the threshold of insanity in the legal sense, he was suffering from a mental obsession that significantly altered his cognitive functioning compared to that of an ordinary individual. The Court reasoned that his reaction might have been different had he not been mentally affected, suggesting that his mental state impaired his ability to process the situation with normal judgment.

Taking a rational and humane approach, the Court carefully analysed all relevant circumstances and opted for a reduced punishment under Section 302 IPC, instead of the capital sentence. This ruling underlines the judiciary's recognition of psychological impairment as a relevant factor during sentencing, even in the absence of a successful insanity defence. It strikes a nuanced balance between the principles of justice and compassion, acknowledging that mental

[7] 1981 Cri LJ 1205
[8] AIR 1973 SC 806

ISSN: 2582-6433

health issues—though not amounting to full insanity can still diminish criminal culpability.

Niman Sha v. State of Madhya Pradesh[9], Niman Sha, the accused, fought with his father before attacking and killing two ladies, Nanjo Bai and Jhini Bai, via an axe. The trial court convicted him of murder and sentenced him to death. The case was referred to the Criminal Procedure Code for confirmation of the death sentence, and the accused filed an appeal against the verdict. Throughout the proceedings, questions were expressed about the accused's state of mind, but the trial court conducted no extensive investigation or medical evaluation. A key issue before the Court was whether the defence of legal insanity under Section 84 of the IPC was applicable in this case. The failure of the lower court to adequately investigate the accused's state of mind, cast serious doubt on the fairness at trial process.

The Supreme Court ultimately held that the accused was entitled to the benefit of Section 84 IPC, recognizing his mental illness. However, considering the gravity of the offense and the potential threat he posed to society, the Court declined to release him outright. Instead, invoking Section 335(1)(a) of the Cr.P.C, the Court directed that the accused be confined to the Mental Health Institute at Gwalior until such time as he regains sanity and is deemed fit for release. This judgment underscores the importance of carefully evaluating claims of mental illness in criminal trials. While the Court acknowledged the applicability of the insanity defences, it also prioritized societal protection and the need for psychiatric care. The decision reflecting a balance legal approach—ensuring both are the justice and treatment of mental health by substituting punitive incarceration with custodial psychiatric rehabilitation.

Shrikant Anandrao Bhosale Vs. State of Maharashtra[10]

The Accused, Shrikant Anandrao Bhosale a police constable. He killed his wife by strangling heer with a nylon rope. The accused pleaded insanity under section 84 of IPC. It was argued that the accused had a history of mental illness (paranoid schizophrenia). Evidence included medical reports, prior treatment, erratic behaviour, and witness statements about his mental condition. The prosecution side argued that the act was deliberate and intentional. The Supreme Court of India acquitted the accused by granting him the benefit of Section 84 IPC. The Court held that “The evidence clearly pointed towards the fact that the accused was suffering from paranoid schizophrenia at the time of the commission of the offence and hence was incapable

[9] 1997(1) MPCJ 536
[10] W.P (C) 3190/2021

ISSN: 2582-6433

of knowing the nature of the act or that it was wrong or contrary to law.[11]"

The judgment reaffirmed that medically proven mental illness can be a valid legal defence if it impaired the accused's understanding at the time of the offence. The Court emphasized compassion and focused on the mental state during the incident. It strengthened jurisprudence under the Mental Health Act, 1987, and continues to guide interpretation under the 2017 Act.

The Mental Healthcare Act, 2017 mandates police and medical officers to ensure proper assessment and care of individuals with mental illness, especially during arrest and custody. Section 100 requires protective custody for those unable to care for themselves. Medical officers must certify mental fitness before remand. A case in Tirunelveli highlighted the consequences of failing to diagnose bipolar disorder, leading to suicide. The judgment revealed systemic gaps and emphasized the need for compassionate, legally sound treatment of mentally unstable persons in custody**.**

THE ROLE OF COURTS IN ENFORCING AND REVIEWING THE MENTAL HEALTHCARE ACT 2017

The Indian judiciary has not only followed the exact words of the Mental Healthcare Act, 2017 (MHCA) but also focused on its purpose and spirit. The courts play a responsible role in making sure the Act was properly implemented and reviewed. Key parts of the Act, like setting up Mental Health Review Boards (MHRBs) and State Mental Health Authorities (SMHAs), were necessary for its success. When some states failed to establish these bodies, the courts stepped in and gave directions to ensure they were created.

For example, in 2019, the Delhi High Court sent a notice to the SMHA of Delhi asking why Review Boards had not yet been formed. In 2020, the Karnataka High Court asked the state government about the delay in setting up the Authority of State Mental Health. Similarly, in Punjab and Kerala, courts ordered the state governments to form review boards after petitions were filed. Most recently, on August 2, 2023, while hearing two petitions about MHCA implementation, the Delhi High Court called for the Health Secretary of Delhi and expressed disappointment that the State Mental Health Authority had still not been set up under MHCA 2017 and the related Rules of 2018.

[11] W.P (C) 3190/2021

ISSN: 2582-6433

Another case of **Dr. Sangamitra Acharya & Another v. State (NCT of Delhi)**[12], The court asked the police to develop guidelines with the assistance of mental health and legal specialists. These instructions were intended to raise knowledge about the Mental Healthcare Act, particularly the sections dealing with the rehabilitation of homeless people with mental illnesses. The court also said that the Central Government and the State Mental Health Authority (SMHA) should work together with state judicial academies to organize regular training programs. To better understand and support individuals with mental illness, these programs should involve police officers, attorneys, judges, resident welfare associations, and civil society organizations.

Shikha Nischal v. National Insurance Company Limited & Anr[13]**.** The Delhi High Court said that people with mental illness (PMI) have the right to health insurance, whether from a private or government company. The petitioner's insurance company refused to pay for the treatment of his mental ailment, so the court ordered the company to pay her ₹25,000. After this case, the Insurance Regulatory and Development Authority of India (IRDAI) was told to make sure all insurance companies follow Section 21 of the MHCA, 2017.

In March 2023, the Supreme Court, while hearing the case ***Gaurav Kumar Bansal v. Mr. Dinesh Kumar (2018)***[14], noted that many people are kept in mental health facilities for long periods. The court said it would take steps to ensure that proper rehabilitation homes and halfway homes are set up soon.

In another case, ***Shankar Sopan Shikare v. The State of Maharashtra***[15], A individual suffering from mental illness was granted bail by the Bombay High Court and ordered to be admitted to a mental health hospital for treatment and care. The court further noted that the Maharashtra government had yet to make guidelines under Section 121 of the Act. The court faulted the police, jail officers, and lower courts for failing to comply with the Mental Healthcare Act of 2017. It also addressed the financial, emotional, and social challenges that relatives of people with mental illnesses experience.

[12] W.P (Crl) 1804/2017
[13] AIR 2002 SC 3399
[14] Contempt Petition 1653/18 in W.P (C) No;412/2016
[15] LAWS (BOM) – 2020-12-352

ISSN: 2582-6433

ANALYSIS FROM THE JUDICIAL PRONOUNCEMENT:

The above cases reflect strong judicial activism, showing that despite the shortcomings of the Mental Health Act, 1987 in safeguarding the rights of persons with mental illness (PMI), Indian courts have taken significant steps to address these issues. The judiciary has worked toward improving the functioning of mental health institutions, their management, staff structure, and ensuring the right of PMI to work and earn a livelihood. Through such proactive efforts, courts have consistently upheld and promoted the rights of PMI in various situations. In some instances, state governments were directed to ensure that at least one mental health hospital exists in every state and to treat all PMI including those in institutions, prisons, communities, and even the homeless with dignity and compassion.

The new laws, including the Mental Healthcare Act (MHCA) of 2017, has filled many of the gaps that were previously identified by the courts. It addresses issues like social stigma, the importance of safeguarding the rights of PMI, rehabilitation for recovered individuals, raising public awareness about mental health, and establishing regulatory bodies at national, state, and district levels. These developments clearly highlight the critical role of court judgments in shaping mental health policies and legal reforms.

At present, one of the judiciary's key responsibilities is to monitor government agencies and ensure that the MHCA 2017 is implemented both effectively and faithfully. The responsibility now lies with the executive branch to act decisively and put into operation the various provisions of the Act to protect the rights of PMI. The courts, by interpreting the legal framework, and the legislature, by creating rights-based policies, have both played commendable roles in defending and advancing mental healthcare rights. Ultimately, a nation cannot be considered truly healthy unless its citizens are both physically and mentally well-equipped to function in everyday life.

CHALLENGES OF IMPLEMENTATION OF MHCA 2017:

There are several significant gaps and challenges in its implementation,

a) Lack of Infrastructure and Trained Professionals

Psychiatric nurses, psychiatric social workers, clinical psychologists, and psychiatrists are in low supply in India. According to the World Health Organization, India has approximately 0.3 psychiatrists per 1,000,000 people. restricts the availability of high-quality mental health care,

ISSN: 2582-6433

particularly in rural locations.

b) Poor Awareness and Stigma

Lack of awareness among the public and even healthcare providers about rights under the Act. Patients may not know they can give informed consent, access free treatment, or appeal involuntary admissions. Police, judiciary, hospital staff, and community health workers are often unaware of patient rights under MHCA. Training modules for implementing authorities, especially in district hospitals and primary health centres, are either inadequate or absent. Mental illness remains heavily stigmatized, leading to: Family abandonment. Social exclusion and marginalisation. Delay in seeking help due to fear of discrimination.

c) Inadequate Implementation of Mental Health Review Boards (MHRBs)

The Act mandates the creation of MHRBs in each district, but many states have yet to constitute them. No checks and balances on involuntary admissions or violations of patients' rights. State Mental Health Authorities (SMHAs) are either not formed or not fully functional in many states.

d) Limited Budget Allocation

The mental health budget is less than one percent of the total health budget. There is no clear budgetary plan provided by states or the Centre for properly fulfilling the rights protected under the Act.

e) Challenges in Ensuring Rights-Based Approach

The Act emphasizes informed consent, autonomy, and dignity, but Families often bypass patient consent due to stigma or urgency. Patients' rights to refuse treatment are not respected in practice. Advance Directives and Nominated Representatives are not widely understood or implemented.

f) Lack of Integration with Criminal Justice System

Persons with mental illness in conflict with the law often face: Delayed diagnosis and treatment in prisons. Lack of coordination between mental health institutions and judicial/correctional institutions.

ISSN: 2582-6433

RESEARCH GAP ANALYSIS:

1) Inadequate access to mental health facilities:

Both legal and ethical standards mandate that incarcerated individuals receive mental healthcare equal to or better than that available to the general population, prisons frequently fall short due to insufficient resources, inadequate infrastructure, and There is a shortage of skilled mental health providers. The situation is further aggravated by the absence of proper psychiatric care, restricted access to essential medications, and poor coordination with public hospitals. As a result, the psychological needs of inmates remain largely neglected, and there is no structured system in place to ensure continued mental health support after their release. This scenario calls for the urgent implementation of the District Mental Health Programme within the prison system, along with the development of a comprehensive and sustainable framework to guarantee timely and adequate mental healthcare for inmates.

2) Absence of mental health disorder identification and early detection:

Another key concern among mentally sick offenders is a lack of early diagnosis and identification of mental health illnesses among prisoners. This often leads to delayed or poor treatment. Research shows that when the mental illness offenders are admitted, they usually go through only a physical health check-up, while their mental health is not assessed. Without early detection, prisoners do not receive the help they need in time, which violates their right to proper mental healthcare. This highlights the need to set up a special mental health screening unit within prisons. This should carry out a complete mental health evaluation of every inmate at the time they enter the prison.

3) Lack of behavioural therapy programme:

This creates a serious problem for their successful reintegration into society and increases the chances of them repeating criminal behaviour. In many cases, mental illness offenders do not receive proper behavioural therapy to help them manage issues like anger, stress, and impulsive actions. Also, there is no personalised support such as life skills programme, counselling to the family, or cognitive behavioural therapy, which are important for their rehabilitation. This shows the necessary need to a complete behavioural therapy program inside prisons to support the mental well-being and social reintegration of inmates.

4) Lack of collaboration with several departments:

The issue stems from a lack of coordination among the various ministries and organisations in

ISSN: 2582-6433

charge of prisoners' mental health and welfare. The inability of these groups to collaborate effectively makes it extremely difficult to address issues that require the cooperation of the law department, jail officials, human rights organizations, social welfare services, and the health and family welfare departments. This poor coordination also leads to weak services and poor support for prisoners, both before and after they are in jail. There are many reasons for this failure, and one big reason is the shortage of resources and skilled staff to manage the work properly.

6) Issue of Separate Healthcare Staff Recruitment:

Mental illness offenders face a serious lack of medical staff and resources. Hiring full-time doctors or psychiatrists is difficult, and temporary setups are inadequate. Telemedicine is rarely used, and basic medicines are often unavailable. This poor healthcare system leads to preventable illnesses and early deaths among inmates.

FINDING:

- In January 2023, the NHRC found serious issues in all 46 government mental health institutions, including poor services, rights violations, staff shortages, and illegal detention of recovered patients. Suo motu action was taken, and notices were issued to health authorities. The NHRC criticized the failure to uphold rights under the MHCA 2017 and international standards, highlighting the ongoing lack of proper care despite legal protections.
- The MHCA 2017 guarantees equal, quality mental healthcare and protection from discrimination for persons with mental illness (PMI), including the right to health insurance. However, over 36% of patients in state hospitals remain institutionalized for over a year, showing serious implementation failures.
- The MHCA 2017 mandates states to establish Mental Health Authorities and Review Boards, but most are non-existent or inactive. High setup costs (₹1 crore annually per authority) have limited their implementation, with only a few states having active bodies.
- Though the Act shifts care responsibility to the state, only 0.05% of the 14 crore people needing mental healthcare are supported by institutions; over 99% rely on families. The Act also directs police to assist neglected PMI by informing a magistrate, arranging medical exams, and ensuring temporary care or shelter.

ISSN: 2582-6433

- Section 18(2)(b) of the MHCA 2017 mandates states to set up halfway homes for discharged patients needing continued care. But due to the absence of such facilities, many end up in old-age or beggar homes, where proper care is lacking.

RECOMMENDATIONS:

Based on the review of existing literature from books, research articles, government data, online resources, and databases, as well as an analysis of MHCA 2017 in the balance of criminal liability and the researcher makes the following recommendations.

1) **Robust application of mental health legal provisions is needed:**

   The Act's broad definition of 'mental illness' is seen as problematic, focusing on illness over the individual. Dr. J.T. Antony argues it lacks legal clarity, making enforcement difficult. Terms like 'mental health facility' are also too vague, risking misuse. Provisions like advance directives assume all patients can make informed choices, which may not apply to severe cases like paranoid psychosis. Clearer definitions and tailored safeguards are needed for effective implementation.

2) **Need to Create Awareness in the society:**

   Mental illness is still stigmatized in society, though most people believe it deserves the same compassion as physical illness. In India, stigma-reduction training for health workers is often ineffective. While face-to-face interaction with mentally ill individuals reduces stigma, it's not always feasible. Instead, audio-visual stories and indirect contact have proven effective and practical for training and awareness programs.

3) **Primary Health Care needs to be Strengthen for Early Detection:**

   Early detection and treatment of mental illness require integrating mental health into primary care. This needs trained staff, family involvement, and community-based support. Early intervention, especially for schizophrenia, improves outcomes. Global research and Asian models support this approach.

4) **Role of Government and NGO's:**

   Across India, numerous government agencies and non-governmental organization are implementing creative initiatives to tackle mental illness, along with related challenges such as gender-based violence, homelessness, and substance abuse. For these efforts to bring about lasting change, they need to be expanded on a wider scale. One notable example is *The Banyan*, a Chennai-based NGO leading in mental healthcare for vulnerable women. It has developed innovative service models and is actively expanding its impact by collaborating with universities and government bodies nationwide. At the

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same time, it is essential for the government to evaluate, support, and strengthen such initiatives. Social and health workers urge the government to prioritize mental health care across India. They suggest introducing high-interest India Relief Bonds to support NGOs working with mentally ill persons. Psychiatrists play a vital role in advocating for better mental health policies and ensuring their effective implementation.

5) **Use of Expert Panels in Trials:**

Mandate courts to consult multi-disciplinary mental health expert panels (psychiatrists, psychologists, social workers) in cases involving the insanity defence or diminished responsibility, ensuring informed and fair judicial outcomes. Provide specialized legal aid units trained in mental health law to represent mentally ill accused persons, ensuring fair trial rights are upheld throughout the criminal process.

6) **Rehabilitation-Oriented Sentencing:**

In cases where criminal responsibility is diminished but not eliminated, courts should prefer rehabilitative sentencing, such as psychiatric supervision, community service, or monitored treatment programs over incarceration. Develop formal diversion programs for mentally ill accused charged with non-violent or petty offences, directing them to treatment and rehabilitation instead of trial or imprisonment. Leverage Section 115 of MHCA, 2017, which decriminalizes suicide attempts, to argue for leniency or treatment-first approaches in related offences.

CONCLUSION:

This study concluded by critically analyzing the criminal liability of people with mental illness and the right to mental health, with a focus on the application of the Mental Healthcare Act of 2017. The analysis finds a wide disparity between the Act's legislative objective and its execution, particularly inside the detention system. The main concerns include inadequate mental health infrastructure, a shortage of psychiatric treatment facilities, and an insufficient number of skilled professionals to manage mental health difficulties in mentally ill criminals. Despite the progressive vision of the Act, several structural and operational shortcomings were identified. Notably, many prisons across India lack designated medical or mental health units, and several provisions of the Act remain unimplemented. Moreover, there is an absence of post-treatment rehabilitation for mentally ill offenders.

The recommendations proposed in this study aim to bridge these gaps by advocating for accessible, holistic mental healthcare, early diagnosis, and effective treatment for issues such

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as addiction and suicidal tendencies. Collaboration with non-governmental organizations (NGOs) and mental health organisations is critical to ensuring that these reforms are effectively implemented. Finally, this thesis highlights the critical need for institutional upgrades in India's criminal justice system. These reforms must focus mental health and foster a more humane and rehabilitative environment that adheres to national and international human rights norms.

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