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CRIME AND MENTAL ILLNESS: A CRITICAL LEGAL ANALYSIS OF CRIMINAL RESPONSIBILITY, RIGHTS, AND INSTITUTIONAL RESPONSES IN INDIA

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Abstract

The relationship between crime and mental illness presents a profound challenge to criminal jurisprudence. The doctrine of criminal responsibility presumes rational agency, yet psychiatric impairment may undermine cognition, volition, and moral judgment. With the enactment of the Bharatiya Nyaya Sanhita, 2023 (BNS), Section 22 now governs the defence of mental incapacity, replacing Section 84 of the Indian Penal Code. While the statutory language preserves the classical cognitive test derived from the McNaughten Rules, contemporary psychiatric knowledge, constitutional developments, and empirical realities within Indian prisons demand a re-evaluation of how criminal responsibility is assessed and institutional responses are structured. This paper undertakes a comprehensive doctrinal, constitutional, empirical, and institutional analysis of criminal responsibility in cases involving mental illness in India. It examines Supreme Court jurisprudence on insanity, evaluates evidentiary burdens under Section 22 BNS, analyses prison mental health statistics, assesses forensic psychiatric limitations, and interrogates the interface between criminal law and the Mental Healthcare Act, 2017. Drawing upon National Crime Records Bureau data and psychiatric research, the paper demonstrates a significant gap between legislative recognition and systemic implementation. It argues that while India formally acknowledges mental incapacity as a ground of exculpation, the narrow cognitive framework, structural inequities in evidentiary standards, and custodial mental health deficits undermine substantive justice. The paper concludes with a calibrated reform framework grounded in constitutional morality, therapeutic jurisprudence, and institutional modernization.

Keywords

Section 22 BNS; Insanity Defence; Criminal Responsibility; Bharatiya Nyaya Sanhita 2023; Mental Healthcare Act 2017; Prison Mental Health; Forensic Psychiatry; Supreme Court of India; Constitutional Dignity; Criminal Justice Reform.

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Conceptual Foundations of Criminal Responsibility and Mental Incapacity in Indian Law

Criminal responsibility rests upon a foundational moral assumption: that individuals are rational agents capable of making choices informed by understanding and free will. The doctrine of *mens rea* embodies this premise by requiring not merely the commission of a prohibited act (*actus reus*), but the presence of a culpable mental state accompanying it. Criminal law, therefore, is inherently moral in character. It assigns blame, expresses societal condemnation, and legitimizes punishment only where the offender possessed sufficient mental capacity to appreciate the nature and consequences of their conduct. If an accused lacked the ability to comprehend the nature or wrongfulness of their act, the moral foundation of punishment collapses. The insanity defence thus functions as a structural limitation on punitive authority, ensuring that criminal law does not devolve into mechanical retribution devoid of moral evaluation.

The philosophical basis of this defence can be traced to classical theories of punishment. Retributive theory insists that punishment is justified only where desert exists. A person who lacked meaningful understanding of their conduct cannot be said to deserve punishment in the moral sense. Similarly, utilitarian theories, which justify punishment in terms of deterrence, incapacitation, or social protection, presuppose rational responsiveness to incentives. Where mental illness disrupts rationality, both retributive and utilitarian justifications weaken. The insanity defence, therefore, reflects not leniency but coherence — it preserves the internal logic of criminal law by aligning liability with agency.

In India, this safeguard was historically codified in Section 84 of the Indian Penal Code, 1860, incorporating the McNaughten Rules of 1843. With the enactment of the Bharatiya Nyaya Sanhita, 2023, the defence is now contained in Section 22. Although the statutory framework has been modernized, the conceptual core remains unchanged. Section 22 continues to hinge upon cognitive incapacity: whether, by reason of mental condition, the accused was incapable of knowing the nature of the act or that it was wrong or contrary to law at the time of its commission. This continuity reflects legislative conservatism rather than doctrinal innovation.

The McNaughten formulation emerged in a historical context where psychiatric science was limited. It conceptualized insanity as a "defect of reason" arising from "disease of the mind," thereby framing responsibility in binary terms — sane or insane, responsible or not responsible.

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Contemporary psychiatry, however, recognizes mental disorders as existing along spectrums. Conditions such as schizophrenia may involve episodic psychosis; bipolar disorder may produce impulsivity during manic phases; severe depression may distort judgment without eliminating awareness; neurocognitive impairments may affect executive functioning rather than basic comprehension. These complexities challenge the adequacy of a rigid cognitive standard.

Modern psychiatric analysis distinguishes between cognitive impairment (inability to understand) and volitional impairment (inability to control conduct despite understanding). Section 22 BNS, like its predecessor, recognizes only cognitive incapacity. The absence of recognition for volitional impairment reveals limited engagement with contemporary mental health science. An individual who understands that an act is legally wrong but is unable to resist compulsive impulses due to severe psychiatric disorder remains fully liable under Indian law. This exclusion of volitional incapacity represents a significant doctrinal limitation.

The normative implications are substantial. If criminal responsibility is grounded in moral blameworthiness, then substantial psychiatric impairment should arguably mitigate culpability even where cognitive awareness is not wholly extinguished. Yet Indian law maintains a binary framework: either total incapacity leading to acquittal, or complete responsibility leading to punishment. Unlike certain jurisdictions that recognize diminished responsibility or partial defences, Indian criminal law provides no graded spectrum of culpability for mental impairment. This rigidity raises concerns of proportionality and fairness.

The constitutional dimension intensifies this inquiry. Article 21 of the Constitution guarantees life and personal liberty except according to procedure established by law. Judicial interpretation, particularly in *Maneka Gandhi v. Union of India*, has expanded this guarantee to include fairness, reasonableness, and substantive due process. Punishing an individual who lacked meaningful agency due to mental illness would undermine constitutional dignity and violate principles of non-arbitrariness. The insanity defence therefore derives legitimacy not only from common law tradition but from constitutional morality.

At the same time, criminal law must account for societal interests. Public safety, deterrence, and victim protection remain legitimate concerns. Expanding the defence indiscriminately risks eroding public confidence and encouraging fabricated claims. The presumption of sanity,

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embedded within evidentiary principles, reflects institutional caution against misuse. Section 22 BNS thus embodies tension: the need to protect the mentally incapacitated while preserving accountability.

However, empirical evidence suggests that insanity pleas are relatively rare and succeed infrequently. The greater risk may lie not in overuse but in under-recognition. Access to psychiatric diagnosis and treatment remains uneven across India. Stigma, poverty, and limited healthcare infrastructure often result in untreated mental illness. If documentary medical history becomes central to proving incapacity, individuals from marginalized backgrounds are disadvantaged. The law's conceptual neutrality may thus mask socio-economic inequity.

The temporal requirement under Section 22 — that incapacity must exist at the time of the act — further complicates matters. Mental illness is frequently episodic and fluctuating. Retrospective reconstruction of mental state involves forensic uncertainty. The conceptual clarity of the cognitive test may therefore conceal practical ambiguity in application.

Ultimately, the conceptual foundation of criminal responsibility in India must reconcile three principles: moral blameworthiness, constitutional dignity, and social protection. Section 22 BNS reflects an attempt at reconciliation but remains rooted in a nineteenth-century formulation. Whether this doctrinal inheritance can adequately serve contemporary India depends upon judicial sensitivity, forensic development, and institutional reform. The continued vitality of criminal law's moral foundation depends upon its capacity to recognize the realities of mental incapacity without abandoning the demands of accountability.

Section 22 of the Bharatiya Nyaya Sanhita: Structure, Burden, and Judicial Interpretation

Section 22 of the Bharatiya Nyaya Sanhita, 2023 provides that nothing is an offence if, at the time of doing the act, a person, by reason of mental condition, was incapable of knowing the nature of the act or that it was wrong or contrary to law. The provision substantially mirrors Section 84 of the Indian Penal Code, 1860, thereby preserving doctrinal continuity despite broader criminal law reform. While the terminology has shifted from "unsoundness of mind" to "mental condition," the substantive threshold remains anchored in the classical cognitive incapacity test derived from the McNaughten Rules. The core inquiry continues to be whether the accused lacked the cognitive ability to understand either the nature of the act or its

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wrongfulness at the precise time of commission.

Structurally, Section 22 involves three elements: the existence of a mental condition, a causal link between that condition and incapacity, and the requirement that such incapacity existed at the time of the act. Each element raises interpretative challenges. The statute does not define "mental condition," leaving courts to interpret the phrase through precedent and psychiatric evidence. While this allows flexibility, it has also resulted in conservative judicial standards that narrowly construe incapacity.

The temporal requirement significantly restricts the defence. Mental illness is often episodic and fluctuating, making retrospective determination of mental state inherently complex. Courts frequently infer sanity or insanity from surrounding circumstances and post-offence conduct. At the same time, the evidentiary burden lies upon the accused. Under principles now reflected in the Bharatiya Sakshya Adhiniyam, the accused must prove the defence on a preponderance of probabilities. Although this standard is lower than proof beyond reasonable doubt, it can be practically onerous, particularly where documentary psychiatric history is absent. In many parts of India, limited access to mental healthcare means that genuine psychiatric illness remains undocumented, and absence of records is often interpreted as evidence of sanity rather than systemic neglect.

Supreme Court jurisprudence reflects both fairness and caution. In *Dahyabhai Chhaganbhai Thakker v. State of Gujarat*, the Court clarified that the accused need only create reasonable doubt regarding sanity. However, subsequent decisions such as *Hari Singh Gond v. State of Madhya Pradesh* and *Surendra Mishra v. State of Jharkhand* emphasized that legal insanity differs from medical insanity and that abnormal or eccentric behavior alone does not suffice. These rulings reinforce the narrow cognitive threshold and the presumption of sanity.

Courts frequently rely on behavioural inference, treating post-offence actions such as fleeing, concealment, or coherent interaction as evidence of awareness. Yet psychiatric conditions like schizophrenia or bipolar disorder may involve lucid intervals or organized behavior coexisting with delusional beliefs. Over-reliance on behavioural inference risks oversimplification of psychiatric complexity.

Empirical analyses indicate that insanity pleas succeed in fewer than twenty percent of cases,

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with success strongly correlated to prior documented treatment and well-reasoned expert testimony. This pattern reveals structural inequality: documented illness enhances credibility, while undocumented illness invites skepticism.

Section 22 thus operates within a doctrinally stable but socially unequal framework. While judicial caution seeks to prevent misuse, excessive rigidity may undermine fairness. The challenge lies in ensuring that constitutional dignity and evolving psychiatric understanding inform the interpretation of this carefully guarded exception within Indian criminal law.

The Mental Healthcare Act, 2017 and Criminal Justice Integration

The Mental Healthcare Act, 2017 (MHCA) represents one of the most progressive legislative interventions in India's mental health landscape. It marked a decisive departure from the custodial and institutional model that characterized earlier mental health regulation under the Mental Health Act, 1987. Unlike its predecessor, which focused primarily on regulation of psychiatric institutions, the MHCA adopts a rights-based framework centered on dignity, autonomy, and non-discrimination. The Act was enacted in furtherance of India's obligations under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), particularly the principles of equal recognition before the law, informed consent, and access to justice. In doing so, it reconceptualizes persons with mental illness not as objects of control but as rights-bearing individuals entitled to state-supported care.

At the core of the MHCA lies Section 18, which guarantees the right to access mental healthcare and treatment funded by the appropriate government. This statutory recognition is significant because it transforms mental healthcare from a discretionary welfare service into a legally enforceable entitlement. Importantly, the right extends to persons in custody, including prisoners and undertrial detainees. Theoretically, therefore, individuals accused of offences are entitled to psychiatric assessment, medication, counselling, and rehabilitation services equivalent to those available in the community. This provision has direct implications for criminal justice, particularly in cases involving Section 22 of the Bharatiya Nyaya Sanhita (BNS), where mental incapacity is raised as a defence.

However, the practical realization of Section 18 within the criminal justice system remains uneven. Implementation varies considerably across states, reflecting disparities in healthcare infrastructure, budgetary allocation, and administrative prioritization. Many prisons lack full-

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time psychiatrists or trained mental health professionals. In several jurisdictions, psychiatric consultations occur only on a visiting basis, often once or twice a month. Overcrowding further complicates delivery of care. As a result, the statutory right to mental healthcare frequently exists more robustly on paper than in practice. The gap between normative entitlement and institutional capacity undermines the transformative potential of the MHCA.

Section 115 of the Act provides another significant reform by effectively decriminalizing suicide attempts. It presumes that any person attempting suicide is under severe stress and mandates care, treatment, and rehabilitation rather than prosecution. This provision reflects a broader philosophical shift from punishment to therapeutic intervention. Historically, attempted suicide was punishable under Section 309 IPC, reinforcing stigma and criminalization of mental distress. The MHCA's approach aligns with contemporary psychiatric understanding and public health policy. Within the criminal justice system, this reform signals recognition that mental vulnerability must be addressed through care rather than sanction. Yet its influence on broader criminal responsibility doctrine remains limited.

Despite these normative advancements, criminal courts rarely integrate MHCA principles into adjudication under Section 22 BNS. There is no statutory mandate requiring early psychiatric screening at the stage of arrest, remand, or charge framing. Consequently, many accused persons with mental illness remain undiagnosed during crucial procedural stages. By the time psychiatric evaluation is ordered, significant time may have elapsed, complicating retrospective assessment of mental state at the time of the offence. The absence of structured integration between criminal procedure statutes and MHCA safeguards represents a critical institutional gap.

Another area of concern relates to post-acquittal management. When an accused is acquitted on grounds of mental incapacity, courts may order hospitalization or custodial care. However, such orders are not consistently subjected to periodic review under MHCA mechanisms such as Mental Health Review Boards. The Act emphasizes least-restrictive care and periodic reassessment of involuntary admission. Failure to align criminal court orders with these safeguards risks prolonged institutionalization that may be disproportionate and inconsistent with the rights-based ethos of the MHCA. Without systematic review, individuals may remain confined in psychiatric institutions longer than clinically necessary.

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The Supreme Court's jurisprudence reflects increasing sensitivity to psychiatric vulnerability within the criminal justice system. In *Shatrughan Chauhan v. Union of India*, the Court held that execution of prisoners suffering from severe mental illness would violate constitutional dignity under Article 21. This decision underscores the constitutional dimension of mental health within criminal adjudication. It affirms that psychiatric impairment is not merely a medical concern but a constitutional issue implicating fundamental rights. However, while such decisions address extreme scenarios like capital punishment, similar sensitivity is not consistently visible in routine criminal trials.

Furthermore, the MHCA introduces concepts such as advance directives and nominated representatives, reinforcing autonomy and supported decision-making. Yet these mechanisms are seldom invoked within criminal proceedings. Accused persons with mental illness may lack effective legal representation capable of asserting these rights. Legal aid systems are overburdened, and coordination between mental health professionals and defence counsel remains limited. This disconnect further weakens the practical integration of the MHCA into criminal justice.

The normative transformation introduced by the MHCA thus stands in contrast to the operational inertia within criminal adjudication. While the Act envisions dignity, autonomy, and community-based care, criminal procedure continues to operate within a predominantly adversarial and custodial paradigm. The failure to institutionalize mandatory psychiatric screening, structured forensic evaluation, and systematic review mechanisms prevents meaningful harmonization between Section 22 BNS and the MHCA.

In essence, the MHCA provides a progressive framework capable of reshaping the treatment of mental illness within the criminal justice system. However, legislative aspiration alone cannot produce institutional reform. Effective integration requires coordinated policy measures, training of judicial officers and police personnel, expansion of forensic psychiatric services, and strengthened prison mental healthcare infrastructure. Without such measures, the promise of the MHCA risks remaining aspirational rather than transformative.

Mental Illness in Indian Prisons: Empirical Data and Structural Gaps

Indian prisons represent one of the most significant yet under-examined sites where mental illness and criminal justice intersect. While criminal responsibility is adjudicated in

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courtrooms, the lived reality of mental illness within the justice system unfolds largely within custodial institutions. Empirical data reveal a disturbing gap between official records and clinical reality. According to the National Crime Records Bureau (NCRB) Prison Statistics (2022–23), approximately 1.7% of inmates are officially recorded as suffering from mental illness. However, independent clinical studies published in peer-reviewed psychiatric journals estimate that the prevalence of mental disorders among prison populations ranges between 20% and 33%, depending on methodology and diagnostic criteria.

This discrepancy cannot plausibly be explained by statistical variation alone. Rather, it indicates systemic under-detection and under-reporting. Many prisons lack mandatory mental health screening at the time of admission. Instead of structured psychological assessment upon entry, identification of mental illness often occurs only after visible behavioral disturbance, self-harm attempts, or disciplinary infractions. Psychiatric services within prisons are therefore reactive rather than preventive. This approach results in large numbers of inmates with untreated depression, psychosis, anxiety disorders, or substance-use-related psychiatric conditions remaining undiagnosed.

The problem is compounded by the composition of India's prison population. Undertrial prisoners constitute approximately 75% of all inmates, reflecting significant delays in investigation and trial. Prolonged pre-trial detention has well-documented psychological consequences. The uncertainty of pending charges, separation from family, overcrowded living conditions, and limited access to legal counsel collectively exacerbate anxiety and depressive symptoms. For individuals already suffering from psychiatric vulnerability, incarceration can accelerate deterioration. The presumption of innocence that formally applies to undertrials is often undermined by the harsh realities of custodial confinement.

Table 1: Prison Population and Mental Health Indicators

Indicator	Value	Source
Total Prison Population (2023)	~5.7 lakh	NCRB
Officially Recorded Mentally Ill Inmates	~1.7%	NCRB
Estimated Clinical Prevalence	20–33%	Indian Journal of Psychiatry
Undertrial Percentage	~75%	NCRB

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The disparity between official and clinical figures reflects structural weaknesses in mental health governance within prisons. India's psychiatrist-to-population ratio stands at approximately 0.75 per 100,000 persons, significantly below global benchmarks. Within prisons, availability is even more limited. Many correctional institutions rely on visiting psychiatrists who attend intermittently, making continuity of care difficult.

Table 2: Mental Health Workforce Indicators

Indicator	Value	Source
Psychiatrists per 100,000	~0.75	National Mental Health Survey
Recommended Global Benchmark	~3 per 100,000	WHO Guidance

These workforce gaps have constitutional implications. In *Sunil Batra v. Delhi Administration*, the Supreme Court affirmed that prisoners retain fundamental rights except those necessarily curtailed by incarceration. Denial of adequate mental healthcare violates Article 21's guarantee of dignity and humane treatment. The constitutional obligation of the state does not diminish at the prison gate. Yet, infrastructural limitations and budgetary constraints frequently result in mental health being treated as a peripheral concern rather than a core custodial responsibility.

Addressing prison mental health deficits requires systemic reform. Structured screening at admission, periodic reassessment, telepsychiatry integration for remote facilities, and dedicated budget allocation for mental healthcare services are essential measures. Without such reform, prisons risk functioning as de facto psychiatric institutions without therapeutic capacity, perpetuating cycles of untreated illness and criminalization.

Forensic Psychiatry and Evidentiary Limitations

Forensic psychiatric assessment plays a decisive role in the adjudication of Section 22 BNS. Determining whether an accused lacked cognitive capacity at the time of the offence requires expert evaluation grounded in psychiatric science. However, India's forensic psychiatric infrastructure remains underdeveloped and unevenly distributed.

Few states maintain specialized forensic psychiatric units attached to medical colleges or mental health institutions. In many cases, general psychiatrists conduct medico-legal evaluations without specialized forensic training. Retrospective assessment presents

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methodological challenges, as evaluations often occur months after the alleged offence. Memory degradation, symptom fluctuation, and lack of contemporaneous documentation reduce accuracy. The inherently reconstructive nature of such assessments makes rigorous methodology indispensable.

Standardized malingering detection tools, neuropsychological testing protocols, and structured interview frameworks are not uniformly implemented across jurisdictions. As a result, forensic reports vary significantly in depth and analytical quality. Courts frequently receive brief medical certificates that state conclusions without detailed reasoning connecting psychiatric findings to the legal criteria under Section 22. This lack of structured articulation contributes to judicial skepticism and cautious interpretation.

Table 3: Structural Challenges in Forensic Psychiatry

Challenge	Consequence
Delayed Evaluation	Reduced retrospective accuracy
Lack of Specialized Units	Inconsistent methodology
Absence of Standard Protocols	Judicial distrust
Limited Forensic Training	Weak medico-legal articulation

Judicial hesitation to accept psychiatric evidence often stems not from hostility to the defence but from inconsistency in expert reporting. Strengthening forensic capacity is therefore essential for meaningful implementation of Section 22 BNS. Establishing regional forensic centers, standardizing medico-legal reporting templates, and providing specialized training to psychiatrists in legal criteria would enhance reliability and judicial confidence.

Constitutional and Human Rights Framework

The insanity defence derives its legitimacy from constitutional morality. Article 21 protects not merely life but dignified existence and fair procedure. Punishment without culpability offends substantive due process and undermines the moral authority of the state. If criminal liability presupposes rational agency, then imposing punishment upon those deprived of such agency constitutes constitutional arbitrariness.

India’s obligations under the UN Convention on the Rights of Persons with Disabilities

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reinforce this constitutional framework. The Convention mandates equal recognition before the law and requires reasonable accommodation in judicial proceedings. Persons with psychosocial disabilities must be provided appropriate support to participate effectively in legal processes. Yet procedural accommodation in Indian criminal trials remains limited. There is no comprehensive statutory mechanism mandating psychiatric screening or communication assistance during trial.

Supreme Court jurisprudence has increasingly acknowledged psychiatric vulnerability in sentencing contexts, particularly in capital punishment cases. However, doctrinal sensitivity has not fully permeated routine criminal adjudication. Institutional reform must therefore harmonize Section 22 BNS with constitutional commitments to dignity, fairness, and non-discrimination.

Reform Framework

India requires a calibrated, multi-layered reform approach to reconcile criminal responsibility doctrine with psychiatric reality. First, early psychiatric screening at arrest and remand stages should be institutionalized through statutory amendment or judicial guidelines. Early detection would improve evidentiary accuracy and ensure timely treatment.

Second, forensic psychiatric infrastructure must be expanded. Establishing dedicated forensic units, standardizing assessment protocols, and enhancing medico-legal training would strengthen the reliability of expert testimony.

Third, prison mental health services require structured funding and administrative prioritization. Telepsychiatry networks can bridge workforce gaps in remote regions. Periodic independent audits of custodial mental healthcare would enhance accountability.

Fourth, diversion mechanisms for non-violent offenders with significant psychiatric impairment should be piloted. Community-based treatment programs reduce recidivism and align with therapeutic jurisprudence.

Fifth, post-acquittal hospitalization orders must be subjected to mandatory periodic judicial review to prevent indefinite confinement inconsistent with least-restrictive-care principles.

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Reform must balance accountability with compassion. Protecting society and upholding constitutional dignity are not mutually exclusive objectives. A mature criminal justice system recognizes that punishment is justified only where culpability exists and that treatment, not incarceration, is appropriate where mental incapacity prevails.

Conclusion

Section 22 of the Bharatiya Nyaya Sanhita, 2023 represents continuity rather than rupture in India's approach to criminal responsibility and mental incapacity. By retaining the classical cognitive test derived from the McNaughten formulation, the legislature has reaffirmed the foundational principle that punishment is justified only where rational understanding exists. At a conceptual level, this reflects a morally coherent commitment: criminal liability must rest upon agency, and agency presupposes cognition. The law cannot condemn what the mind could not comprehend.

However, the preservation of doctrinal continuity cannot obscure the deeper institutional and structural challenges revealed through this analysis. The cognitive threshold embedded in Section 22, while theoretically sound, operates within a criminal justice system marked by evidentiary rigidity, forensic underdevelopment, and custodial mental health deficits. Judicial interpretation has remained cautious, often relying heavily on documentary psychiatric history and post-offence behavioural inference. In a socio-economic context where mental illness frequently remains undiagnosed due to stigma, poverty, and inadequate healthcare access, such evidentiary expectations risk producing unequal outcomes. The defence may be available in theory, yet inaccessible in practice to the most vulnerable.

Empirical data from Indian prisons further illuminate this gap. The stark discrepancy between officially recorded mental illness rates and independent clinical prevalence estimates reveals systemic under-detection and insufficient screening mechanisms. Undertrial incarceration, overcrowding, and limited psychiatric staffing compound the vulnerability of individuals with mental illness. When the criminal justice system becomes a primary site for the management of untreated psychiatric conditions, the distinction between punishment and neglect becomes blurred. Article 21's guarantee of dignity and humane treatment demands more than formal recognition; it requires substantive institutional response.

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The Mental Healthcare Act, 2017 provides a progressive rights-based framework grounded in autonomy and non-discrimination. Yet its integration into criminal procedure remains incomplete. Without mandatory early psychiatric screening, standardized forensic protocols, and periodic review of custodial hospitalization orders, the transformative aspirations of the MHCA remain only partially realized. Constitutional morality requires harmonization between substantive criminal law and mental health governance.

Ultimately, the legitimacy of criminal law depends upon its fidelity to moral culpability. A system that punishes those deprived of meaningful agency undermines its own ethical foundation. At the same time, accountability remains essential to public confidence and social order. The task, therefore, is not to weaken criminal responsibility but to refine it — to ensure that culpability is assessed with scientific rigor, constitutional sensitivity, and institutional fairness.

The future of criminal responsibility in India lies not in abandoning Section 22, but in strengthening the ecosystem within which it operates. Forensic capacity must be enhanced, prison mental healthcare must be institutionalized, and procedural safeguards must be integrated at the earliest stages of criminal process. A mature justice system recognizes that compassion and accountability are not adversaries but complements. To punish the culpable and treat the incapacitated is not merely a policy choice; it is a constitutional imperative.

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