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State of Mind: The 'Lunatic' in Prisons

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Issue Brief

State of Mind:

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II INTRODUCTION

The prevalence of mental illness in prison settings is significantly higher than in the general population—approximately 3-6 times higher, as available evidence indicates (Andersen, 2004; Fazel & Danesh, 2002; Lamb & Weinberger, 1998; Taylor, 2010; Wilper et al., 2009). Substance use disorders (alcohol, nicotine, cannabis, opioid, cocaine, benzodiazepines and other drugs) are the most frequently diagnosed condition (Wilper et al., 2009). Other commonly occurring mental disorders are depression, anxiety disorders, personality disorders, and psychosis (Andersen, 2004; Fazel & Danesh, 2002; Lamb & Weinberger, 1998).

There is a strong medical rationale for this high prevalence, what can be called the presence of environmental and emotional stressors. There are both external and internal factors that contribute to the worsening of mental health conditions within prisons. External factors largely stem from the prison environment itself—including overcrowding, unsanitary and unhygienic living conditions, poor-quality food, inadequate healthcare, and exposure to physical or verbal aggression from other inmates. The lack of meaningful or purposeful activities, the availability of illicit substances, and the experience of either enforced isolation or the absence of privacy further compound psychological distress. Internal factors, on the other hand, are emotional and psychological in nature. Prisoners are likely to experience guilt, shame, and stigma associated with their offences and imprisonment. Many struggle with anxiety about their families, feelings of social alienation, and uncertainty about reintegration into society after release. The cumulative impact of these environmental and emotional stressors—when left unaddressed—can severely exacerbate mental morbidity, undermining not only the mental health and wellbeing of inmates but also that of prison staff who operate within such strained environments (Blaauw & Van Marle 2007). With regards to US prisoners, 56% of the state prison inmates had some mental health problem, while 45% of the federal prison inmates and 64% of the local jail inmates had symptoms of a mental health problem. Symptoms of psychotic disorders were present among 20% of the state prisoners (James et al., 2006).

Despite such strong evidence, there is a lack of research on mental health in prisons in the Indian context. Rabiya and Raghavan (2018) found only twelve studies on prison mental health between 2000 and 2017, underscoring the lack of empirical engagement. Even with the rights-based Mental Healthcare Act, 2017, which replaced stigmatizing terminology, there is a clear dearth of any large-scale systematic study of the incidence of mental illnesses in prisons in India. This is despite a strong rationale for high incidence as well as a strong demonstration of presence of mental illnesses in prisons around the world. In the Indian context, recently, a study by the National Institute of Mental Health and Neuro Sciences consisted of almost 5000 inmates in the Bangalore prison. The incidence of major mental illnesses among the inmates was quite low, but the high prevalence of these illnesses and the presence of emotional and environmental factors that could aggravate the incidence, calls for a large-scale study of the status of mental illness in Indian prisons. This would help drive academic and policy engagement on questions of prison reforms of the mentally ill. Other studies like Tirumani et al. reported an overall 83.5% prevalence of psychiatric illness in prisoners having depression (46.5%) as the major illness (Tirumani et al., 2020)

II THE CRIMINAL, THE 'LUNATIC', AND THE ORDER

It is insightful to try and place both the criminal and the 'lunatic' in contrast to the normal, for they are both seen as 'deviants'. They stand on the other side of the point between normal and abnormal, rational and irrational, sane and insane. Looking at the mentally ill persons within prisons could, therefore, be all the more revealing as to how our and the state's understanding of the 'deviant' emerges and evolves.

It is crucial to begin with the central question of perception. How does the state see prisoners and the 'lunatics', and the 'lunatics' who are prisoners or prisoners who are 'lunatics'? The Mulla Committee, which is probably the most prominent source on prison reforms, asks a similar question of perception about prisons, which forms the bedrock of all its enquiries. Is prison a place for detention or is it a place for reform? It draws on the history of understanding jails to situate two opposing views. A human-rights centric view argues for the prisons as places of reforms, post which prisoners could be moved back to the society. The report quotes Gandhi "If we were not under the spell of a long-lived custom, we should not find it a difficult task to turn our prisons into reformatories" (Committee on Jail Reforms, 1983). It rues a missed opportunity when moving to present the opposing view. The custom that Gandhi refers to is the dominant approach of the state globally—of keeping prisons as places of isolation, and that has been no different in the Indian case.

Looking at the Article 433A amendment can be a useful case study. The committee notes that 'lifers' (those sentenced for life) made up a large portion of the jail population, and therefore, was one of the major categories of prisoners it focussed on. "Our survey of jails shows that if the 'lifers' and the undertrials are not counted, the jail population will come down to between 25 and 30 per cent of its present strength" (Committee on Jail Reforms, 1983). The presence of a high quantity of these lifers can be interpreted in numerous ways, but it certainly does paint the prison as the place for 'deviants' in the eyes of the state. This can, however, be more concretely linked if the lifer is seen in relation to the 433A amendment. It states that if a person is sentenced to life imprisonment for a crime where death could also have been given as punishment (for example, murder), or if their death sentence has been changed to life imprisonment, then they must at-least serve 14 years in prison (Devgan, 2022). The Royal Commission on Capital Punishment 1949-53, mentions that those handed life imprisonment in-fact have a higher incentive to have best behaviour (Royal Commission on Capital Punishment, 1953). Enactment of section 433 A ensures the incentive to be well behaved is gone. A demonstration of the tendency of the state to detain rather than reform (Committee on Jail Reforms, 1983)¹.

II THE CRIMINAL, THE 'LUNATIC', AND THE ORDER

A key point which the Mulla committee raises is the need to understand prisons and their reforms in conjunction with different parts of the state that shape them. It spoke about "interaction of Legislature, the Police, the Judiciary, and finally the Jails—and the need for any substantive analysis to be in this framework" (Committee on Jail Reforms, 1983). The Mulla Committee, in its landmark All-India Committee on Jail Reforms report (1983), underscored that prison reform cannot be confined within the four walls of jails; rather, it calls for an integrated understanding that would emanate from combing the legislature, the police, the judiciary, and the jails themselves (Ministry of Home Affairs, 2003). The rationale is that each of these institutions shapes the inflow, classification, detention conditions, oversight, and exit of prisoners. At the legislative level, the Committee recommended comprehensive penal and prison legislation (e.g., consolidation of jail laws, inclusion of prison and allied institutions

under the Concurrent List) to provide uniform statutory footing across states (Ministry of Home Affairs, 2003). The police, being in-charge of arrest and remand, should strive to comply and enforce standards related to the same. Abuse or delays at this stage devolve into overcrowding, exploitation, and arbitrary detention. The judiciary intervenes through bail, remand orders, and custodial review but must be sensitised to supervise and correct police and jail practices (e.g. through Undertrial Review Committees). Finally at the jails, through prison administration, implementation of humane classification, medical care, rehabilitation, mental health screening, and release protocols must be followed. If one institution fails while others operate well, systemic dysfunction persists.

For instance, even if prison medical standards are good, weak judicial oversight or police remand excess results in overcrowded, unmanageable settings. The 2023 Rajya Sabha Standing Committee on Prisons reaffirmed the Mulla Committee's integrated framework, observing that reforms across infrastructure, legislative architecture, judicial procedure, and prison administration must proceed in a coordinated manner (Department-related Parliamentary Standing Committee on Home Affairs [DPSCH A], 2023). A cohesive approach, linking the apparatus and intent of different institutions involved, is the only effective method for reform of the correctional system in India.

II DIFFERENCE IN THE CLASSIFICATION OF THE TWO DEVIANTS

The distinction between the 'lunatic' and the 'criminal' historically reflects two different axes of social and legal classification, one anchored in rationality, the other in morality. The 'lunatic', defined in colonial and early postcolonial Indian legal discourse as an "idiot or person of unsound mind" (Indian Lunacy Act, 1912), was viewed through the prism of reason or, the absence of it. Lunacy denoted a lack of being able to comprehend, a failure of mental faculties that rendered the individual incapable of intent or judgment. The criminal, by contrast, was conceptualized as a rational moral agent who chose to transgress. Crime was a deviation not from reason, but from morality of the state; it was a breach of the moral order rather than a collapse of mental order. This rational-moral divide structured both colonial and modern legal systems, where punishment and treatment became bifurcated responses to two forms of deviance—the moral and the mental. In practice, however, the boundaries between these categories were deeply unstable.

The CrPC's provisions on "persons of unsound mind" (Government of India, 1973, §§ 328–339) demonstrate how courts struggled to reconcile questions of intent and responsibility when reason itself was in doubt. Was the "mad" offender a patient or a moral transgressor? The answer often depended not on medical diagnosis, but on legal expediency and institutional convenience. This uneasy overlap between rationality and morality continues to haunt India's treatment of mentally ill prisoners—who remain suspended between punishment and care, between the moral and the medical.

II THE INDIAN LUNACY ACT, AND THE STATE'S COMPREHENSION OF MENTALLY ILL PERSONS

The Indian Lunacy Act spells the confines of understanding the 'abnormal', the mentally ill, and the 'lunatic'. Norms formed the first basis of institutional segregation of the 'lunatic', with the police and the judiciary given a free hand to decide it (Indian Lunacy Act, 1912). The other major aspect of understanding, which overlaps with the 'criminal', is the unrelenting desire to detain. For instance, on what avenues can a mentally ill person be detained? The act says: "If a lunatic released under sub-section (1) or (2) does not return to the asylum at the expiration of the period for which he was

released...is at any time during the period of his release, found to be unmanageable or dangerous or unfit to be at large and the person who applied for his release states by a written application to the person in charge of the asylum that he is unable to bring him to the asylum such lunatic shall be deemed to have escaped from the asylum and may at any time within one month after the expiration of the said period be retaken to and detained in the asylum in the manner provided in Section 36" (Indian Lunacy Act, 1912).

In other words, even if a person is released, any normative deviation, felt by the family, can make the state liable to detaining them as lunatics. Here too, one sees how norms, rather than medical procedure, form the line of separation. Looking into the transfer of lunatics and criminal lunatics can also be useful in understanding how the state finds it essential to detain and wants to create regulations around that central principle.

An amendment in 1926 makes moving of mentally ill persons and criminal 'lunatics' across different state confinements quite hasslefree. Can this be interpreted as another, more sophisticated, case of increasing the ease of detainment of the 'criminal lunatic'—a veiled and cumbersome matter of keeping the double deviant away from the 'society'? (Indian Lunacy Act, 1912, § 35(1)). On the transfer of the criminal lunatic, the act says "The State Government may make such general or special order as it thinks fit directing the removal of any person for whose detention an order has been made under Section 466 or Section 471 of the Code of Criminal Procedure...to any asylum, jail or other place of safe custody in the State" (Indian Lunacy Act, 1912, § 35(2))

II HISTORY OF CLASSIFYING THE MENTALLY ILL IN PRISONS

Classification in India began under a confinement-centred model. The Indian Lunacy Act, 1912 institutionalised the legal category of the "lunatic" and framed mental disorder primarily as a ground for custodial care in asylums rather than therapeutic engagement; courts and prisons were given statutory routes to send "lunatic prisoners" to asylums. This produced an early law-policy alignment that equated mental illness with institutional custody rather than integrated health services (Indian Lunacy Act, 1912). There was some mention of the need for reform in a 1838 Prison Discipline Committee (PDC) report, but these were few and far in between. Additionally, the major thing briefly touched upon there was the status of mental health with regards to solitary confinement. "A number of more specific issues relating to health were raised, including mortality resulting from chronic disease and concern about poor ventilation and overcrowding in a hot climate. The mental health of prisoners is briefly discussed in terms of the use of solitary confinement. However these issues lacked any substantive discussion or recommendations for addressing the situation and yet were the main references to medical issues throughout the 1838 PDC report" (Clark, 2015).

I PROCEDURAL (CRIMINAL-LAW) CATEGORIES: "UN SOUND MIND" AND MEDICO-LEGAL PROCESSES

When India adopted the CrPC in 1973, it consciously preserved procedural structures inherited from colonial-era codes, notably the CrPC of 1898, which treated mental illness less as a health concern and more as a procedural irregularity that could impede a fair trial (Rizwana, 2019). Alongside asylum law, the criminal procedure framework developed distinct categories which had connotations of a legal-but-medical category. The CrPC contains detailed procedures for when an accused is declared a "lunatic" or a person of "unsound mind". This is called the "Provisions as to Accused Persons of Unsound Mind" (CrPC Secs. 328–339) and specific powers (Secs. 330, 335) that permit detention in a mental hospital instead of prison during trial or after conviction (Government of India, 1973, §§

328–339).

The Prisoners Act, 1900 also contained provisions for dealing with lunatic prisoners (procedures for removal to asylums and reckoning asylum time as part of the sentence), embedding the idea that psychiatric custody was an administrative variant of penal custody rather than a health-first response. This shaped how prison authorities operationalised “classification” (prisoner who is also a patient) (Government of India, 1900). These provisions created a dual classification system. A legal one with categories like ‘fit’ or ‘unfit for trial’ juxtaposed with the ‘convict’ and ‘undertrial’, and the other a medical one through those diagnosed with mental illness. This, ultimately, led to courts mediating transfers between penal and psychiatric custody (Devgan, 2022).

I LEGAL CLASSIFICATION: FITNESS TO STAND TRIAL, SUSPENSION, AND DETENTION

Section 328 provides the procedural entry point. If an accused appears to be of “unsound mind” and incapable of defending themselves, the magistrate must order a medical examination by a civil surgeon or psychiatrist. If found unfit, the court postpones proceedings and may order the person’s remand to a mental health facility (CrPC §328). This marks the first legal distinction—fit or unfit for trial. Section 329 extends this inquiry to ongoing trials before higher courts. If an accused’s mental soundness becomes doubtful, proceedings must be suspended pending psychiatric evaluation. This prevents trials in absentia of mind and safeguards due process (CrPC §329; Devgan, 2020).

Where unsoundness is confirmed, Section 330 empowers courts to detain the accused in a mental hospital or other place of “safe custody.” Such detention is not punishment but protective custody for treatment and security (CrPC 330). Here, the first institutional transfer occurs—from the penal to the medical domain.

I MEDICAL CLASSIFICATION AND POST-TRIAL CUSTODY

When an accused is acquitted because of mental illness, Section 335 of the CrPC governs their post-trial status. The court must decide whether the person can be safely released; if not, it may order confinement in “safe custody,” typically in a psychiatric hospital rather than prison (CrPC §335). This merges legal acquittal (no culpability under IPC §84) with continuing medical detention (Rabiya & Raghavan, 2018). Section 336 authorizes the State Government to appoint responsible officers—superintendents of jails or mental hospitals—to execute detention or discharge orders issued under Sections 330 or 335. This administrative framework ties the judiciary’s classification power to the executive machinery of prisons and hospitals (Government of India, 1973). The classification remains fluid: Sections 337–338 mandate re-evaluation and potential release of persons detained for unsoundness of mind. Upon medical certification of recovery (Sec. 337), courts may resume trial or order release (Sec. 338). Thus, a detainee oscillates between being “mentally ill” and “fit,” depending on psychiatric certification—a dynamic reflecting continuous re-classification rather than a fixed legal identity (Devgan, 2020).

These sections institutionalized two overlapping but distinct forms of classification. In essence, there is a legal classification focusing on fitness for trial and criminal responsibility, and a medical classification that emphasizes diagnosis and treatment. The state through the judiciary became a mediator between penal custody (prisons) and psychiatric custody (mental hospitals/asylum).

I THE DUALITY OF CLASSIFICATION

The underlying principle was that an accused incapable of understanding proceedings should not be processed like a conventional defendant. Accordingly, Chapter XXV (Sections 328–339) sets out mechanisms to determine mental capacity at different stages of the criminal process—pretrial, trial, and post-trial (Government of India, 1973). These provisions do not attempt psychiatric diagnosis *per se*, but operate at the intersection of legal capacity and medical evaluation, producing a hybrid system where judicial logic determining fair trial and culpability, interacts with medical logic that is to determine diagnosis and custodial treatment.

Courts thus mediate between penal custody and psychiatric custody. For instance, a person declared unfit for trial under §328 may be transferred to psychiatric custody under §330; one acquitted under §335 remains in psychiatric detention until certified fit under §337. Is the need of this mediation a legitimizing tool for the state? A rational or objective justification of the state's desire to detain the deviant? If so, it creates a moral basis of rationality being used for categorisation and acting upon those categories. Or is it a less sensationalist procedural reality on which judgements on keeping the mentally ill criminal are based? In both conditions, a more rooted and extensive engagement of medical processes and psychiatric truths need to be drawn upon to make the categorisation truly move towards a scientific or medical classification.

This interplay also produces institutional ambiguity: Who decides when a “patient” becomes a “prisoner” again? Who guarantees continuity of care during transition? These dilemmas are visible in cases such as *Charanjit Singh & NHRC v. NCT Delhi* (Delhi HC, 2005), where prolonged criminal proceedings against a mentally unfit prisoner were quashed and the court directed his continued treatment under NHRC supervision. The case highlighted how judicial processes grapple with competing custodial and therapeutic imperatives (NHRC, 2019). The Charan Singh case starkly illustrates the institutional and moral ambiguities that emerge at the intersection of criminal law, mental health, and state responsibility. Charan Singh, an undertrial prisoner declared of unsound mind, remained in judicial custody for nearly fifteen years without trial. The trial court, unable to proceed against an individual incapable of defending himself, repeatedly deferred justice while his confinement continued by default. When the court finally ordered his release on bail in 2000, Singh failed to appear—unsurprisingly, given his mental instability—leading to the revocation of his bail and his re-incarceration. Even when the Supreme Court later quashed the FIR, the judiciary hesitated to release him outright, remarking that “once Charanjit Singh ceases to be an undertrial prisoner and there is no criminal case pending against him, the State could wash its hands off. We did not want this consequence of quashing the FIR as his ‘freedom’ to the undertrial prisoner would have denied him the medical treatment and put him in a worse position than what he has today.”

This judicial hesitation exposes the deep uncertainty about where such individuals belong: the jail or the asylum, punishment or protection. The oscillation between these institutions reflects the state's conflicted stance toward the “deviant”—a figure simultaneously feared, pitied, and disowned. By retaining Charan Singh in custody even after his criminal liability was nullified, the state assumed a paternalistic role, confining him ostensibly for his own welfare, yet effectively denying him the autonomy that the law was meant to restore. His case underscores how the juridical and medical systems collude in producing a liminal space where individuals deemed mentally unfit are suspended between care and coercion, sanity and deviance, freedom and control. The Charan Singh judgment thus becomes emblematic of the costs of administrative indecision and the blurred boundaries between justice, psychiatry, and governance.

II POST-INDEPENDENCE REFORMS AND SLOW SHIFT TO TREATMENT

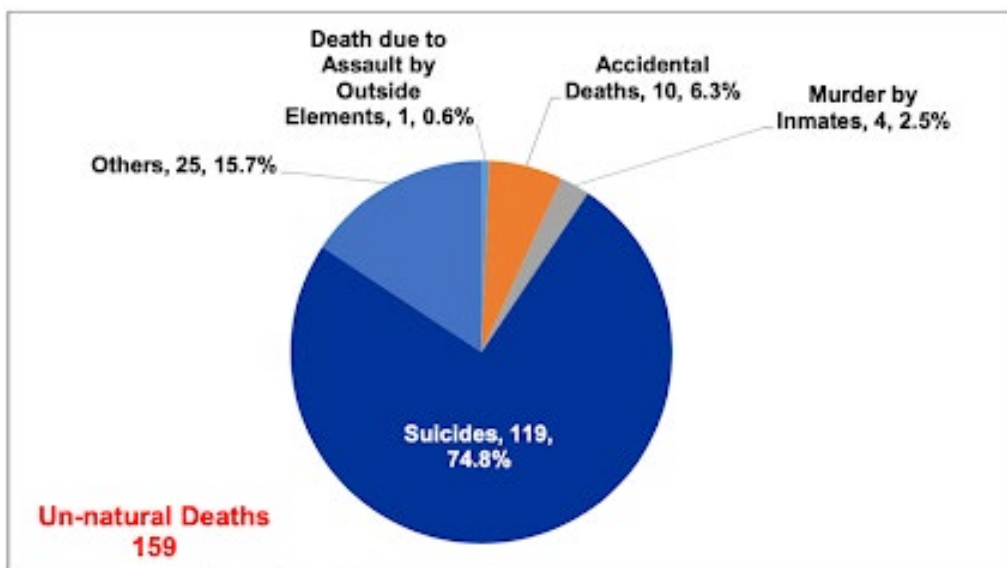
The Mental Health Act, 1987 began to move discourse away from pure confinement toward regulation of institutions and patients' rights, while the National Mental Health Programme (NMHP) sought community mental health capacity. With the Mental Healthcare Act, 2017 the direction taken has had a rights-based turn. The Mental Healthcare Act (MHCA), 2017 marks a doctrinal shift: it replaces stigmatizing labels with clinical and rights-based terminology ("mental illness", "person with mental illness"), creates Mental Health Review Boards, and explicitly recognises prison referrals—Section 103 provides that orders under CrPC §§330/335 or the Prisoners Act suffice to admit prisoners to mental health establishments. In principle MHCA reframes classification toward care and legal oversight rather than automatic custodial categorisation (Government of India, 2017). If a court or competent authority passes an order under CrPC 330 or 335 (or under Army/Navy/Air Force/Prisoners Acts), directing that a prisoner with mental illness be admitted into a mental health establishment, that order is sufficient authority to admit and treat them. For the person to be receiving mental care, the state needs to have judicial intervention to be classed from the convict to the mentally ill. Thus, despite a rights-based turn, the initial wailing found in Mulla committee reforms of prisons being a reformatory seems well out of the way, and the treatment of them as deviants continues.

Nevertheless, implementation gaps have largely left prisons out of mainstream public-health planning: psychiatric care in jails remained ad-hoc and heavily dependent on judicial or human-rights interventions. The National Mental Health Survey (NIMHANS, 2015–16) later documented a very large treatment gap in the community, signalling that prisons (with even scarcer services) were at even greater risk of neglect (National Institute of Mental Health and Neuro Sciences, 2016). Additionally, as we have previously alluded to the lack of empirical attention, expectedly systematic empirical work on prison mental health in India is scarce relative to community studies as well. Reviews and short surveys (e.g., Rabiya & Raghavan's 2018 review) document only a small number of focused studies on prisoner psychiatric morbidity, and these are usually single-site, cross-sectional, or small-sample are insufficient for national policy design. NIMHANS' Mind-Imprisoned study (Central Prison, Bangalore) is a notable, larger inquiry, but such studies remain exceptions, not the rule.

II PRISON SUICIDES: A HEAVY COST OF THE STATE'S PERCEPTION

The data on unnatural deaths in Indian prisons reveal a grim and persistent pattern: suicide accounts for the overwhelming majority of such fatalities.

Figure 2: FAIR and CARE principles in complementarity (Global Indigenous Data Alliance, 2019)



• As per data provided by States/UTs.

Deaths of Prison Inmates due to Un-natural Causes during 2022

Chart – 8.4

Source: *Prison Statistics India, 2022*

As shown in Chart 8.4 (National Crime Records Bureau, Prison Statistics India 2022), of the 159 unnatural deaths recorded that year, nearly three-fourths (74.8%) were suicides, with other causes such as accidents (6.3%), murder by inmates (2.5%), and deaths due to assault by outsiders (0.6%) forming only minor proportions. This pattern underscores an alarming trend—suicide remains the single largest cause of unnatural death among Indian prisoners, a finding consistent with both national and international research.

The Mind Imprisoned report by NIMHANS (2021) highlights similar trends, noting that the majority of unnatural prison deaths in India over the last decade have been due to suicide. Globally too, the World Health Organization (WHO, 2014) and the United Nations Office on Drugs and Crime (UNODC, 2019) report that suicide is the leading cause of death in prisons, often exceeding rates in the general population by a wide margin. For instance, the WHO estimates that suicide rates among prisoners are approximately three to nine times higher than those observed outside prisons, depending on country and context. This number is even higher among the youth. Young people in prisons are 18 times more likely to commit suicide than young people in community.

In India, suicides are significantly higher in prisons than in the outside community (Paliath 2025;NCRB, 2021). Comparable disparities are observed globally: in the United Kingdom, the suicide rate in custody is roughly six times higher than in the general population (Ministry of Justice, 2023), while

in the United States, prison suicide rates are over three times higher (Fazel et al., *The Lancet Psychiatry*, 2017). The convergence of these figures suggests that the carceral environment itself—characterized by isolation, stigma, and limited access to mental healthcare—acts as a critical risk amplifier for self-harm and suicide.

A large body of psychiatric and criminological research identifies mental illness as a key underlying factor in prison suicides. Fruehwald et al. (2007) conducted a seminal case-control study across Austrian correctional facilities (1975–1999), finding that prisoners with psychiatric diagnoses, past suicidal behavior, and psychotropic medication histories were significantly more likely to die by suicide than matched controls. Among sentenced offenders, psychiatric illness and solitary confinement emerged as the most consistent predictors. Earlier studies echo these patterns: Weinstein (1989) observed that most prisoners who committed suicide suffered from treatable psychiatric illnesses, while Durand et al. (1995) found that suicide rates among inmates with previous suicide attempts were 100 times higher than those in the general population.

The Bangalore Prison Mental Health Study conducted by NIMHANS confirms these findings within the Indian context. The study observed that 45–63% of suicide victims in Indian prisons had a prior history of suicide attempts, and many had communicated their intent to others before the act. It also found that psychiatric morbidity—particularly depressive disorders and psychosis—was significantly higher among inmates who attempted or completed suicide. These findings reveal a dual failure: of mental health systems to identify and treat high-risk individuals and of prison administration to provide environments conducive to psychological well-being.

In sum, both Indian and international evidence converge on the point that suicide in prisons is not an isolated behavioral anomaly, but rather a predictable outcome of the intersection of untreated mental illness, environmental stressors, and systemic neglect. It reflects both the absence of robust mental health screening and care mechanisms, and the punitive rather than rehabilitative orientation of Indian prison systems. In other words, prevalence of suicides among the mentally ill prisoner is another massive cost of how this deviant is perceived, so that detention takes precedence over life. It leads one back to the core question asked within the Mulla Committee, as to how the state sees the prison setting—whether as a place of reform or a place of detention.

Addressing the crisis of suicides requires integrating mental health services within prisons, ensuring early detection of psychiatric disorders, and replacing custodial isolation with psychosocial support—steps essential not only to reduce suicides but also to restore dignity to the incarcerated. Suicide prevention in prisons requires a structured, clinically informed, and institutionally coherent framework, and comparative evidence from international correctional systems shows that such frameworks must integrate security practices with mental-health care. The American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC) outline the most widely used suicide-prevention standards globally, emphasising a written, facility-wide suicide prevention programme; systematic identification of at-risk prisoners through intake screening; continuous training of correctional staff; graded levels of observation; environmental safety measures; and post-incident reporting and review (Bonner, 2000; NCCHC, 2004). These guidelines highlight that prevention is not merely a clinical function but an operational sequence linking screening, assessment, monitoring, and communication between health and custodial personnel.

The NHRC Advisory on Mitigation of Suicide and Self-Harm in Prisons (2023) closely mirrors these principles. It mandates the incorporation of mental-health screening into initial health assessments, specifies that medical staff be trained by mental-health professionals where specialists are unavailable, and prescribes a two-level monitoring system with continuous supervision for high-risk

prisoners (NHRC, 2023). It further requires mental-health literacy in basic and refresher training for prison officials, Psychological First Aid (PFA) training, adherence to means-restriction protocols, and documentation and preservation of evidence following any suicide attempt. In this respect, the NHRC advisory aligns closely with ACA and NCCHC expectations on screening, staff training, monitoring, intervention, and administrative review.

Yet the comparison also highlights systematic gaps in India's institutional arrangements that impede effective implementation. While ACA and NCCHC standards assume the presence of a stable, adequately staffed correctional health infrastructure—either integrated within the prison system or supported through dedicated clinical services—the NHRC begins by acknowledging the chronic shortage of personnel and the absence of mental-health professionals in most Indian prisons (NHRC, 2023). Its recommendation that sanctioned staff strength be expanded to include psychologists, medical officers, and counsellors underscores the structural weakness of Indian prisons, where health services rely heavily on overburdened medical staff or external referrals. Moreover, while the NHRC encourages coordination between medical and prison staff, it does not provide enforceable protocols or institutional mechanisms that bind state prison departments and state health departments into a shared operational chain. This institutional separation—administratively, financially, and in terms of reporting lines—remains the primary obstacle to translating screening and monitoring guidelines into practice. This harks back to the central point raised in Mulla Committee as well about the need for cohesion of different state apparatuses for any effective prison. Even though the NHRC prescribes family contact during periods of acute risk and the use of technologies such as CCTV for 24x7 monitoring, these measures cannot substitute for an integrated clinical governance structure in which mental-health professionals participate in routine risk assessment, monitoring plans, and case review. By contrast, the NCCHC model requires clear clinical oversight, interdepartmental communication protocols, and mandatory administrative and medical reviews after every suicide attempt—elements that ensure accountability and continuous learning across custodial and clinical systems.

Therefore, while the NHRC advisory provides a necessary framework, substantive reform requires binding institutional linkages. These include: (a) posting dedicated mental-health officers within each prison or cluster as part of the state health department; (b) establishing joint Standard Operating Procedures (SOPs) signed by Directors General of Prisons and Directors of Health Services, detailing pathways from intake screening to psychiatric referral and escalation; (c) creating integrated data systems and shared incident logs accessible to both custodial and clinical authorities; and (d) ensuring predictable funding for mental-health staffing and tele-psychiatry services in regions where on-site specialists are unavailable. Without such structural integration, India's suicide-prevention strategies risk remaining fragmented and reactive. The NHRC's convergence with international standards thus provides a conceptual and normative foundation, but only institutional cohesion between the prison and medical systems can translate these standards into sustained reductions in self-harm and suicides in custodial settings.

II CONCLUSION

How the state sees, coexists with the question of how much can the state see. The cost of lack of state capacity can be understood quite insightfully with *Mrs. Veena Sethi vs. State Of Bihar And Ors.* It talks about 16 mentally ill prisoners who continued to be in jail as asylums were overcrowded, and the court was unable to concretely receive reports from the prisons about their condition (*Mrs Veena Sethi vs State of Bihar*). Despite a seemingly robust statutory framework, major gaps persist.

Psychiatric infrastructure in prisons is grossly inadequate; most facilities lack mental-health wards or trained professionals to implement CrPC protocols (National Human Rights Commission [NHRC], 2020). Jurisdictional ambiguities persist between prison and health departments, leading to administrative neglect. Additionally re-evaluation delays under Sections 337–338 often result in de facto indefinite detention (Rabiya & Raghavan, 2018). This is another way in which the state’s neglect of mental health and intent of detention may come out. The concept of “safe custody” itself remains custodial rather than therapeutic, conflicting with the rights-based approach of the Mental Healthcare Act, 2017, which mandates treatment in the least restrictive environment. Even with the rights based approach, the question of how the state sees the criminal lunatic itself seems to not have reformed and that remains the central node from which such dualities flow. Custodial logic replicates prison conditions within hospitals, thereby re-criminalizing illness. Furthermore, empirical data on mentally ill prisoners in India remain sparse, as Rabiya and Raghavan (2018) observe, making policy reform difficult to calibrate.

Aspects of the CrPC reflect a colonial legacy in which mental illness was treated as a procedural irregularity rather than a public-health concern. Through intertwined legal and medical classifications, the Code attempts to balance trial fairness and public safety, but this dual system produces uncertainty, bureaucratic overlap, and rights violations. Bridging this gap requires aligning criminal procedure with the therapeutic and rights-based vision of the Mental Healthcare Act, 2017, ensuring that individuals with mental illness are no longer trapped between the legal identities of prisoner and patient but recognized as persons entitled to both justice and care.

ENDNOTES

- 1 Relevant points from the history of the amendment :
 - a. Maru Ram v. Union of India (1981): The Supreme Court upheld the constitutionality of Section 433A but clarified that it does not curtail the constitutional powers of the President (Art. 72) or Governor (Art. 161) to grant pardon, commutation, or remission. (<https://www.dhyeyalaw.in/maru-ram-v-union-of-india1981-scc-1-107>)
 - b. Laxman Naskar v. Union of India (2000): Laid down guidelines for premature release of life convicts even after 14 years, stressing that public interest, conduct of the prisoner, and nature of the crime must be considered. (<https://blog.lukmaanias.com/2024/01/10/unlawful-remission-on-the-bilkis-bano-case/#:~:text=In%20'Laxman%20Naskar%20v.,crime%20being%20repeated%20in%20future%3F>)

REFERENCES

- Andersen, H. S. (2004). Mental health in prison populations. A review—with special emphasis on a study of Danish prisoners on remand. *Acta Psychiatrica Scandinavica*, 110(s424) onlinelibrary.wiley.com/doi/abs/10.1111/j.1600-0447.2004.00436.2.x
- Blaauw, E., & van Marle, H. J. (2007). Mental health in prisons. *Health in prisons: A WHO guide to the essentials in prison health* (p. 133). World Health Organization.
- Bonner, R. L. (2000). Correctional suicide prevention in the year 2000 and beyond. *Suicide and Life-Threatening Behaviour*, 30(4), 370-376.
- Clark, J. (2015). Prison reform in nineteenth-century British India (University of Canterbury). University of Canterbury Research Repository. <https://ir.canterbury.ac.nz/server/api/core/bitstreams/3931a8b4-c5a5-4ad4-a6e3-5bee6f052086/content>
- Committee on Jail Reforms (Mulla Committee). (1983). Report of the All India Committee on Jail Reforms (1980–83) (Vols. I & II). Bureau of Police Research & Development, Ministry of Home Affairs, Govt. of India. (<https://archive.org/details/dli.csl.1257/page/n7/mode/1up?view=theater>)
- Department-related Parliamentary Standing Committee on Home Affairs. (2023). Two hundred forty-fifth report: Prison conditions, infrastructure and reforms (R.S. Report No. 245). Rajya Sabha Secretariat.
- Devgan, R. (2022, October 31). CrPC Section 433A—Restriction on powers of remission or commutation in certain cases. A Lawyer's Reference. <https://devgan.in/crpc/section/433A/>
- Devgan, R. (Ed.). (2022, October 31). Code of Criminal Procedure, 1973. A Lawyer's Reference. <https://devgan.in/crpc/>
- DuRand, C. J., Burtka, G. J., Federman, E. J., Haxcox, J. A., & Smith, J. W. (1995). A quarter century of suicide in a major urban jail: Implications for community psychiatry. *Am J Psychiatry*, 152, 1077–1080
- Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23 000 prisoners: a systematic review of 62 surveys. *The Lancet*, 359(9306), 545-550. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(02\)07740-1/abstract?cc=y%3D](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(02)07740-1/abstract?cc=y%3D)
- Foucault, M. (1961). *Madness and civilization: A history of insanity in the age of reason* (R. Howard, Trans.). Monoskop. https://monoskop.org/images/1/14/Foucault_Michel_Madness_and_Civilization_A_History_of_Insanity_in_the_Age_of_Reason.pdf
- Frühwald, S., Seyringer, M., Matschnig, T. et al. (2007). Epidemiology of jail and prison suicides in Austria. *BMC Psychiatry*, 2(Suppl 1), S18. <https://doi.org/10.1186/1471-244X-7-S1-S18>
- Government of India. (1900). The Prisoners Act, 1900 (Act No. 3 of 1900). https://www.indiacode.nic.in/bitstream/123456789/11092/1/the_prisoners_act_1900.pdf
- Government of India. (1912). Indian Lunacy Act, 1912 (Act No. IV of 1912). https://www.indiacode.nic.in/bitstream/123456789/11080/1/indian_lunacy_act_1912.pdf
- Government of India. (1973). The Code of Criminal Procedure, 1973 (Act No. 2 of 1974). https://www.indiacode.nic.in/bitstream/123456789/15272/1/the_code-of-criminal-procedure%2C_1973.pdf
- Government of India. (2017). The Mental Healthcare Act, 2017 (Act No. 10 of 2017). <http://www.indiacode.nic.in/bitstream/123456789/2249/1/A2017-10.pdf>
- https://books.google.co.in/books?hl=en&lr=&id=vvTZFFe_yv8C&oi=fnd&pg=PA133&dq=Blaauw+and+Van+Marle+2007&ots=ZW1CxIvEb9&sig=fQ88Mu_S0jxhtcwZpejBxR6FisE&redir_esc=y#v=onepage&q=Blaauw%20and%20Van%20Marle%202007&f=false
- Indian Lunacy Act, No. 4 of 1912, § 35(1) (India). Retrieved October 22, 2025, from <https://indiankanoon.org/doc/176557045/>
- Indian Lunacy Act, No. 4 of 1912, § 35(2) (India). IndianKanoon. Retrieved October 22, 2025, <https://indiankanoon.org/doc/67809402/>
- Indian Lunacy Act, No. 4 of 1912. (1912). Government of India. <https://indiankanoon.org/doc/128750983/>
- James, D. J., & Glaze, L. E. (2006). Mental health problems of prison inmates. Special Report of the Justice

Statistics.

- Lamb, H. R., & Weinberger, L. E. (1998). Persons with severe mental illness in jails and prisons: A review. *Psychiatric services*, 49(4), 483–492. <https://psychiatryonline.org/doi/full/10.1176/ps.49.4.483>
- Ministry of Home Affairs, Government of India, & Bureau of Police Research & Development. (2003). Implementation of the recommendations of All-India Committee on Jail Reforms (1980-83): Volume I [Report]. <https://www.mha.gov.in/sites/default/files/Mulla%20Committee-%20implementation%20of%20recommendations-%20Vol%20I.pdf>
- National Commission on Correctional Health Care. (2004). Suicide prevention resource guide. https://www.ncchc.org/wp-content/uploads/Suicide_Prevention_Resource_Guide.pdf
- National Crime Records Bureau. (2023). Prison Statistics India 2022 (as on 01.12.2022). Ministry of Home Affairs, Government of India. https://www.ncrb.gov.in/uploads/nationalcrimerecordsbureau/custom/ps_iyearwise2022/1701613297PSI2022ason01122023.pdf
- National Human Rights Commission (India). (2023, June 19). Advisory on deliberate self-harm and suicide attempts by prisoners. Government of India. https://nhrc.nic.in/sites/default/files/NHRC%20Advisory%20on%20DSH%20and%20Suicide%20attempts%20by%20prisoners_2023.pdf
- National Human Rights Commission. (2020). Annual report 2019–2020. National Human Rights Commission. https://nhrc.nic.in/sites/default/files/AR_2019-2020_EN.pdf
- National Institute of Mental Health and Neuro Sciences. (2016). National Mental Health Survey of India, 2015-16: Prevalence, patterns and outcomes [Report 2]. <http://indianmhs.nimhans.ac.in/phase1/Docs/Report2.pdf>
- National Institute of Mental Health and Neuro Sciences. (2016). National Mental Health Survey of India, 2015–16: Prevalence, patterns and outcomes (Report 2). <https://indianmhs.nimhans.ac.in/phase1/Docs/Report2.pdf>
- Paliath, S. (2025, August 2). The brewing mental health crisis in Indian prisons. IndiaSpend. <https://www.indiaspend.com/governance/the-brewing-mental-health-crisis-in-indian-prisons-963116>
- Rabiya, S., & Raghavan, V. (2018). Prison mental health in India: Review. *Indian Journal of Social Psychiatry*, 34(3), 193-196. https://doi.org/10.4103/ijsp.ijsp_9_18
- Rizwana, B. N. (2019). Locating mental disabilities in colonial Indian legislation: A study of acts and remedies. *Commonwealth Law Review Journal*, 5, 321–332. <https://thelawbrigade.com/wp-content/uploads/2019/07/BABY-RIZWANA-N-V.pdf>
- Taylor, E. (2010). A review of mental health need in prison. *Probation Journal*, 57(2), 188–189. <https://journals.sagepub.com/doi/abs/10.1177/02645505100570020302>
- Tirumani, S. R., Vennam B. S., Seepana R. (2020). A study on prevalence of psychiatric morbidity and substance abuse among prisoners. *Open J Psychiatry Allied Sci*, 11, 96–9.
- United Nations Office on Drugs and Crime. (2025). Global prison population and trends: A focus on rehabilitation (Prison Brief, May 2025) https://www.unodc.org/documents/data-and-analysis/prison/Prison_brief_2025.pdf
- Weinstein, H. C. (1989). Psychiatric services in jails and prisons: who cares? (editorial). *Am J Psychiatry*, 146: 1094–1095
- Wilper, A. P., Woolhandler, S., Boyd, J. W., Lasser, K. E., McCormick, D., Bor, D. H., & Himmelstein, D. U. (2009). The health and health care of US prisoners: results of a nationwide survey. *American journal of public health*, 99(4), 666–672. <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2008.144279>



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