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Criminal responsibility and mental illness in India: A human rights critique of the insanity defence and fitness to stand trial

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Abstract: *Criminal responsibility, a cornerstone of criminal law, is predicated on the assumption that individuals possess the mental capacity to understand the nature and consequences of their actions. However, this premise becomes complex when mental illness affects an individual's cognitive or volitional faculties. This study undertakes an analysis of the interface between mental illness and criminal responsibility within the Indian legal framework, with particular focus on the insanity defence and the role of forensic psychiatry. Drawing on statutory law, judicial interpretation, and emerging human rights perspectives, it critically evaluates how Indian criminal law addresses mentally ill offenders and assesses the adequacy of existing legal standards and institutional mechanisms. The study further explores the challenges posed by unstructured psychiatric assessments and the absence of formalised protocols, with selective reference to international practices to contextualise the Indian framework. The research concludes with recommendations to harmonise Indian criminal law with evolving psychiatric knowledge and international human rights obligations. It proposes a set of reforms aimed at enhancing the doctrinal coherence, clinical accuracy, and constitutional validity of India's approach to criminal responsibility in cases involving mental illness.*

Keywords: *criminal responsibility; insanity defence; forensic psychiatry; fitness to stand trial*

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1. Introduction

The intersection of mental health and criminal responsibility is a nuanced and consequential issue that lies at the nexus of legal and psychological disciplines. This multifaceted domain delves into the intricate relationship between mental illness and culpability within the criminal justice system, raising fundamental questions about the principles of justice, fairness, and individual rights. Understanding this interplay is paramount, particularly in India, where the legal landscape is shaped by a blend of cultural heritage, historical legacies, and modern legal principles. The intersection needs to be considered in terms of human rights as well, specifically with references to constitutional guarantees of equality, dignity, and personal liberty. The issue of whether a criminal is responsible in cases of mental illness is not just a matter of law but directly concerns the accused's right to a fair trial, their effective involvement in the legal proceedings, as well as the right against arbitrary deprivation of liberty. In the event of mental incapacity being poorly evaluated or misconstrued, it does not just mean wrongful conviction but also unjust and prolonged institutionalisation, which becomes a grave concern given Article 21 of the Constitution of India(Mani, n.d.).This makes a human rights-based approach the necessary measure to determine whether current legal norms have any significant protection of the procedural and substantive rights of mentally ill individuals in the criminal justice system.

A foundational concept in this discourse is fitness to stand trial, which determines whether an accused person possesses the mental competence to understand and meaningfully participate in legal proceedings. The concept of competency to stand trial originated in United States jurisprudence, particularly in the landmark case of *Dusky v. United States, 362 U.S. 402 (1960)* where the Supreme Court held that a defendant must possess "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding" and a "rational as well as factual understanding of the proceedings against him" to be deemed fit to stand trial (Gay et al. 2017).

India inherited this legal construct through its common law framework and codified it in the Criminal Procedure Code (CrPC) (1973)(*THE CODE OF CRIMINAL PROCEDURE, 1973 _____ ARRANGEMENT OF SECTIONS*, n.d.), specifically under Sections 328 and 329. These provisions empowered courts to order medical evaluations first by a civil surgeon, and subsequently by a qualified psychiatrist or psychologist, when there is reason to believe the accused is mentally unfit to participate in their defence. Although Indian statutes do not explicitly refer to the term fitness to stand trial, the judiciary has consistently treated it as distinct from the insanity defence outlined in Section 22 of the Bharatiya Nyaya Sanhita (BNS)(*MINISTRY OF LAW AND JUSTICE (Legislative Department)*,

n.d.). While the insanity defence concerns the mental state at the time of the offence, fitness to stand trial focuses on the accused's present ability to understand and participate in legal proceedings (Arrigo and Bardwell 2000; Cruise and Rogers 1998).

The Bharatiya Nagarik Suraksha Sanhita (BNSS) (2023) built upon this framework under Chapter XXVII (Sections 367–378), updating procedural mechanisms such as mandatory psychiatric evaluations, postponement of proceedings, and conditional resumption once the accused is declared mentally fit. This statutory transition reflects a continuity with earlier principles while introducing structural reforms aimed at procedural clarity and therapeutic justice.

Despite such legislative advancements, there are significant concerns. Many people with mental disorders may still be prosecuted and imprisoned unfairly, often for relatively minor offences, leading to prisons effectively becoming *de facto* mental hospitals (Kathane et al. 2022). This highlights a troubling gap between the occurrence and treatment of mental disorders, with reports indicating that approximately 76–85 percent of individuals with severe mental disorders in low-and middle-income countries (LMICs) receive no treatment(*Convention on the Rights of Persons with Disabilities (CRPD) | Division for Inclusive Social Development (DISD)*, n.d.). The current legislative frameworks often fall short in adequately addressing the complexities of mental health issues among offenders, underscoring the need for continuous review and updating of legislation, especially in LMICs, to ensure the maximal utilisation of scarce resources.

This paper aims to investigate and analyse the legal standards governing mental illness in the context of criminal law in India, while briefly referring to international practices where relevant. It will explore the statutory provisions, judicial interpretations, and practical challenges associated with assessing mental capacity and criminal responsibility and delve into the criminological aspects of mentally ill offenders. The study ultimately seeks to provide insights into effective intervention and rehabilitation strategies, highlighting the importance of compassionate and informed approaches to address mental health issues within the criminal justice system. In doing so, the paper situates the doctrines of insanity defence and fitness to stand trial within a broader human rights framework, interrogating whether the Indian legal system adequately reconciles principles of culpability with the rights of mentally ill accused persons. It further examines whether existing procedural safeguards effectively uphold fair trial guarantees or whether structural and institutional deficiencies continue to undermine these protections in practice. This paper builds on existing scholarship while identifying gaps in the integration of criminal law doctrine, forensic psychiatric practice, and human rights frameworks.

2. Research methodology

This study adopts a doctrinal research methodology, relying on the analysis of primary and secondary legal sources. Primary sources include statutory frameworks such as the BNS(*MINISTRY OF LAW AND JUSTICE (Legislative Department)*, n.d.), the BNSS(Vlk/Kkj.k MINISTRY OF LAW AND JUSTICE (Legislative Department), n.d.), and (*Mental Healthcare Act, 2017*, 2017) along with relevant judicial decisions interpreting the insanity defence and fitness to stand trial. Secondary sources include scholarly literature in criminal law, forensic psychiatry, and human rights law. The study also employs a selective comparative analytical approach by examining legal and forensic practices in jurisdictions such as the United States, the United Kingdom, and Canada. The research is qualitative in nature and is limited by its reliance on doctrinal and literature-based analysis without empirical field data.

3. Review of literature and conceptual framework

The nexus of mental illness and criminal responsibility has been explored within a variety of disciplinary practices, such as criminal law, forensic psychiatry, and human rights law. Classical legal theory has paid much attention to the doctrinal constraints of the insanity defence, especially its continued reference to M'Naghten rules, which emphasise cognitive inability but mostly omit volitional defects (Morse 2011). This has resulted in consistent criticism that the legal test is not reflective of modern psychiatric knowledge of mental disorders.

In line with this, the forensic psychiatric literature has discussed the issues related to the determination of competency and criminal responsibility. Grisso (2006) discusses the significance of well-constructed evaluation instruments and standardised procedures to assess fitness to stand trial, as lack of such systems usually results in the lack of consistency in expert testimony and judicial verdicts. On the same note, Appelbaum (2007) points to the clinical and ethical issues of determining mental capacity, especially in a legal adversarial context where the subjectivity of diagnosis could pose a threat to the reliability of evidentiary practice.

Human rights-wise, there has been an increasing trend of focusing on the implications of mental illness in the criminal justice system. One target of this discussion has been the United Nations Convention on the Rights of Persons with Disabilities (CRPD), especially regarding Article 12, which recognises the equal legal capacity of persons with disabilities. Scholars, including Dhanda (2007) and Minkowitz (2007), believe that the insanity defence and other aspects of the conventional law can be inconsistent with the focus of the CRPD on autonomy and non-discrimination; thus, a reassessment of the conceptualisation of capacity and responsibility of the legal framework is necessary.

Nevertheless, current literature tends to consider these areas, namely the criminal law doctrine, the forensic psychiatric practice, and the human rights norms, as analytically separate ones. Appreciable absence of factual scholarship that critically looks at how these constructs have harmonised to formulate how mentally ill accused persons are treated in legal systems, especially in the Indian context. This paper aims to fill this gap by placing the insanity defence and fitness to stand trial within a single analytic framework that integrates the legal, clinical, and human rights approaches to the issue. Against this backdrop, the following sections examine the Indian legal framework governing criminal responsibility and mental illness.

4. Legal framework on mental illness and criminal responsibility in India

India's legal approach to mental illness and criminal responsibility is deeply rooted in English common law principles. A foundational tenet of criminal jurisprudence – *actus non facit reum nisi mens sit rea* "an act does not make a person guilty unless done with a guilty mind" – serves as the basis for assessing culpability in cases involving mental illness (Morse 2011).

4.1. Evolution of the insanity defence in Indian law

The legal treatment of mental illness in India has undergone a significant transformation from its colonial origins. The Lunacy Acts of 1858 and later the Indian Lunacy Act of 1912 were primarily custodial in nature, aimed at segregating mentally ill individuals for public safety. These early statutes focused more on institutionalisation than treatment or rights. A paradigm shift occurred with the (*Mental Healthcare Act, 2017*, 2017), which attempted to frame mental illness in more humane terms by promoting care and treatment. However, it was still criticised for emphasising legal procedures over mental healthcare delivery and lacking adequate provisions for protecting patient rights. The introduction of the MHCA marked a transformative moment in Indian mental health law (Kaur and Dangwal 2024). The MHCA adopts a rights-based approach, aligning with international human rights standards. It expands the definition of mental illness, strengthens patient autonomy and rights, and notably decriminalises suicide under Section 115, presuming that anyone attempting suicide is suffering from severe stress and thus requires care, not punishment.

4.2 Section 22 of the BNS and the M'Naghten Rule

Section 22 of the BNS provides the principal legal basis for the insanity defence as it states:

"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."

This provision is largely derived from the M'Naghten Rules, established in England in 1843, which emphasise the accused's cognitive incapacity at the time of the act. The test assesses whether the accused understood the nature and consequences of the act or recognised that it was wrong. Importantly, this legal standard does not account for volitional impairment or irresistible impulse. The presumption in law is that every person of sound discretion is considered sane, and thus, the burden lies on the accused to establish insanity (Asokan 2014).

4.3. Judicial interpretation and key case law

The Indian judiciary has played a crucial role in interpreting and applying the insanity defence, drawing a clear line between legal insanity and medical insanity. A psychiatric diagnosis alone does not absolve criminal responsibility; the court requires evidence that the accused was legally insane at the time of the crime, i.e., incapable of understanding the nature or wrongfulness of the act.

Regarded as a foundational case in Indian criminal jurisprudence on mental illness, the Supreme Court in *Dahyabhai Chhaganbha Thakker v. State of Gujarat*, held that the defence must prove unsoundness of mind on a preponderance of probabilities, not beyond a reasonable doubt. This standard was reaffirmed in *Surendra Mishra v. State of Jharkhand* where the Court emphasised that a history of mental illness alone is insufficient; it must be shown that the accused was mentally impaired at the time of the offence.

In *Shrikant Anandrao Bhosale v. State of Maharashtra*, the Court reiterated the necessity of corroborative behavioural and medical evidence to support claims of insanity.

A key precedent was set in *Devidas Loka Rathod v. The State of Maharashtra*, where the Supreme Court ruled that investigators have a duty to ensure immediate medical examination of an accused, with a known history of mental illness. Failing to do so undermines the credibility of the prosecution's case.

4.4. Fitness to stand trial under Chapter XXVII of the BNSS

The concept of fitness to stand trial, also referred to as competency to stand trial or fitness to plead, is a crucial intersection of psychology and law, determining whether an accused individual possesses the mental capacity to comprehend legal proceedings and participate meaningfully in their defence (Appelbaum 2007). Across jurisdictions, legal systems require that an accused

person must understand the nature, purpose, and potential outcomes of the proceedings and be able to effectively communicate with legal counsel to ensure a fair trial. The notion of fitness to stand trial is inseparable in human rights consideration with the right to a fair trial and due process. An accused who is unable to comprehend proceedings or hire counsel is virtually deprived of meaningful involvement in their own defence. This not only compromises procedural fairness but also has constitutional implications with regard to Article 21, which affirms the right to life and personal liberty, including fair and just legal procedure. In this regard, fitness tests play a vital role in preventing miscarriages of justice because only when the accused has the necessary level of mental competence, the criminal trials may be undertaken. For instance, the widely used *Dusky* standard in the United States defines competency as the accused's ability to consult with a lawyer with a reasonable degree of rational understanding, as well as a rational and factual grasp of the legal process (Pillay 2014).

In India, the framework for determining fitness to stand trial is laid out under Sections 367 to 379 of the BNSS which provide procedural safeguards when an accused is suspected to be mentally unfit. These provisions include mandatory medical evaluations, the postponement of trials, hospitalisation for treatment, and specific criteria for resuming proceedings once the individual is deemed mentally fit. If a *prima facie* case is established and the accused shows signs of mental illness, they are referred to a district surgeon, who in turn directs them to a qualified psychiatrist or psychologist. The accused is then admitted to a psychiatric facility for treatment until they are fit to participate in the trial. Consistent with international practice, criminal proceedings are generally suspended until fitness is restored (Chadda 2013).

Despite the existence of these legal provisions, the implementation of fitness to stand trial assessments in India faces several challenges. These include insufficient infrastructure for forensic psychiatric evaluation, a lack of coordination between legal and medical systems, and delays arising from the absence of legally mandated timelines for conducting forensic psychiatric assessments (Pillay 2014). There is also no standardised or uniform method for evaluating mental capacity across jurisdictions in India, further complicating the process (Asokan 2014). In some countries, such as South Africa, the indeterminate duration of psychiatric hospitalisation for individuals found unfit to stand trial has raised ethical concerns, as some individuals risk being detained indefinitely within the mental health system without a clear legal or therapeutic resolution (Houidi et al. 2018).

Although Indian case law specifically addressing fitness to stand trial implementation is limited, judicial interpretations reinforce the necessity of thorough medical evaluation and procedural diligence in cases involving mental illness. Courts have emphasised that the accused's right to a fair trial includes proper assessment and treatment where needed. The case of

Devidas Loka Rathod v. the State of Maharashtra exemplifies the judiciary's growing awareness of this issue, affirming the investigator's duty to ensure timely psychiatric evaluation where a history of mental illness is apparent. This approach underscores the importance of a multidisciplinary, systematic framework, particularly in complex cases involving multiple mental health conditions, to uphold justice and procedural fairness.

5. Role of forensic psychiatry and expert evidence: Comparative insights and the Indian context

Having examined the statutory and judicial framework governing criminal responsibility, it becomes necessary to consider the role of forensic psychiatry in operationalising these legal standards within the criminal justice process. Forensic psychiatry occupies a critical interface between law and mental health, applying clinical and scientific expertise to resolve complex legal questions across criminal, civil, correctional, and legislative contexts (Naik and Damodharan 2021). In the criminal justice system, it plays a foundational role in determining the mental state of accused individuals at various procedural stages, most notably, criminal responsibility, fitness to stand trial, and appropriate therapeutic disposition. In India, forensic psychiatric evaluations are conducted under Sections 367–368 of the BNSS, wherein court-ordered assessments assist in deciding whether an accused person possesses adequate cognitive ability to engage meaningfully in legal proceedings or to be held criminally accountable.

Evaluations in India typically assess the accused's understanding of the nature and consequences of the charges, familiarity with courtroom procedures, and ability to consult with legal counsel. Importantly, hospitalisation is not mandatory, and outpatient forensic psychiatric assessments are increasingly utilised for their cost-effectiveness and alignment with liberty-preserving principles (Nambi et al. 2016). A multidisciplinary team, often comprising psychiatrists, psychologists, social workers, and mental health nurses, may be involved, and their findings may be presented through expert testimony, generally admissible under Section 39 of the (*THE BHARATIYA SAKSHYA ADHINIYAM, 2023*, n.d.) which governs expert evidence in matters requiring specialised knowledge.

However, systemic challenges persist. The subjectivity inherent in psychiatric diagnosis, compounded by divergent clinical interpretations, theoretical orientations, and uneven interviewing styles, can lead to inconsistencies in expert findings. This variability is particularly problematic in high-stakes determinations such as legal insanity or unfitness to stand trial, where cross-examination often exposes diagnostic ambiguity. The lack of standardised diagnostic protocols in Indian forensic practice further complicates the reliability of such assessments (Chadda 2013).

The expert psychiatric evidence in Indian courts, however, is not evenly represented. Although courts have the privilege of admitting expert opinion when it comes to legal insanity or fitness to stand trial, it is not regarded as conclusive and can be questioned by the courts. The lack of standardised forensic assessment procedures also adds to the weight given to such testimony since different clinical views can be reached on similar cases. This non-uniformity is not only a problem that impacts the uniformity of the results of the judicial process, but it also puts the mentally ill accused on the losing end, especially in cases where the onus of proving insanity is on the accused. Enhancing the reliability and institutional credibility of forensic psychiatric evidence is thus crucial to the attainment of both evidentiary fairness and substantive justice.

5.1 Comparative insights: Learning from international practice

To address these challenges, several jurisdictions have adopted structured assessment tools and institutional models that strengthen the credibility, consistency, and legal utility of forensic psychiatric evidence.

In the United States, for example, the MacArthur Competence Assessment Tool-Criminal Adjudication (MacCAT-CA) is widely employed to assess a defendant's competence to stand trial. This standardised instrument evaluates cognitive and decisional capacities such as understanding, reasoning, and appreciation, providing courts with objective data to supplement clinical opinion. The United States also emphasises structured documentation, courtroom training for forensic experts, and interdisciplinary collaboration across mental health and legal domains (Wood et al. 2017).

The United Kingdom, while still guided by the traditional M'Naghten Rules for insanity, incorporates medical experts frequently under Section 1 of the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 and provides for psychiatric diversion where possible. The UK legal system allows for court-appointed experts and encourages joint expert reports in contested psychiatric issues. Furthermore, the UK makes use of structured assessment tools such as the HCR-20 (Historical, Clinical, Risk Management–20) for violence risk evaluation, used extensively in forensic hospitals and parole settings (Dolan and Campbell 1994).

Canada, under Section 16 of its Criminal Code, utilises the not criminally responsible due to mental disorder (NCRMD) standard. Canadian forensic psychiatry is deeply embedded in the legal process, with Review Boards playing a quasi-judicial role in overseeing both fitness to stand trial and long-term dispositions post-acquittal (O'Shaughnessy 2007). Canadian forensic institutions apply structured assessment protocols and emphasise ethical transparency, procedural fairness, and public safety, making expert evidence both influential and accountable (Chaimowitz et al. 2022).

While this paper does not undertake a full comparative legal analysis, references to international practices serve a limited but important function in contextualising the Indian framework. Jurisdictions such as the United States, the United Kingdom, and Canada have developed more structured approaches to forensic psychiatric evaluation and competency assessment, reflecting a greater degree of institutional integration between law and mental health systems. These comparative insights highlight potential pathways for reform but are used here primarily to illuminate gaps within the Indian system rather than to provide an exhaustive comparative study.

6. Rights-based analysis and institutional gaps

Beyond doctrinal and procedural considerations, the treatment of mentally ill accused persons raises significant human rights concerns that extend to issues of dignity, equality, and access to justice. The evolution of mental health legislation in India, particularly with the enactment of the MHCA of 2017, signals a growing commitment to human rights and alignment with international norms. Replacing the MHA of 1987, the MHCA represents a major shift toward a rights-based framework, emphasising autonomy, dignity, and access to care. It broadens the definition of mental illness to include substance use disorders and other conditions that significantly impair judgment, behaviour, or perception of reality (Duffy and Kelly 2019). This rights-based orientation is reflected not only in the broader framework of the Act but also in specific provisions that directly impact the treatment of individuals within the criminal justice system. One of its most progressive features is Section 115, which decriminalises suicide attempts by presuming severe stress in such cases unless proven otherwise, thereby adopting a compassionate public health perspective. The Act also enables the transfer of prisoners with mental illness to mental health establishments (MHCA 2017, Section 102), ensures access to rehabilitation, regulates neurosurgical interventions, and allows individuals to draft advance directives expressing their preferences for treatment during future mental health crises. Importantly, it restricts involuntary admissions to specific circumstances, subject to oversight by Mental Health Review Boards (MHRBs), further safeguarding individual rights (Raveesh et al. 2019).

India's ratification of the CRPD in 2008 reinforced the obligation to reform mental health laws in line with its human rights principles (Raveesh et al. 2019). The CRPD adopts a transformative approach to disability, including mental illness, by recognising legal capacity, equality, and the right to support in decision-making. Article 12 is particularly significant, affirming that all individuals possess full legal capacity and must not be denied their rights based on mental capacity assessments. While the CRPD does not explicitly prohibit involuntary treatment, it urges Member States to implement safeguards against its misuse and encourages supportive, rights-respecting alternatives. Nonetheless, there are normative complexities in the implementation of the CRPD framework into the criminal law.

Although Article 12 recognises the equal legal capacity of persons with disabilities (including mentally ill) the conservative criminal law principles like the insanity defence assume that some persons are not capable of the necessary capacity to commit a crime. This creates a normative tension between recognising individual autonomy and acknowledging diminished criminal culpability. A human rights-based approach thus demands a sensitive balancing of these principles so as not to deny people unfairly the right to legal agency, but at the same time not to leave them unfairly liable to criminal responsibility due to defective mental capacity. The lack of a defined doctrinal convergence between these stances is a significant gap in the Indian legal framework.

While the statutory framework reflects a progressive rights-based orientation, its effectiveness ultimately depends on institutional implementation. While these legislative advancements signal a progressive shift in principle, their effectiveness remains contingent upon institutional implementation. Many States have failed to establish Mental Health Authorities or MHRBs and have not issued the necessary regulatory guidelines for mental health institutions, preventing individuals from exercising their rights under the MHCA. Inadequate budgetary allocations have led to a shortage of trained professionals and poorly equipped facilities. Furthermore, although the Act recognises the right to community living under Section 19, progress toward developing community-based services has been negligible. In the absence of adequate community-based and institutional support systems, these legal guarantees often fail in practice. The absence of such infrastructure has effectively turned prisons into substitute mental health institutions, where a significant portion of the incarcerated population suffers from untreated mental illness. Overcrowding, solitary confinement, and a lack of psychiatric care worsen mental health conditions and increase the risk of recidivism, with long-term consequences extending beyond imprisonment (Philip et al. 2022).

Judicial interpretation further reflects these inconsistencies. The case of *Mahendra K. C. v. The State of Karnataka* exemplifies the judicial system's occasional insensitivity to mental health issues. In this case, the Supreme Court criticised the High Court for labelling the deceased as a "weakling" without properly evaluating the mental health context, cautioning against the application of rigid and simplistic standards to such complex matters. This highlights a broader issue of stigma and bias within the criminal justice system (Gu and Ding 2025). This is not an isolated concern but reflects a broader systemic pattern. People with mental illness often face discriminatory treatment at the hands of law enforcement, prosecutors, and even judges, which can result in unjust outcomes. These individuals are overrepresented in the criminal justice system due to structural factors such as poverty, homelessness, and limited access to mental health services. The continued presence of societal stigma further marginalises them, reinforcing cycles of disadvantage and exclusion. While the MHCA

sets an ambitious framework for the protection of mental health rights, its true impact depends on sustained institutional reform, resource allocation, and cultural change within both the mental health and criminal justice systems. Taken together, these legal, institutional, and social factors reveal a pattern of fragmented protection. This analysis highlights a critical gap between legal doctrine and its practical implementation, raising important questions about the adequacy of existing safeguards in protecting the rights of mentally ill accused persons, particularly in the context of criminal responsibility, the insanity defence, and the accused's ability to meaningfully participate in trial proceedings.

7. Reform proposals and comparative models

Rethinking criminal responsibility and the insanity defence in India necessitates a paradigm shift that harmonises legal principles with contemporary psychiatric knowledge and international human rights standards. A truly integrative approach must begin with capacity-building at both legal and medical-psychiatric levels. One of the most urgent legal reforms is to revise Section 22 of the BNS to broaden the current understanding of criminal incapacity beyond purely cognitive dysfunctions. By incorporating volitional impairments, as recognised in the American Law Institute Model Penal Code Test, Indian law can more accurately reflect the nuanced realities of mental illness and culpability.

India's legal framework currently lacks any explicit recognition of "diminished responsibility," a partial defence that permits judicial discretion in cases where mental illness does not meet the full threshold of legal insanity. This concept, long embedded in jurisdictions such as the United Kingdom through the (*Homicide Act 1957*, n.d.), allows courts to consider reduced culpability in sentencing, reflecting a more graduated and clinically informed model of criminal responsibility. The absence of such provisions in the BNS represents a significant gap in aligning Indian law with contemporary forensic psychiatric principles.

From a forensic systems perspective, India's forensic psychiatric evaluations currently rely heavily on unstructured clinical judgment, interviews, and observational assessments, which, while important, lack the objectivity and reproducibility of structured diagnostic frameworks. Although international tools such as the MacCAT-CA and the DR.SED paradigm offer robust models (Wood et al. 2017), their wholesale adoption may not suit the Indian legal and clinical ecosystem without context-specific adaptation. There is an urgent need to develop India-specific forensic assessment protocols, integrated with guidelines tailored to Indian jurisprudence, socio-cultural realities, and resource constraints.

Equally important is training judicial officers and legal counsel in the interpretation and limits of psychiatric evidence, thereby fostering mutual

respect and interdisciplinary competence between the legal and mental health systems. The Indian judiciary would particularly benefit from mandatory, specialised training in forensic psychiatry, especially for trial court judges, prosecutors, and court-appointed medical officers. A lack of familiarity with psychiatric diagnoses, treatment trajectories, and the clinical criteria for unfitness to stand trial can undermine both judicial accuracy and procedural fairness.

Institutional investment is also critical. India currently lacks dedicated forensic psychiatric hospitals, resulting in ad hoc treatment within general hospitals or prisons that are often ill-equipped to handle complex mental health cases. The establishment of dedicated forensic psychiatry units, the peer review of expert reports, and the codification of standards for psychiatric testimony would enhance both the probative value and ethical soundness of expert evidence in Indian courts. Additionally, the creation of national codes of practice and interdisciplinary review panels to resolve conflicting expert opinions would strengthen the evidentiary integrity of psychiatric inputs in legal proceedings.

Another critical area requiring reform is post-acquittal and post-release rehabilitation. The absence of structured halfway homes, supervised community placements, and psychosocial reintegration services leaves mentally ill offenders at risk of institutional cycling, relapse, and long-term marginalisation. A continuum of care, spanning custodial treatment to supported community living, is essential for promoting therapeutic recovery and upholding constitutional commitments to dignity and non-discrimination.

Comparative international practices provide instructive models for reform. In the United States, competency to stand trial is assessed using the *Dusky* standard, while the Insanity Defence Reform Act of 1984 narrowed the federal insanity defence and introduced greater procedural rigor. Several States in the United States have adopted "guilty but mentally ill" verdicts, permitting simultaneous incarceration and psychiatric care, thus balancing accountability and treatment (Fentiman 1985). In Canada, Section 16 of the Criminal Code employs the NCRMD standard, where Review Boards oversee individualised treatment plans and public safety conditions. Canadian law also provides clear procedures for determining temporary or permanent unfitness to stand trial, ensuring due process while accommodating mental incapacity (Chaimowitz et al. 2022).

India can also draw valuable lessons from mental health courts and diversion programmes in jurisdictions such as the United States, Canada, and Australia. These courts redirect eligible mentally ill offenders away from punitive systems into community-based care, applying therapeutic jurisprudence through individualised treatment planning, regular judicial monitoring, and cross-sector collaboration. Empirical studies show that such programmes

significantly reduce recidivism, psychiatric relapse, and the burden on penal institutions, while enhancing therapeutic and social outcomes.

Adopting such reforms in India could transform the treatment of mentally ill offenders – shifting from a custodial, deficit-based model to a rights-based, recovery-oriented framework. By aligning legal reforms with psychiatric expertise and international best practices, India can ensure that its criminal justice system becomes more constitutionally compliant, clinically sound, and ethically defensible. Ultimately, these changes are essential to uphold the principles of justice, fairness, and human dignity at the intersection of criminal law and mental health.

The above discussion shows that criminal responsibility, mental illness, insanity defence, the test of fitness to stand trial, and human rights are not independent areas of legal consideration but highly related aspects of the criminal justice system. Although the law is aimed at balancing culpability and protection, its existing structure does not always sufficiently incorporate psychiatric realities with constitutional and human rights guarantees. This disengagement is reflected in the inconsistent application of the judicial process, inadequate procedural protection, and institutional failures, all of which lead to the lack of fairness and justice. To resolve these problems, the reform of doctrines is not only necessary but also a more consistent, rights-based approach to the treatment of mental illness in the realm of criminal law.

8. Conclusion

The intricate interplay between mental health and criminal responsibility presents profound challenges for justice systems worldwide, including India. This paper has examined the multifaceted realities that people with mental illness face within the criminal justice process, highlighting the interplay between legal frameworks, judicial interpretation, the role of forensic psychiatry, and the institutional deficiencies that persist. While foundational legal instruments such as Section 22 of the BNS and the MHCA offer a structured approach to addressing mental illness in legal contexts, their implementation frequently falls short of achieving a compassionate and just response. The continued judicial debate around distinguishing legal from medical insanity, the evidentiary burden placed on the accused, and the difficulty of reliably assessing mental capacity reveal the legal system's ongoing struggle to keep pace with psychiatric complexities. Forensic psychiatric expertise plays a pivotal role in informing courts, yet issues around diagnostic reliability, credibility of testimony, and the limited psychiatric literacy within the legal profession remain serious concerns.

The adoption of a rights-based approach, aligned with the CRPD and embedded in the MHCA , marks an important shift toward safeguarding the dignity and well-being of those with mental illness. The decriminalisation

of suicide attempts represents a particularly progressive step, recognising the need for care over punishment. However, systemic shortcomings, including inadequate mental health infrastructure, limited funding, and the continued use of prisons as de facto mental health institutions, undermine the realisation of these rights and obstruct meaningful rehabilitation. Addressing these shortcomings requires comprehensive reforms that not only amend existing laws to expand the understanding of mental impairment beyond cognitive dimensions to include volitional and emotional aspects but also involve significant investment in forensic psychiatry infrastructure and the specialised training of legal and mental health professionals. The development of mental health courts and diversion programmes can offer alternatives to incarceration, emphasising treatment and community reintegration over punitive responses. Equally important is the establishment of robust post-release care systems to support individuals with mental illness, reduce recidivism, and promote social reintegration.

Ultimately, creating a more humane, effective, and equitable criminal justice system demands an integrated and multidisciplinary approach grounded in evidence-based practices and a sustained commitment to justice and human rights. By acknowledging and addressing the nuanced realities of mental illness, India can work toward a legal framework that ensures not only accountability but also compassion, support, and the opportunity for genuine rehabilitation. This ongoing process will require continued dialogue, empirical research, and progressive policymaking to ensure that legal responses meaningfully reflect the complexities of mental health within the realm of criminal responsibility.

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