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# BEHIND BARS AND BEYOND DIAGNOSIS: MENTAL HEALTH LAWS, GAPS, AND THE INVISIBLE CRISIS OF WOMEN IN INDIAN PRISONS

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## ABSTRACT

A visit to a women's prison in India quickly reveals something quickly: these spaces were not made for women. The infrastructure is inadequate, the staff ratios are inadequate, and mental health services are largely absent. This paper is about that absence and about the law that should be addressing it but is not. India's prisons held 21,772 women in 2022. More than 76% of them were undertrials, meaning they had not yet been convicted. They were waiting sometimes for years in facilities built for male offenders, with almost no psychological support in sight. The Mental Healthcare Act 2017 nominally provides prisoners a right to mental health treatment. Section 103 is explicit on this point. And yet, the Supreme Court's own research wing found in 2024 that 25 States and Union Territories do not have a single psychiatrist or psychologist working in any of their prisons. This paper asks a basic question: why? And what should be done about it? Drawing on constitutional law (Articles 14, 21, 39A), relevant case law from Sheela Barse to the 2021 suo motu mental health proceedings, international benchmarks like the Bangkok Rules and Nelson Mandela Rules, and NCRB data, the paper maps the gap between what the law promises and what incarcerated women actually receive. Five reform proposals are offered, each one grounded in authority that already exists. The argument, simply stated, is this: what women in Indian prisons face when it comes to mental health is not a resource problem; it is a rights violation.

**Keywords:** Women Prisoners, Mental Healthcare Act 2017, Bangkok Rules, Prison Reform, Article 21, Undertrial Detention, Trauma-Informed Care, Gender-Sensitive Governance.

## I. INTRODUCTION

Consider the following statistic: of the roughly 21,772 women in Indian prisons as of 2022, over 16,500 had not been convicted of any crime. They were undertrials. They were there because bail was too expensive, because a lawyer was too expensive, or because the system simply hadn't processed their cases. And while they waited in overcrowded cells designed decades ago with male inmates in mind their psychological state was unassessed. In most states, qualified personnel were unavailable for such assessments.

Indian prison law still runs on the Prisons Act 1894. Notably, that year is correct. The Act was passed during the British Raj, before the Constitution existed, before psychiatry had any serious institutional standing in India, and decades before gender-sensitive governance was conceptualized. It separates women from men barely, through Section 27 and then ceases to address the question of women prisoners entirely. Mental health doesn't come up at all.

The extent of what is being overlooked becomes clearer with data. The NCRB's *Prison Statistics India 2022* put total prison occupancy at 5,73,220 against a capacity of 4,25,609 that's 131.4% occupancy.<sup>1</sup> Of the 21,772 women in that system, 76.1% were undertrials. A 2024 Supreme Court report found that 25 States and UTs have zero qualified mental health professionals in any of their prisons.<sup>2</sup> The official count of mentally ill prisoners in 2022 was 9,084 across the entire country. This is not a prevalence figure; rather, it indicates a detection failure. You can only count the cases you have the staff to find.

This paper addresses the following topics. Part II examines the legal framework constitutional, statutory, and policy that is supposed to govern women's mental health in prisons. Part III considers what courts have done with these provisions. Part IV identifies four structural failures that explain why the framework is not working. Part V offers five specific reforms. Throughout, the aim is to be direct: what's happening inside women's prisons is not administrative lag or resource scarcity. It is a sustained denial of rights that the Constitution, properly interpreted, does not permit.

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<sup>1</sup>National Crime Records Bureau, *Prison Statistics India 2022* (Ministry of Home Affairs, Govt of India, 2023) <<https://ncrb.gov.in>> accessed 5 April 2025.

<sup>2</sup>Centre for Research and Planning, Supreme Court of India, *Prisons in India 2024* (Supreme Court of India, November 2024) 68–91, Appendix D.

## II. THE EXISTING LEGAL FRAMEWORK

### A. Constitutional Foundations

**Article 21** is where any discussion of prisoner rights in India must begin. The Supreme Court has, over the decades, expanded what “life and personal liberty” means and it now clearly includes the right to healthcare, to live with dignity, and, as courts have more recently confirmed, to treatment for mental illness.<sup>3</sup> The critical point one that prison administrators tend to overlook is that Article 21 does not weaken when someone is incarcerated. If anything, it strengthens. The State has taken complete control of a person’s life. It cannot disclaim responsibility for what that life looks like from inside a cell.

Three more provisions are directly relevant. **Article 14** guarantees equal protection of the law. If male prisoners receive healthcare services that are categorically unavailable to women, that guarantee is being violated. **Article 15(3)** gives the State the power and, in some readings, the obligation to make special provisions specifically for women. In the context of prison healthcare, this is not just permissive language. **Article 39A** is about legal aid. It requires the State to ensure that the justice system actually delivers justice, and that those who cannot afford lawyers still have access to one. Most women who enter Indian prisons enter without legal representation. Article 39A exists precisely for them.

### B. The Mental Healthcare Act 2017

The Mental Healthcare Act 2017, which came into force in May 2018, was a genuine legislative step forward. The older 1987 Act was built around institutional control what the State could do to or for people with mental illness. The 2017 Act is built around rights what people with mental illness can claim from the State. That shift brought India into closer alignment with the UNCRPD and made mental healthcare something citizens are entitled to; not something institutions dispense at their discretion.

**Section 18** imposes a duty on state governments to ensure mental health services are available, accessible, affordable, and non-discriminatory. In the prison context, it also requires

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<sup>3</sup>Constitution of India 1950, arts 14, 15(3), 21, 39A; *Maneka Gandhi v Union of India* AIR 1978 SC 597; *Francis Coralie Mullin v Administrator, Union Territory of Delhi* AIR 1981 SC 746.

that medical officers in jails be trained in basic and emergency mental healthcare.<sup>4</sup> This is a statutory obligation. Not a recommendation. Not a target. The fact that it is being ignored across most of the country is, in itself, a legal problem not just a policy one.

**Sections 21 and 103** are the provisions most directly applicable to women in prison. Section 21 prohibits discrimination in mental health treatment on the basis of gender, persons with mental illness must receive the same standard of care regardless of sex. Section 103 requires that prisoners with mental illness receive assessment, treatment, and counselling. The Mental Healthcare Rules 2018 fill in the operational details through Rule 11: screening, psychosocial interventions, minimum medications.<sup>5</sup> The framework is, on paper, quite complete. The problem is not what it says, but that nobody is implementing it.

**Section 115** is often overlooked in discussions of prison mental health, but it is highly significant. It decriminalises attempted suicide instead of prosecution, the person receives care. The State is required to respond to self-harm with treatment, not punishment.<sup>6</sup> In women's prisons, where self-harm rates are significantly higher than in the general population, and where many inmates carry years of unaddressed trauma into custody, this provision should be driving a very different institutional response than what currently exists.

### C. Prison Law and Policy Instruments

**The Prisons Act 1894** is still the governing statute in most Indian states. Its contribution to women's mental health: nil. **Section 27** requires separation of women from men. Beyond that, women barely appear. Mental health doesn't appear at all. The Model Prison Manual 2016 was prepared by the Ministry of Home Affairs and is far more progressive dedicated chapter on women prisoners, one counsellor per 500 inmates, female welfare officers, rehabilitation-oriented philosophy.<sup>7</sup> The catch: it is advisory. States can adopt it or ignore it. Many have ignored it.

**The Model Prisons and Correctional Services Act 2023** is the most recent attempt to push reform at the national level. It explicitly incorporates mental health, mandates gender-

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<sup>4</sup>Mental Healthcare Act 2017 (Act 10 of 2017) s 18(2)(g); Mental Healthcare (Rights of Persons with Mental Illness) Rules 2018, r 11.

<sup>5</sup>Mental Healthcare Act 2017, ss 21(1)(a), 103(1).

<sup>6</sup>Mental Healthcare Act 2017, s 115(1).

<sup>7</sup>Ministry of Home Affairs, *Model Prison Manual 2016* (Govt of India 2016) ch XVIII.

specific accommodation, and adopts trauma-informed language.<sup>8</sup> However, prisons sit under Entry 4 of List II of the Seventh Schedule — State List. Therefore, the 2023 Act is, by design, a model. States choose whether to adopt it. As of 2024, the uptake has been slow and uneven.

#### D. India's International Commitments

Two international instruments are central here. **The Bangkok Rules**, formally the UN Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders, adopted by the General Assembly in 2010 was the first body of international standards focused specifically on women in criminal justice. **Rules 12 and 13** require mental health screening at admission and periodically throughout detention. Rule 25 requires that mental health services be gender-responsive.<sup>9</sup>

**The Nelson Mandela Rules** (revised 2015) set the broader baseline. Rule 24 establishes equivalence: prison healthcare should match what's available in the wider community. Rule 82 extends this to mental health either specialist facilities within prisons, or reliable referral arrangements.<sup>10</sup> India formally endorses both sets of rules. In most states, the endorsement hasn't translated into practice.

### III. JUDICIAL PRONOUNCEMENTS: THE COURTS SPEAK

Where the legislature hasn't moved, courts have sometimes filled the gap, but not always, not completely, but enough to create a body of case law that matters. The Supreme Court's practice of treating letters and petitions from prisoners, advocates, and journalists as writ petitions has produced some of the most important prisoner rights decisions in Indian constitutional law.

The case to start with is *Sheela Barse v State of Maharashtra (1983)*. Sheela Barse was a journalist. She visited Bombay Central Jail, interviewed women, found evidence of custodial violence, no female officers during interrogation, no legal help of any kind. She wrote a letter to the Supreme Court.<sup>11</sup> The Court treated it as a writ petition, ordered female officers at all interrogations and arrests, female-only enclosures staffed by women, and declared legal

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<sup>8</sup>Ministry of Home Affairs, Model Prisons and Correctional Services Act 2023 (Govt of India 2023) ss 4, 29, 54; Constitution of India 1950, Seventh Schedule, List II, Entry 4.

<sup>9</sup>UNGA Res 65/229 (21 December 2010) UN Doc A/RES/65/229 (Bangkok Rules), Rules 12, 13, 25.

<sup>10</sup>UNGA Res 70/175 (17 December 2015) UN Doc A/RES/70/175 (Nelson Mandela Rules), Rules 24(1), 82.

<sup>11</sup>*Sheela Barse v State of Maharashtra* (1983) 2 SCC 96; AIR 1983 SC 378.

aid a constitutional right. What makes this case foundational isn't the specific directions but it's the underlying principle: the State's duty of care toward women in its custody is active, not passive. It doesn't end at the cell door.

In *RD Upadhyay v State of Andhra Pradesh (2006)*, the Court turned its attention to something that had been almost entirely invisible: the children who live in prison with their mothers.<sup>12</sup> It recognised that psychological damage from incarceration isn't just about the prisoner, it's about the relationships incarceration destroys. States were directed to report on the number and conditions of women prisoners and their children. The data that came back showed staggering variation between states in even the most basic provisions. The case quietly made the argument that national minimum standards were long overdue.

In *Sunil Batra v Delhi Administration (1980)*, Krishna Iyer J said something that still needs saying more often: prisoners do not give up their fundamental rights when they walk through the prison gate.<sup>13</sup> Conditions of confinement that cause or worsen psychological harm violate Article 21. The implication for mental health is direct: a prison system that generates psychiatric illness and then provides no treatment is engaged in a constitutional violation.

In *Shatrughan Chauhan v Union of India (2014)*, the Court confronted mental illness directly in the context of capital punishment.<sup>14</sup> It held that mental illness in a prisoner is not a peripheral consideration but it is one that creates mandatory State obligations. No legal process affecting a mentally ill prisoner's fate should continue until that illness has been diagnosed and treated. The case was about death row, but the principle that the State cannot treat a prisoner's mental health as irrelevant — clearly is not limited to that context.

Then there is *In Re: Mental Health and Mental Healthcare*, the suo motu case initiated by the Supreme Court in 2021.<sup>15</sup> The Court's decision to take this up on its own motion signals recognition that individual litigation cannot solve a systemic problem. Whatever remedial architecture eventually emerges from that case needs to address the specific situation of women prisoners, a group that sits at the intersection of two systematically underserved categories, and whose needs have been almost entirely absent from public discourse on mental health.

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<sup>12</sup>*RD Upadhyay v State of Andhra Pradesh* (2006) 3 SCC 212, paras 14–19.

<sup>13</sup>*Sunil Batra v Delhi Administration* AIR 1980 SC 1579 (Krishna Iyer J).

<sup>14</sup>*Shatrughan Chauhan v Union of India* (2014) 3 SCC 1, para 59.

<sup>15</sup>*In Re: Mental Health and Mental Healthcare* Suo Motu WP (Civil) No 3/2021, order dated 27 July 2021.

#### IV. THE CRITICAL GAPS: WHERE LAW FAILS WOMEN

The previous two sections showed that the legal framework for protecting women prisoners' mental health is more developed than most people assume. The Constitution is broad. The MHCA has specific provisions. Courts have, over forty years, imposed meaningful obligations on the State. And yet the reality inside women's prisons reflects almost none of this. Four structural failures explain the disconnect.

##### A. The Framework Has No Gender Lens

This is the foundational problem. Both the MHCA 2017 and the Model Prison Manual 2016 treat prisoners as a single, undifferentiated category when it comes to mental health. Men and women, in these frameworks, are presumed to have essentially the same needs and to benefit from the same interventions. They do not. Women who enter prison are disproportionately survivors of domestic violence, sexual abuse, and intimate partner violence.<sup>16</sup> This is not background noise, it is the central clinical fact about women's mental health in custodial settings. Incarceration does not neutralize prior trauma; it tends to reactivate it. A mental health protocol that doesn't account for this will fail women not through malice but through indifference to how their situations actually differ from men's. Trauma-responsive care designed by clinicians who understand the gendered etiology of psychological harm simply does not exist in Indian prison mental health policy.

##### B. Section 103 Is a Dead Letter in Most States

Section 103 of the MHCA states that prisoners with mental illness must receive care and counselling. Rule 11 of the Mental Healthcare Rules 2018 details the procedure. However, 25 States and UTs do not employ a single qualified mental health professional in any of their prisons.<sup>17</sup> The 9,084 mentally ill prisoners recorded officially in 2022 can't be taken as a count of actual prevalence, it is a measure of detection capacity, which is close to zero. The National Mental Health Survey 2015-16 estimated that about 10.6% of the general Indian population lives with a mental disorder.<sup>18</sup> Even applying a fraction of that to a prison population

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<sup>16</sup>Commonwealth Human Rights Initiative, *Prisons in India: Reflections on Standards* (CHRI 2018) 44–47; NLU Delhi Prison Project, *Status of Prisons in India 2021* (NLUD 2021) 38.

<sup>17</sup>Centre for Research and Planning, Supreme Court of India, *Prisons in India 2024* (Supreme Court of India, November 2024) 68–91, Appendix D.

<sup>18</sup>National Mental Health Survey 2015–16 (NIMHANS, Bengaluru 2016) 28; Centre for Research and Planning (n 2) Appendix D.

characterised by poverty, trauma, and prolonged stress, the true figure runs far into the thousands. These individuals remain untreated, undiagnosed, and invisible in the data because no one has the training to find them.

### **C. The Law Treats All Prisoners as the Same Person**

Research on the profile of women in Indian prisons reveals a consistent pattern: they are, as a group, poor, often from Scheduled Caste or Scheduled Tribe communities, frequently from minority religious groups, typically without literacy or stable employment, and almost universally without the money to pay for a lawyer or post bail.<sup>19</sup> The mental distress that many of these women experience was not created by incarceration alone. It was built up over lifetimes of poverty, abuse, and exclusion and then compounded by arrest, pre-trial detention, and the specific indignities of a prison system that wasn't designed for them. India's mental health legislation has no framework for recognising or responding to this kind of layered disadvantage. The result is predictable: the women with the most severe and complex needs get the least care.

### **D. Prolonged Pre-Trial Detention Creates the Illness It Ignores**

Over three quarters of women in Indian prisons are awaiting trial. The psychiatric literature is clear about what extended pre-trial detention does to people: it drives up rates of depression, anxiety disorder, PTSD, and suicidal ideation in populations that may have entered custody without any of these conditions.<sup>20</sup> The legal remedy already exists. Section 479 of the BNSS 2023 (previously Section 436A CrPC) gives undertrials who have served half the maximum applicable sentence a right to apply for bail. Undertrial Review Committees are meant to flag these cases. In practice, the provision is inconsistently applied at best, and for women specifically, almost never applied with any attention to mental health status. The system manufactures preventable psychiatric harm and then provides no mechanism to address what it creates.

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<sup>19</sup>Commonwealth Human Rights Initiative, *Prisons in India: Reflections on Standards* (CHRI 2018) 44–47; NLU Delhi Prison Project, *Status of Prisons in India 2021* (NLUD 2021) 38.

<sup>20</sup>Stuart Grassian, 'Psychiatric Effects of Solitary Confinement' (2006) 22 *Washington University Journal of Law and Policy* 325, 333; *Hussainara Khatoun v Home Secretary, State of Bihar* AIR 1979 SC 1360; BNSS 2023 (Act 46 of 2023), ss 479–480.

## **V. RECOMMENDATIONS: TOWARDS A GENDER-RESPONSIVE MENTAL HEALTH LAW**

Five proposals follow. None of them require creating new constitutional authority or entirely new primary legislation. Each proposal is grounded in powers that already exist. What they need is not legal innovation, it's political will to use the tools that are already there.

### **A. A Women's Prison Mental Health Protocol Under Section 121, MHCA**

The Central Government's rule-making power under Section 121 of the MHCA 2017 should be used to notify a Women's Prison Mental Health Protocol as binding subordinate legislation. It should require: mental health screening by a qualified clinician within 72 hours of a woman's admission to custody; reassessment every 90 days; individual care plans developed by staff trained in trauma-responsive practice; at least one female mental health professional at every facility holding women; and clear pathways to specialist care when needed. Non-compliance should be judicially reviewable before the relevant High Court.

### **B. Amend Section 103: Make Minimum Staffing Non-Negotiable**

Section 103 of the MHCA needs an amendment that specifies a floor: at a minimum, one full-time qualified female mental health professional in every prison or wing that holds women. This should not be something states can defer on grounds of budget or convenience. A phased implementation timeline with central funding through the National Mental Health Programme should accompany the amendment, and the High Court of each state should have jurisdiction to enforce compliance and address non-compliance.

### **C. Reconstitute Mental Health Review Boards for Prison Contexts**

Under Section 73 of the MHCA, Mental Health Review Boards must include as a mandatory member where the Board has jurisdiction over any area containing a women's prison, someone with professional expertise in forensic psychiatry and the mental health consequences of gender-based violence. Boards should be required to review women prisoners' mental health records quarterly. They should have the authority to recommend early release on medical grounds, transfer to a specialist facility, or modification of custody conditions. Those recommendations shouldn't be advisory, they should trigger documented responses from prison authorities and, where appropriate, from the relevant court.

#### **D. Convert the Bangkok Rules into Justiciable Domestic Standards**

Rules 12, 13, and 25 of the Bangkok Rules should be given domestic legal force, either through rules notified under Section 121 of the MHCA, or through a National Policy on Women in Conflict with the Law that has statutory backing. Once they are part of domestic law, the National Human Rights Commission should monitor compliance, with powers to receive complaints, conduct inspections, and issue enforceable recommendations. Currently, India formally endorses these standards internationally and functionally disregards them domestically. That gap needs to be addressed.

#### **E. A Real Undertrial Review System, Not a Paper One**

High Courts should issue directions to Undertrial Review Committees requiring monthly review of every woman who has been in pre-trial detention for more than six months. Mental health status should be a mandatory documented item in each review, not a box that gets left blank. Courts should be directed through practice directions to treat an undertrial woman's mental health as a material consideration in bail proceedings, not a footnote. Where Section 479 BNSS bail rights are persistently ignored, contempt jurisdiction should be available to enforce them.

### **VI. CONCLUSION**

There's a type of institutional failure that's hard to see from the outside. It doesn't announce itself. It accumulates quietly in the distance between what a statute says and what a prison ward looks like in practice, between a constitutional guarantee and a cell block with no trained staff, between international commitments made in Geneva and a system that hasn't bothered to count how many of its prisoners have mental illness.

This is the failure this paper has been describing. India has the legal tools. Article 21 is broad enough. The MHCA 2017 is specific enough. The courts, from *Sheela Barse* in 1983 to the 2021 suo motu mental health proceedings, have been persistent enough. What is missing is not legal authority, but the political decision to use these tools for women behind bars to treat their mental health as something the State is actually answerable for, and not a category that falls outside anyone's responsibility.

The five reforms proposed in this paper are not legally complicated. A Protocol notified

under Section 121. An amendment to Section 103. Reconstituted Review Boards. The Bangkok Rules given domestic legal force. A functioning undertrial review system. None of this is beyond the current legal framework. All of it is within the powers of governments and courts that already exist. What's keeping it from happening is not law, but the continued invisibility of women prisoners in political and legislative life, their absence from budgets, from manifestos, from headlines.

Those women won't be lobbying anyone. They won't appear before parliamentary committees or at press conferences. They are, in almost every formal sense, not part of the political conversation of the country that's holding them. Which is exactly why the law seriously applied, consistently enforced is the only institution with both the authority and the reach to stand between them and a system that has, for too long, treated their suffering as someone else's problem.