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Psychological degradation of prisoners in India and its relation to Article 21 of the Indian constitution

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Abstract

The study interrogates the pervasive phenomenon of psychological degradation within Indian prisons, situating it against the constitutional ethos of human dignity enshrined in Article 21 of the Indian Constitution. It contends that systemic neglect, custodial violence, and the absence of structured mental healthcare have transformed lawful confinement into a state of existential disintegration. Through a jurisprudential reading of Article 21 and allied judicial precedents, the research redefines “life and personal liberty” as encompassing the psychological integrity of the incarcerated, thus rendering mental health a constitutional entitlement rather than a benevolent concession.

Engaging with the normative interface between constitutional morality and penal philosophy, the study exposes the moral dissonance between India’s reformatory ideals and its punitive realities. A comparative exposition of the Norwegian correctional paradigm, grounded in normalization and equivalence of care, demonstrates the viability of a humanistic model where punishment operates within the bounds of dignity, empathy, and therapeutic intervention.

Ultimately, the discourse advances the argument that the Indian State’s carceral obligation is not exhausted by physical custody but extends to the preservation of mental equilibrium. It advocates the reconstitution of the prison system through independent mental health governance, architectural humanization, and rehabilitative modalities such as meditation and vocational therapy—thus transforming incarceration from an instrument of retribution into an agency of reformation consonant with the constitutional promise of dignified existence.

Keywords: Article 21, psychological degradation, prison reform, constitutional morality, penal humanism, Norway model, mental health jurisprudence

1. Introduction

The Indian penal system continues to grapple with multifaceted structural inadequacies that profoundly compromise the mental well-being and inherent dignity of incarcerated individuals. Chronic overcrowding, substandard infrastructural conditions, inadequate healthcare facilities, and the persistent resort to isolation practices collectively precipitate severe psychological detriment. Although imprisonment is designed as a mechanism of lawful punishment, it cannot transgress the fundamental contours of human rights—particularly the right to live with dignity. This discourse endeavours to critically examine the psychological repercussions of incarceration within the Indian context and to elucidate their constitutional implications through the interpretative prism of Article 21 of the Indian Constitution.

2. The Role of Article 21

Article 21 of the Constitution enshrines that “no person shall be deprived of his life or personal liberty except according to the procedure established by law.” Initially perceived as a procedural safeguard, judicial interpretation has transformed this provision into a vibrant repository of substantive human rights. Through a progressive hermeneutic expansion, the Supreme Court has articulated that the *right to life* encompasses the right to live with dignity—a protection that extends unambiguously to those under state custody.

This transformative trajectory was emphatically reaffirmed in *Inhuman Conditions in 1382 Prisons*, In re [(2016) 3 SCC 700] ^[1], wherein the Supreme Court, acting *suo motu*, acknowledged the deplorable state of Indian prisons. The Court categorically held that chronic overcrowding, deficient sanitation, and inadequate medical care constitute a direct infringement of the constitutional guarantee under Article 21. This reasoning was further consolidated in *Re: Inhuman Conditions in Prisons (2021)* ^[2], where the apex court reiterated that dignity forms an inseparable and intrinsic component of the right to life.

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The judgment mandated state authorities to secure proper healthcare, legal aid, and psychological services for inmates—thus reaffirming the constitutional imperative of humane detention.

The jurisprudential breadth of Article 21 was further expanded in *Paramvir Singh Saini v. Baljit Singh* (2020) ^[3] wherein the Court directed the installation of CCTV cameras across police stations and correctional facilities to deter custodial violence and enhance institutional transparency. Likewise, in *People's Union for Civil Liberties v. State of Maharashtra* (2014) ^[4], the Court underscored the necessity of judicial oversight in custodial death cases, emphasizing that humane treatment of prisoners is not an act of administrative benevolence but a constitutional entitlement emanating from the sanctity of human life and dignity.

Empirical evidence substantiates these judicial observations. The NHRC Report (2016) ^[5] disclosed that Indian prisons function at an average of 118% capacity, with certain states exceeding 150% occupancy, thereby engendering environments inimical to mental and physical health. The BPR&D Report (2021) ^[6] revealed that approximately 70% of inmates are undertrials subjected to prolonged detention, systemic alienation, and resultant psychological distress. Similarly, a WHO study (2014) ^[7] identified a strong causal correlation between overcrowded prisons and the prevalence of mental disorders, aggression, and self-destructive tendencies.

Collectively, these developments mark a paradigmatic shift in India's constitutional philosophy of incarceration—from punitive retribution to reformative humanism. The evolving jurisprudence surrounding Article 21 thus establishes the normative foundation for recognizing prisoners as enduring bearers of constitutional rights. Preservation of dignity, access to humane living conditions, and opportunities for moral and psychological rehabilitation are not administrative favours but constitutional imperatives flowing inexorably from the ethos of Article 21.

3. Psychological Degradation in Indian Prisons

Although incarceration is intended as a lawful deprivation of liberty, it must not extinguish an individual's inherent dignity. In practice, however, Indian prisons have metamorphosed into sites of psychological attrition. Overcrowding, deplorable living standards, absence of psychological care, and excessive isolation constitute the structural bedrock of mental disintegration among inmates.

Empirical scholarship reinforces this assertion. The Bangalore Prison Mental Health Study (2016) ^[8], commissioned by the Ministry of Home Affairs, found that nearly 80% of inmates exhibited symptoms of mental disorder (including substance-use disorders), while 27-30% suffered from psychiatric illnesses excluding substance dependence. Predominant afflictions included depression, anxiety, psychosis, and substance-related pathologies—conditions exacerbated by overcrowded cells, unhygienic conditions, inadequate nutrition, and minimal psychiatric care. Prolonged undertrial detention further fosters despondency, alienation, and cognitive exhaustion. Consequently, incarceration functions less as a reformative enterprise and more as a sustained apparatus of psychological punishment.

In contrast, official statistics grossly underrepresent this crisis. According to NCRB's Prison Statistics India (2023), merely 1.7% of prisoners are recorded as mentally ill—an implausible figure reflecting diagnostic neglect, paucity of

trained psychiatric personnel, and entrenched stigma. Scholars have repeatedly recommended systemic reform: periodic psychological assessments, recruitment of mental health professionals, establishment of dedicated psychiatric units, and the deployment of telepsychiatry to augment access. The persistence of psychological degradation thus reveals a constitutional dissonance—between the aspirational dignity guaranteed by Article 21 and the grim realities of carceral life.

4. Overcrowding and Lack of Personal Space

Among the foremost afflictions of the Indian prison system is endemic overcrowding. Reports by the NCRB and human rights bodies consistently expose the chronic excess of inmate populations beyond sanctioned capacities. In these congested environments, inmates endure the erosion of privacy, perpetual discomfort, and unrelenting noise—conditions that erode psychological equilibrium.

The absence of personal space breeds anxiety, irritability, and a pervasive sense of impotence. Constant surveillance and lack of solitude deprive prisoners of opportunities for reflection and self-restoration, thereby diminishing their self-worth. Overcrowding, therefore, is not merely an administrative shortcoming but a profound psychological assault that transforms the experience of confinement into sustained mental degradation.

5. Poor Living Conditions and Lack of Basic Amenities

Beyond overcrowding, the deplorable material conditions within prisons exacerbate mental distress. Inadequate sanitation, unsafe drinking water, poor nutrition, and deficient hygiene cumulatively degrade inmates' physical and psychological health. Dilapidated infrastructure, inadequate ventilation, and limited bedding engender chronic discomfort and disease vulnerability.

Persistent exposure to unhygienic environments fosters despair and helplessness. These circumstances not only negate the intrinsic dignity of individuals but also intensify their psychological decline. The deprivation of recreation, education, or vocational engagement perpetuates monotony and purposelessness, reinforcing mental stagnation. In effect, the absence of rehabilitative engagement transforms incarceration into a psychologically corrosive existence.

6. Solitary Confinement and Isolation

6.1 Nature and Concept

Solitary confinement epitomizes the most extreme and ethically contentious dimension of punitive detention, characterized by near-total sensory and social deprivation for twenty-two to twenty-four hours daily. Traditionally justified as a measure of institutional discipline or protective segregation, this practice has been widely condemned by human rights jurists as antithetical to reformative justice. It supplants the ideals of rehabilitation with mechanisms of exclusion and psychological annihilation—subverting both constitutional and humanitarian principles of modern penology.

6.2 Psychological and Physiological Effects

A vast corpus of interdisciplinary research documents the deleterious consequences of extended isolation. Solitary confinement engenders acute psychological disintegration—manifesting through anxiety, paranoia, hallucinations, cognitive erosion, and suicidal tendencies. The deprivation of

human contact corrodes an individual's perception of time and identity, resulting in enduring trauma akin to Post-Traumatic Stress Disorder (PTSD). Physiologically, isolation disrupts circadian rhythms, impairs sleep, and induces psychosomatic dysfunctions. Cumulatively, these effects dismantle mental coherence and erode the very essence of human identity, rendering solitary confinement an antithesis to rehabilitation.

6.3 Comparative Perspectives

International jurisprudence has progressively repudiated solitary confinement as incompatible with human dignity. The European Court of Human Rights, in *Ramírez Sánchez v. France* (2006) ^[10], adjudged prolonged isolation to constitute "inhuman and degrading treatment" in violation of Article 3 of the European Convention on Human Rights. Similarly, the U.S. Supreme Court, in *Hutto v. Finney* (1978) ^[11], imposed temporal limits on solitary confinement, while Justice Kennedy, in *Davis v. Ayala* (2015) ^[12], poignantly described it as a condition that "comes perilously close to a penal tomb." The Supreme Court of Canada, in *British Columbia Civil Liberties Association v. Canada* (2019) ^[13], declared indefinite isolation unconstitutional as it contravened the Canadian Charter of Rights and Freedoms.

These comparative precedents collectively signify a global jurisprudential evolution that aligns with the United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules)—affirming that solitary confinement, especially of prolonged or indefinite duration, constitutes cruel, inhuman, and degrading treatment incompatible with contemporary constitutional and humanitarian ethics.

7. Psychological Effects and Mental Health Outcomes

The combined effects of overcrowding, inadequate healthcare, poor living conditions, and solitary confinement have profound psychological impacts on prisoners. These effects range from anxiety and depression to more severe conditions like PTSD, psychosis, and suicidal tendencies.

Depression is one of the most common mental health issues among prisoners in India. Harsh prison conditions, lack of support, and long periods of confinement lead many prisoners to experience feelings of hopelessness and despair. Being separated from family, friends, and society exacerbates the sense of isolation and contributes to mental deterioration. Some prisoners also develop PTSD due to physical abuse, exposure to violence, or the degrading conditions within the prison system.

The psychological effects of imprisonment can be long-lasting. Many individuals released from prison struggle to reintegrate into society due to the mental health issues developed during their incarceration. The stigma associated with being an ex-prisoner, coupled with untreated psychological conditions, often hampers their ability to find employment, rebuild relationships, and live fulfilling lives post-release.

Substance abuse is also prevalent in Indian prisons, with many prisoners using drugs or alcohol as a coping mechanism for their emotional distress. Although this may provide temporary relief, substance abuse only exacerbates mental health issues and can lead to dependency and further psychological harm.

8. Protection from Cruel, Inhuman, or Degrading Treatment

The protection from cruel, inhuman, or degrading treatment represents a cornerstone of international human rights jurisprudence and modern correctional philosophy. This protection transcends the mere prohibition of physical torture, encompassing any act or condition that inflicts psychological torment, humiliation, or erosion of personal dignity. Within the Indian constitutional framework, this principle is mirrored in Article 21, which guarantees the right to life and personal liberty—an entitlement judicially interpreted to include humane treatment and respect for the intrinsic worth of the individual.

At the global level, the Universal Declaration of Human Rights (1948) ^[15] under Article 5, and the International Covenant on Civil and Political Rights (ICCPR, 1966) ^[16] under Article 7, categorically prohibit torture and cruel, inhuman, or degrading punishment. These provisions have acquired the status of *jus cogens* norms, binding all states irrespective of specific treaty obligations. The United Nations Convention Against Torture (UNCAT, 1984) ^[17] further extends this mandate by obligating member states to prevent not only acts of overt torture but also carceral conditions that diminish human dignity or inflict unnecessary suffering.

Empirical evidence, though varied across jurisdictions, consistently demonstrates the profound psychological and physiological repercussions of inhuman custodial practices. Reports by the United Nations Special Rapporteur on Torture (2011) ^[18] highlighted that solitary confinement extending beyond a brief, defined period may amount to torture due to its irreversible impact on mental health, often leading to anxiety, hallucinations, depression, and suicidal tendencies. Likewise, assessments by international health agencies have noted that overcrowding, lack of sanitation, and inadequate mental healthcare compound the psychological distress of inmates, effectively transforming imprisonment from a lawful deprivation of liberty into an assault on human dignity.

The cumulative findings of such studies underscore a universal consensus: that the legitimacy of punishment ceases where the suffering inflicted becomes disproportionate, degrading, or devoid of rehabilitative purpose. International human rights law, as articulated through instruments such as the Nelson Mandela Rules (2015) ^[14], affirms that humane treatment of prisoners is not a privilege but a non-derogable right inherent to human existence.

The global legal and ethical framework posits that the State's authority to punish is bounded by its duty to protect the prisoner's physical and psychological integrity. Practices that cause severe mental anguish or negate human dignity, whether through prolonged isolation or neglect of basic care, contravene not only international law but the moral foundations of justice itself. The essence of humane punishment lies in restraint — ensuring that incarceration curtails liberty, not humanity.

9. Mental Healthcare Act, 2017 and Its Nexus with Prisoners' Rights

The Mental Healthcare Act, 2017 (MHCA) constitutes a significant epistemic and normative reorientation within Indian mental health jurisprudence. It abandons the antiquated custodial paradigm of the Mental Health Act, 1987, substituting it with a rights-centric architecture that foregrounds dignity, autonomy, and non-discrimination as cardinal principles. The Act's text is consciously framed in

universalist idiom—bestowing its guarantees upon “every person”—thus extending its operational reach to incarcerated individuals, whose mental well-being has historically been marginalized within the penal discourse. In its conceptual design, the MHCA endeavours to reconstitute mental health not merely as a clinical concern but as an inalienable dimension of human rights, inseparable from the broader constitutional promise of dignified existence under Article 21. At the core of the statute lie a series of provisions that embed justiciable entitlements within the domain of mental health. Section 18 enshrines the right to access mental healthcare and treatment of an acceptable quality and at affordable cost, free from institutional discrimination—a mandate that, by implication, applies to custodial environments. Section 19 advances the principle of community living, prescribing that persons suffering from mental illness ought to receive care in the least restrictive setting possible, thereby repudiating the punitive use of isolation and solitary confinement as *de facto* therapeutic interventions. Complementarily, Section 20 guarantees protection from cruel, inhuman, and degrading treatment, a safeguard of particular salience for prisoners, whose subjection to coercive medication or neglect is a recurrent phenomenon within carceral institutions.

The most direct textual interface between the MHCA and the prison system, however, manifests through Sections 103 and 104, which delineate the procedural regime governing persons with mental illness in custodial institutions. Section 103 imposes a positive statutory obligation upon prison authorities to ensure that any individual manifesting signs of mental illness be examined by a qualified professional, and, where clinically warranted, transferred to a registered mental-health establishment for appropriate care. Section 104 further stipulates that incarceration cannot be perpetuated solely on account of mental illness when requisite treatment facilities are unavailable within the prison system. These provisions, when read conjointly, signify a legislative intent to dismantle the historical conflation of penal custody with psychiatric confinement, transforming the carceral space from an instrument of containment into a conduit of rehabilitative care.

Yet, the transformative aspirations of the Act remain largely theoretical, undermined by bureaucratic inertia, fiscal parsimony, and administrative fragmentation. The Act presupposes the existence of functional State Mental Health Authorities (SMHAs) and Mental Health Review Boards (MHRBs) empowered to supervise custodial institutions and adjudicate grievances. In reality, these mechanisms are either dormant or non-existent in many jurisdictions. The structural incongruity between the prison administration (governed by Home Departments) and mental-health governance (entrusted to Health Departments) generates an inter-departmental vacuum where neither entity assumes full responsibility for implementation. The absence of dedicated budgetary allocations, coupled with the chronic paucity of trained psychiatrists and clinical psychologists within prison establishments, renders statutory compliance illusory. Consequently, Sections 103 and 104, though normatively potent, remain juridical ornaments without functional efficacy.

The constitutional symbiosis between the MHCA and Article 21 of the Indian Constitution is unmistakable. Judicial exegesis of Article 21 has long transcended the narrow connotation of mere physical survival, expanding to encompass mental integrity, emotional well-being, and the

right to live with dignity. Landmark decisions such as *Sunil Batra v. Delhi Administration* and *Sheela Barse v. State of Maharashtra* have underscored that incarceration does not entail the extinction of fundamental rights, save those unavoidably curtailed by the fact of detention. The MHCA, in this sense, operationalizes the abstract moral content of Article 21, transforming it into a tangible statutory entitlement enforceable through legal process. When state authorities fail to provide requisite psychiatric care, the omission is not merely administrative negligence but a constitutional dereliction, violative of the prisoner’s inherent right to dignified existence.

Moreover, the decriminalization of suicide under Section 115 of the Act holds profound implications for custodial settings. It replaces the punitive logic of the Indian Penal Code with a therapeutic jurisprudence that presumes mental illness in cases of attempted suicide, mandating care rather than punishment. In the prison context—where suicides and self-harm are often symptomatic of untreated psychiatric distress—this provision imposes a positive obligation on the State to provide preventive counselling, crisis intervention, and post-attempt rehabilitation. Failure to do so subverts both the MHCA’s remedial architecture and the constitutional ethos of humane treatment.

The implementation deficit, however, persists as the principal obstacle to actualizing this normative framework. Institutional apathy, stigmatization of mental illness, and absence of inter-sectoral coordination continue to impede the realization of prisoners’ mental health rights. Budgetary allocations for prison healthcare are often subsumed within generic “medical” heads, devoid of earmarked funding for psychiatric care, rendering the MHCA’s mandates fiscally unsustainable. Similarly, the absence of empirical auditing, periodic mental-health screenings, and independent oversight allows violations to remain unrecorded and unredressed. Such systemic lacunae demonstrate that legislative recognition without administrative reinforcement degenerates into symbolic justice, incapable of transforming lived realities within prisons.

To render the MHCA’s provisions genuinely transformative, multi-dimensional reforms are imperative. First, state budgets must incorporate dedicated line-items for prison mental healthcare, facilitating recruitment of psychiatrists, psychologists, and counsellors within correctional facilities. Second, institutional convergence mechanisms must be established between prison and health departments, supported by regular inspections from SMHAs and MHRBs. Third, a rehabilitative culture must be cultivated within prisons through psychological education, stigma reduction, and therapeutic interventions such as meditation, art therapy, and vocational training. Only when these administrative, fiscal, and cultural transformations coalesce can the MHCA evolve from a textual declaration into a living instrument of constitutional justice under Article 21.

10. Norway - A Paradigm of Psychological Humanism in Penal Administration

Norway’s correctional architecture epitomizes the ascendancy of humanistic penology over retributive orthodoxy. Its carceral philosophy, deeply embedded in the Nordic welfare ethos, rejects the notion of punishment as vengeance and instead conceives incarceration as an ethically bounded deprivation of liberty whose ultimate object is *reformation through dignity*. This paradigm—often encapsulated in the

phrase “*the Nordic Model of Incarceration*”—derives its legitimacy from the moral conviction that the loss of freedom does not entail the forfeiture of humanity. Within this normative matrix, mental health is not treated as an ancillary welfare concern but as an indispensable component of restorative justice, ensuring that the prisoner’s psyche is healed rather than further disfigured by confinement.

10.1 The Principle of Equivalence of Care: A Constitutionalized Ethical Imperative

The conceptual cornerstone of Norway’s prison health regime is the Principle of Equivalence of Care, which mandates that every individual deprived of liberty must receive healthcare—physical and psychological—of a quality identical to that available in the wider community. This principle, enshrined in both domestic legislation and Norway’s international obligations under the European Convention on Human Rights and the United Nations Standard Minimum Rules for the Treatment of Prisoners (Mandela Rules), embodies a radical affirmation of equality within coercive institutions. In operational terms, this principle manifests through the transfer of medical governance from prison authorities to the public health system. The structural bifurcation between penal administration and medical authority is of profound ethical significance—it prevents the subordination of therapeutic autonomy to custodial discipline, thereby ensuring that medical interventions remain acts of care rather than instruments of control.

10.2 Structural Organization of Mental Healthcare: The Therapeutic Continuum

Norway’s model of prison mental health operates through an intricately tiered system that facilitates a continuum of psychological care from admission to post-release reintegration. The first tier, *primary care*, is embedded within the prison establishment itself, staffed by physicians, nurses, and psychologists who conduct comprehensive intake assessments encompassing mental disorders, addiction profiles, and emotional vulnerabilities. Prisoners possess the right of self-referral, a procedural guarantee that destigmatizes mental health support and reinforces autonomy even within captivity. For cases requiring advanced psychiatric intervention, referrals are made to District Psychiatric Centres (DPS) or to specialized mental hospitals under the national health framework. Crucially, therapeutic continuity is maintained beyond incarceration through formal coordination between correctional institutions and municipal health services, ensuring uninterrupted access to medication, counselling, and psychiatric supervision post-release. This continuum transforms mental health from a reactive service into a sustained rehabilitative process.

10.3 The Ethic of Normalization: Architecture as an Instrument of Dignity

Perhaps the most visually and experientially distinctive dimension of the Norwegian system is its architectural and philosophical commitment to normalization—the principle that life within prison should approximate, to the maximum extent possible, life within the community. Prisons such as Halden and Bastøy exemplify this ethos: their design replaces coercive rigidity with spatial dignity. Cells resemble modest apartments, adorned with windows, natural light, and private sanitation, while communal areas encourage social interaction and educational engagement. Correctional officers function

less as custodians of authority and more as facilitators of rehumanization, engaging with inmates in dialogue, mentorship, and emotional support. The environment itself thus becomes a therapeutic agent, reducing hostility, fostering self-reflection, and mitigating the psychic disintegration typically induced by confinement. In this way, the Norwegian prison ceases to be a site of exclusion and becomes a laboratory of moral restoration.

10.4 Empirical Validations: The Psychosocial Efficacy of the Model

Quantitative and qualitative evidence from Norwegian correctional research substantiates the transformative efficacy of this model. Studies by Bjørngaard *et al.* (2024)^[33] and Lindquist *et al.* (2020)^[34] indicate that approximately 60-65% of Norwegian prisoners experience diagnosable mental disorders—ranging from depression and anxiety to substance-use and personality pathologies—yet the treatment accessibility rate within prisons remains markedly higher than in most jurisdictions. These interventions have produced demonstrable outcomes: the nation’s recidivism rate, hovering around 20%, is among the lowest globally, and instances of self-harm, suicide, and inter-prison violence have declined precipitously. The empirical correlation between humane treatment and reduced criminal relapse reveals a profound jurisprudential truth—rehabilitation is not a derivative ideal of punishment, but its moral justification.

10.5 Constitutional and Ethical Dimensions of Penal Humanism

Although Norway lacks a codified constitution akin to India’s, its governance is permeated by the normative spirit of constitutional morality, articulated through welfare legislation and human rights jurisprudence. The Execution of Sentences Act, 2001, explicitly articulates that the purpose of imprisonment is “to prevent new criminal acts and to help the sentenced person become a good citizen.” This statutory philosophy encapsulates the fusion of penal necessity and moral compassion. It resonates with India’s constitutional interpretation of Article 21, which the Supreme Court has expanded to encompass dignity, mental well-being, and humane treatment. Thus, Norway’s penal framework provides a living illustration of what a constitutionally moral carceral order might look like—a system in which punishment is domesticated by ethics and guided by the inviolability of human personality.

10.6 Emerging Challenges and Ethical Reflexivity

Even this exemplary system is not devoid of friction. Norway confronts rising incidences of substance abuse disorders, sporadic shortages of psychiatric professionals, and the difficulty of delivering culturally nuanced care to foreign nationals. Yet the country’s defining virtue lies in its institutional reflexivity—a readiness to engage in self-critique and empirical reassessment. Regular evaluations conducted by the Norwegian Directorate of Health, in collaboration with the Correctional Services, ensure that deficiencies are neither concealed nor normalized. This transparency reinforces the legitimacy of the model and maintains its alignment with the ethical imperatives of human rights and evidence-based governance.

10.7 Transpositional Insights for the Indian Context

The Norwegian paradigm offers a constellation of insights for

India's prison reform discourse. Foremost among these is the necessity of transferring prison healthcare to the public health domain, thereby insulating medical practice from bureaucratic apathy and custodial dominance. Routine psychological assessment at both entry and exit stages should be institutionalized, and post-release counselling integrated within community psychiatry. The principle of normalization demands architectural and administrative reform to replace punitive isolation with rehabilitative engagement. Above all, India must reconceptualize mental healthcare for prisoners not as an act of benevolence but as a constitutional obligation emanating directly from Article 21's guarantee of life and dignity. In doing so, India can begin to mitigate the pervasive psychological degradation that has become endemic within its custodial structures.

10.8 Dignity as the Measure of Justice

Norway's correctional enterprise redefines the ontological premise of punishment. It demonstrates that incarceration, when administered under the auspices of dignity, empathy, and psychological care, can serve as an instrument of moral regeneration rather than of state-sanctioned despair. The Norwegian experience affirms that mental health care within prisons is not peripheral but foundational to justice itself. By institutionalizing equivalence of care, therapeutic governance, and post-release continuity, Norway manifests the ethical essence of a civilized society—the conviction that even those who have erred remain bearers of inalienable human worth. For India, the Norwegian model thus serves not merely as a comparative benchmark but as a moral mirror, reflecting what a genuinely constitutional democracy owes to those within its custodial grasp: not cruelty in the name of order, but humanity in the name of justice.

11. Recommendations for Addressing the Psychological Degradation of Prisoners in India

The psychological degradation of prisoners in India is a pressing issue that demands immediate and holistic reform. To effectively address this concern, the following recommendations can help develop a prison system that respects human dignity and encourages rehabilitation.

First, it is imperative to institutionalize a *trauma-informed correctional framework* that recognizes the psychological antecedents of criminal behaviour and the emotional vulnerabilities exacerbated by incarceration. Prison administration should be restructured to operate under trauma-sensitive protocols, wherein all personnel are trained to identify signs of mental distress, post-traumatic stress, and maladaptive coping mechanisms among inmates. This paradigm shift would humanize carceral governance by replacing coercive control with therapeutic engagement, thereby mitigating the cycle of re-traumatization that often perpetuates psychological decay within prisons.

Second, the State must establish *integrated psychological resilience centres* within prison complexes, functioning as specialized units dedicated to emotional rehabilitation. These centres should employ clinical psychologists, behavioural therapists, and social workers to deliver evidence-based interventions such as cognitive-behavioural therapy (CBT), dialectical behaviour therapy (DBT), and group psychotherapy. Such sustained psychological engagement would not merely treat mental disorders but also cultivate self-awareness, impulse regulation, and prosocial behaviour—thus addressing the deep-seated emotional desolation that

underlies much of the psychological degradation experienced by inmates.

Third, a comprehensive *digital and educational reformative infrastructure* must be developed to cognitively stimulate inmates and reduce the intellectual stagnation inherent in confinement. Access to digital learning platforms, skill-enhancement programs, and creative expression modules (art, music, literature) can foster psychological empowerment, intellectual autonomy, and a renewed sense of identity. This engagement would not only counteract the ennui and alienation associated with incarceration but also facilitate smoother reintegration into the social and economic mainstream post-release.

Fourth, the government should introduce a *restorative human-connect initiative* designed to rebuild the prisoner's social identity and emotional stability through structured interaction with families, mentors, and community representatives. Periodic family therapy sessions, mentorship programs, and restorative dialogues between victims and offenders can serve as powerful psychological correctives, reducing guilt, hostility, and social alienation. By re-establishing emotional bonds and moral accountability, such initiatives can restore a sense of belonging and purpose—key antidotes to psychological degeneration in the carceral environment.

12. Conclusion

The discourse on the psychological degradation of prisoners in India reveals an unsettling incongruity between the constitutional ideal of dignified existence and the empirical realities of incarceration. While Article 21 has evolved into a repository of expansive human rights jurisprudence, encompassing dignity, health, and humane treatment, its practical manifestation within Indian carceral spaces remains fractured and nominal. The architecture of punishment continues to be animated by deterrence rather than restoration, thereby perpetuating an environment of psychic erosion and institutionalized dehumanization. The prison, instead of functioning as an agency of moral reclamation, has metamorphosed into a site of constitutional estrangement, where the individual's mental sanctity is subordinated to administrative indifference and custodial rigidity.

The research establishes that the preservation of psychological integrity within prisons is not an auxiliary welfare measure but a constitutional compulsion—an intrinsic extension of the right to life itself. The jurisprudence of Article 21, interpreted through the lens of constitutional morality, mandates that the State's punitive authority must be tempered by empathy, care, and therapeutic governance. The Norwegian paradigm exemplifies this harmonization, demonstrating how correctional philosophy can coexist with compassion, and how institutional design, mental healthcare, and humane engagement can collectively neutralize the psychological corrosion of incarceration.

India's path forward thus necessitates a radical re-envisioning of its penal philosophy: the transference of healthcare governance from prison authorities to independent public health bodies; institutionalization of mental health assessment, counselling, and post-release rehabilitation; and the architectural and administrative normalization of prison life. Only through such systemic recalibration can the carceral order be reconstituted from a mechanism of punishment into a constitutional enterprise of reformation, where dignity is not suspended at the prison gate but reaffirmed within it.

In its ultimate reckoning, the study concludes that the true measure of a constitutional democracy lies not in the efficiency of its punitive machinery but in the humanity with which it treats those it chooses to confine. The reclamation of the prisoner's mind, therefore, becomes the highest expression of constitutional morality and the most authentic vindication of Article 21's emancipatory promise.

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