PRESIDENTIAL ADDRESS

THE INDIAN LUNACY ACT, 1912
The Historic Background

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Distinguished Guests, Fellow-Members and Friends,

While welcoming one and all to the 39th Annual Conference of the Indian Psychiatric Society being held in Calcutta from today, I would be failing in my duty if I do not express my sincere and humble thanks to all its members for electing me to the highest office of the Society for the year 1987.

This historic city has already extended its cultured hospitality twice to the members of the Society in 1960 and 1977. Now, once again after a decade, we are indebted to our hosts of Calcutta for their spontaneous generosity. It is needless to point out the rich heritage and culture which Bengal has contributed to our national life. The tunes of Vande Mataram and Jana Gana Mana flowed from here; the Bhakti cult of the great Chaitanya emanated from here and the Hindu revivalism by the Sage Ramakrishna and Swami Vivekananda flowered in this soil and spread its divine fragrance all over the world.

The contribution to Indian psychiatry by the psychiatrists of Calcutta and Bengal cannot be gone into in detail for want of time, but a few are worth remembering. Dr. N. N. De was one of the founding fathers of the Society in January 1947 and presided over the first conference in 1948 at Patna. Girindrasekhar Bose founded the Indian Psychoanalytic Society. Other notable names are: Dr. C. C. Saha, Dr. S. N. Banerjee, Dr. J. B. Mukherjee, Dr. A. K. Roy Chowdhury, and Kaviraj Atul Behari Dutt. The services of the past presidents, Drs. Ajita Chakraborty, D. N. Nandi and G. C. Boral are quite fresh in our minds.

Col. P. N. Bardhan presided over the 13th Annual Conference and in his presidential address referred to various affairs of the Society, which “have much to mend.” This conference was held in the campus of the Bhangiya Unmad Ashram. It has a very personal significance for me because I had the privilege of presenting my first paper during its scientific session. My great teacher, late Dr. D. L. N. Murthy Rao was listening with his characteristic posture of half-closed eyes; my other teacher, the late Dr. M. V. Govindaswami could not be present due to his last illness. In 1977 Dr. J. S. Neki, in his presidential address dealt with Psychotherapy in India with his usual analytic bent.

Before I could come to the topic of my address I should remember my predecessors from Madras, who had a distinct role in the affairs of the Society; the late Dr. A. S. Johnson was one of the founding members in January 1947; Lt. Col. G. R. Parasuram was the president and Dr. T. George was the secretary in 1957 and my friend and colleague Dr. A. Venkoba Rao had this honour in 1978. The topic for my address is The Indian Lunacy Act, 1912 - its historic background. Some of you might be wondering about the appropriateness of the subject as this
Act is fortunately to pass into history. As history cannot be erased and many of the characteristics of the 1912 Act's background continues to have relevance to the present day legislation, I would plead for your indulgence and forbearance.

**THE INDIAN LUNACY ACT, 1912**

The Historic Background

The withering away of the old and the establishment of the new are but natural in the passage of time.

— Sage Bavanandi Nannool

The institutional care of the mentally ill in large separate asylums has a long history (Henry 1941). Most of the earlier asylums were to be found in the Western countries, though there were few important exceptions. In 1173 A.D. there was a large building at Baghdad called Almeeraph Tan or House of Grace, to which the insane were brought from all parts of Persia and where they received medical care until they recovered. Sulemania asylum established in 1560 employed 150 persons to take care of not more than 20 patients who were treated very compassionately.

In India the care of the mentally ill in the asylums is a British innovation (Sharma and Varma 1984). This does not mean that the mentally ill were neglected or ill treated before the arrival of the British. There are elaborate descriptions of various forms of mental disorder in separate treatises in Ayurveda (Somasundaram 1984). The Siddha system of medicine has laid particular emphasis on the phenomenology of the various forms of abnormal behaviour (Somasundaram et al. 1986). Sage Agasthya's descriptions and forms of treatment should be of great interest to all psychiatrists.
Manimekalai encounters a mad man on her way to the flower garden:
Shoulders adorned with garland of pink 'alari',
Neck adorned with a garland of bad odoured 'erukkam' flower,
Twigs of the mighty tree has he gathered to hold together
Tatters on his person, his entire body is smeared with white paste of ash and sandal,
Talks he with others in a senseless blabber,
He cries, he falls, he blurs, he shouts,
He worships, he bellows, he gets up, he twists, he circles,
He turns, he moves to a corner and lies down, he shouts,
And picks up a quarrel with his shadow,
And varily behind the mad young man, who is hapless and functionless,
The people stand around and gape at his tragedy.

— Sathanar

The above quotation is from the great Tamil epic Manimekalai, the second of the five great epics by the Buddhist author Sathanar of II century A.D. We, not only get a good idea of the catatonic schizophrenic's hypermotility, hypomotility and incoherence of thought and speech. We can also glean the attitude of the public which is one of compassion and a desire to help. There is no sense of fear, frivolity or prejudice. Probably some of these people were looked after in hospitals like those of Veera Rajendra Deva of IX century A.D. referred to in the inscription found in the inner sanctuary of a temple dedicated to Lord Venkateswara at Thirumukkudal, Chingleput District, Tamil Nadu. It mentioned a hospital, a school and the expenses for maintaining the hospital and for the festivals of the Deities. This Veera Choleswara Hospital contained 15 beds; attached to the hospital were a physician-surgeon, 2 male and female nurses, servants, 1 gatekeeper, 1 washerman and 1 potter. The duty of the male nurses was to bring herbs and firewood and prepare medicines whereas the female nurses' duty was to administer doses, feed the patients and do the cooking. There was no specific mention about the segregation of the psychiatric patients (Subba Reddy 1971).

The Arabic medicine took the form of the Unani system during the Muslim period. Najabuddin Un Hammad (1222 A.D.) made a special study of mental diseases and described 7 varieties of the illness. There was a mental hospital at Dhar, near Mandu in Madhya Pradesh, which was established by Mahmood Khilji (1436-1469) and Maulana Fazular-Lah Hakim was its physician.

There is some clear evidence that modern medicine and hospitals were first brought to India by the Portuguese during the 17th Century in Goa. However, the segregation of the lunatics in mental asylums and their supervision were entirely of British origin.

The India Act introduced by Pitt in 1774 set up a double government by which the company was overseen in London by a minister known as the President of the Board of Control and in Calcutta by a Governor-General, in whose appointment the state had the dominant voice. Thus British India broadly came under national control and was subject
to the Parliamentary directives of non-aggression, clean administration, and attention to the welfare of the people (Spear 1965). Subsequent developments of the asylum era in India could be found in the article of Sharma and Varma (1984).

Before the 1912 Act came into effect, the various enactments controlling the care and treatment of the mentally ill of the then British India could be enumerated as follows:

1. The Lunacy (Supreme Courts) Act, 1858 (Act XXXIV of 1858).
2. The Lunacy (Districts Courts) Act, 1858 (Act XXXV of 1858).
3. The Indian Lunatic Asylums Act, 1858 (Act XXXVI of 1858).
4. The Military Lunatics Act, 1877 (Act XI of 1877).
5. The Indian Lunatic Asylums (Amendment) Act, 1886 (Act XVIII of 1886).
6. The Indian Lunatic Asylums (Amendment) Act, 1889 (Act XX of 1889).
7. Chapter XXXIV of the Code of Criminal Procedure, 1898.
8. Section 30 of the Prisoners' Act, 1900.

The British Background

We can be quite sure that these Indian Acts have their origins in the 1845 English Acts – the Lunatics Act and the Lunatic Asylums and Pauper Lunatics Act. In the earlier period the various Statutes which controlled the care and treatment of lunatic in the asylums and mad-houses were (1) Act for regulating private Madhouses, 1774, (2) County Asylums Act, 1808. (Jones 1972). Without going into the details, the reports of the Metropolitan Commissioners' in Lunacy issued between 1829 and 1842, which are admirably chronicled by Jones (vide supra) culminated in the Lunatics Act of 1845.

Lord Ashley had an important role in the passing of this Act. Ashley, who became the Earl of Shaftesbury after the death of his father, introduced in 1853 the following amending Acts:

1. Lunacy regulation Act, 1853.
2. Lunatics care and treatment amendment Act, 1853 and
3. Lunatic asylums amendment Act, 1853.

Even though many of his views, far in advance of his times, could not find a place here “These unhappy persons (mentally ill) are outcasts from all the social and domestic affection of private life... and have no refuge, but in the laws.” He was more interested in the treatment rather than mere custody of the patients. “Do we not discover the protection to the public rather than the cure of the sufferer is the predominating principle inculcated in our Acts of Parliament? The guardians of the poor are instructed to send patients to the county asylums when they become dangerous. Our county asylums have thus become, and the evil is daily increasing, places of security rather than curative establishment.”

This Act has paid more attention to
increase the legal safeguards against wrongful detention, and introduced rigorous forms for the certification of the mentally ill. This Act has piled safeguard on safeguard to protect the sane against illegal detention and paved the way for the triumph of legalism. The protection of the sane dominated the thoughts of many like those of the Alleged Lunatics Friend Society formed in 1845 "for the protection of the British subject from unjust confinement on the grounds of mental derangement and for the redress of persons so confined."

The British Scene existing in the middle of the nineteenth century served as the background of the lunacy legislation in that period in India. The various Acts of 1858 naturally reflected the legalistic frame for the management of the mentally ill. This Act gave guidelines for the establishment of mental asylums and the procedure to admit mental patients. This Act was later modified by a committee appointed in Bengal in 1888 and elaborate instructions, and guidelines for the admission and treatment of criminal lunatics were given (Sharma and Varma 1984).

Again to the British Scene

It is now necessary to turn our attention to the British scene during the period 1845 to 1890. The Lunacy Act of 1890 came into effect and its background is summarised thus: "The very length of this Act singles it out from all previous attempts at lunacy legislation, and it bears the heavy impress of the legal mind. Every safeguard which could possibly be devised against illegal confinement is there. Dillwyn’s suspicions, Mrs. Welldone’s accusations, Shaftesbury’s doubts, Hack Tuke’s fears, Milltown’s wrath and the determination of three successive Lord Chancellors helped to shape it. The result, from the legal point of view was very nearly perfect. From the medical and social viewpoint, it was to hamper the progress of the mental health movement for nearly 70 years." (Jones 1972). Some of the allusions could be elaborated further.

The fear of the insane and the fear of illegal detention of the sane reached their zenith in this period. There were articles in the press deploiring the tendency of the present laws to protect the liberty of the lunatic at the expense of the lives, limbs and comfort of the sane. Mrs. Welldone, a wealthy eccentric lady in spirits and media, when deserted by her husband who wanted her to be treated psychiatrically against her wish sued him for restitution of conjugal rights; Dr. Forbes Winslow who attempted to remove her to his asylum, for libel, assault, wrongful arrest, false imprisonment and trespass, sued the two doctors who signed the certificates and also the two editors. She was considered a normal person by a number of enlightened people, who felt like Baron Huddleston: "It is somewhat startling it is positively shocking that if a pauper or crossing-sweeper should sign an order and another crossing-sweeper should make a statement and then that two medical men who had never had a day's practice in their lives, should, for a small sum of money, grant their certificates, a person may be lodged in a private lunatic asylum."

Lord Milltown, had this to say during this period: "The existing state of the lunacy laws is unsatisfactory and constitutes a serious danger to the liberty of the subject. He described the state of the lunacy laws as intolerable... a damning blot... on the statute book. Inspire of the vehement opposition of Lord Shaftesbury who was nearing his deathbed, and the
asylum doctors, the overriding power of the magistrate in the certification process was a \textit{sine qua non} of the Lunacy Reform in the view of all the Lord Chancellors who had to do with this bill. The fear of illegal detention, rather than the early recognition and treatment of the mentally ill overhung the minds of the lay people and this was strengthened by literary figures like Charles Reade, who described such an occurrence in his novel 'Hard Cash' appearing in 1863. The misgivings in this regard were expressed in an editorial written by Daniel Hack Tuke in the Journal of Mental Science in 1884. "Of one thing we are sure and that is that troublesome times are before those entrusted with the care of the insane."

The supremacy of the magisterial role in the care and treatment of the mentally ill became a fait accompli when the Lunacy Treatment Bill received the Royal Assent on 26th August 1889. The Act entered the statute books in 1890.

The Indian Scene

With this British background the curtain rises in the Viceregal Lodge of Simla on Monday the 18th September 1911 with Baron Hardinge of Penshurst presiding over the Council of the Governor-General of India. The Hon'ble Mr. Jenkins moved to introduce a bill to consolidate and amend the law relating to lunacy. He observed "We propose to consolidate these enactments and to introduce certain amendments and especially to bring the law in certain important particulars into line with the modern English act," the Lunacy Act, 1890 as amended by the Lunacy Act, 1891. The legislative department of the Council was complimented for its painstaking labour. He considered that it is more fit for careful examination with regard to all details in the Select Committee, than for general discussions in the Council. The Council met on Wednesday the 10th January, 1912 under the presidency of the Hon'ble Sir Guy Fleetwood Wilson, and referred the Indian Lunacy Bill to the Select Committee consisting of:

1. The Hon'ble Sir J. L. Jenkins
2. The Hon'ble Mr. Syed Ali Imam
3. The Hon'ble Moulvi Syed Shamsul Huda
4. The Hon'ble Mr. Dadabhoy
5. The Hon'ble Babu Bhupendra Nath Basu
6. The Hon'ble Mr. Gates
7. The Hon'ble Mr. Mudholkar
8. The Hon'ble Surgeon-General Sir C. P. Lukis
9. The Hon'ble Mr. Kenrick
10. The Hon'ble Mr. Madge
11. The Hon'ble Mr. Vincent
12. The Hon'ble Mr. Carr
13. The Hon'ble Mr. Arthur, and
14. The mover.

Certification and Reception on petition:

The present act enumerates these procedures in Sections 5 to 11 and 18 to 20, replacing Section 7 of the Lunatic Asylums Act, 1858. The same fear of false detention of sane people is reflected in the passage found in the statement of objects and reasons for the introduction of the bill: the procedure prescribed for the issue of reception orders are based on the English Lunacy Act, 1890. The manner in which medical certificates are to be given and the method of examination are carefully prescribed in the Act. "Every care has been taken to prevent the improper confinement of any person in an asylum.
on a false allegation of lunacy."

It is interesting to note that the Governor of Madras, Sir Thomas David Gibson Carmichael, in his letter to the Governor-General on this subject in 1912 is not even able to see the necessity for this type of admission. "In the opinion of this Government the necessity for a reception order issued by a magistrate has not been established in Madras. Regarded as an additional protection from the risk of improper confinement, the new procedure has no clear advantages over that embodied in the existing law, for the magistrate is very unlikely to refuse to act upon the two medical certificates and from the point of view of the lunatics' relatives there is the objection that the provisions of the bill will unnecessarily complicate procedure and even though the enquiries are held in camera, will increase very largely the probability of publicity."

The Governor has suggested to disqualify absolutely the Superintendent or any medical officer attached to an asylum from granting a certificate for admission. This suggestion was not incorporated in the act. The suggestion is enforced in the state by the Mental Hospital Code of the State government.

**Voluntary Boarder:**

It should be said to the credit of the then Governor of Madras that he brought to the notice of the Governor-General that an additional category of patients—voluntary boarders—should be included in the Act. The Government further consider that advantage may be taken of the present opportunity to incorporate the provision of the Scottish law section 15 of 29 and 30 Vict. Chapter 51, which allows admission of uncertified cases as voluntary boarders in asylums. The Governor in Council believes that such provisions will be taken advantage of occasionally even now and that they will eventually be of considerable value.

Here we should pay tribute to the foresight of the Governor of Madras when we remember that the voluntary admissions were made possible in England and Wales only in 1930 by the Mental Treatment Act. Voluntary admissions have increased considerably in the recent years and Channabasavanna et al. (1981) noted that in 1977, 67% belonged to this category in mental hospitals of India and 77% in mental hospitals with teaching and research facilities. The voluntary admissions in the Madras Mental Hospital has reached the figure of 76% in 1982, rising to this figure from 53% in 1973. (Somasundaram and Suresh Kumar 1984). In 1913 itself Madras Lunatic Asylum (whose emblem at that time is illustrated) started admitting voluntary boarders.
Judicial Inquisitions as to Lunacy:

These procedures are dealt with in the 1912 Act with reference to Presidency towns in Chapter IV and those outside Presidency towns in Chapter V. This is almost a reproduction of the Lunacy (Supreme Courts) Act, 1858.

Patients under this group correspond to the Chancery lunatics of England. "That small group of persons who had originally been specified by an act of Edward II, and for whom a special procedure existed. This procedure was derived from the Praerogativa Regis of Edward II, which is often taken as the starting point of lunacy legislation.

Wandering or dangerous lunatics and lunatics treated or not under proper care and control:

These groups of patients are taken care of in the Sections 13, 14 and 15 of 1912 Act correspond to the vagrant and pauper lunatics of England. Their control rested with Vagrants Acts of 1714 and 1744 (Section 20).

Special groups of mentally ill:

The procedures with regard to the mentally ill in the armed forces and the mentally abnormal offenders, both undertrials and those serving a sentence are covered by the act and are not materially different from the earlier acts, mentioned before. Thus the act revealed the desire of the then Government of India which was of the opinion that in the public interests it is desirable that complete control should be exercised over all private institutions where lunatics are confined for payment and public institutions.

The Select Committee submitted its final report to the Council of the Governor-General of India on 28th February 1912. They have received the reports of the following agencies:

- Raja of Burdwan.
- Chief Commissioners of Baluchistan, Coorg, Ajmer and N. W. Frontier Province.
- Governments of United Provinces, Burma, Punjab, Eastern Bengal and Assam, Central Provinces, Bengal, Bombay and Madras.
- High Court of Calcutta.

Their most important recommendation was with regard to the voluntary boarders. "We regard this provision as one which is likely to be of considerable value."

At the time when the Indian Lunacy Act came into force on 16th March 1912 the following mental hospitals were in existence: (Overbeck-Wright 1921).

- Assam: 1. Tezpur (Indians).
- Bihar and Orissa: 1. Ranchi (Europeans) 2. Patna (Indians).
- Bengal: 1. Berhampur (Indians) Central 2. Dacca (Indians).
- Bombay: 1. Yerawada, Poona (Europeans and Indians) Central 2. Naupada Thana (Indians) 3. Ahmedabad (Indians) 4. Dharwar (Indians) 5. Ratnagiri (Indians) 6. Hyderabad, Sind (Indians).
- Burma: 1. Rangoon (Europeans and Burmese) Central 2. Minbu (Burmese Criminal lunatics).
- Central Provinces: 1. Nagpur (Indians).
- Madras Asylum (Europeans and Indians) Central 2. Calicut (Indians) 3. Vizagapatnam (Indians).
- Punjab: 1. Lahore (Europeans and Indians); Central United Provinces: 1. Agra (Indians) Central 2. Bareilly (Indians) 3. Banaras (Indians).
In 1913 there was accommodation for 7,243 ill persons for the total population of 259,716,306 (Overbeck-Wright 1921). In 1965 the General Bureau of Health Intelligence Government of India listed 31 mental hospitals with a total bed strength of 16,500. The terminology 'lunatic asylum' in the Act was changed to 'mental hospitals' in 1922.

Concluding Remarks:

We have travelled a long way from that time politically, socially and economically. Our position amongst the nations of the world is pivotal one serving as an example to a number of developing countries but we have not made any headway till recently with the mental health legislation, which was archaic, outmoded and obsolete. A recent survey (1975-77) of major enactments of mental health legislation of 43 countries carried out by Curran and Harding (1978) showed India, Pakistan and Nigeria were following the laws of 1912, 1912 and 1916 respectively, while most of the countries revised their mental health legislation more than once in recent years in accordance with the modern public health legislation and psychiatric service objectives.

The 1912 Act guided the destiny of psychiatry in India and its abuses are ably pointed out by Dutt (1985). A change in mental health legislation was insisted upon by the Indian Psychiatric Society since its formative years (Kirpal Singh 1984). As early as 1950 the Society, after burning midnight oil on many successive nights submitted a draft of mental health Bill to the Government and repeatedly brought up this subject at its successive annual meetings. The Bill was referred to one of the Society's senior members, Dr. D. Satyanand for review. This Bill was considered by the Superintendents of mental hospitals at Agra in 1961 and subsequently by the Central Ministries of Health and Law. Our Society has also submitted its latest memorandum in 1983.

The toils of the Society over the past four decades have borne fruits at last with the passage of the Indian Mental Health Bill by the Rajya Sabha in November 1986.

We, the members of this Society place on record our deep sense of appreciation to the Government of India for fulfilling the long felt need. The role of the magistrate continues to be dominant in the present legislation. Without resting on the oars, we should continuously strive to assimilate advancements in knowledge and continue to update our laws in consonance with present day thinking (Somasundaram 1982). At the present time when the running down of the mental hospitals and closure of them in the U.K., the U.S.A and Italy, to mention a few countries only, careful thought should be given to the relationship between institutional treatment and community care of the mentally ill (Wilkinson and Freeman 1986, Jones and Poletti 1986). "Any fool can close a long-stay hospital; it takes more time and trouble to do it properly and compassionately" (Parliamentary Social Services Committee 1985). To conclude:
Get away! Ye Bharath, that confuses victorious truth with untruth through faulty vision.

Go away! Ye Bharath, that but resemble the dust collecting on and diminishing the brightness of Ruby!

Welcome thou Bharath! with the sharpness of wisdom in you.

Welcome thou Bharath! Who would brighten the country subdued in the darkness with the lighting up rays of the rising Sun!

Subramania Bharathi

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