Indian Journal of Psychiatry, 2000, 42 (4), 347-355

A DECADE WITH THE MENTAL HEALTH ACT, 1987

JAMES T. ANTONY

ABSTRACT

The Mental Health Act,1987 came into force in 1993. Mental Health Authorities that were created by this Act are useful, but the present situation of not having Government Mental Hospitals under the scrutiny of these authorities is a shortcoming.The high capital needed for upgradation of Government mental hospitals: is likely to be found, only with the intervention of Mental Health Authorities. Creation of a funding agency of Government of India is also needed. Denying profoundly retarded persons access to a psychiatric hospital is a hard situation. Psychiatric patients in general hospitals' having to face the hassles of mental hospital admission is against the spirit of the act, and needs to be remedied. Courts' directly determining the presence of psychiatric illness in persons is not serving the end of justice. They should do this on the basis of evidence. Several avoidable hardships that may be caused by having the act in the present form has to be corrected. This could be done by amendment of the act in certain cases, by approaching the High Court in certain others and by thoughtfully framing the State Mental Health Rules in a quite a few other situations. The success of Mental Health Act,1987 is in its effectiveness to ensure basic human rights of mental patients. A set of Mental Health Rules, that incorporates adequate provisions to protect human rights of patients, in all respects, can go a long way to strengthen the Mental Health Act.

Key words : Mental health act, hospitals, authorities

After long years of waiting, the Mental Health Act finally became law in 1987. The general expectation was that this legislation would usher in a new era of proper care and dignified life for victims of major psychiatric disorders. But when it finally arrived, the impression is that while some welcome features are there, the law has not adequately dealt with, many important issues.

The order by Government of India, to bring this Act into force, was issued only in April,1993. A careful reading of the Act shows that many of the high ideals mentioned in the "Objects and Reasons", are not finding expression in at least some of it's sections. Presently, with an experience of over seven years it is timely that professions of both psychiatry and law examine dispassionately, on whether during these first few years, this law has achieved what it sought to achieve.

The creation of Central as well as State Mental Health Authorities is certainly a step in the right direction. Even here, doubts have been expressed in some quarters, on the usefulness of this. These are created by the Act, to function as watchdog bodies for quality assurance in the entire field of Mental Health. In this regard it is a laudable step. Even so there is a strong feeling, atleast in some quarters that Mental Health Authorities along with various other regulatory devices for psychiatric hospitals, would put psychiatrists running private hospitals to hardships. It has been said that it would amount to using a different yardstick for psychiatrists, as compared to doctors in other branches of medicine.

This concern being expressed by the profession, one may say, is not quite appropriate The situation in other branches of medicine is

not quite identical. Patients' being placed totally under the care of treating doctors, is something unique to psychiatry. And neither these patients [because of illness] nor their relatives, who are not allowed to be present, are in a position to protect their basic human rights. To say that there is no need to safeguard the patients' interests by suitable statutory devices, even in this situation of extreme vulnerability, would appear less than fair.

Psychiatrists running private hospitals have expressed serious objection to the elaborate procedures regarding obtaining and renewal of license to maintain a psychiatric hospital and so on (Dutta, 1995; Gopalakrishnan, 1990). But when patients are being placed under 'total care' conditions, it is necessary to regulate these institutions by prescribed rules, unlike in the case of patients being treated in a general hospital, along with a relative.

Akhtar et al. (1998) have expressed a view that if review of admission by a psychiatrist under special circumstances using section 19, is made by a magistrate, as per section 40, it might be controversial. Dutta (1995) feels that having some role for the judiciary in admission and discharge of psychiatric patients is giving these things a 'criminal flavour'.

Having provisions for an occasional judicial or quasi-judicial review of even our professional action, has to be viewed as a fair price being paid for having a healthy, transparent system, in our sphere of activity as well. What ought to be done to obviate genuine difficulties is to ensure that when rules are framed they are simple and easy to practice and are taking care of the essentials, both in terms of the patients human right concerns as well as the doctors' professional freedom. For example the rule to scrutinize treatment and clinical records of patients in psychiatric hospitals may state that the inspecting officers are to be qualified psychiatrists. If on the other hand, the profession of psychiatry is to grudge each and every judicial review of our decisions, enlightened people outside the profession will only see all this as, our wanting to be above law.

A serious shortcoming of the Mental Health Act is the exclusion of Government Mental Hospitals from the scrutiny of Mental Health Authorities. This has inflicted a grave injury to the very soul of this Act! The realization of the high ideals showcased in the "Objectives and Reasons" of the Act, one may say, has to really begin in our Government Mental Hospitals.

Despite earnest efforts by many stalwarts, even today, our Government Mental Hospital do not have acceptable minimum facilities. All along the hope used to be that with the coming into force of the much-looked-forward-to Mental Health Act, Mental Hospitals will get transformed into the therapeutic communities, they are supposed to be. The creation of State Mental Health Authorities indeed could have been a useful measure, in this regard. All that was needed was to arm these authorities with statutory powers, that could be used to compel concerned state governments, to upgrade facilities in mental hospitals, to acceptable minimum standards.

To pull dawn and reconstruct large number of buildings in mental hospitals, that are very old and are absolutely un-suitable for their intended purpose, capital expenditure, in a big way will be needed. High capital expenditure is also needed in several other areas of mental hospital upgradation. Fairly high recurring expenditure is to be incurred for the creation of positions of many specialist staff. To do all these, state governments that are always short of funds are simply incapable of. And politicians, it is well known, are keen to push populist projects only!

In these present circumstances, unless there is a compulsion by law, there is no chance of any state Government mobilizing adequate funds. It is in this background, the exclusion of Government Mental Hospitals from any surveillance by the Mental Health Authorities is a great disappointment. The only way of remedying the present state of affairs is by giving powers to the State Mental health Authorities to lay down minimum facilities and standards of

care, in government mental hospitals. Already, as per the act they are to do this in the case of private institutions. This measure will also rectify the existing discriminatory treatment meted out to private hospitals, in the matter of overseeing of their institutions.

A second important requirement to upgrade the quality of care of victims of major psychiatric illnesses, as a whole, is by providing adequate funds to improve Government Mental Hospitals. These hospitals after all, is the final abode for the most unfortunate ones among psychiatric patients, whose treatment response is poor, besides being from the most disadvantaged sections in the community. Government of India should create a funding body _ something like a Mental Hospital Grants Commission_ to make available funds for upgrading mental hospitals as per the directions of respective State Mental Health Authorities. As the issue involved, in this up-gradation of mental hospitals throughout India is that of human rights, it will be quite appropriate for the Central Government to take up this responsibility.

These two provisions_ placing Government Mental Hospitals under the statutory surveillance of Mental Health Authority, and having a central funding agency for upgrading mental hospitals_ have to find a place in the Mental Health Act, to realize the high ideals sought to be achieved by this law. An amendment of the act for this purpose is an absolute necessity.

A point made very emphatically in the act is to exclude mentally retarded persons from the preview of this act. In chapter 1, on definitions, in clause (1), it is given as follows : "mentally ill person means a person who is in need of treatment by reason of any mental disorder other than mental retardation".

Trivedi (1989) has lamented that what constitutes 'mental disorder' has not been defined. Sharma (1995) has lauded this position of excluding mental retardation, as according to him, the law has considered 'treatability' as the major criterion for being included as mental patient. He has welcomed the Act for being not applicable to "untreatable conditions like mental retardation, dementia and the like".

This stand is not acceptable for many good reasons. Firstly by taking the 'treatability' criteria to exclude persons in need of care, will be against the very spirit of this law. Neither 'treatment' nor 'mental disorder' has been defined in this law. This, one may say, is a very good thing. Psychiatry could go by its traditions and teachings to decide what constitutes mental disorder. Also it could always go by the humane traditions of psychiatry, and maintain a very broad meaning for the term 'treatment'. Maintaining a therapeutic milieu, or in a plain language 'caring for sick persons' also should consitute 'treatment' In this sense even to consider conditions like mental retardation and dementia as 'untreatable' will be an attitude, that is less than professional for psychiatrists.

To be true to the spirit of this law it should not be the assessment of 'treatability' by individual psychiatrists the criteria, but the need of a particular patient, for care and protection, should determine whether he has a 'mental disorder'. A law for helping victims of mental illness should not exclude victims of profound mental retardation from its purview, as they too are in great need for treatment and care. They too should have access to psychiatric Hospitals. If the law presumes that profound mentally retarded persons could be adequately taken care of in the existing institutions for the mentally retarded, it is certainly not based on ground realities and is bound to turn out to be a serious mistake

Institutions for the retarded are suitable only for persons with mild and moderate mental retardation They are institutions, where principles of special education and training are put to use to improve the plight of those who have mild or moderate retardation. The professional service of these institutions, though commendable, has limitations. They do not have the competence or facilities to take care of patients in states of acute excitement, impulsive

violence and so on. Mental Health Act, by its present definition of "mental patient" has put an explicit bar on the treatment of all mentally retarded persons, including the profoundly retarded, in psychiatric hospitals. At the same time, as the existing institution for retarded are unable to take care of them, patients of profound retardation have no place to seek professional help and assistance, even in their state of utter helplessness!

Even the fact that most of these patients are victims of definite medical diseases, was apparently ignored while deciding to keep them away from psychiatric hospitals! Persons who have profound mental retardation are after all, in a more pitiable condition than worst victims of most mental illnesses are. They need care in total care institutions where a psychiatrist's expertise is available, along with all other standard facilities of a psychiatric hospital.

While evaluating the effectiveness of the Mental Health Act it will be necessary for mental health professionals to find out the actual kind of care that is being provided at present to the profoundly retarded persons. After banishing them from psychiatric hospitals by law, are they being provided adequate care and protection, as per their actual need? If the state at present is not providing adequate, professionally managed institutional set up for their care, a way has to be found to fill this serious void.

A remedy for the present unsatisfactory situation is to delete the words "other than mental retardation" at the end definition for "mentally ill person" given in the definition of section 2 (1) of the act. If this objective can be achieved, by including suitable provisions in the State Mental Health Rules that should be done. But if provisions in the rules cannot achieve this, the act itself may have to be amended. This is something experts from the professions of law and psychiatry have to jointly sort out. In any case, victims of profound mental retardation should not be denied the right kind of professional care they need, as is presently the case.

In chapter 1 again, while defining psychiatric hospitals and psychiatric nursing homes in the early part. by section 2(q), those established by the government and those established by any other person are taken on the same footing. This is certainly a laudable approach, as the rights of patients need the same kind of protection, whether the institition they stay, is owned by government or by a non government agency. But in the latter part of this very same definition, while dealing with general hospitals, only government institutions are mentioned. General hospitals in the private sector are left out. This means that mental patients in private general hospitals shall be regulated by rules applicable to mental patients in total care psychiatric hospitals.

Here mental patients in private general hospitals are picked up for a special unfavourable treatment, as against all other patients in the same hospital. This stand will amount to discrimination. While all other patients in a general hospital, can get treatment without any hassles, only by making use of one of the provisions of the Mental Health Act, one could admit mental patients for treatment! Also they will be under the surveillance of the board of visitors and so on. This situation is against the very aims and objectives of the Mental Health Act 1987. At the very outset, in this act, the main objective given, is as follows : "thus the mentally ill persons are to be treated like any other sick persons and the environment around them should be made as normal as possible"!

This appears to be an error that has crept in while bringing out the act in a printed form. An error is suspected for two reasons. Firstly if the definition is to remain in the present form it is negating the very objective of the act. Secondly, similar errors are seen in other parts of the act as well. For example in chapter 7, section 78(b), it is stated "no provision for bearing the cost of maintenance of such a district court under this chapter". Here "district court" is inadvertently inserted in place of "mental patient"! In the present form with the words "district court", one could not read any sense

out of it!

It is absolutely necessary that all definitions in the act are in consonance to the 'objects and reasons' of the act. The definition of "psychiatric hospital" or "psychiatric nursing home" also has to be appropriate, logical and meaningful. This can be ensured only by inserting the words "or any other person" after the word "government" in the latter part of the definition given in section 2(q) also, as has been done in the beginning of that definition.

If an amendment of the act is the only way to rectify this error, such an amendment has to be resorted to, with utmost urgency. In the present form, if general hospital psychiatry units, where patients stay with their relatives and get treated, are to be brought under the surveillance of the board of visitors and so on, it will defeat the very purpose of the Mental Health Act. A possible remedy for the present situation could be to approach one of the High Courts with a writ-petition, as the present discrimination would, besides being opposed to the stated objectives of the act, violate relevant provisions in the constitution.

It is mentioned in chapter 1 of the act [clause 3,(5)] that one of the objectives is "to provide facilities for establishing guardianship or custody of mentally ill persons who are incapable of managing their own affairs". But in the main corpus of the act, only persons possessing property seems to be adequately covered in this regard. A long chapter (chapter 6) on judicial inquisition is devoted in the act for taking care of persons with property. But persons who do not have any property, but are mentally ill are not given the kind of attention they deserve. This shortcoming has to be remedied to the extend possible, by including suitable provisions in the State Mental Health Rules.

The powers and duties of police officers in respect to certain mentally ill persons have been laid dawn in chapter 4 part B (section 23), of the act. But we have even to this day, a large number of mentally ill persons wandering in public places in conditions of total neglect and squalor. This indeed is testimony to the fact that the way section 23 is presently put to use has failed to achieve the objectives of the act. It is also relevant that, when we have such a large number of neglected patients in public places, in all probability, we have a much larger number of persons who are, neglected, denied elementary creature-comforts, cruelly treated in their own homes and are allowed to perish.

This situation has to be remedied. Only by ensuring that police discharge their duties more diligently, as required per section 23 this could be done. One way to achieve this is by senior police authorities ensuring that their officers, who are required to act as per section 23 of the act, discharge their duty, more vigorously. A second, more pragmatic way is to provide a less cumbersome option for the police than producing patients before courts for ordering their admission. This is possible by having suitable provisions in the State Mental Health Rules that will enable the police to take patients to the nearby government psychiatric hospitals or in the alternative to private psychiatric hospitals, in special circumstances. The psychiatrist in charge at these institutions should be able to tackle the matter, making use of section 19 of the act. Along with police taking on a role of concerned social worker, NGOs should be persuaded and guided to take up the cause of neglected patients in and out of their homes.

While a suggestion is made to extend the scope of some provisions of the act, to reach out to patients in need of care, apprehension might be expressed in some quarters. Dutta (1995) while criticizing section 19 on admission under special circumstances, has drawn attention to the situation when a relative or friend may get a patient admitted under section 19 and may not re-appear to take back the patient. Such a situation can be taken care of by having suitable provisions in the rules. Also provisions in general law to tackle breach of contract and similar other remedies should be handy. It is a criticism by many (Akhtar,1990; Nambi,1996) that in this era of

community psychiatry, the mental health act has not given any importance to it. Such criticisms will be meaningless if even the existing provisions in the act like section 19, section 23 etc are not made use of, for developing outreach services in the community. Community services could be supplemented further, by having suitable provisions in the State Mental Health Rules.

Akhtar et al. (1998) as well as Nambi (1996) have raised questions on issues related to not having any mention about 'competence' 'consent' presumption of 'global incompetence' and so on in the act. These are terms that are rightly to be dealt with in general laws, and it is not necessary for us to dissect out all these issues, for the day to day application of provisions of the Mental Health Act. At this point it may be better that we revert back to the definitions, where : "a mentally ill person means a person who is in need of treatment". And when such a person is admitted, as per section 19, it is the psychiatrist's job to administer him treatment.

The bonafides of treatments that are given could be made transparent by recording in case-files the reasons leading to particular decisions and also getting fellow-professionals involved in certain complex and delicate decisions. Even with a special section (section 92) in the act to protect psychiatrists for actions taken in good faith, it is quite unwarranted for professionals to be unduly concerned about 'the risk of punishment', as apprehended by Akhtar (1990). Despite section 83, on punitive actions for wrong actions, as observed by a learned judge in the Youngberg vs Romeo case, "professional judgement is presumptively valid unless it is a 'substantial departure' from generally accepted standards".

In the chapter (chapter 4) dealing with admission procedures there are certain inadequacies needing remedy. As things stand now, there is a chance of mis-use of provision for voluntary admission, as per section 17. The whole thing can be made more safe for patients, by having clauses in the State Mental Health Rules that will require a medical officer incharge, who make an admission on the basis of section 17, to inquire and confirm the following. (a) The person seeking admission as a voluntary patient is capable of giving an informed consent; (b) A less restrictive institution is inadequate for proper treatment and care of the patient. The admitting doctor could record these points in the case-record, as a routine.

Section 18(2) of the act deals with admission of minors. The situation as it stands now is that a minor patient who is in hospital on the request of his guardian, may be forced to remain in hospital even if he does not want it, for a further period of one month, after he has ceased to be a minor. This is because the psychiatrist in charge is allowed thirty days time for discharging the patient. This unfair situation can be obviated by a clause in the rules requiring the psychiatrist in charge to inform the minor patient about his date of becoming a major a month in advance of the crucial date. And if such minor patient informs the psychiatrist that he does not want to continue as a voluntary patient once he is a major, the psychiatrist can be required to make the discharge within 24 hours of the patient attaining major-ship.

In instances where a voluntary patient wants a discharge, but the psychiatrist incharge thinks such discharge is unsafe, section 18(3) allows the psychiatrist 72 hours to invocke provisions in section 19. This section is for an admission without the patient's consent. But this provision, when it is put to practice, is going against the requirement in section 18(1) that requires the psychiatrist to discharge voluntary patients within 24 hours of the patient requesting the same. This awkward situation can be set right by altering the time allowed in section 18 (3) to 24 hours from the present 72 hours. In the alternative, the psychiatrist whose view is that it is unsafe to discharge the patient may be required to constitute a board to go into the matter within 24 hours, of the request. And this board shall be required to decide the matter within 72 hours. Here again, this objective can

be achieved by having a suitable provision in the State Mental Health Rules.

The maximum time allowed for non-voluntary admission by the psychiatrist incharge is a period not exceeding 90 days. If further stay in hospital is deemed necessary by the psychiatrist he is required to approach the Magistrate as per section 20(2). But in this provision, i.e. section 20(2), the requirement is that the court may be approached when the mentally ill person's stay is of more than six months. This means that the psychiatrists is neither able to keep the patient in the hospital nor to approach the court for a period of three months after the initial period of 90 days! This difficulty can be obviated by inserting the words "three months" in place of "six months" in section 20(2) (a) of the act. Here again the discrepancy has probably crept in by mistake. If to correct this, an amendment of the act is absolutely essential that has to be resorted to. The other less cumbersome option, of moving if a High Court with a writ petition can also be considered.

A serious snag that emerge repeatedly in chapter 4 of the act is an assumption that the court could examine patients and determine the presence of mental illness. Indeed the court could examine evidence to determine the presence of mental illness in patients. And this prerogative to make such a determination should be of courts' alone. But what is stated in section 22 (3) is that the Magistrate "shall personally examine the alleged mentally ill person". The same position is repeated in section 24, section 25, and so on.

It is a serious error to presume that judicial officers can determine the presence and nature of illnesses in people by personally examining patients. The right position ought to be that they are to be required to get persons suspected to be mentally ill, examined by qualified psychiatrists and shall decide the issue on the basis of evidence deposed before them, by those psychiatrists.

A correction of the present situation is certainly a most urgent requirement, for the dignified practice of the profession, psychiatry. Many problems that psychiatrists' face in their practice, these days, could be traced to a very prevalent misconception, that laymen could make psychiatric diagnosis! Politicians, priests, pressmen and even policemen venture to make diagnosis of mental illness, these days. When this widely prevalent wrong notion is given the stamp of approval by a Central Act, the damage is just terrible! Not only that, the end of justice could not be met, in individual cases, if magistrates, who do not have the required competency in this matter, are to decide the presence of mental illness or otherwise in a person, by directly making a clinical examination! How this present situation is to be remedied is something needing to the most urgent attention of professions of both psychiatry and law.

An important provision in the mental health act is the provision in section 22 (7) wherein the magistrate is enabled to "consider applications for reception order in camera...". The lawmakers, with a lot of empathic consideration about human right and human dignity issues of psychiatric patients, have included this provision. After over six years of working the act it is important for all of us to know, whether presiding officers of courts, all over the country are resorting to this provision while dealing with mentally ill persons. Or do we still continue to have the old practice, of mental patients being forced to hang around court verandahs, often in handcuffs, merely for the crime of falling ill? If even in the courts of law mental patients are to face contempt and disdain like everywhere else, the objectives and goals of the mental health act may never be realized. The legacy of treating mental patients as worse than criminals has to stop

An equally important matter that has to be addressed is to find out whether psychiatrists all over the country are making proper use of the provision of admission under special circumstances as per section 19 of the Act. This section 19 is indeed a great improvement from the situation that prevailed during the old Lunacy Act days. Admissions AGAINST the patient's will

was possible in olden days, only on a reception order issued by a court. Many a time "doctored" "voluntary admissions" those days, used to be justified on a reasoning that, it was the only way to avoid cumbersome court proceedings. The question now is whether, even with the new act, the old practice of, what Thomas Szasz called "an unacknowledged practice of medical fraud", the so called "voluntary admission", that everyone known is not voluntary, is still being resorted to? Or are we making use of the provision in section 19 to arrange admission of mental patients, against their will, in the legally proper manner? This again is a matter that should be found out by a national survey conducted by an appropriate body like the forensic psychiatry section of Indian Psychiatric Society (Szasz,1972).

Sharma (1995) as well as Akhtar et al. (1998) have emphasized the need to give more attention to the human right issues of mental patients. Having a whole chapter devoted for securing the human rights of the mentally ill in the mental health act is a very progressive measure. The proof of the pudding, as far as the Mental Health Act, 1987 is concerned; is in ensuring basic human rights of mental patients. Only when patients are assured of a dignifined treatment, in homes, hospitals, courts and other public places mental health legislation can be viewed as a success. A set of Mental Health Rules, that incorporates adequate provisions to protect human rights of patients, in all respects, can go a long way to strengthen the Mental Health Act.

On a reading of the act, one will come across the word 'prescribed' time and again. Only when something is prescribed in the State Mental Health Rules this word 'prescribed' would acquire some meaning. Persuading state governments to make rules is therefore a pressing need to give teeth to the Mental Health Act.

This attempt to focus on some of the shortcomings that have crept in the Mental Health Act is certainly, not meant to convey an impression that the Mental Health Act is not a good legislation. On the contrary, despite some errors and inadequacies there are many positive things in this act that has to be welcomed wholeheartedly and made use of by the profession for the welfare of the mentally ill. Provision for admission against will, even without court intervention, provision for discharge of court ordered admission by psychiatrists, without having to wait for any decision by the board of visitors are all major positive steps.

Remedying the discrepancies inadequacies and errors that have crept into the act is an important step to strengthen this important legislation. Let us not forget that Indian Psychiatry has strived hard to get this law enacted with very high hopes and expectations of ushering in a new era of high quality service in the entire field of mental health.

REFERENCES

Akhtar,S., Khess,C.R.J. & Sinha,V.K. (1998) Human Rights of the Mentally Ill : The Scenario in India. *Journal of Eastern Zonal Branch : Indian Psychiatric Society.*

Akhtar,S. & Jagawat,T. (1993) Restraining Psychiatric Outpatients : Necessity, Justification or Violation of Human Rights? *Indian Journal of Psychiatry*, 36, 2, 115-118.

Akhtar,S. (1990) Mental Health Act,1987: Issues and Perspectives. *Indian Journal of Psychological Medicine*, 13, 2, 196-200.

Dutta,A.B. (1995) Medicolegal Problems of Psychiatrists in Private Practice. *Journal of Clinical Psychiatry*, Vol.1, No.1, January.

Gopalakrishnan,G. (1990) Mental Health Act of 1987 : Looking Beyond Law. *Indian Journal of Psychological Medicine*, 13, 1, January.

Indian Lunacy Act 1912 : Law Publishers, Allahabad.

Mental Health Act 1987 : with short notes, Eastern Book Agency, Lucknow.

Munjal,G.C. & Ahuja,N. (1992) Forensic Psychiatry. In : *Postgraduate Psychiatry*, Edn.1, (Eds.) Vyas,J.N. & Ahuja,N., pp 636-658. New Delhi : BI Churchill Livingstone.

Nambi,S. (1996) Legal aspects of psychiatry. *Indian Journal of Psychological Medicine*, Vol.19, No.2, July, pp 19-39.

Sharma,S.D. (1995) Human Rights and Mental Illness : The Souvenir, 47th Annual National Conference. *Indian Psychiatric Society*, 8-10.

Sharma,S. & Chadda,P.K. (1996) Mental Hospitals in India : Delhi : Institute of Human Behaviour and Allied Sciences.

Szasz,T. (1972) Voluntary Mental Hospitalization; an unacknowledged practice of Medical Fraud. *New England Journal of Medicine*, 287, 279-280.

Trivedi, J.K. (1989) The mental health act 1987. In : *Ethics in Psychiatry*, (Eds.) Agarwal,A.K., Trivedi,J.K.,Sinha.P.K. & Katiyar, M., 158-160, Lucknow . L.P.H.

JAMES T. ANTONY, MD, DPM, MRCPsch., Consultant Psychiatrist, 20/380, Poothole Road, Trichur-680 004, Kerala.