removed under civil provisions of the Mental Health Law before trial and/or conviction? There also do not appear to be provisions equivalent to those of our "consent to treatment".

The MHL 1988 also contains a few features which have no corresponding leaf in the MHA 1983, such as Chapter IV containing Articles 52 to 57, entitled 'Penal Provisions' which deals largely with the punishment meted out to the possible misdemeanours of mental health professionals (*The Mental Health Law*, 1988). While it is the case that in the United Kingdom, professional staff are legally liable for non-compliance with duties specified under the respective mental health laws of the United Kingdom, in Japan, breach of confidentiality, for example, specifically attracts imprisonment with hard labour for a period of not longer than one year, or a fine not exceeding yen 3000,000* (239.5 yens to the £) as per Article 53. It may be of some interest to NHS managers auditing the medical services in their newly-formed trust hospitals, that according to Article 55 Para. 3 of the Mental Health Law of Japan, "The superintendent of a mental hospital who did not make a report . . ." shall be punished with a fine not exceeding yen 100,000. Such explicit financial penalties in the United Kingdom might certainly expedite any dilatory psychiatric report writing – such as of reports for Mental Health Review Tribunals and Home Office Annual Statutory reports for "restricted" patients. They may not yet have "security units", but they certainly seem to have been provided with an incentive powerful enough to maintain their characteristic efficiency!

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**See the following letter from Dr Sakuta.*

References

SAKUTA, T. (1991) New mental health legislation in Japan. *Psychiatric Bulletin*, **15**, 559–561

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DEAR SIRS

I read the letter from Dr Gandhi and Treasaden with great interest. I agree with them that the Mental Health Law of Japan (MHL 1988) has similarities with the Mental Health Act of England and Wales (MHA 1983) and that the MHL 1988 was influenced by the MHA 1983. Yet, historically speaking, the MHL 1988 has its foundation in the Mental Hygiene Law of Japan enacted in May 1950 (MHL 1950). A Designated Physician of Mental Health in MHL 1988 was called A Physician of Judgement of Mental Hygiene in MHL 1950. According to the MHL 1950, two Physicians of Judgement of Mental Hygiene had to judge when a mentally disordered person was involuntarily admitted by the Prefectural Governor, as in the MHL 1988.

A "temporary admission" and an "involuntary admission by the Prefectural Governor" were in the MHL 1950.

An "emergency admission" was newly introduced in the MHL 1988. The MHL 1988 also newly allowed the detention for not more than 72 hours of a voluntarily admitted patient seeking discharge, if ". . . the physician considers it necessary to continue the admission". Drs Gandhi and Treasaden referred to the lack of detail regarding the provisions for mentally disordered offenders. Certainly, there are few articles concerning mentally disordered offenders in MHL 1988. But in Japan too, the mentally disordered who commited crimes are regarded as either criminally irresponsible or of reduced responsibility. Suspected mentally disordered offenders are examined by psychiatrists at the request of public prosecutors, barristers or judges. Mentally disordered offenders in need of in-patient psychiatric treatment are removed before trial and/or conviction and sent to designated psychiatric wards for "Involuntary admissions by the Prefectural Governor". They can be discharged any time when the doctor in charge considers they do not need further hospitalisation.

This ease of discharge and repeated offences by the same mentally disordered offender are regarded as a current problem in Japan.

Breach of confidentiality attracts imprisonment with labour for a period of not longer than one year, or a fine not exceeding 300,000 yen (not 3000,000). Article 53 is rather a moral statement for mental health professionals. I have never heard of any case of the practical application of the article. There are patients difficult to treat. They tend to be refused inpatient treatment by most psychiatric units. For these reasons, the idea of "security units' is being discussed now in Japan.

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Learning about management through observation

DEAR SIRS

Higher psychiatric trainees need management training as part of their preparation to become NHS

consultants. Usually senior registrars obtain management experience by attending special courses, as at the King's Fund or University of Keele, and by being members of local medical committees. We wish to report our experience in extending this form of training by arranging (RR) and receiving (DB) a special 'management module' in general management during a senior registrar placement.

Medway Management Training Programme for Senior Registrars in Psychiatry

The training programme started with DB attending the well-established three day course at Keele University. This provided useful lectures and discussions on subjects like the relationship between the consultant psychiatrist and the multi-disciplinary team, the clinician as leader, the new NHS, medical audit.

The subsequent six months practical training involved DB spending one session a week with a wide range of local managers, the whole programme being co-ordinated by RR. The attachments involved one, two or three sessions with each 'trainer manager', to include tutorials and attendance (with observer status) at high level management meetings like the District Health Authority Unit Management Board, District Commissioning Advisory Group and Directorate meetings. Tutorial-type discussions took place with the Director of Finance, Contracts Director and Director of Human Resources. The role of information technology in management was outlined by a physician and a surgeon, currently working in resource management. Detailed learning about mental health services, shadowing the Clinical Director and attending the Directorate and Service Review Meetings, provided insight about organisation and service delivery aspects of mental health services.

Such a programme provided management training from a number of helpful perspectives. The theoretical knowledge acquired on a course can be 'tested out' in discussion with local managers, and after the committee meetings with senior clinicians. Observation, from the relatively unthreatening position of senior registrar, of the ways in which managers make and carry out decisions, will facilitate better understanding and help the aspiring consultant to join the ranks of managers in future. Following participation in such a programme even those who do not wish to be involved in management should find it easier to know how to put forward their own proposals to managers.

Our experience suggests that:

(a) provision should be made in each Region/District for training senior registrars in management

(b) such a training should involve a theoretical course as well as practical "hands on experience" through observation and tutorials. The duration should be at least 6 months with a half day session each week

(c) involvement of local managers in the programme is more effective as the trainee can understand the local issues from a different perspective.

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Somatic correlates in mental retardation

DEAR SIRS

In the study of mental retardation, 'somatic correlates', the physical features typically characteristic of disorders associated with mental retardation, have traditionally attracted great importance. Textbooks on mental deficiency and clinicians of yesteryear emphasised the minutiae of different syndromes. This preoccupation with detail earned such quips as "syndromitis" and "syndromatosis" and as "like a zoo" for doctors' demonstrations of patients.

In long-stay hospitals captive populations have been accessible for research into their various abnormalities. Anatomical anomalies of developmental origin appear to be more frequent and more marked among mentally retarded people. These physical features can be classified as primary, a *sine qua non*, and pathognomonic of a condition, as secondary, not essential but distinctive and supporting a diagnosis, and as tertiary, incidental to the diagnosis.

In the 125 years since Dr John Langdon Haydon Down described "Down's Syndrome" in 1866, numerous conditions with mental retardation have been recognised on a basis of a constellation of observable physical characteristics. Where a biochemical or chromosomal defect has been the first identification of a disorder, it has been necessary to re-examine series of patients to discover any distinguishing physical features. Anatomical abnormalities can alert the practitioner to a need for further investigations.

In the move to concentrate on "The Psychiatry of Mental Handicap" the status and relevance of somatic correlates are open to question. A number of reasons can be offered why specialists in mental retardation should not "de-skill" themselves by abandoning the somatic dimension. Mentally retarded patients who have had no previous assessment by a specialist are still not infrequently referred to the service. The cause of mental retardation in patients may have significant implications for their families and relatives. The recognition of somatic