the theme of socio-therapy on an acute admission ward. In the current climate of extolling the virtues of community care and relegating in-patient care to institutionalism with its ills, to read about creatively organising the delivery of in-patient care is heartening. My basic training in psychiatry (early 1980s) involved working in a therapeutic community approach hospital run on similar lines and catering for a catchment area. As a trainee this experience was enriching. Sadly, that sort of approach soon got steam-rolled by the organisational changes and increasing shift towards biological psychiatry.

I also very much agree with Professor Cox's comments about the confusion relating to bed requirements and a disinterest in adequately resourcing in-patient units in district general hospitals. My experience locally has been similar and in a recent meeting with managers relating to future plans we had to defend very strongly the need for an adequately resourced in-patient unit as a significant component of comprehensive psychiatric service delivery. A recently published study (Lawrence *et al*, 1991) points towards "a bed-rock of illness which will always need inpatient care however comprehensive the community resources."

I think it is important that the issue of in-patient care – the number of beds and the optimum clinical style – be kept under review and a situation avoided of creating a poor back up service for the community care teams. Financial constraints fed by polarised thinking may become a recipe for failure for the much publicised community care!

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Mental Health Review Tribunals

Dear Sirs

I hesitate to add to this already protracted correspondence but would like to point out to Dr O'Dwyer (*Psychiatric Bulletin*, January 1992, **16**, 43) that, sadly, we have to operate the system as it is. This is not to deny that some less complex system of safeguarding patients' rights might be introduced. I am quite sure that all psychiatrists wish to do the best for their patients but the law requires (quite rightly) that the deprivation of a person's liberty be open to scrutiny – in the case of detained patients by three persons – medical, legal and lay. I am saddened to see that Dr O'Dwyer seems to think that a layman or woman has no part in this. The history of psychiatry and contemporary practice suggests the opposite and some lay Tribunal members might find Dr O'Dwyer's comments both hurtful and offensive.

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Mental health legislation in Japan and the UK

Dear Sirs

It was with great interest that we noted the similarities between the revised Mental Health Law of Japan in July 1988 (MHL 1988) and the Mental Health Act of England and Wales (MHA 1983) on which it has clearly drawn. Certainly, UK mental health legislation is known as the most complex in the world. Given such an opportunity as afforded to Japan, would we have modified our Mental Health Act in a similar fashion?

In Japan, a "mentally disordered person" refers to a psychotic person (including those who are psychotic due to intoxication), a mentally retarded person or a psychopathic person. "Mental disorder" in England and Wales could be either a mental illness, arrested or incomplete development of mind, psychopathic disorder or any other disorder or disability of mind. In England and Wales, mental illness is undefined but is taken to include neuroses, for which it appears one cannot be detained in Japan. However, in practice it is becoming increasingly rare in the United Kingdom for those with neuroses to be considered detainable.

A "Designated Physician of Mental Health" as per MHL 1988 has the same powers as any psychiatrist who is "Approved under Section 12" of MHA 1983. An "emergency admission" in Japan has the same purpose and time limitation for hospital detention as Section 4 of the MHA 1983. A "temporary admission" under MHL 1988, likewise, corresponds to involuntary hospital admission under Section 2 of the MHA 1983, albeit with a shorter time period of three weeks instead of four. For all practical purposes, an "involuntary admission by the Prefectural Governor" in Japan is similar to hospital detention under Section 3 of the MHA 1983. The MHL 1988 also allows 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" – as does Section 5 (2) of the MHA 1983.

Another striking feature, however, is the surprising lack of detail, at least as detailed in the article by Sakuta (1991), with regard to the provisions for mentally disordered offenders. Does the criminal law merely take its course? Are mentally disordered offenders in need of in-patient psychiatric treatment

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.*

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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