

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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#### References

- LAWRENCE, R. E. COPAS, J. B. & COOPER, P. W. (1991) Community care: does it reduce the need for psychiatric beds? – A comparison of two different styles of service in three hospitals. *British Journal of Psychiatry*, **159**, 334–340.

#### *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