that while I agree that Section 3 of the Mental Health Act contains important safeguards for patients providing consultation with the nearest relative, I would like to add that this in some cases is merely a complicating factor. I have been involved in the detention of patients on a Section 3, where the next of kin has absolutely refused to give consent for such an order. This has resulted in patients being inadequately treated and leaves the psychiatrist in a state of helplessness. On the whole, Social Services appear to be loathe to displace relatives as next of kin and in view of the long and complicated processes of same, this is hardly surprising. However, as this is the only way around the problem I feel that some patients are being treated less than adequately when the relatives refuse to give consent. Furthermore, I have found when the next logical step, i.e. displacement of the nearest relative as next of kin, is pointed out to the nearest relative that they tend to withdraw their objections which can be seen as a subtle means of manipulation which is hardly in the spirit of the act.

Dr Kennedy suggests that, when a patient is well known to the service, community care should be offered without recourse to hospital admission. I find this rather naive and in the present climate of bed shortages, etc. I find it hard to believe that there are many psychiatrists admitting patients unnecessarily under the Mental Health Act. However should there be a clause in the current Mental Health Act to include compulsory treatment in the community, then perhaps his suggestions would be more relevant.

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Need for continuing support for carers

DEAR SIRS

I would like to comment on the letter from Drs Lawrence, Blakely and Rossor headed 'Every Day Life in a Drug Trial' (*Psychiatric Bulletin*, **15**, 770). The substance of the letter concerns a phenomenon which providers of services for dementia sufferers view with a mixture of pleasure and pain. It is a privilege for the research team members to enter, however briefly, into the real life stories of those caring for the demented. It is no less a privilege for the client group to have the attention of talented workers in the research field. The danger lies in the tendency for the researchers to become briefly over-involved and to devalue the work of those permanently "out there" struggling with inadequate resources to prop up an admittedly inadequate system. That the involvement in the drug trial has been "interesting and formative" in the researchers' training experience is not in dispute. The advantage which their involvement confers on the "clients" would be lasting if they were to ensure that there would be some continuing support for the carers after the project team's withdrawal. In many cases the research subjects will be known to local statutory or voluntary agencies. Where they are not, the team members should be asking questions.

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Psychological treatments by psychiatrists

DEAR SIRS

I was interested to read the letter from the Dean regarding her conversations with the President and her concerns about improving the capacity of psychiatrists to engage in psychological treatments (*Psychiatric Bulletin* 1991, **15**, 699). I was particularly interested because I had just read in *Psychiatric News* of 15 November 1991, a publication of the American Psychiatric Association, an account of an address by the President of the Association, Dr Lawrence Hartmann, at the opening of the Institute on Hospital and Community Psychiatry. In this he said, "I worry that in 1991 psychiatry has regressed from what was a fairly sound bio/psycho/social model, partly because of biological advances." "As part of the new biological advances and the remedicalization of the field, psychiatry as a model of illness and wellness has shrunk back from bio/psycho/social integration towards the narrower, more purely physiological medical model . . ."

Humane values and bio/psycho/social integration "require us to be aware of and care for and treat WHOLE people – whole biological, psychological, and social people, in context and over time." He quoted George Engel, M.D., who questioned in his writings the exclusively biological focus of modern medicine. That focus "assumes disease can be fully accounted for by deviations from the norm in measurable biological variables . . . It leaves no room in the framework for the social, psychological, and behavioural dimensions of illness".

Dr Hartmann continued, "In some ways, we psychiatrists with our excellent but unbalancing advances in brain biology – probably need to pay attention to Engel's work even more than we did fifteen years ago."

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A psychiatrist with beds . . .

DEAR SIRS

How refreshing it is to read Professor Cox's article (*Psychiatric Bulletin*, 1991, **15**, 684–686) expounding

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