consider the validity of consent. I was surprised, and relieved, that the Local Ethics Committee did not address this complicated issue.

I am confident my research does no harm but I do not consider it to be in the best interest of the patient. I consequently rely on varying levels of consent. First, verbal consent is obtained by the consultant psychogeriatrician selecting the patients at initial assessment, but however open-ended the request it must feel compelling to agree. Second, I write prior to visits, giving an outline of my role and project, request for a meeting, suggested date and estimate of the time we will need. I confirm confidentiality will be respected and, whatever decision is made, will not compromise future management. My home telephone number is included.

On meeting I explain again and read a brief consent form. Usually this is willingly signed. Occasionally I receive a 'proxy consent' by a relative or warden not empowered to do so! Sometimes conditions are stipulated by the carer, usually that she remains in the room. Interestingly, relatives often encourage me to 'entertain' the elderly person, and those who remain are often delighted by 'pockets of retained knowledge and insight'.

Despite these safeguards, I rely at a personal level on good faith. The willingness to be accepted and welcomed into a home and the initial agreement for me to interview them is critical. Often, when I leave, the person is unable to recollect my name, occupation or reason for being there.

I am not convinced my consent is valid but implied consent and mutual good will are vital for continued research and interest in elderly people with dementia.

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Substance misuse in medium secure units

Sir: In my experience of working in a medium secure unit I was struck by the widespread consumption of alcohol and illegal drugs. It was virtually impossible to control the entry of drugs and education or other treatment programmes systematically failed. However unethical it may seem I believe there was a positive aspect to it. A large proportion of forensic patients misuse drugs and/or alcohol and it would be naive to expect them not to continue to do so following discharge into the community. In a drug-free environment we would be missing an essential aspect of the assessment, namely, the effect that alcohol or drugs have on the mental state of patients with a long history of substance misuse. In these patients the positive effect of psychiatric medication may be suppressed by alcohol or drugs and it is important that prior to discharge we are aware of this.

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Falls in the elderly

Sir: We performed an audit of falls on an assessment ward for the organically mentally ill. The risk factors for falls and strategies for their prevention have been well researched (Myers *et al*, 1991; Rubenstein *et al*, 1994).

Using the incident report forms from the ward for 1994 and 1995 we looked retrospectively at the circumstances of 95 falls over a 21 month period. There were four main circumstances in which patients were likely to fall: while walking 21%, while getting onto or off a chair/lavatory seat 20%, falling out of bed/at night 19% and unknown 19%.

Forty-one per cent of falls occurred while staff were observing patients (walking or sitting), when two fractures occurred. Being seen to fall makes it more likely that a fall will be reported but we felt that this was an area which could be improved upon. We had expected to find that most patients would have fallen at night or while unobserved during the day, which would be a function of the ward layout and staffing levels.

We hope that by alerting staff on the ward that patients are as likely to fall while they are observing them as when they are not that the incidence of falls can be reduced.

MYERS, A. H., *et al* (1991) Risk factors associated with falls and injuries among elderly institutionalized persons. *American Journal of Epidemiology*, **133**, 1179–1190.
RUBENSTEIN, L. Z., JOSEPHSON, K. R. & ROBBINS, A. S. (1994) Falls in the nursing home. *Annals of Internal Medicine*, **121**, 442–451.

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Medical members of Mental Health Review Tribunals

Sir: Concern has been expressed by some of our psychiatrist members who are medical members of Mental Health Review Tribunals (MHRTs) as to their position regarding any allegations or claims made against them arising from preliminary psychiatric examinations prior to tribunal hearings.

When sitting in a judicial capacity psychiatrists are of course immune from suit as regards their