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

decision making. However, our members have expressed anxiety as to what may happen if problems arise in a preliminary examination that might lead to at least a need for legal representation or even claims for compensation.

In order to clarify this matter, I have been in touch with both the Lord Chancellor's Department and the Mental Health and Community Care Division of the Department of Health. I have now been informed that the Departments' solicitors' view is that, as members of the tribunal, psychiatrists would be carrying out statutory functions under the Mental Health Act 1983 and that it would be unreasonable for them to be expected to incur any financial liability that may arise. As the Department of Health pays remuneration to members of the MHRT, the Department of Health would bear the cost of any successful claim made for damages.

It is also pointed out that the Mental Health Review Tribunal is established under the Mental Health Act 1983 and Section 139 of the Act provides some protection for persons carrying out functions under the Act. No civil proceedings can be brought against any person without the leave of the High Court, who would have to confirm the act was done in bad faith or without reasonable care.

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Code of Practice; Section 2 or Section 4?

Sir: The Code of Practice dictates that patients should be assessed for Section 2 wherever possible rather than Section 4. Under the provisions of the Mental Health Act (Scotland) 1984 such a practice is legally impossible. What then is true good practice? I would argue that the Scottish Act has it about right. A patient presenting acutely in a state which requires admission to a mental hospital should be admitted with minimum infringement of rights. Section 2 is, to all intents and purposes (electroconvulsive therapy excluded), a treatment order and such detention should not be embarked on lightly. The Code of Practice, however, interpreted by purchasing authorities and social services seems to demand that senior psychiatrists attend patients at unearthly hours of the night with only two options: release them or detain them under Section 2 which, of course, permits the most junior on call doctor to impose any medication she sees fit. If this is good practice, what is bad?

'Real' good practice dictates that a patient should be addressed for detention under Section 2 by a consultant or equivalent who is functioning on all cylinders which few of us are when we attend a police station at 3 or 4 am. And even if our decision making is reasonable at these hours, what effect does sleep deprivation have on the quality of our decision making in out-patient clinics, ward rounds, and domiciliary visits conducted after such an assessment in the early hours of the morning?

I would argue that Section 2 assessments at unsocial hours should be the rarity rather than the norm. We do not after all convene Mental Health Review Tribunals at 3 am immediately to hear appeals against detention!

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Whose journal is it anyway?

Sir: Samuel Stein & Rex Haigh (*Psychiatric Bulletin*, February 1996, **20**, 115) pose the question, "how many would stop buying the Journal if it were purchased separately from membership subscription, given the discrepancy between what College members are interested in and what is published?" I would be one such member.

Another interesting analysis would be the percentages of mental health budgets that are spent on sub-specialties compared to general psychiatry.

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Sir: Stein & Haigh (*Psychiatric Bulletin*, February 1996, **20**, 115) show that the *British Journal of Psychiatry* published disproportionately few articles in specialisms such as psychotherapy and child psychiatry. Their data confirmed what has been my impression over the years.

However, an addendum to their findings is that the book review section has a very different pattern, with a surprisingly high proportion of psychotherapy evident. Taking the last six months' sample, of the total books reviewed, I calculate that 33% are psychotherapy or related subjects, 13% child and adolescent psychiatry and all other subjects total 54%.

Varied conclusions may be developed from this, but one might be: an academic journal doth not a College make.

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