further research will be required to clarify causal pathways: in particular: (a) whether low blood pressure causes depression through one of the organic mechanisms discussed by the authors; (b) whether low blood pressure and depression are both secondary to early cognitive decline; and/or (c) whether low blood pressure is a marker for other, more psychological risk factors for depression, such as the impact of poor physical health and functional limitation.

Boshuizen, H. C., Izaks, G. J., van Buuren, S., *et al* (1998) Blood pressure and mortality in elderly people aged 85 and older: community based study. *British Medical Journal*, **316**, 1780–1784.

Paterniti, S., Verdier-Taillefer, M.-H., Geneste, C., *et al* (2000) Low blood pressure and risk of depression in the elderly. A prospective community-based study. *British Journal of Psychiatry*, **176**, 464–467.

Prince, M. J., Harwood, R. H., Blizard, R. A., *et al* (1997) Impairment, disability and handicap as risk factors for depression in old age. The Gospel Oak Project V. *Psychological Medicine*, **27**, 311–321.

R. Stewart Section of Old Age Psychiatry, Institute of Psychiatry, De Crespigny Park, London SE5 8AF

Complex medical roles in mental health review tribunals

Gibson (2000) makes a thoughtful rejoinder to the suggestion by Richardson & Machin (2000) that the dual nature of the roles exercised by the mental health review tribunal (MHRT) medical member precludes open-mindedness. That this need not be the case was demonstrated some years ago by Langley (1990, 1993) and Brockman (1993). Gibson suggests that the role of the MHRT doctor was introduced in the 1959 Act to facilitate examination of the "hospital notes without ruffling medical feathers". In reality, the issue of the medical member's role was more complex than this. During the parliamentary debates on the 1959 Act there were very conflicting views expressed as to who was best fitted to make judgements concerning the need for detention, bearing in mind the then current legislation which involved a purely judicial decision. A compromise appears to have been reached by the introduction of the present three-member MHRT panel.

Gibson's remedy, which would involve tribunal members reading the medical notes for half an hour prior to the hearing, has two serious weaknesses. First, in many cases the notes are too voluminous and complicated to make this possible in the time-scale suggested. Second, medical notes sometimes require a certain degree of medical interpretation for the benefit of the two non-medical members of the panel. However, these issues may turn out to be academic in the light of the current Government's proposals for reform of the 1983 Act (Department of Health, 1999) involving a considerably more complicated (and, most likely, more costly) system than we have at present; a system which also comes very close to infringing the European Convention on Human Rights' mandates. It is also very clear that the Government's proposals have not found favour with some members of the Scoping Study Review Team (Peay, 2000). There is an old adage 'marry in haste, repent at leisure'. Maybe in this case it would be appropriate to substitute for this phrase, 'legislate in haste' (on the basis of a pre-determined and heavily constrained remit and time-scale by Government) and we will be most certain to 'repent at leisure'.

Brockman, B. (1993) Preparing for Mental Health Review Tribunals: reports and dilemmas. *Psychiatric Bulletin*, **17**, 544–547.

Department of Health (1999) *Reform of the Mental Health Act, 1983: Proposals for Consultation*. London: Stationery Office.

Gibson, A. C. (2000) Medical roles in mental health review tribunals (letter). *British Journal of Psychiatry*, **176**, 496–497.

Langley, G. E. (1990) The Responsible Medical Officer and Mental Health Review Tribunals. *Psychiatric Bulletin*, **14**, 336–337.

—— (1993) Mental Health Review Tribunals in practice. *Psychiatric Bulletin*, **17**, 331–336.

Peay, J. (2000) Reform of the Mental Health Act, 1983: Squandering an Opportunity. *Journal of Mental Health Law*, **3**, 5–15.

Richardson, G. & Machin, D. (2000) Doctors on tribunals. A confusion of roles. *British Journal of Psychiatry*, **176**, 110–115.

H. A. Prins Lay Member, Mental Health Review Tribunal, 1 Home Close Road, Houghton on the Hill, Leicester LE7 9GT

Forensic trials inform the present and future

Lindqvist & Skipworth (2000) emphasised the shortage of high-quality randomised trials dealing with the treatment and rehabilitation of mentally disordered offenders and highlighted problems of undertaking such studies. Currently, we are involved in a project, funded by the UK National Health Service Research and Development Programme on Forensic Mental Health, to create a register of randomised controlled trials dealing with the management of violent or aggressive people. Initial searches identified 22 000 citations, over 2000 of which were relevant trials. We are now surveying the subset of 350 trials of most interest to the forensic mental health services. Data on content and quality are being reliably recorded and a report will be produced for publication. Already some of these trials are of sufficient quality to be included in systematic reviews (Brylewski & Duggan, 2000; Fenton *et al*, 2000; White *et al*, 2000).

It is likely that Lindqvist & Skipworth are correct to suggest that high-quality studies are rare. Many trialists, however, have used the 'gold standard' of mental health care evaluation (World Health Organization Scientific Group on Treatment of Psychiatric Disorders, 1991), the randomised trial, to investigate the value of interventions relevant to forensic services. Much can be learnt from such studies, even if they are of limited quality. Systematic appraisal of such work may inform practice, but certainly guides future research. Lindqvist & Skipworth listed considerable difficulties encountered by trialists of interventions relevant to forensic services. These difficulties have all, to a greater or lesser extent, been considered and addressed, and large, simple randomised trials could overcome most problems. Indeed, many of the treatments commonly used for offenders with mental disorders may be unethical outside of such trials (White *et al*, 2000).

Brylewski, J. & Duggan, L. (2000) Antipsychotic medication for challenging behaviour in people with learning disability (Cochrane Review). In *The Cochrane Library*, Issue 2. Oxford: Update Software.

Fenton, M., Coutinho, E. S. F. & Campbell, C. (2000) Zuclopenthixol acetate in the treatment of acute schizophrenia and similar serious mental illnesses (Cochrane Review). In *The Cochrane Library*, Issue 2. Oxford: Update Software.

Lindqvist, P. & Skipworth, J. (2000) Evidence-based rehabilitation in forensic psychiatry. *British Journal of Psychiatry*, **176**, 320–323.

White, P., Bradley, C., Ferriter, M., *et al* (2000) Managements for people with disorders of sexual preference and for convicted sexual offenders (Cochrane Review). In *The Cochrane Library*, Issue 2. Oxford: Update Software.

World Health Organization Scientific Group on Treatment of Psychiatric Disorders (1991) *Evaluation of Methods for the Treatment of Mental Disorders*. Geneva: WHO.

S. J. Cure, C. E. Adams Cochrane Schizophrenia Group, Summertown Pavilion, Middle Way, Summertown, Oxford OX2 7LG

https://doi.org/10.1192/bjp.177.2.182-a Published online by Cambridge University Press