conclude that mental health professionals "should be aware of the mistakes of the past".

I would like to point out that comparable mistakes continue in many parts of the world where homosexuality is still pathologised and substantially stigmatised. For example, according to the second revised edition of the Chinese *Classification of Mental Disorders* published in 1995, homosexuality remains a diagnosable psychiatric disease in China (Lee, 1996). A senior professor argued that this is because there is a lack of either biological or psychological evidence to show that homosexuality is 'absolutely normal' and that some homosexual people do seek medical or psychological help (Young, 1994). However, Lau & Ng (1989) maintained that homosexuality not only has a long history but is also common in Chinese society.

In the USA the diagnostic category of 'egodystonic homosexuality' was not deleted from the DSM system until recently (American Psychiatric Association, 1987). It remains to be seen whether China's rapid economic reforms and admittedly more sluggish political liberalisation will lead to the de-pathologisation of homosexuality and the ripening of the Chinese gay community.

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Sir: King & Bartlett (1999) outline the generally unhappy relationship between British psychiatry and homosexuality. Although British psychiatry never embraced psychoanalysis as in the USA, it still produced its own crop of negative and even homophobic theorising and practice. O'Connor & Ryan (1993) have mapped out the work to be done for psychoanalytic psychotherapy from a lesbian perspective and I have attempted a smaller-scale exercise for gay men (Ratigan, 1998). We still have a long way to go to match the confidence of the lesbian and gay critiques of both psychiatry and psychoanalysis to be found in the USA (Cabaj & Stein, 1996).

Working in a specialist National Health Service psychotherapy unit as a psychoanalytic psychotherapist, who happens to be gay, I come across gay men and lesbians who, while being generally content with their sexual orientations, nevertheless have major mental health problems, including personality disorders or perversions. I do not assume that homosexuality is a perversion *per se*; but there are gays and lesbians and heterosexuals with perversions.

At a recent conference at University College London on 'Narcissism and perversion: modern Kleinian perspectives' none of the clinical material was from the psychotherapies of gay or lesbian patients. It was as if it was not safe publicly to talk about gay or lesbian patients with perverse or narcissistic character structures for fear of being accused of homophobia. This was a pity as it deprives the lesbian and gay communities of current thinking in this area. I could not have imagined such a conference 10 years ago omitting homosexual material – there would have probably been little else.

Attempts to develop a lesbian and gay affirmative stance in psychotherapy are currently being proposed; it is a liberal not a radical response. Psychoanalysis needs to be challenged to return to its roots and regard all sexualities as problematic. Too much would be lost if we surrendered (the attempt at) therapeutic neutrality in psychoanalytic psychotherapy, especially in work with gay or lesbian patients with major mental health problems.

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Old age forensic psychiatry

Sir: The close collaborative working relationship that Gairin & Quinn (1999) describe between the Yorkshire forensic and old age psychiatry services is interesting and could possibly serve as a model for how services might be organised elsewhere.

The relationship they describe, however, is far from universal and this is precisely the point of my editorial (Yorston, 1999) that psychiatric services for elderly mentally disordered offenders are patchy and uncoordinated with little or no research literature to act as a base for decision-making.

The fact that the number of elderly offenders is small (i.e. there is little demand) should no longer be accepted as a reason for neglecting this group. Whether there is a need for old age forensic psychiatry should be the question that is asked. In my experience, and that of many other old age and forensic psychiatrists, this need clearly exists and is inadequately met in many areas.

The way forward must surely involve more research in this area to determine need, and more debate of the various local solutions that have been found to meet it.

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Serving the interests of the *Journal*'s readers

Sir: It is genuinely encouraging to see how the *Journal* is now supporting parallel publication of electronic and paper systematic reviews relating to the care of people with mental health problems (Chalmers, 1999). Other journals have been doing this for a while (Johnstone & Zolese, 1999; Soares & McGrath, 1999; Wahlbeck *et al*, 1999).

We hope this also heralds a sea change in policy regarding treatment reviews in the *Journal*. In January–July 1999 the *Journal* published its randomised trials, all, of course, with a Methods section, encouraging the view that these were as objectively undertaken as possible. Nine of the 15 trials were clearly industry sponsored, which is probably a similar rate to other key journals.

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