Premenstrual syndrome should not be forgotten as a causative factor in behaviour disturbances in mentally handicapped females of reproductive age and if its existence is suspected appropriate treatment should be instituted. Although its specificity of use and optimum dosage remain obscure, pyridoxine is one of the potential therapies available.

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Consent and the mentally handicapped

DEAR SIRS

I have recently been involved in the care of a woman with mental handicap, where some apparent confusion has arisen as to whether parents have the right to give consent on behalf of their offspring. The case concerns a 29-year-old woman with moderate mental handicap and a manic-depressive psychosis, circular type. During a period of hospitalisation, prophylactic treatment with lithium was commenced, following appropriate investigation. The clinical judgement of the Responsible Medical Officer was that the patient was not able to give informed consent. The parents were informed of the change of treatment the following day. They expressed immediate alarm at the use of such a "toxic drug" and insisted that the treatment be stopped at once.

Lithium was discontinued and the parents interviewed. Despite detailed explanation by senior staff about the medical aspects of the therapy, the parents were unwilling to accept reassurance that lithium was appropriate or safe. The parents insisted that they had the right to decide on their daughter's treatment and would not consent to the use of lithium. There has followed an unresolved dispute involving the parents, consultant, hospital administrators and Health Authority, as to who has the right to provide consent. Advice has been sought from the Welsh Office.

The important issues about consent and the mentally handicapped have been touched upon by G. C. Kanjilal (*Psychiatric Bulletin,* February 1989, **13,** 82–83). In his article, Dr Kanjilal describes current practices. These include the process whereby, "The parents are kept fully informed and when available, give the consent instead (of the patient). However, in an emergency the consultant gives the consent and obtains the parents' consent as soon as practicable". Dr Kanjilal then addresses the validity of such consent, should there be disagreement between the consultant, multidisciplinary team or parents.

My view of this matter concerns the very essence of consent. Consent has been defined as "voluntary agreement or acquiescence in what another proposes or desires". This description has a very personal flavour. I would contend that once the age of majority has been reached, it is not possible for valid consent to be given by one person on behalf of another. If a patient is unable to give informed consent, doctors generally like to have the agreement of colleagues and relatives when embarking on treatment, but this agreement does not amount to consent (Bicknell, 1989).

People who are mentally ill or handicapped may assent to treatment without necessarily having much reasonable insight into its nature or implications. Such compliance does not really constitute informed consent. Nobody else has the legal authority to provide consent. The Mental Health Act bestows only the power to treat in the absence of consent, although this may not itself be appropriate unless there are other grounds for its use (Browne, 1985). In the absence of informed consent, the need for agreement from all parties is paramount.

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The Costs of Hospital Closure: Providing services for the residents of Darenth Park Hospital

DEAR SIRS

We would like to congratulate Professor Glennerster (*Psychiatric Bulletin,* March 1990, **14,** 140–143) on his clear and lucid evaluation of the two settings. We are particularly pleased to see the use of marginal costs and opportunity costs in his analysis. While we appreciate that this is a difficult area to give justice to, we do however feel that the analysis would have been more meaningful if benefits were included in the equation.

We find it surprising that the opportunity cost has only been analysed in terms of capital costs. It does not seem that it has taken into account the cost of possible loss of trained staff, as well as spacious grounds and recreational facilities.

We note the relatively small expenditure on health authority services. We wonder how did the use of these services relate to the availability as well as identification of need by health service providers (Bouras & Drummond, 1989).

We feel that awareness of economical issues in the Health Service provisions as well as further research with more refined tools of assessment would enhance the development of responsive services for this population.

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Importance of basic sciences to education in psychiatry

DEAR SIRS

I read the article by Professor Crisp (*Psychiatric Bulletin*, March 1990, **14**, 163–164) with great interest.

I agree with the importance of understanding basic research methodology and training at registrar level. I would also like to draw attention to the importance of continuing education and training in the basic sciences as relevant to psychiatry.

Having to organise the North West Thames Regional Health Authority Senior Registrar Post-Graduate training scheme in the psychiatry of mental handicap, I had to review the basic specialists' training programme in psychiatry, and also evaluate the present senior registrars' training needs, together with general research interests and publication trends in the psychiatry of mental handicap.

I screened all subjects and headlines on mental retardation in the *Cumulative Index Medicus* for the year 1988, and also six outstanding clinical journals of mental handicap for the year 1988.

Comparing the total number of papers on mental retardation in *Cumulative Index Medicus* (n = 1575) to the numbers of papers in six journals of mental handicap (n = 210), showed that only 13.5% of all the papers on the subject were published in the journals of mental retardation. Of all the papers, 86.5% were published in journals of general psychiatry, medicine, neurology, genetics and in the whole range of basic behavioural sciences publications as covered by *Cumulative Index Medicus*.

This is a proof of both the wealth of information on the subject of mental handicap and also the contribution of those clinical subjects and sometimes scientific dilemmas to all basic sciences and other disciplines.

It is also a proof of the clinician's need to understand and follow basic scientific progress and its importance in applying new diagnostic and treatment methods and designing sophisticated research programmes.

Both basic specialist and post-graduate training in all sections of psychiatry should underline the importance of basic sciences as well as teaching and research experience.

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Section 37 – Mental Health Act

DEAR SIRS

There is a curious provision in the Mental Health Act 1983 for the discharge of patients admitted under S.37 of the Act. Schedule I Part I of the Act modifies the applicability of the powers of discharge under S.23(2)a of the Act so that the nearest relative does not have the power of discharge, but the powers of the hospital managers to discharge the patient are retained. Indeed the Mental Health Act Leaflet 8 ("Your rights under the Mental Health Act 1983") which is handed to patients admitted under S.37 states:

> "If you think you should be allowed to leave hospital you should talk to your doctor. If he thinks you should stay, but you still want to leave, you can ask the hospital managers to let you go. You should write to them to ask them to do this".

It is surprising that the hospital managers should have powers which can override the decision of even a High Court judge, who makes a Hospital Order after considering "all the circumstances including the nature of the offence and the character and antecedents of the offender . . ." (S.37(2)b), before deciding that a Hospital Order is the most appropriate disposal. Many colleagues, including Mental Health Act Commissioners, seem unaware of this provision, and it would be interesting to know what the effects are in practice. So far, none of my own patients have been discharged in this way, but I know of one case where a S.37 patient was discharged by the managers against the advice of the Responsible Medical Officer (although their decision proved invalid for technical reasons). One fears that if the courts become aware that their decisions can be overruled by hospital managers against medical advice, they may be less ready to accept medical recommendations for a Hospital Order.

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