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).