

In addition, medication adherence is not available in the NHIRD. Therefore, these points should be considered as limitations of our study.

Finally, we defined the use of carbamazepine, valproic acid, lithium or lamotrigine as the use of any mood stabiliser. Guidelines have suggested that combination therapy is an acceptable strategies for treating bipolar disorder.<sup>4</sup> Similar to the results of our prior study,<sup>5</sup> we believe that combination therapy for bipolar disorder may have contributed to the gap between the number of patients receiving any mood stabiliser and the sum of patients as per the numbers given separately for carbamazepine, valproic acid, lithium and lamotrigine in our study.

## References

- 1 Chen PH, Tsai SY, Pan CH, Chang CK, Su SS, Chen CC, et al. Mood stabilisers and risk of stroke in bipolar disorder. *Br J Psychiatry* 2019; **214**: 305.
- 2 Pavlova B, Perlis RH, Mantere O, Sellgren CM, Isometsä E, Mitchell PB, et al. Prevalence of current anxiety disorders in people with bipolar disorder during euthymia: a meta-analysis. *Psychol Med* 2017; **47**: 1107–15.
- 3 Wotton CJ, Goldacre MJ. Record-linkage studies of the coexistence of epilepsy and bipolar disorder. *Soc Psychiatry Psychiatr Epidemiol* 2014; **49**: 1483–8.
- 4 Yatham LN, Kennedy SH, Parikh SV, Schaffer A, Beaulieu S, Alda M, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) collaborative update of CANMAT guidelines for the management of patients with bipolar disorder: update 2013. *Bipolar Disord* 2013; **15**: 1–44.
- 5 Yang SY, Liao YT, Liu HC, Chen WJ, Chen CC, Kuo CJ. Antipsychotic drugs, mood stabilizers, and risk of pneumonia in bipolar disorder: a nationwide case-control study. *J Clin Psychiatry* 2013; **74**: e79–86.

**Chian-Jue Kuo**, Attending Psychiatrist, Taipei City Psychiatric Center, Taipei City Hospital; and Associate Professor, Department of Psychiatry, School of Medicine, College of Medicine, Taipei Medical University, Taiwan; **Pao-Huan Chen**, Lecturer, Department of Psychiatry, School of Medicine, College of Medicine, Taipei Medical University; and Attending Psychiatrist, Department of Psychiatry and Psychiatric Research Center, Taipei Medical University Hospital, Taiwan. Email: [tcpckuo@seed.net.tw](mailto:tcpckuo@seed.net.tw)

doi:10.1192/bjp.2019.64

## Timing of onset of lithium relapse prevention - how early, how late?

In a recent paper, Dr Taylor raises an important issue: how long does it take for people with bipolar disorder to respond to lithium treatment?<sup>1</sup> In meta-analysis of data from three clinical trials, he found that patients randomised to lithium had significantly lower relapse rates than those receiving placebo, even in the first 2 weeks of treatment. This conclusion, however, does not answer the more relevant question as to how long a treatment trial should last before it can be established whether it is effective. In other words, is it worth waiting for let us say a year before switching to another option?

Clinical experience would suggest that there is a great range of time to response, which may relate to diagnostic and genetic heterogeneity.<sup>2</sup> Some patients respond within a few weeks whereas others may continue having major mood symptoms during the first year of treatment. Patients in the latter group will be inevitably categorised as ‘non-responders’ if even a single relapse is the criterion of treatment failure.

In Dr Taylor’s study all three trials were based on discontinuation designs and were enriched for acute response to quetiapine or lamotrigine. However, enriched discontinuation designs with time to relapse as the outcome variable are less than ideal for evaluation of treatments of an illness that runs a lifelong course that is often highly unpredictable. Furthermore, most recent studies of long-term treatment of bipolar disorder (including the three trials

discussed here) evaluate continuation treatment rather than recurrence prevention.

With respect to the minimal necessary length of treatment trial, there is practically no systematic data and the existing bipolar treatment guidelines stay away from the subject as well. In an earlier study, Ahrens *et al* attempted to estimate the time needed for patients to benefit from the suicide-reducing effect of lithium; they concluded that a treatment period of at least 2 years was necessary to return suicide risk to population baseline.<sup>3</sup> Given this, a more realistic design of maintenance studies might consider different outcome criteria such as affective morbidity assessed periodically over a sufficiently long observation period. As for a practical decision as to how long a treatment trial needs to last, it may become easier with advances in personalised treatment and discoveries about predictors of treatment response. Then it should be possible to individualise the length of a treatment trial – longer in those people expected to benefit from a specific treatment and abandon unsuccessful treatment earlier in those where the likelihood of response is equivocal.

## References

- 1 Taylor MJ. Timing of onset of lithium relapse prevention in bipolar disorder: evidence from randomised trials. *Br J Psychiatry* 2018; **213**: 664–6.
- 2 Manchia M, Cullis J, Turecki G, Rouleau GA, Uher R, Alda M. The impact of phenotypic and genetic heterogeneity on results of genome wide association studies of complex diseases. *PLoS One* 2013; **8**: e76295.
- 3 Ahrens B, Muller-Oerlinghausen B, Grof P. Length of lithium treatment needed to eliminate the high mortality of affective disorders. *Br J Psychiatry* 1993; **163** (suppl 21): 27–9.

**Nathan Corbett**, MD. Resident, Department of Psychiatry, University of Toronto, Canada; **Martin Alda**, MD FRCP. Professor and Killam Chair in Mood Disorders, Department of Psychiatry, Dalhousie University, Halifax, Canada. Email: [malda@dal.ca](mailto:malda@dal.ca)

doi:10.1192/bjp.2019.65

## Author’s reply

Corbett & Alda raise the interesting question of how long a treatment trial should last before it can be established whether lithium is effective for a specific individual. As they note, existing experimental studies are not necessarily designed to address that particular question, which raises significant conceptual and analytic challenges.

Their interesting suggestion of assessing maintenance treatments through comparison of cumulative morbidity over long periods may be becoming a more feasible prospect through the combination of electronic health records analysis<sup>1</sup> with the increased availability of longitudinal mood monitoring outside experimental studies.<sup>2</sup>

Pending these new data, the available evidence indicates that lithium is likely to reduce the risk of manic relapse rapidly, whereas full effects against depressive relapse probably develop over a longer period.<sup>3</sup>

## References

- 1 Hayes JF, Pitman A, Marston L, Walters K, Geddes J, King M, et al. Self-harm, unintentional injury, and suicide in bipolar disorder during maintenance mood stabilizer treatment: a UK population-based electronic health records study. *JAMA Psychiatry* 2016; **73**: 630–7.
- 2 McKnight RF, Bilderbeck AC, Miklowitz DJ, Hinds C, Goodwin GM, Geddes JR. Longitudinal mood monitoring in bipolar disorder: course of illness as revealed through a short messaging service. *J Affect Disord* 2017; **223**: 139–45.

- 3 Taylor MJ. Timing of onset of lithium relapse prevention in bipolar disorder: evidence from randomised trials. *Br J Psychiatry* 2018; **213**: 664–6.

**Matthew Taylor**, Consultant Psychiatrist, University Department of Psychiatry, Warneford Hospital, Oxford. Email: [matthew.taylor@psych.ox.ac.uk](mailto:matthew.taylor@psych.ox.ac.uk)

doi:10.1192/bjp.2019.66

### Montgomery and changes to the process of consent: debate required

The doctrine of precedence is a feature of common law jurisdictions such as that in England and Wales, Scotland and other areas of the UK. It allows for judgments made in courts of law to be followed by other courts, unless they are replaced by different decisions in a higher court. In a similar fashion, rulings in courts tend to be taken by professions and incorporated into practice. The case discussed by Adshead *et al* refers to a judgment in the UK's highest court, where a decision about information required to achieve appropriate consent for the delivery of a pregnancy was heard.<sup>1</sup> Adshead *et al* argue that the judgment should be followed when, for example, medication is discussed with patients by psychiatrists.

In order for a lower court to follow a previous judgment, the subsequent case must be similar in nature or fact, so that precedence can be applied. Therefore, it follows that if a court judgment is to be applied to clinical practice, then the case it concerns should be similar to the patient being seen. As a child and adolescent psychiatrist, I am interested in the application of the judgment to patients under 18, and whether *Montgomery* is similar enough to be applied to the process of consenting minors to take psychotropic medication? The legal case concerned a 'clearly highly intelligent' mother with diabetes.<sup>2</sup> Is this the case for a significant number of patients seen in child and adolescent mental health services? Does the procedure of a caesarean section or an instrumental delivery of a baby resemble closely enough aspects of treatment using psychotropic medication?

Clearly, informed consent needs to involve the presentation of appropriate information to enable patients to make a choice, and that information presented needs to be adequate and tailored to the individual concerned. Making a patient aware of material risks of treatment or procedures is a laudable aim, but knowing every patient's life, aspirations and interests in sufficient detail in which to form a definitive view of what risks to include may be unachievable in normal clinical practice. I fear that, in order to avoid criticism and censure, clinicians may take an approach that presents all risk information without filter or context. Some might describe this as defensive medicine.

I make these points, not to imply they represent my opinion or point of view, but rather to stimulate debate and argument, so that we, as a profession, are not necessarily bound by decisions that are made in situations that cannot be properly applied to the patient in front of us. Accusations of pedantry and missing the point could be levelled at such arguments, but the law is precise, and so should those who follow the law. This is such a very important topic that

could have ramifications throughout the psychiatric (and medical) world. I note that Adshead *et al* recommend the Royal College of Psychiatrists' Professional Practice and Ethics Committee update Good Psychiatric Practice to incorporate the *Montgomery* ruling. I say that we, as a membership and profession, need to have a debate first, before agreeing what becomes our College's guidance for consent, as this will be the guidance to which our practice is measured against.

### Declaration of interest

I was a member of the Professional Practice and Ethics Committee from 2012 to 2016.

### References

- 1 Adshead G, Crepaz-Keay D, Deshpande M, Fulford KWM, Richards V. *Montgomery* and shared decision-making: implications for good psychiatric practice. *Br J Psychiatry* 2018; **213**: 630–2.
- 2 *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

**John Watts**, Child and Adolescent Psychiatrist, South London and Maudsley NHS Foundation Trust, UK. Email: [john.watts@nhs.net](mailto:john.watts@nhs.net)

doi:10.1192/bjp.2019.67

### Author's reply

We are grateful to Dr Watt for his thoughtful response. He makes the very point that we raised in our editorial; namely that applying *Montgomery* in practice raises interesting questions for different psychiatrists working in different settings. One of us is a consultant in forensic child and adolescent mental health services so recognises the issues Dr Watts describes; another is a consultant in long-term secure care where patients and professionals may have different value perspectives on risk.

We therefore entirely concur that more debate and discussion about the *Montgomery* judgment is needed; and we hoped our editorial would stimulate this kind of debate. We especially hope that the *Montgomery* judgment will encourage psychiatrists in all settings to think about how best to establish dialogue with patients about treatment that allows exploration of different values from the both the patients' and the professionals' perspective. It is this emphasis on exploration of what is important to all parties in terms of treatment experience and outcome (not just risk) that makes *Montgomery* such an interesting case for psychiatrists.

**Gwen Adshead**, Consultant Forensic Psychotherapist, Southern Health Foundation Trust, UK; **Mayura Deshpande**, Consultant Forensic Psychiatrist, Southern Health Foundation Trust, UK; **K. W. M. (Bill) Fulford**, Emeritus Professor, University of Warwick, UK. Email: [g.adshead@nhs.net](mailto:g.adshead@nhs.net)

doi:10.1192/bjp.2019.68