British Journal of Psychiatry (1996), **168**, 381–385

Correspondence

Contents: Informed consent in chronic schizophrenia/Lithium revisited/GP monitoring of lithium levels/Long-term treatment with clozapine in schizophrenia/Psychological debriefing techniques/Brief psychotic episodes in puberty/ Non-Alzheimer dementias in young patients/ Quality of statistics in psychiatric research

Informed consent in chronic schizophrenia

SIR: In his description of the complexity involved in judgements of probabilities Jones (1995) implies that a high threshold of competence is uniformly required to provide consent. The fundamental question is not whether the patient has cognitive deficits but whether he or she is able to pass the test for competence as required by law.

Jones quotes the definition of consent contained in the Department of Health's 1993 Code of Practice for the Mental Health Act 1983, which focuses on understanding treatment information. The Code of Practice talks of the patient understanding the nature of the treatment 'in broad terms'. Section 15.11 cautions the reader that: "Capacity to consent is variable in people with mental disorder and should be assessed in relation to the particular patient, at the particular time, as regards the particular treatment proposed". Recent case law has amplified the meaning of capacity to make treatment decisions with a 'three stage' test: a person must be capable of: i) comprehending and retaining relevant treatment information; ii) believing it; and iii) weighing it in the balance to arrive at a choice (Re C, 1994).

In a study that required patients to meet all three criteria for competence similar to those accepted in English Law ('understanding', 'appreciation', and 'reasoning'), only 52% of patients hospitalised with schizophrenia were considered to have impaired decision making ability concerning treatment for the disorder (Grisso & Appelbaum, 1995).

Jones states that neuropsychological tests may help clinicians make assessments of whether patients are fit to give informed consent, but in practice the law and clinicians require a demonstration of an individual's competence to consent to a specific issue, not a test of general ability. The required threshold for competence varies in relation to the seriousness of the decision being made, and an excessively high level may unnecessarily deny patients their autonomy. For example, in deciding how much treatment information should be provided and understood, simple statements of whether an outcome or side-effect is likely to occur may be all that is required (Brazier, 1991).

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K. SUTHERBY

PRiSM, Institute of Psychiatry
London SE5 8AF

G. SZMUKLER

Maudsley Hospital
London SE5 8AZ

A. HALPERN

Trinity Hall
Cambridge CB2 1TJ

Lithium revisited

SIR: Scepticism about the evidence base for the value of lithium is overdue and well reviewed in the editorial by Moncrieff (1995). My doubts are increased by the methodological problems of removing bias from randomised controlled trials of lithium.

Although patients and healthy volunteers do not seem to be very good at identifying whether they are taking lithium or placebo in a clinical trial (Calil *et al*, 1990), it is the unblinding of raters which produces bias in clinical trials. In a study of lithium prophylaxis, patients' relatives' guesses far exceeded