the columns

correspondence

Donezepil and those with learning disabilities

Sir: We read with interest of the protocol-based approach for prescribing donezepil described by Jani and Prettyman (*Psychiatric Bulletin*, May 2000, **25**, 174–177). However, the criteria suggested as guidelines for making the diagnosis of Alzheimer's disease and tests used to determine the therapeutic outcome are not appropriate for assessment of the population with learning disability, in whom, particularly in those with Down's syndrome, there is a high prevalence of dementia. There are, however, scales such as the Dementia Questionnaire for Mentally Retarded Persons and the Dementia Scale for Down's syndrome, which can give useful measurements. It is therefore unfortunate that the guidelines on prescribing donezepil and similar treatments recently produced by the National Institute for Clinical Excellence lean so heavily on the Mini Mental State Examination, which is not a validated instrument for this purpose in those with learning disability, who will score poorly whether they have dementia or not. They also seemingly limit the initiation of such treatments to old age psychiatrists, neurologists and care of the elderly physicians, many of whom do not deal with those with learning disabilities. This policy would seem to clash with the recent White Paper *Valuing People*, which states that all health services should be available to those with learning disabilities with a significant role for learning disability psychiatrists such as ourselves, who know this patient group best, and should surely also be authorised to initiate these treatments.

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Suicide and the internet

Sir: Although Prasad and Owen's recent findings on the internet as a source of self-help for people who self-harm (*Psychiatric Bulletin*, June 2001, **25**, 222–225) provided a valuable insight into internet sites devoted to deliberate self-harm, some of their other conclusions were inaccurate. Specifically, although they acknowledge that other authors have located sites giving explicit instructions on committing suicide, they conclude that because they didn't find these sites using their search criteria (HOW TO COMMIT SUICIDE), such information is not easily available. In their discussion, they also state that "although nine out of 10 hospital contacts resulting from self-harm involve self-poisoning, we found few sites that dealt with self-poisoning", implying that the internet is unlikely to facilitate self-poisoning.

Sadly, information on how to commit suicide and the number of pro-suicide groups on the internet are burgeoning, as evidenced by the amount of information (especially concerning self-poisoning) and the increasing number of high-traffic newsgroups encouraging suicide present on the internet, compared to my review of such sites in 1999 (editorial, *Psychiatric Bulletin*, August 1999, **23**, 449–451). These sites can be located using a search criterion of SUICIDE or PROSUICIDE. Details of how lethal chemicals can be purchased over the internet, and lethal doses, are very explicit. We already know that both American and British individuals (Alao *et al*, 1999; Suresh & Lynch, 1998) have attempted and completed suicide using this information.

Although it is true that many regard internet information about self-harm as a valuable service (especially sites devoted to prevention and self-help), a growing body of potentially destructive information that has been acted upon remains, and it would be difficult to recommend that patients contemplating suicide should surf the internet.

ALAO, A., YOLLES, J. C. & ARMENTA, W. (1999) Cybersuicide: the internet and suicide. *American Journal of Psychiatry*, **156**, 1836–1837.

SURESH, K. & LYNCH, S. (1998) Psychiatry and the WWW: some implications. *Psychiatric Bulletin*, **22**, 256–257.

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Advice given to psychiatric in-patients concerning driving: a completed audit cycle

Sir: There is evidence to suggest that people suffering from psychiatric disorder are more likely to be involved in road traffic accidents (Silverstone, 1988). Moreover, there is a clear expectation that doctors should offer advice to their patients regarding their fitness to drive. It is therefore good practice not only to give such advice to patients but to document the advice adequately.

We examined the case notes of 45 patients consecutively discharged from an acute psychiatric hospital. In only four cases (9%) was there any evidence of advice having been given concerning driving. Following an educational programme to highlight this issue a further 60 case notes were examined, demonstrating no improvement in the recording of advice. This was evident even among those patients known to be drivers and who met Driver and Vehicle Licensing Agency (DVLA) criteria for requiring guidance (DVLA, 2001).

There are many reasons why advice regarding fitness to drive may not be passed on to patients or documented in their case notes (Humphreys & Roy, 1995; Morgan, 1998). Failure to share the information with our patients may have lasting consequences; for the patient, the health professional and the general public. It is therefore important to highlight this issue and to incorporate it into clinical governance.

DVLA (2001) *At a Glance Guide to the Current Medical Standards of Fitness to Drive*. Swansea: DVLA.

HUMPHREYS, S. & ROY, L. (1995) Driving and psychiatric illness. *Psychiatric Bulletin*, **19**, 747–749.

MORGAN, J. F. (1998) DVLA and GMC guidelines in 'Fitness to Drive' and psychiatric disorders: knowledge following an educational campaign. *Medicine, Science and the Law*, **38**, 28–31.

SILVERSTONE, T. (1988) Influence of psychiatric disease and its treatment on driving performance. *International Clinical Psychopharmacology*, **3**(Suppl 1) 59–66.

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columns

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Community psychiatry in developing countries – Sri Lanka

Sir: We have read the article "Community psychiatry in developing countries – a misnomer?" (Farooq & Minks, *Psychiatric Bulletin*, June 2001, **25**, 226–227) with interest.

The content of the article is also very relevant to our country. The majority of patients live with their families and it is in this setting that almost all psychiatrists (grossly inadequate in number for the entire population) practise. A few reasonably organised community rehabilitation centres are available only in the major cities.

We agree fully that psychiatry in developing countries should be rooted in primary health care. With this in mind, the state health authorities in Sri Lanka have taken measures to place medical officers with a basic training in psychiatry in the hospitals, where there are no qualified psychiatrists, and the medical schools too have laid a greater emphasis on giving better training in psychiatry for undergraduates.

However, adopting the term 'primary care psychiatry' would not be prudent because primary care implies a basic level of care available to all (Declaration of Alma Ata) and would not include the greater degree of services that will have to be provided for those with psychiatric illness who live in the community. In this sense, the service provided should be more in line with the principles of community psychiatry, albeit somewhat different from that implemented in developed countries.

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Lithium non-adherence

Sir: MacCleod and Sharp's attention to lithium non-adherence is welcome (*Psychiatric Bulletin*, May 2001, **25**, 183–186). I have concerns, however, that the authors' conclusion may instil complacency, given that they state that "all patients were defined as currently compliant".

The study uses a definition of non-compliance that requires both subjective and objective criteria to be fulfilled. A patient is then deemed 'compliant' by default if they do not meet both sets of criteria. Thus, for instance a patient in the study could have no measurable lithium in his or her serum at all but be deemed 'compliant' because he or she and his/her psychiatrist judge him or her to be so. Clinicians' judgements of patients' compliance have been found wanting in almost every study in which they have been tested. In fact the sensitivity of clinical judgement for detecting non-compliance has been quoted as an embarrassing 10% (Stephenson *et al*, 1993).

The authors have not cited any of the work in this field in the past 10 years. In a recent study of compliance in lithium clinics (Schumann *et al*, 1999) it was noted that 53.9% of patients discontinued lithium prophylaxis at some time. Even more striking is the finding that 76 days is the median duration of continuous lithium adherence before patients elect to discontinue treatment (Johnson & McFarland, 1996).

Given the potentially catastrophic outcomes of medicine non-adherence in major mental illness there remains a priority to identify strategies that will enhance adherence with the medicines we prescribe.

JOHNSON, R. E. & McFARLAND, B. H. (1996) Lithium use and discontinuation in a health maintenance organization. *American Journal of Psychiatry*, **153**, 993–1000.

SCHUMANN, C., LENZ, G., BERGHÖFER, A., *et al* (1999) Non-adherence with long-term prophylaxis: a 6-year naturalistic follow-up study of affectively ill patients. *Psychiatry Research*, **89**, 247–257.

STEPHENSON, B. J., ROWE, B. H., HAYNES, R. B., *et al* (1993) Is this patient taking the treatment as prescribed? *Journal of the American Medical Association*, **269**, 2779–2781.

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That 'Praecox feeling'

Sir: 'Anonymous' (*Psychiatric Bulletin*, July 2001, **25**, 275) should not be too worried that his or her children will develop schizophrenia. The Finnish adoptive family study (Tienari *et al*, 1994) suggests that the genetic risk is buffered by a happy family.

TIENARI, P., WYNNE, I. C., MORING, J. *et al* (1994) The Finnish adoptive family study of schizophrenia. Implications for family research. *British Journal of Psychiatry*, **164** (suppl. 23), 20–26.

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the college

Distinction awards

College nomination procedures in England and Wales

The Department of Health is currently undertaking a review of the procedures, operation and practice of the distinction and meritorious service award scheme. The following paper describes the College's current nomination procedure in England and Wales. It may be necessary to change this procedure when details of the new arrangements are received from the Department of Health. Further details will, therefore, appear on the College's website (http://www.rcpsych.ac.uk).

The President has identified two distinction awards advisers in each NHS region in England (apart from London, which has four advisers) and two in Wales. At least one, and often both, of the advisers will also serve on his or her regional awards committee. Statistics showing the speciality/gender/ethnic backgrounds of those consultants eligible for awards are produced each year by the College secretariat. Although awards continue to be made on merit, regions, faculties and sections are asked to consider these statistics when submitting their list of recommendations.

Towards the end of the year the distinction awards advisers in England and Wales, in consultation with the chairmen of divisions and other senior award holders, produce a list of nominations in rank order for their region. The chairmen of faculties and sections (if eligible), in consultation with senior award-holders in their faculty or section, also produce lists in rank order. Senior College officers meet to consider members who have made a significant contribution to the College. They will also consider individual nominations from College members concerned that they have been overlooked. Any College member wishing to be considered in this way should write to the College Secretary by the end of October, requesting an Advisory Committee on Distinction Awards curriculum vitae (ACDA CV) questionnaire form.

These various lists of nominations are sent to the College and are merged to

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