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.

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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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