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Treatment for Alzheimer's disease in people with learning disabilities: NICE guidance

In January 2001 the National Institute for Clinical Excellence (NICE) published *Guidance on the Use of Donepezil, Rivastigmine and Galantamine for the Treatment of Alzheimer's Disease*. The guidance indicates that the drugs should be made available within the National Health Service to people with mild to moderate Alzheimer's disease whose mini-mental state examination (MMSE) score is above 12 points. The Institute's guidance does not mention the use of anti-dementia drugs in people with learning disabilities and Alzheimer's disease. Studies have shown that the prevalence of Alzheimer's disease in those with learning disabilities is higher than in the normal population (Patel *et al*, 1993). This is likely to increase in the future because of the rising life expectancy of people with learning disabilities (Zigman *et al*, 1997). In Down's syndrome, approximately 40% develop dementia of Alzheimer type by the age of 60 (Holland *et al*, 1998).

It is known that clinical evidence for the effectiveness of various psychiatric treatments in the learning disability population is scanty and specialists rely on evidence from the normal population. In this situation, a specialist in the psychiatry of learning disability might consider following the NICE guidance in treating dementia in the people under his or her care. However, there is a major problem, as NICE guidance suggests that treatment should be monitored by MMSE score but the MMSE cannot be used reliably in people with learning disabilities (Deb & Braganza, 1999). This means that NICE guidance on the use of anti-dementia drugs is not applicable to people with learning disabilities. This is likely to discourage specialists from prescribing treatment for some patients with a learning disability and Alzheimer's disease who may benefit from it in future. In its guidance, NICE mentioned limitations on the use of the MMSE in people whose Alzheimer's disease is complicated by dysphasia and whose first language is not English, but failed to identify that the MMSE is not standardised for people with learning disabilities who make up 2% of our population. The fact that this group of people, with a high prevalence of dementia, was completely ignored within the guidance is quite worrying. We appreciate that the guidance from NICE is not prescriptive and does not replace individual judgement; however, complete omission of learning disability could potentially exclude people from receiving beneficial treatment.

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Community care for mental disorders in developing countries: a perspective

Given the limitations of the existing model of community care for mental disorders in developing countries, Jacob (2001) has tried to construct another model and has focused on some of the constituent elements of such a model. Although Jacob insists on a potentially innovative approach to the provision of mental health services in developing countries, the framework within which to take forward the debate regarding community care fails to analyse in depth the sociopolitical and economic contexts in which community care is constructed. Owing to the strong emphasis placed upon discriminatory social and political structures, an analysis of what it is to be mentally ill, and the sociological and psychological implications of this, has largely been ignored.

I agree with Jacob that cooperation between governments and non-governmental organisations (NGOs) in providing community care will help in implementing health care policies. However, by their very nature, NGOs are heterogeneous and vary from large agencies operating in many countries (e.g. Oxfam, Save the Children Fund) to very small organisations operating at village level. Despite the growth of NGO activity in the past decade, there remain questions regarding their effectiveness in achieving their stated objectives (Nyoni, 1987). Evaluation of an NGO's effectiveness can become something of a propaganda exercise, aimed more at impressing donor agencies than at a critical analysis of the NGO's activities. A related issue concerns the mixed accountabilities of NGOs – 'downwards' to their collaborating partners and 'upwards' to their donor agencies. These issues result in difficulties of monitoring and enforcement (Brett, 1993).

We know that the lives of individuals with mental illnesses around the world are usually limited far more by prevailing social, cultural and economic constraints than by their illnesses. If this is the case, then the issues related to community care for people with mental disorders move from those of health to those of human rights. Their lives are hard indeed. Mental health professionals can help to change this state of affairs. Whether the issue is community care in urban London or in rural India, professionals who work on mental

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