27 - Key practice areas

Key practice areas

824 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 10 Learning disabilities General considerations1 Prescribing psychotropic medications for people with learning disabilities (LD) is a - challenging and controversial area of psychiatric practice.2,3 There are concerns that psychotropic drugs of all kinds (antipsychotics, antidepressants, benzodiazepines [both regular and as required] and antiepileptics as mood stabilisers) are overprescribed with poor review and assessment of their benefit. The LD field is notable in having only a small therapeutics research base of its own, with particular ethical and practical considerations regarding how emotional and behavioural disturbances are classified and treated. Although prescribing for individuals with mild or borderline intellectual impairment may be undertaken by mainstream mental health services, the assessment and treatment of behavioural and emotional disorders in people with more marked (or, as in the case of autism, atypical) patterns of significant cognitive impairment should be undertaken in the first instance by, or at least in consultation with, specialist clinicians. The term ‘dual diagnosis’ in this context refers to the co-occurrence of an identifiable psychiatric disorder (mental illness, personality disorder) and LD. ‘Diagnostic overshadowing’ is the misattribution of emotional or behavioural problems to LD itself rather than a comorbid condition. LD is an important risk factor for all psychiatric disorders (including dementia, particularly for individuals with Down’s syndrome).4 Where it is possible to diagnose a mental illness using conventional or modified criteria then drug treatment in the first instance should, in general, be similar to that in the population at large. Most treatment guidelines are increasingly stating their intended applicability to people with LD. Mental illness may present in unusual ways in LD, for example depression as self- injurious behaviour, or persecutory ideation as complaints of being ‘picked on’. Conversely, behaviours such as self-talk may be normal in some individuals but mistakenly identified as a disorder such as psychosis. In general, diagnosis becomes increasingly complex with increasing severity of disability and associated communication impairment. Comorbid autistic spectrum disorder has special assessment considerations and in its own right is an important risk factor for psychiatric disorder, in particular anxiety and depression, bipolar spectrum disorder, severe obsessional behaviour, anger disorders and psychosis-like episodes that may not meet criteria for schizophrenia but nonetheless require treatment. Autistic traits are common among patients using LD services. Guidance on the treatment of mental health problems in autism can be found in Chapter 5. Key practice areas Capacity and consent It is uncommon for patients in LD services (who often represent a subpopulation of those identified with special educational needs in childhood) to have sufficient understanding of their treatment in order to be able to take truly informed decisions. There is inevitably an increased onus on the clinician to bear the weight of decision-making. The patient’s decision-making capacity, depending on the severity of intellectual

Drug treatment of psychiatric symptoms in the context of other conditions CHAPTER 10 impairment, may be improved through appropriate verbal and written communication. The involvement of carers in this process is generally essential. Physical comorbidity, especially epilepsy Epilepsy is over-represented in LD populations, becoming more prevalent as severity increases, with approximately one-third of affected individuals developing a seizure disorder by early adulthood. Special consideration is needed when considering the use of medications that may lower seizure threshold or interact with drugs used for epilepsy. Assessment of care environments Behavioural and emotional disturbance may sometimes be a reflection of problems or failings in the care environment. Different staff in a care home may have different thresholds of tolerance (or make different attributions) for these difficulties which can lead to varied reports of their significance and impact. Allowing for a period of prospective assessment and using simple assessment tools (e.g. simple ABC or sleep charts) can be very helpful to the clinician in making judgements about recommending medication. If medication is used in a care home, staff may need special education in its use and anticipated adverse effects and, for ‘as required’ medications, clear guidelines for its use. This may make it difficult to initiate certain treatments in the community. Adverse effect sensitivity It is widely thought that people with LD are especially sensitive to adverse effects of psychotropics and more at risk of long-term effects such as the metabolic syndrome. However, we only know of one study that has given support to this view. A cohort study extracting information from a large UK primary care database compared the incidence of EPSEs of antipsychotics in adults with LD with that in adults without LD. The incidence of EPSEs was 30% higher in people with LD than in those without LD.5 It is good practice to start at lower doses and increase more slowly than might be usual in general psychiatric practice. Notable adverse effects include worsening of seizures, sedation, extrapyramidal reactions (including with risperidone at normal doses, especially in individuals who already have mobility problems), problems with swallowing (with clozapine and other antipsychotics) and worsening of cognitive function with anticholinergic medications (see Chapter 6). Psychological interventions In the absence of an identifiable mental illness (including atypical presentations) with clear treatment implications, psychological interventions such as functional behavioural analysis should be considered as first--line intervention for all but the most serious or intractable presentations of behavioural disturbance (Table 10.8). In studies where it has been possible to infer the severity of challenging behaviour, treatment response is generally associated with more severe problems at baseline.

826 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 10 Table 10.8 Some notes on currently and historically used medications for behaviour disorder. Drug class Clinical applications Notes Antipsychotics6 Use in psychosis with LD is justified Used across a broad range of behavioural disturbances7 May be useful for aggression and irritability The most widely used8,9 yet most controversial medication for behavioural problems.10,11 Although an RCT12 casts doubt on their efficacy for this indication the study was not without its problems and there is a significant body of other evidence supporting their use, including a number of small RCTs in children with LD. Discontinuation studies in long-term treatment commonly (but not always) show re-emergence of problem behaviours. NICE suggests considering slow withdrawal of antipsychotics in all those who do not have psychotic symptoms.13 The UK STOMP programme promotes deprescribing of antipsychotics.14 It has been successful, but antipsychotics are often replaced by other psychotropics.15 A 2022 analysis of UK NHS data suggests antidepressants now replace antipsychotics as the most widely prescribed psychotropic.16 Before the advent of SGAs the best evidence was for haloperidol17 in the context of autism and for zuclopenthixol for behavioural disturbance.18 Zuclopenthixol may reduce aggression and challenging behaviour.19 Among SGAs

the best evidence is for risperidone20,21 at low dose (0.5–2mcg) for aggression and mood instability, particularly with associated autism though also in non-autistic cases. Aripiprazole has a US FDA licence for behavioural disturbance in young people with autism.22,23 Some evidence to support olanzapine24 and case reports of clozapine25 for very severe cases of aggression, though not widely used and unlikely to be used outside highly specialist (in-patient) settings. In 2015, Cochrane uncovered 38 case reports and chart reviews but found no RCT evidence for the use of clozapine in psychosis in LD.26 Results for quetiapine are modest at best.27 SSRIs Helpful for severe anxiety and obsessionality in autistic spectrum disorder. Use here is off-licence unless an additional diagnosis of anxiety disorder or OCD is made Also used as a first-line alternative to antipsychotics for aggression and impulsivity Commonly used in combination with antipsychotics though limited evidence base for combination treatment. Effectiveness in absence of mood or anxiety spectrum disorder is unclear, however, and a 2013 Cochrane review was pessimistic28 about the evidence for their effectiveness for behaviour disorder in autistic children (who may be at heightened risk of adverse effects) though a little more encouraging for use in adults. Some good evidence for fluoxetine in OCD in LD/autism although the drop-out rate is high.29 Generally, quality of trials is poor and effects may be exaggerated by use in less severe cases.30 Caution needed because of the risk of precipitation of hypomania in this population.31 As with antipsychotics, there are major concerns about overprescribing.32 Venlafaxine is probably not effective.33

Revision #1
Created 2026-01-04 20:17:45 UTC by Omar Ayman
Updated 2026-01-04 20:17:45 UTC by Omar Ayman