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Medication in people with learning disability and mental illness

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Abstract
Psychiatric medications are often used in the treatment of mental disorders as well as for problem behaviours in people with learning disabilities. However, there is little evidence directly relating to people with learning disability, and most treatment decisions and experience of medication are based on research in the general population. Good practice demands that clinicians make every effort to ascertain whether the presenting complaints are those of a diagnosable mental disorder and that there is multidisciplinary support to ameliorate problem behaviours.

Keywords
Evidence-based practice
Learning disability
Mental disorders
Psychiatric medication

Introduction
The clinical management of people with learning disability affected by mental illness often entails drug therapy. This is, of course, only instigated as one part of the treatment programme, in conjunction with the other key elements of the multimodal plan. In the management of mental illness among people with learning disability, the clinician is often required to address aspects of physical and general health, rather than primarily mental illness per se. However, this is not covered in the present article, which concentrates on the use of psychopharmaceutical agents.

Principles of drug prescribing for mental illness in learning disability

Establish psychiatric diagnosis
Prescribing of medication for mental illness in this population should be diagnosis driven, but this is by no means straightforward. The diagnosis of mental illness among people with learning disability is a complex specialist matter, reviewed on pages 376–81 (in this issue). As emphasized throughout these articles on learning disability, many of the behavioural constellations encountered in clinical practice among people with learning disability do not constitute diagnosable mental illness. However, diagnosable psychiatric disorder is common among people with learning disability, and, where possible, the diagnosis should be the starting point in the use of pharmacological approaches to treatment.

Establish cause and severity of learning disability
The severity, or degree, of learning disability has major implications for the use of drug therapy. At a basic level, there is the pathoplastic effect of the severity, or degree, of learning disability on
psychiatric disorder. This effect is mediated through the individual’s cognitive level because so much of the expression of psychopathology is determined by overall intelligence and cognition. The more severely learning disabled the individual, the greater will be the divergence from more familiar presentations of any psychiatric disorders – and this effect operates in addition to the proneness of a particular condition to have its own, unique, behavioural phenotype. Standardized clinical assessment of the severity of learning disability and, where possible, establishment of the underlying cause are both prerequisites to planning for drug treatment.

Heed the evidence base
All prescribing of medication must be informed by the available evidence base, although the evidence base for use of psychopharmacological agents in people with learning disability per se is scant. This is principally because, for ethical reasons, few drug trials can be carried out in a population that includes so many people who are not capable of giving consent to such research, and so the evidence base for the use of psychopharmaceutical agents derives mainly from findings among the general population. The principal evidence base to be consulted and followed in prescribing for mental illness in learning disability is therefore the mainstream evidence base for prescribing for the diagnosis in question. This is supplemented by drug treatment studies that have been carried out among people with learning disability. Many of these, notably one major recent multicentre study, have highlighted the need for a cautious approach to prescribing. Most studies that have focused on prescribing for behaviour disorder rather than mental illness in learning disability have found little evidence of clear benefit of drug treatment for behaviour disorder in the absence of a psychiatric diagnosis. Faced with this problem, a useful consensus document has been developed based on the experience of UK clinicians in this area.

Take caution with dosage
Here, the rules are simple – start low, go slow. For all psychopharmacological treatment of people with learning disability, the starting dose should be lower than for other patients; in most cases, half the usual dose to be recommended. This is done in order to minimize unwanted side-effects, particularly any sedation, movement problems, or central nervous system side-effects, all of which are more common among people with major developmental disabilities. For the same reason, incremental increases in dosage should be made more slowly, with the result that attaining dose for maximal effect is reached over twice the time-frame that applies in mainstream practice.

Avoid polypharmacy
It is particularly important to minimize polypharmacy in the management of mental illness among people with learning disability. This is important because of the prominent problems of side-effects in the index patient group, and also because of the difficulties inherent in discerning the positive and negative effects of individual drugs when given in combination – especially to people who may lack the ability to communicate their experience of drug effects. Not infrequently in this area of practice, however, the clinician will be faced with requests to use more and more medication, especially where there has been some initial positive effect that has subsequently apparently dissipated. In this common scenario, it is important to reappraise the individual’s whole situation, rather than add additional medication. In individuals in whom polypharmacy becomes established, the clinician’s first duty is to take a thorough drug history, from the individual as far as possible, and from key carers including family members. This can serve to identify issues such as the positive or negative impact of any medication that has been used, and drug interactions can also be identified and minimized in the future.
Consider formulation
For the most part, orthodox formulations, whether of oral or parenteral medication, will apply. However, especially where any compliance issues have arisen – and also where there are physical factors interfering with, for example, swallowing – it is occasionally necessary to explore less orthodox preparations or methods of administration. This may be something as simple as rendering the treatment more pleasurable, perhaps by attention to colour or taste. Any such considerations may be best worked through in close collaboration with a pharmacist.

Optimize compliance
More than elsewhere in psychiatric practice, much of this drug therapy will be under supervision of carers and/or family. The clinician must offer the relevant family/carers every possible assistance and support in this endeavour, for their efforts will be the main determinants of compliance. In turn, their efforts will be all the more determined if they are fully informed of the effects of the medication in question, including side-effects. This can be quite a challenge, especially where unwanted effects have been experienced from any previous medication used. However, only a full and informed account of any likely problems will be accepted now by most carers, parents, and families.

Follow informed consent
In the treatment of children with learning disabilities, consent to treatment is essentially the province of the parent/carer. Careful close consideration of the emergence or non-emergence of the capacity to consent to treatment in adulthood must be given, under the respective legislation.4,5

Initiating drug treatment
The decision of whether to incorporate drug treatment into a multimodal programme of management in clinical practice relies on a clear understanding of the nature and circumstances of the presenting problem. Behavioural problems that are brief, self-limiting, a reflection of intercurrent physical health problems, or due some identifiable environmental or personal stressor in the individual’s life do not merit psychotropic medication. However, a decision to commence drug treatment may be sometimes taken too late, on the basis that all other avenues should be explored first of all. Where a diagnosable psychiatric disorder presents that has clear treatment implications, such as depression, the decision to adopt psychopharmacology may be taken more readily.

Maintaining and withdrawing drug treatment
The decisions to maintain and withdraw drug treatment should be approached with the same care and caution as the decisions to initiate drug treatment (Box 1). Duration of drug treatment will depend on various factors, including compliance, habituation and course of titration to maximal effect, response to treatment, occurrence of side-effects, and the natural history of the disorder being treated. The timescales of duration of treatment and withdrawal regimens should be extended, in line with the timescales for initiation and titration.

Practice points
- The three golden rules of prescribing in patients with learning disability and mental illness:
  - Start low
  - Go slow
  - Keep the number of drugs low
• Drug treatment of mental illness in learning disability
  ○ Must be initiated as part of a wider plan
  ○ Is likely to cause central nervous system side-effects
  ○ Should be based on diagnosis, not behaviour
  ○ Should be based on a cautious approach
  ○ But ‘when in doubt, don’t use drugs’ must be tempered with ‘when confident of diagnosis, do’

**Box 1**
The decision to maintain or withdraw drug treatment
• Should be made in partnership with the patient, family, and carers
• Is dependent on the clinical response to treatment
• Is dependent on occurrence of side-effects
• Should follow a period of clinical recovery
• Is informed by the natural history of the condition being treated
References

Further reading