**Background Notes:**

1. Quality evidence for the efficacy or lack of efficacy of antipsychotic medication in the Learning Disabled population is scanty (1,2).
2. For schizophrenia, evidence tends to be extrapolated from the “normal” population (1). For treatment of schizophrenia in people with Learning Disability the same approach should be used as in other patients with schizophrenia (see Priorities Forum Policy Statement No. 30) – though drug choice should be informed by the relative impact of specific side-effects.
3. There is some evidence that individuals with neurological damage are more prone to the adverse side effects of antipsychotic medication than non-brain damaged comparison populations (6-10).
4. Evidence relating to paediatric Learning Disabled populations is similarly scanty (3-5).
5. People with Learning Disability often display behaviours that challenge and require assessment and management. The main components are, in varying proportions, restlessness, anxiety, aggression to people and/or property and self-injury.
6. For these “challenging” behaviours, there is limited high quality evidence (2).

**References**

PRIORITIES FORUM POLICY STATEMENT

NUMBER: 36

SUBJECT: Antipsychotic medication in the treatment of people with learning disability and challenging behaviour

DATE OF DECISION: 14 December 2000

POLICY

1. The first line of approach should be careful assessment to detect physical or mental illness which, when present, should be treated.
2. Following exclusion of physical or mental illness, a functional analysis of the behaviour should be conducted to enable communication, environmental and behavioural approaches to management to be explored.
3. Medication should not be regarded as first line management for behaviour disorders in people with Learning Disability, except when the behaviour is so severe and intense as to require immediate tranquillisation, and delay would be dangerous. In this case, treatment with lorazepam may be preferred.
4. In general, antipsychotic drugs should only be used if other approaches alone have failed, or if the behavioural disorders are sufficiently severe and/or persistent as to warrant it. They can be fruitfully used in combination with other approaches.
5. Antipsychotics are only one group of medications that might be utilised. The underlying aetiological factors of the challenging behaviour require consideration. For example, other medications that could be used to treat aggression include:
   - the 5HT1A agonist buspirone (short-term use only) if there is underlying anxiety,
   - the beta-blockers if there is underlying anxiety with physical symptoms,
   - the SSRI’s or anticonvulsants with mood stabilising properties such as carbamazepine or sodium valproate if there is underlying mood disorder.
6. If in doubt, advice can be sought from consultant psychiatrists via the community teams for people with learning disability.
7. The therapeutic usefulness of antipsychotics must be balanced against their potentially unpleasant and/or dangerous side effects, predominantly extra pyramidal, excessive sedation, weight gain, tardive dyskinesia and paradoxical effects.
8. The best drug for a particular patient is one that has previously been found to work and be well tolerated by them.
9. If the patient has a past history of unacceptable side effects or lack of response to a conventional antipsychotic, an atypical antipsychotic should be used.
10. Any particular medication should be started only after carrying out the appropriate health checks recommended in the BNF. They will need to be monitored at regular intervals.
11. Baseline assessments of target symptoms should be recorded prior to treatment, and both treatment and side effects be subsequently routinely monitored and recorded. This should be first done not more than 1 week after starting the treatment, then fairly frequently during the next 3 months and subsequently at least every 6 months.
12. People with Learning disability are often sensitive to, and respond to, modest doses. It is therefore advisable to consider using starting doses in the range that is applicable in the elderly.
13. The aim is to use the lowest dose of the drug that adequately controls the target symptoms. Consideration should therefore be given to reducing the dosage, and eventually even to stopping the treatment, once symptom control has become adequately established.
14. A chosen antipsychotic should be gradually stopped if
   (a) it has no beneficial effect on target symptoms after a 1-month trial
   (b) side-effects are problematic and dose reduction does not alleviate the problem.
15. The decision in this group of patients to use an “atypical” antipsychotic, or to change to one from a conventional antipsychotic, should wherever possible only be made on the advice of a psychiatrist.