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Research in Developmental Disabilities 25 (2004) 509–521
Research in Developmental Disabilities

Psychotropic medication in adults with mental retardation: prevalence, and prescription practices

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Received 7 January 2004; received in revised form 9 March 2004; accepted 26 March 2004

Abstract

People with mental retardation comprise an overmedicated population. Studies the last 20 years or so indicate that nearly 50% of people with mental retardation receiving care have been using psychotropic medication, in the treatment of psychiatric disorders and/or problem behaviours. The recent years guidelines for prescription of psychotropics have been developed, emphasizing, e.g. the presence of a diagnosis, consideration of alternatives, and evaluation. In spite of all this, we found that 37% of people with mental retardation in one Norwegian county were using psychotropics, mostly neuroleptics. Moreover, prescriptions frequently violated current guidelines, especially when conducted by general practitioners. For example, a lot of prescriptions had not been indicated by a diagnosis, alternatives to medications had rarely been explored, and evaluation of effects and side effects were exceptions. Psychiatrists complied more with current guidelines. Implications of the findings are discussed.

Keywords: Psychotropic medication; Prevalence; Prescription practices

1. Introduction

Psychotropic medication is a common approach to dealing with psychiatric disorders and problem behaviour in people with mental retardation. Studies some years ago showed that 30–75% of the people with mental retardation living in institutions in the US had been prescribed psychotropics (Aman & Singh, 1988; Martin & Agran, 1985; Stone, Alvarez, Ellman, Hom & White, 1989). More recently, studies conducted in both community and

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0891-4222/$ – see front matter
doi:10.1016/j.ridd.2004.03.004

institutional settings show that about 35–40% are using psychotropics (Pyles, Muniz, Cade & Silva, 1997; Rinck, 1998). People with mental retardation comprise perhaps the most overmedicated population we have (Matson et al., 2000; Reiss & Aman, 1997).

A common assumption is that medications which are successful in the treatment of psychiatric disorders in persons without mental retardation are equally successful in treating the same disorders in persons with mental retardation (Sevin, Bowers-Stephens, Hamilton & Ford, 2001). Consequently, the likelihood of effective treatment should increase with precise diagnoses. However, diagnosing might be a difficult task in itself, especially in people with severe and profound mental retardation, although diagnostic instruments have been improved in recent years (Sturmey, 1995).

An important question becomes how well treatment efficacy is documented. After a thorough review of the literature, Sevin et al. (2001) concluded that there ''is at least moderate support for the efficacy of psychotropic medications in treating some types of psychopathology in persons with mental retardation'' (p. 464). Efficacy of psychotropic medication on problem behaviours like self-injury, stereotypies, physical aggression, overactivity, destructiveness, and disruptive behaviour, has also been investigated (Matson et al., 2000). Generally speaking, some efficacy seems to be documented. However, most studies of psychotropic treatment of psychiatric disorders and problem behaviours in people with mental retardation have severe methodological flaws (Matson et al., 2000). Typical ones are lack of behavioural assessment and treatment prior to medications, e.g. in order to see whether medications are necessary at all, or can be combined with behavioural interventions. Others are changes in treatment during the course of the study, and lack of objective measurements and clearly defined dependent variables. Although psychotropics have a place in the treatment of psychiatric disorders and behaviour problems in people with mental retardation, the scientific basis for prescribing psychotropics to persons with mental retardation must be said to be insufficiently established.

Although efficacy is limited, psychiatric disorders and problem behaviours are frequently managed by medication alone. There is some consensus that psychotropics are overused, i.e. used more than what is justified by treatment efficacy (Baumeister & Sevin, 1990; Reiss & Aman, 1997). Studies indicate that a peer review process with a psychiatrist may reduce the use of psychotropics in this population by as much as 50%, without any adverse effects upon the person's psychiatric illness or problem behaviour (Molyneux, Emerson & Caine, 1999). More specifically, studies have also demonstrated successful withdrawal of neuroleptics in many cases (Ahmed et al., 2000; Branford, 1996).

A significant proportion, one study indicate 20% (Aman & Singh, 1988), even show adverse reactions to psychotropics. Examples are exacerbation of self-injurious behaviour, agitation, aggression, onset of psychosis and depression, and negative effects on learning (Aman & Singh, 1988; Pyles et al., 1997). Moreover, medications are sometimes prescribed without a psychiatric diagnosis, or for behaviours not scientifically demonstrated to be influenced by them (Schaal & Hackenberg, 1994). Suppression of problem behaviours through sedation is only recommended as a last resort, and not for long periods (Matson, Bielecki, Mayville & Matson, 2003; Pyles et al., 1997). Another matter of concern is polypharmacy, i.e. prescribing more than one medication in order to treat the same symptoms (Sturmey, 1999).