

ARTICLE

Stopping inappropriate medication of children with intellectual disability, autism or both: the STOMP–STAMP initiative

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SUMMARY

Children with intellectual disability are often prescribed psychotropic medication to manage behaviours that challenge. Unfortunately, many receive medication with potentially serious long-term side-effects that has been prescribed inappropriately or for longer than is necessary. NHS England launched STOMP (stopping the over-medication of people with intellectual disability, autism or both with psychotropic medicines) in 2016 to reduce the inappropriate prescribing in adults. This was broadened to include children in 2018 by the addition of STAMP (supporting treatment and appropriate medication in paediatrics). In this article we review the rationale for STOMP–STAMP, highlight the Royal College of Psychiatrists’ position statement on STOMP–STAMP and give clinical advice for psychiatrists who treat children with intellectual disability, autism and/or attention-deficit hyperactivity disorder (ADHD). Importantly, it is essential to consider that ADHD may have been missed and that by diagnosing and treating it, the need for inappropriate anti-psychotic medication may be reduced.

LEARNING OBJECTIVES

After reading this article you will be able to:

- use STOMP–STAMP principles in prescribing appropriately for children with intellectual disability
- consider challenging behaviour as a communication of an unmet need and use the biopsychosocial model to search for an answer
- think of ADHD and not allow diagnostic overshadowing to let you miss the diagnosis, as it can be treated effectively, allowing behavioural strategies to work better.

KEYWORDS

Intellectual disability; autism spectrum disorders; attention-deficit hyperactivity disorder; antipsychotics; developmental disorders.

retardation’. A provisional diagnosis of a disorder of intellectual development (previously referred to as global developmental delay) is used to describe children with delayed development where the level of their impairment is not yet clear or accurately measurable but where they are likely to have an intellectual disability (World Health Organization 1993, 2022). ‘Learning difficulty’ is an educational term with variable interpretation and will not be used here (Department for Education 2015).

According to DSM-5, there are three criteria that must be fulfilled for the diagnosis of intellectual disability (American Psychiatric Association 2013). These may be summarised as follows:

- (a) deficits in intellectual functioning (including areas such as problem-solving, abstract thinking, judgement, and academic and experiential learning), confirmed by both clinical assessment and standardised IQ testing
- (b) deficits in adaptive functioning that significantly hamper the individual’s ability to conform to sociocultural and developmental standards regarding independence and social participation
- (c) onset of these deficits during childhood.

Approximately 2% of children have an intellectual disability (Cooper 2020). Average IQ (calculated as the developmental age divided by the chronological age and multiplied by 100) is in the range 85–115; scores indicative of different levels of intellectual disability have been identified as follows: borderline intellectual disability 70–84, mild 50–69, moderate 35–49, severe 20–34 and profound 0–19 (Bernard 2020). The level of functioning is often used where formal IQ testing has not been done (Cooper 2020) and the use of formal IQ cut-offs has been abolished in the DSM-5, which uses the equivalent standard deviation from the mean and percentiles instead, and there is a lot more emphasis on adaptive functioning.

There is some suggestion that the number and complexity of difficulties in extremely preterm

‘Intellectual disability’ is the preferred diagnostic term replacing ‘learning disability’ and ‘mental

children and in some children with complex genetic disorders is increasing (Clark 2018). This results in an absolute increase in the number of children with intellectual disability, particularly in the severe to profound disability range. Assessments of developmental delay in young children are good predictors of final IQ in children with severe intellectual disability but are less robust in those with a less severe developmental delay. It is estimated that most intellectual disability is prenatal in origin, with some related to prematurity, particularly in extreme prematurity (<28 weeks' gestation) (Clark 2018). In intellectual disability with a prenatal origin, approximately half of cases will have an attributable cause, for example a chromosomal abnormality, syndromic diagnosis, metabolic defect or abnormality revealed on magnetic resonance imaging such as polymicrogyria or neuronal migration disorder. Perinatal complications such as severe birth asphyxia account for further cases associated with severe physical disability. Postnatal causes for an intellectual disability include brain injuries and brain infections.

Children with intellectual disability have much higher rates of psychiatric and neurodevelopmental disorders, for example attention-deficit hyperactivity disorder (ADHD), autism spectrum disorders, and behavioural, anxiety and mood disorders (Bernard 2020). In addition, there may be self-injury, sleep disorders or a wide range of physical conditions and neurological disorders such as epilepsy (Popow 2021). It is important to note that most children with intellectual disability are happy and settled and challenging behaviour should therefore never be seen as purely due to the intellectual disability.

Background to STOMP–STAMP

Reports into the treatment of people with intellectual disability in institutional settings have highlighted shocking cases of abuse and neglect, occurring with frightening regularity. The Serious Case Review of Winterbourne View Hospital (Department of Health 2012) led NHS England in 2016 to set up STOMP (stopping the over-medication of people with intellectual disability, autism or both with psychotropic medicines). The Winterbourne View review highlighted that too many people with intellectual disability were treated with psychotropic medication without having an underlying mental health condition that would require its prescription according to national guidelines (Branford 2019a, 2019b). This was also found to be the case for children, and in 2018 the Royal College of Paediatrics and Child Health, the British Academy of Childhood Disability and the Council for Disabled Children

introduced STAMP (supporting treatment and appropriate medication in paediatrics) to guide doctors prescribing for children. The Royal College of Psychiatrists (RCPsych) adopted STOMP–STAMP in 2019, supported by its own practice guidelines (Faculty of Psychiatry of Intellectual Disability 2016). NHS England's STOMP–STAMP pledge and underlying principles are shown Box 1 and Box 2.

The main point for psychiatrists in the RCPsych's practice guidelines is that National Institute for Health and Care Excellence (NICE) guidance makes clear that antipsychotics should only be offered in combination with psychological or other interventions. Importantly, inadequacies in care provision should not be masked by the indiscriminate use of symptom-controlling drugs.

Advice for psychiatrists regarding STOMP–STAMP

We are sure that our readers will agree with the STOMP–STAMP pledge and its principles. However, the question that remains is how to implement this in a busy service with limited resources. Clearly, any psychiatrist should prescribe psychotropic medication appropriately, considering the principles of medical ethics, including beneficence, non-maleficence, autonomy and justice.

NICE guidelines support the short-term use of antipsychotics in conjunction with a multidisciplinary approach to reduce the risk that people with intellectual disability and autism may pose to themselves or others (NICE 2015). However, this often results in long-term use, which may not be necessary and which may lead to serious side-effects, including metabolic complications and extrapyramidal side-effects (Pringsheim 2012). The British National Formulary for Children (BNFC) includes risperidone, an atypical antipsychotic, as a licensed short-term treatment for persistent aggression in conduct disorder and severe aggression in autism (Joint Formulary Committee 2022). Medium- to long-term use of risperidone becomes an off-label use of the medication.

It is important to note that many different types of psychotropic medication can cause behavioural side-effects, for example selective serotonin reuptake inhibitors and medication for ADHD and epilepsy (Biswas 2001; Branford 2015). It is therefore prudent to check for behavioural side-effects of existing medication before adding in any further medication to manage behavioural disturbance.

There is a real danger that medication is used to treat the symptom (behaviours that challenge) and not the cause (which may be a combination of

BOX 1 The STOMP–STAMP pledge

‘We pledge to make sure children and young people with a learning disability, autism or both are able to access appropriate medication (in line with NICE guidance), but are not prescribed inappropriate psychotropic medication. Regular and timely reviews should be undertaken so that the effectiveness of the medication is evident and balanced against potential side-effects. This will mean that children and young people are only getting the right medication, at the right time, for the right reason.

We, the undersigned, pledge to work together with children and young people with a learning disability, autism or both, and their parents, carers and families, to take measurable steps to ensure that children and young people only receive medication that effectively improves their lives.

We pledge to set out the actions that our individual organisations will take towards this shared aim and report regularly on the progress we have made, ensuring that we can be held to account.’

(NHS England 2019a)

factors across the biopsychosocial aspects that affect the individual), thus leaving the root cause unmanaged. This leads to the medication being used in the longer term, with the risk of serious side-effects, as any attempt to reduce it results in a return of the challenging behaviour as the underlying cause has not been addressed.

So, what can a psychiatrist do who is asked to intervene in, for example, a high-risk situation to try to prevent a hospital admission or placement breakdown? The STOMP–STAMP position statement from the RCPsych regarding the role of the psychiatrist treating children with intellectual disability offers sound guidance, which is summarised in [Box 3](#).

Behaviours that challenge others

Children with intellectual disability often have needs that are not met and that they may find difficult or impossible to communicate effectively. They may then act in ways that others find challenging, for example by harming themselves, being aggressive to others or by destroying property.

The obvious gold standard solution would be to identify the unmet need and to address that. The biopsychosocial model is a useful framework to use, as needs can be biological (e.g. reflux, constipation, dental pain), psychological (e.g. anxiety, depression) or social (e.g. loneliness, boredom). The key is to identify the underlying problem and to resolve it (Swanepoel 2019). To do so, it is helpful to (a) consider the child’s ability to function and to communicate, (b) assess the function of the behaviour and then (c) decide how to manage it most effectively. These suggestions are discussed in more detail below.

Ability to function and communicate

Accurate assessment of the severity of intellectual disability or developmental delay allows the application of appropriate behavioural strategies matched to the child’s developmental stage. Many behavioural problems are due to limited expressive and receptive communication, reduced levels of understanding, or mental or physical illness. It is helpful to enquire how the child usually functions when all is well and what has changed.

Behavioural assessment

Positive behaviour support (PBS), also called positive behavioural support, has gained traction as an ethical approach to assessing, understanding and managing behaviour that challenges others, although it is not always successful (Hassiotis 2018). It is a variant of applied behavioural analysis that uses only positive approaches, signifying a move

BOX 2 The principles behind the STOMP–STAMP pledge

- Psychotropic medication should only be considered for the management of behaviour that challenges when:
 - alternatives to psychotropic medication alone (such as positive behaviour support) do not produce positive change within an agreed time, or
 - treatment for any coexisting mental or physical health problem has not led to a reduction in the behaviour, or
 - the risk to the person or others is very severe (for example, because of violence, aggression or self-injury).
- Only offer psychotropic medications in conjunction with other interventions.
- Prescribing decisions should be clearly evidenced and documented, along with discussions that have taken place with the young person and their family.
- Prior to prescribing medication, a full functional analysis of the symptoms and behaviours being treated should be fully understood by families, carers and clinicians.
- There should always be a clear diagnosis that is arrived at through a defined and recognised assessment process.
- Consent or best interest decisions should be made in line with the Mental Capacity Act.
- Families, carers and young people should be given accessible, comprehensive information about the medications being offered, so that they are able to understand both the benefits and side-effects that these may have over time.
- With the introduction of any new psychotropic medication, families need time to consider, reflect and ask questions. Any questions they may have should be answered in a clear, balanced and objective way. Reasonable adjustments should also be made to support the child or young person’s understanding.
- The planned duration of treatment with the medication should be clear. Any medication prescribed to avert a crisis should be time limited to ensure regular and timely review.
- Clear guidance about why and when any additional ‘as required’ (PRN) psychotropic medication needs to be given should be discussed with parent and carers and reasonable adjustments made to support the child or young person’s understanding.’

(NHS England 2019b)

BOX 3 The Royal College of Psychiatrists' STOMP–STAMP position statement regarding the role of the psychiatrist

The RCPsych states that psychiatrists must gain a thorough understanding of the potential benefits and adverse effects of the medication for each individual in their care. There should be rigorous scrutiny of the need for medication, the effects of non-psychopharmacological therapies and a clear clinical objective to use the minimum dosage if medication is indicated.

Its recommendations regarding a clinical consultation and review of medication for a child with intellectual disability include the following points:

- All psychiatric consultations/reviews should be person-centred and parents, carers, social workers and teachers may be required to support individuals with intellectual disability to ensure a clinically effective interview.
- Parents/carers should bring to the appointment details of other treatments/changes in

medication made by the general practitioner (GP) or hospital clinic for physical health and changes in care plans. Discharge summaries from acute hospital admissions should be available.

- Where relevant, behavioural records and sleep charts should be reviewed.
- The psychiatrist should undertake an in-depth review of the psychiatric diagnosis and rationale for use of psychotropic medication, weighing up benefits against potential or actual risks and focusing on the impact on the individual's presentation and quality of life.
- The aim should be to achieve the maximum benefit with the minimum dosage of psychotropic medication for the targeted action and to plan a timescale for stopping the medication where possible.

- To gain a holistic picture of the child's well-being, the psychiatrist should put in context the effects and role of behavioural interventions and other therapies.

- It is important to stress to parents/carers that annual health checks at the GP surgery or by a paediatrician (for children at school) are arranged and completed. They typically include measurement of height, weight, body mass index, blood pressure, pulse, blood tests (including tests of liver and kidney function, glycated haemoglobin and serum lipid profile) and an electrocardiogram. Other tests, such as a full blood count and thyroid function tests, may be necessary depending on the psychotropic medication being prescribed.

(After Royal College of Psychiatrists 2021a)

away from sanction-based and aversive systems to manage behaviours (Lovell 2020). This was driven by investigations into the abusive management of people with intellectual disability and/or autism at Winterbourne View (Department of Health 2012) and has led to the creation of a PBS framework (Positive Behavioural Support Coalition 2015).

The functional analysis of challenging behaviour includes the consideration of its antecedents, the behaviour itself and its consequences (ABC) to understand the meaning behind it. This will allow the formulation of intervention strategies to be implemented with support from appropriate professionals (including those in speech and language therapy, nursing, occupational therapy, teaching and clinical psychology). Most behaviours that challenge others are variations of behaviour seen in typically developing children at younger ages and occurring in an inappropriate place or occasion. Understanding the behaviour in relation to developmental level helps guide interventions.

Management of challenging behaviour

Successful management of behaviours that challenge generally requires finding the cause or meaning and treating that as required. This can be difficult in the context of intellectual disability and a systematic approach to the assessment of physical illness and behaviour is often required. As mentioned above, common medical conditions, for example toothache, constipation or infection, may be communicated by a significant change in behaviour. This may require the use of specific

behavioural or pain assessment tools and observation of the behaviours in different settings and might need specialist assessments. Some children have benefitted from sensory integration by a suitably qualified occupational therapist, although the evidence base behind the approach is limited and it did not make it into the NICE autism management and support guidance as a consequence (NICE 2013). If challenging behaviour is extreme, psychotropic medication or admission to a mental health unit specialising in children with intellectual disabilities may be required to supplement other strategies. There are only small numbers of specialist beds nationally and emergency admissions are not usually accepted. In-patient admissions for behaviours alone in the absence of a mental illness are discouraged following NHS England's Transforming Care agenda (Houlden 2015).

Interested readers may want to refer to a recent article in this journal by Tevis & Matson (2022), which details the behavioural assessment and non-pharmacological treatment of intellectually disabled children with behaviours that challenge and lists many useful questionnaires and psychological interventions.

Psychotropic medication

The same principles apply both to intellectual disability and to paediatric prescribing, where consent (competency or capacity) is a recurrent difficulty, increasing the prescriber's responsibility to ensure that the benefits outweigh the risks. Medication should be introduced at a low dose,

gradually increased ('start low, go slow'), closely monitored with the expectation of the unexpected, and constantly reviewed with the intention of its eventual withdrawal (Turk 2014).

The better the available resources, including education, social care and alternative treatments, the less medication is likely to be needed. Antipsychotics and stimulants may be being prescribed more frequently for young people with intellectual disability than for the mainstream population (Tobi 2005; Allerton 2011; Osunsanmi 2016) but this may simply reflect the higher prevalence of behaviours that challenge. There are no published audits of paediatric prescribing in this population but, given that psychiatric prescribing is usually long term and its adverse effects only emerge after some years, it has to be approached with caution (Berney 2020).

Research is beginning to identify which drug is most likely to be effective for a specific disorder or symptom, suggesting, for example, that glutamate antagonists may be a starting point in fragile-X syndrome or oxytocin in autism (Popow 2021). However, the response of a specific individual to a specific drug is so idiosyncratic as to encourage experimental off-licence or off-label prescribing (Berney 2020).

Psychotropic medication in childhood is often continued long past its original rationale for prescribing. This can be because even once the child's behaviour is improved, parents and psychiatrists may be reluctant to risk a reduction and possible return of the behaviours that challenge. However, it is important to review the need for the medication as the side-effects may be detrimental in the short, medium or long term.

Don't forget ADHD

Children with intellectual disability are much more likely than neurotypical children to also have other neurodevelopmental disorders and many have autism and/or ADHD as part of their disability (Antshel 2006; Faraone 2017). It is known that ADHD is underdiagnosed in both children and adults with intellectual disability (Clark 2018; Xenitidis 2020). This is probably at least partly the result of the historic ICD-10 and DSM-IV not allowing concurrent diagnoses of autism and ADHD, which has been corrected in the updated guidance (ICD-11 and DSM-5) as more research has become available to show that intellectual disability, autism and ADHD are very often comorbid (World Health Organization 1993, 2022; American Psychiatric Association 1994, 2013; Clark 2018; Bougeard 2021).

A recent RCPsych report advises early consideration of ADHD in adults with intellectual

disability, with a view to providing treatment, as ADHD symptoms can cause significant functional impairment that limits the individual's ability to achieve their potential (Royal College of Psychiatrists 2021b). This is avoidable. A recent article in this journal gave a helpful overview of diagnosing and managing ADHD (mainly in adults) with intellectual disability (Perera 2022) which is recommended reading for child psychiatrists who treat young adults.

We know that children and adolescents with intellectual disability also have much higher rates of ADHD than the general population and the percentage increases as the severity of the intellectual disability increases (Hastings 2020; Voigt 2006; Ahuja 2013). This is also true for adults with intellectual disability (Perera 2021).

Children with ADHD and intellectual disability face 'double vulnerability': they experience both the deficits imposed by ADHD and those associated with their impaired ability to learn. Unfortunately, this is often not recognised owing to 'diagnostic overshadowing', in which the inattention, hyperactivity and impulsivity are wrongly ascribed to the intellectual disability.

The converse also occurs, where ADHD is wrongly diagnosed in a child who cannot concentrate or sit still in a mainstream class because the work is too hard for them owing to an underlying unrecognised intellectual disability. Identifying the contribution of ADHD to the overall impairment is important, as ADHD symptoms can be treated (Clark 2018) and may reduce the need for anti-psychotic medication (Perera 2021). It is extremely important to realise that ADHD symptoms often present as challenging behaviour, and these respond to treatment (Perera 2021).

Please note that antipsychotic medication can reduce hyperactivity and impulsivity through sedation, but it does not improve concentration and does not enable children to learn any strategies. Antipsychotics work by blocking dopamine, serotonin and histamine transmission in the midbrain (Pringsheim 2012). This unfortunately also affects pleasure and joy and people treated with antipsychotics may become and appear quite 'flat'. These medications therefore act like a chemical straitjacket that calms children but does not help them to concentrate better and to learn. The antihistaminergic side-effects are also sedating (Miller 2004).

It is next to impossible to put a positive behaviour support plan in place for a child who cannot concentrate for more than a few seconds. Therefore, diagnosing and treating ADHD is paramount as it can allow behavioural interventions to be effective. **Box 4** lists practical pointers to diagnosing ADHD

BOX 4 Diagnosing attention-deficit hyperactivity disorder (ADHD) in children with intellectual disability

- The NICE guidance for children with ADHD applies, but is not always relevant, especially in children with severe to profound intellectual disability, for whom available research findings are limited (National Institute for Health and Care Excellence 2018).
- Depending on the level of intellectual disability, different questionnaires may be helpful. In non-verbal children, the Activity Questionnaire (TAQ) is shorter and more relevant (Burbidge 2008, 2010).
- Get feedback from parents and school. However, be aware that parents may not have experience of other children and may wrongly consider ADHD-type symptoms to be due to the intellectual disability and/or autism. It is also important to know what activity, concentration and impulsivity levels are normal for a particular level of intellectual disability at a particular chronological age. In the UK, teachers at specialist schools for children with intellectual disability are not required to have any specialist training in terms of intellectual disability, autism or ADHD. It can be helpful for the teacher to compare the child with their peers but be mindful that this will only be accurate if the other children do not also have untreated ADHD.
- ADHD should be diagnosed when the child's impairment of attention and activity control is out of proportion to their developmental level and impairs educational, social and/or family functioning. Look for patterns of inattention, with flitting and fleeting activity, difficulty waiting, impulsivity and inability to keep still – these should be pervasive across situations and persistent over time. (Hanna 2020: pp. 53–4; Xenitidis 2020)

and Box 5 gives treatment advice for ADHD in children with intellectual disability.

Diagnostic overshadowing can also be problematic when the diagnosis of intellectual disability prevents further thinking about whether criteria

would be met for a diagnosis of an autism spectrum disorder. Reilly et al (2015) described how professionals may lack expertise in the recognition of autism and ADHD in children with intellectual disability that is due to a neurogenetic syndrome.

BOX 5 Treating attention-deficit hyperactivity disorder (ADHD) in children with intellectual disability

- Note that the treatment of ADHD is under-researched in children with ADHD and intellectual disability and the evidence to support treatment is very limited. There is therefore a greater reliance on the therapeutic trial and application of the Bolam principle (that a doctor acts clinically within the parameters of a reasonable body of peers).
- Be careful to 'start low and go slow' and use a quarter to a half of the dosing regimen recommended for neurotypical children. If this is not adequate, the dose can be increased in due course, but it is better to err on the side of caution.
- Stimulant medication is less effective in children with intellectual disability than in neurotypical children and more likely to result in side-effects, for example aggression, agitation, poor appetite and poor sleep.
- The more severe the intellectual disability, the greater the chance that stimulant medication will have an agitating effect. This does not mean that the child does not have ADHD; it just means that stimulants do not work for their ADHD and that a non-stimulant needs to be considered.
- In prescribing stimulant medication, start with the lowest dose possible (e.g. 2.5 mg methylphenidate). If there is increased aggression (a paradoxical effect), stop the medication straightaway. If there are no negative effects, the dose can be increased slowly. Beware of rebound hyperactivity resulting in challenging behaviour when the medication wears off and if this occurs, stop the stimulant. If a child has had some positive effect on methylphenidate but struggles with the kick-in and wear-off effects, you may want to consider lisdexamfetamine or longer-acting formulations of methylphenidate.
- Non-stimulant medication may be a better option, as the child needs 24-h control of their symptoms to reduce challenging behaviours.
- If the child is unable to swallow tablets, recommend that parents and/or school teach them, as this is a useful skill that will increase their medication options in adult life as well. Recommend that a trusted adult demonstrates once a day, by putting a small sweet (e.g. a Tic Tac[®]) on the tip of their tongue and then taking a sip through a straw from a glass. The adult then opens their mouth and shows that it is empty. The child then tries. It is important that there is no pressure and that this is treated as a game. If the child bites the sweet or keeps it in their mouth, the adult just says no problem, we'll try again tomorrow. The reason for sipping through a straw from a glass is to enable the correct head position (chin to chest) and to avoid triggering the gag reflex.
- If the child is unable to swallow tablets, consider atomoxetine, which comes in liquid form. Note that several stimulant capsules can also be opened and sprinkled (e.g. Equasym[®] XL) or dissolved and are tasteless (e.g. lisdexamfetamine). Some medications (e.g. immediate release methylphenidate) can also be crushed.
- If the child can swallow tablets, a low dose of guanfacine can be particularly helpful if they are also anxious and hypervigilant, as it blocks the fight/flight response. Clonidine is also an option if a liquid formulation is needed, and it has the advantage that it is relatively tasteless and can be added to a drink. However, it should be given three times daily with at least 4 h between doses and regularity of dose is essential to ensure that adverse blood pressure liability does not occur. Guanfacine and clonidine are the medications of choice when tics are troublesome.
- Be aware that monitoring requirements continue, specifically of height, weight, blood pressure and pulse as per NICE guidelines. An electrocardiogram may be needed where risks have been identified.
- Physical activity is helpful for children with ADHD and should be recommended wherever possible. (Aman 2014; Clark 2018; Tarrant 2018; Hanna 2020; Miller 2020; Xenitidis 2020; Joshi 2021; Popow 2021)

MCQ answers

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BOX 6 Further reading and resources

- NICE Guideline NG11 (May 2015): *Challenging Behaviour and Learning Disabilities: Prevention and Interventions for People with Learning Disabilities Whose Behaviour Challenges* (www.nice.org.uk/guidance/ng11)
- The Challenging Behaviour Foundation: www.challengingbehaviour.org.uk
- Skills for Care: *Supporting People with Challenging or Distressed Behaviour* (www.skillsforcare.org.uk/Learning-development/ongoing-learning-and-development/behaviours-which-challenge/Behaviours-which-challenge.aspx)
- Bild Centre for Advancement of Positive Behaviour Support: www.bild.org.uk/positive-behaviour-support-pbs
- PBS Academy: *Positive Behavioural Support Competence Framework* (www.pbsacademy.org.uk/pbs-competence-framework)

Conclusions

We hope that this article (and the sources listed in Box 6) will help psychiatrists who work with children with intellectual disabilities. Understanding challenging behaviours as communication of an unmet need can be very helpful in finding the cause rather than just trying to manage the symptoms. It is important to consider the biopsychosocial model and to beware of diagnostic overshadowing. Searching for and treating ADHD can make a big difference, not just in terms of avoiding inappropriate antipsychotic prescribing but also in terms of improving the child's concentration to make better use of behavioural strategies and learn better communication skills.

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Author contributions

Both authors contributed to the conception of the work, revised it, approved the final version and are accountable for the work.

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MCOs

Select the single best option for each question stem

1 STOMP stands for:

- a supporting the obligation of medication for psychosis
- b sympathising with overt mental health presentations
- c signalling the opposition of medicine for people with intellectual disability
- d supplying the overdue medication for provocative behaviours
- e stopping the over-medication of people with intellectual disability, autism or both with psychotropic medicines.

2 STAMP stands for:

- a supporting treatment and appropriate medication in paediatrics
- b stopping avoidable medication problems
- c substituting therapy and medication for problem behaviours
- d subsidising the antipsychotic medication pharmaceutical solutions that avoid medication prescriptions.

3 Which of the following is not correct when prescribing for children with intellectual disability and behaviour that challenges?

- a start low and go slow
- b titrate upwards more quickly than in a neurotypical child
- c monitor as per NICE guidelines
- d consider ADHD
- e consider pain.

4 Diagnostic overshadowing refers to situations in which:

- a the patient has so many diagnoses that it is difficult to help them
- b the deprivations in the environment are worse than the diagnoses
- c all symptoms are falsely attributed to one diagnosis and other conditions are missed
- d the stigma of a diagnosis leads to labelling of the patient
- e a consultant psychiatrist speaks disparagingly of behavioural interventions.

5 Children with intellectual disability who are always on the go, cannot wait for their turn and cannot concentrate for longer than a few seconds should be assessed for:

- a autism
- b anxiety
- c conduct disorder
- d ADHD
- e nothing – it is all understandable as part of the intellectual disability.