UPDATE ON THE USE OF NEW GENERATION ANTIPSYCHOTICS IN ID/IDD

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DRUGS PRESCRIBING IN ID/IDD

- Around 20-45% of PwID receive psychoactive drugs

- 14-30% receive PD for the management of PBs, without an underlying psychiatric diagnosis

- high prescription is not supported by evidence on efficacy and safety

- Around 2/3 of prescribed drugs are antipsychotics
- At least 1 AP is prescribed to 20% of users of supported residential facilities and to 45% of hospitalized persons

1. Deb et al., 1994; Clarke et al., 1990
2. Tyrer et al., 2008; Deb, 2007; Aman et al., 2004; McGillivray et al., 2004; Clarke et al., 1990
3. Sparrow et al., 1991
5. Lindner, 1990
REASONS FOR DRUG PRESCRIPTION IN ID/IDD

N = 4069 adults

- 50% psychiatric disorder
- 13% severe problem behavior
- 38% combination of PD and PB

- 58% psychotropics in general
- 6% typical antipsychotics
- 39% atypical antipsychotics
- 23% antidepressants
- 19% mood stabilizers
- 16% antianxiety agents
- 1-2% anti-impulsivity drugs, stimulants and hypnotics

ANTIPSYCHOTICS PRESCRIBING FOR ID IN PSYCHIATRIC SERVICES

n = 2319
clinical records of 39 mental health services in the UK

- 27% with diagnosis of psychotic disorder (ICD-10 F20-29)
- 27% with diagnosis of affective disorder (ICD-10 F30-39)
- 6% with borderline/mild ID, without any psychiatric diagnosis
- 21% with severe/profound ID, without any psychiatric diagnosis

- most common indications for prescribing:
  - comorbid psychotic illness
  - anxiety
  - agitation
  - a range of behavioural disturbances

- the prevalence of use of AP to manage problem behaviour in the absence of concomitant mental illness increased with the severity of ID
- almost 50% of prescriptions in those with severe/profound were for PB
- adherence to the audit standards related to documentation of clinical indications and review of efficacy was high
- side effect monitoring was less assiduous
Antipsychotic prescribing in people with intellectual disabilities: a clinical audit

Hannah Griffiths, N. Halder and N. Chauudhry

Abstract

Objectives: Antipsychotics are the first-line treatment for people with intellectual disabilities and serious psychiatric disorders. This study aimed to evaluate the prevalence of antipsychotic prescribing and to identify any potential predictors of prescribing in this group.

Method: A retrospective audit of all antipsychotic medication prescribed to patients attending the Salford Intellectual Disability Psychiatric Unit, UK, over a 6-month period. The data collected included demographics, psychiatric diagnosis, and reason for prescribing.

Findings: Of the 178 patients attended, 126 (72%) were prescribed antipsychotic medication. 11 (9%) were prescribed 2 antipsychotic drugs concurrently. 67% had a co-occurrent psychiatric diagnosis. 33% were prescribed off-label. 64% were prescribed by GPs, 28% were prescribed by psychiatrists, and 8% were prescribed by pharmacists.

Conclusion: Antipsychotic prescribing in people with intellectual disabilities is common, but further research is needed to understand the reasons behind off-label prescribing and the potential impact on patient outcomes.

Keywords: Antipsychotics, Intellectual disabilities, Prescribing, Off-label, Psychiatric morbidity

n = 178

(patient attending Salford Intellectual Disability Psychiatric Unit, UK)

- 126 (72%) were prescribed antipsychotic medication
- 11 (9%) were prescribed 2 antipsychotic drugs concurrently
  - 67% had a co-occurrent psychiatric diagnosis
  - 33% were prescribed off-label

first prescriber

- 64% GP on recommendation from secondary care
- 28% unknown
- 8% GP alone or pharmacy
DEFINITION OF MENTAL DISORDER IN ID

- There is no consensus about which MH problem should be included
- Diverse conceptualization of both ID and mental health are evident in the research literature
- Difficulties with the determination of functional impairment
  PwID have fewer role expectations and symptoms do not necessarily relate to the degree of impairment in daily life
- Difficulties with the determination of clinically significant distress
  PwID are constantly exposed to many stressors and symptoms do not necessarily relate to the degree of distress in daily life

DIFFICULTIES WITH THE DIAGNOSTIC PROCESS IN ID

- What the person says they are experiencing
  - Difficulties in communication skills or language impairment
  - Even in verbally competent, auditory hallucination resulted to be the only first-rank symptom that can be detected
- What other say about them and how they are seen to behave
  - A confounding factor is the belief that such problems are inevitable and unchangeable. This means that help is not sought.
  - Diagnostic overshadowing whereby someone’s general mental state or behaviour is attributed to the fact that he or she has an intellectual disability
- History of complaint
  - The development, for example, of maladaptive behaviours, increasing withdrawal, or changes in a person’s state of general well-being may be a marker for a possible mental health problem (baseline exaggeration).
  - Establishing a baseline and recording changes are central to the diagnostic process
- The presentation of symptoms
COMPLEXITY OF PHENOMENOLOGY OF PSYCHIATRIC DISORDERS IN ID

- Level of cognitive ("intellectual distorsion")
- Level of development ("developmentally appropriateness")
- Interpersonal, cultural and environmental influences (psychosocial masking)
- 'ID overshadowing'
  Differentiate between psychiatric symptoms and signs and symptoms of underlying brain damage
- Atypical or masked presentation
  Aggressivity, screaming, maladaptive behaviours, etc.
- Neurovegetative vulnerability
  Somatic complaints, changes in circadian rhythm, NV dystonias
- 'Cognitive disintegration'
  Coping impairment and lower threshold


HIGH RATE OF PROBLEM BEHAVIOUR IN ID/IDD

- 15-25%
- 60% at least 1 PB
  (N=2202)
- 22.5% (with clinical diagnosis)
- 18.7% (with DC-LD diagnosis) (N=1023)
- aggressivity (9.8%)
- SIB (4.9%)
- higher rate when co-occurring ASD or epilepsy

PB IN ID: HIGH PERSISTENCE

2 yrs remission rate¹
SIB 38.2%
agestivity 27.7%

11 yrs permanence rate²
all PB 79%
physical aggressivity 70%
stereotypies 65%
SIB 49%

PROBLEM BEHAVIOURS IN ID

- Persistence levels tended to be high in adults and seem to be stable over time, especially in individuals with autism¹
- The presentation of BPs is determined by a complexity of factors
- The causal value of organic conditions, psychiatric disorders, environmental influences, life-events, operators misinterpretation or a combination of these, has to be carefully established for every single case
- Influence of ID and developmental levels²
- Functional behavioural assessment has gained widespread use in all settings in which people with ID might present behavioural problems
- Recent research has shown promise in training professionals and non-professionals in learning to carry out such assessments and in implementing effective behavioural interventions³

1. Cooper et al, 2009
2. Totsika et al, 2008
4. Tassé, 2006
International guide to prescribing psychotropic medication for the management of problem behaviours in adults with intellectual disabilities


WPA SECTION REPORT

Problem Behaviours in Adults with Intellectual Disabilities


Psychotropic medications are used regularly to manage problem behaviors among people with intellectual disabilities. This cannot come about unless these medications are used in an evidence-based and consensus-based international guide for practitioners for the use of psychotropic medications for problem behaviors among adults with intellectual disabilities. This guide advises on assessment of behaviors, producing a formulation, initiation of treatment, assessment of response and adverse effects, follow-up arrangements, and possibility of discontinuation of treatment.

Key words: Intellectual disabilities, problem behaviors, psychotropic medications, international guide.

(World Psychiatry 2008;8:52–58)

Intellectual disability (ID) or mental retardation or learning disability is a lifelong condition characterized in the group of mental disorder in all the intellectual disability spectrum. It is a common growing (rate syndrome) including a heterogeneous range of clinical conditions characterized by a deficit in cognitive functioning prior to the acquisition of skills through learning. (1) Over 30% of people with ID have a co-occurring psychiatric disorder, which often has its onset in childhood and persists through adolescence and adulthood (2,3). In spite of this evidence, ID and related conditions are still considered a marginal area of psychiatry. In many countries, there is a lack of or inequitable provisions on ID among underdeveloped medical training or psychiatric specialization. The World Health Organization (WHO) has recently highlighted the unique needs of people with ID (4). Psychotropics are the first-line treatments used in this population group and there is a global gap in training and preparation of mental health professionals around ID.

4. Main recommendations

4.1. Anyone prescribing medication to manage problem behaviours among adults with intellectual disabilities should follow this good practice.

- Medication should be used only in the best interests of the person.
- All non-medication management options should have been considered and use of medication should be seen necessary under the circumstances, or alongside non-medication management.
- If possible, evidence to show that the medication is cost-effective should be taken into account. This includes in many countries consideration for the price of the medication and ability to pay for them.
- Information about which interventions worked before and which did not should be noted.
- If previously interventions produced unacceptable adverse effects, the details should be noted and taken into consideration.
- The effect of availability or non-availability of certain services and therapies on the treatment plan should be considered.
- Relevant local and national protocols and guidelines should be followed. If there is a major discrepancy between this guide and the local guidelines then contact people involved with the local guide and/or one of the authors in this guide for more information and a resolution.


Evidence to support poly prescribing

There is a lack of studies of combinations of psychotropic medications to manage problem behaviour among adults with ID. It is not possible to recommend any combination of medications as enhancing the efficacy of medications prescribed on their own. The evidence based on observational studies suggests that the reduction in poly prescribing not only improves behaviour but also the quality of life of the person for whom medication is prescribed.
some evidence on efficacy of TAPs in reducing aggressive behaviour in PwID

most studied and prescribed are haloperidol, thioridazine, and chlorpromazine

many studies pointed out low safety and low tolerability, showing a number of side effects with very high negative impact on PwID (tardive dyskinesia, neuroleptic malignant syndrome, sedation, dystonia, reduction of cognitive performance, extrapyramidal effect)

use limited to very acute phases and at the minimum effective dose


**TYPICAL ANTIPSYCHOTICS IN PwID/IDD**

**NGAs IN AUTISM SPECTRUM DISORDERS**

RISPERIDONE is approved for the treatment of irritability associated with autistic disorder in children and adolescents (ages 5-16 years), including symptoms of aggression, self-injury, tantrums, and quickly changing moods. It is the first prescription medication approved by the FDA for this purpose.

ARIPIPRAZOLE is approved for the treatment of irritability associated with autistic disorder in children and adolescents (ages 6-17 years), including symptoms of aggression, self-injury, tantrums, and quickly changing moods.

NGAs IN ID/IDD

- less effective than placebo for PBs in PwID\(^1\)
- same effectiveness than placebo for PBs in PwID\(^2\)
- much more effective than placebo, across the life span\(^3,4,5\)

\(^1\)Tyrer et al., 2008.  \(^2\)Breylewski et al., 2007.  \(^3\)Aman et al., 2002; Snyder et al., 2002; Turgay et al., 2002.
\(^4\) Butelaar et al., 2001; Franco et al., 2000; McDonough et al., 2000; Zarcone et al., 2001.
\(^5\)McAdam et al., 2002; Janowsky et al., 2003; Boksanska et al., 2003.  \(^6\)La Malfa et al., 2006.

OLANZAPINE VS RISPERIDONE IN TREATING AGGRESSIVE BEHAVIOURS IN ADULTS WITH INTELLECTUAL DISABILITY: A SINGLE BLIND STUDY

Mario Amore\(^1\), Marco Bertelli\(^2,3,5\), Daniele Villani\(^4\), Stefania Tamborini\(^6\) and Michele Rossi\(^2,3,5\)

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5. MAPPS, Medics Associated for Psychiatry and Psychotherapy, Florence (Italy)

Use of the atypical antipsychotics Olanzapine and Risperidone in adults with intellectual disability

H. Williams, R. Clarke, N. Bearas, J. Martin & G. Holt

2 naturalistic studies
- olanzapine more prescribed for psychosis
- risperidone more prescribed for problem behaviours associated with PD
- both resulted to be effective
- results limited by indirect assessment of PBs (through CGI)
Possible clinical effect

SEROTONERGIC
Anxiety, mood regulation, depressive and cognitive symptoms

DOPAMINERGIC
Psychotic, manic and cognitive symptoms

NORADRENERGIC
Depressive, psychotic and cognitive symptoms

HISTAMINERGIC
Somnolence and sedation

* No appreciable affinity for muscarinic receptors, unlike clonazepam and quetiapine

Research in Developmental Disabilities

The use of clonazepam among individuals with intellectual disability: A review
Ashwin N. Singh, Johnny L. Manor, B.D. Hill, Robert D. Pella, Christopher L. Cooper, Angela D. Addazio
Department of Psychology, University of North Carolina, USA

Article info
Article history
 obra /was accepted in the United States on 30th January 2019, the final version on 24th January 2019
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A retrospective chart review was conducted at a large mental health facility, and all patients with intellectual disability and a diagnosis of clonazepam treatment were identified. This study shows that clonazepam can be an effective treatment for specific symptoms in individuals with intellectual disability. The use of this medication in individuals with intellectual disability is consistent with the use of similar medications in the general population. The study also highlights the importance of addressing the underlying causes of symptoms in individuals with intellectual disability, as well as the need for ongoing monitoring and follow-up care.
Table 1. Summary of discipline studies.

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Sample</th>
<th>Randomization</th>
<th>Controlled &amp; blinda</th>
<th>Placebo</th>
<th>Drugblind</th>
<th>Few of other</th>
<th>Follow-up</th>
<th>Initial/intermediate change</th>
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<td>Randomization</td>
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<td>Few</td>
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<td>Controlled study</td>
<td>300-600 mg/day (200 mg/day)</td>
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<td>Few</td>
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<td>Few</td>
<td>No</td>
<td>Controlled study</td>
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<tr>
<td>Barrese et al. (2004)</td>
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<td>Randomization</td>
<td>No</td>
<td>No</td>
<td>Few</td>
<td>No</td>
<td>Controlled study</td>
<td>10-300 mg/day (10 mg/day)</td>
</tr>
</tbody>
</table>

*Adverse effects: headache, nausea, vomiting, diarrhea, dry mouth.*

**Abbreviations:** ACR = American College of Rheumatology; ASAS = Assessment of Spondyloarthritis in Children; DAS28 = Disease Activity Score in 28 joints; EULAR = European League Against Rheumatism; HAD = Hamilton Anxiety and Depression Scale; HAQ = Health Assessment Questionnaire; JADAS = Juvenile Arthritis Disease Activity Score; JADAS27 = Juvenile Arthritis Disease Activity Score in 27 joints; JADAS44 = Juvenile Arthritis Disease Activity Score in 44 joints; JCVI = Joint Committee on Vaccination and Immunisation; LIHAO = Italian Rheumatology Society; MDA = Medical Disorders of Alcohol; NICE = National Institute for Health and Care Excellence; OMERACT = Outcome Measures in Rheumatology; PASI = Psoriasis Area and Severity Index; PediCS = Pediatric Crohn's Disease Score; PediIBD = Pediatric Inflammatory Bowel Disease Score; PSQI = Pittsburgh Sleep Quality Inventory; SCOFF = Screen for Complaints Often Forgotten; SIC = Scottish Intercollegiate Guidelines Network; SIBO = Small Intestinal Bacterial Overgrowth; SIRS = Systemic Inflammatory Response Syndrome; VAS = Visual Analog Scale; WAIS = Wechsler Adult Intelligence Scale; WISC = Wechsler Intelligence Scale for Children; WMA = World Medical Association.
CLOZAPINE

- mostly used for PBs
- some evidence of efficacy in case series
- efficacy on aggressivity, SIB, and disruptive behavior, even at low dose
- rare but relevant side effects (attention to neutropenia and seizures)
**Risperidone**

- most studied among NGA
- more effective than TAPs on problem behaviours with lower extrapyramidal side effects.
- first choice drug for PBs in ID/IDD
- frequent hyperprolactinemia

Connor and Posever, 1998; Advokat et al., 2000; La Malfa et al., 2006; Janowsky et al., 2003; Pato et al., 2004.
**OLANZAPINE**

- mostly used for PBs
- some evidence of efficacy in case series
- good efficacy on disorders different from schizophrenia, particularly mood disorders
- efficacy on aggressivity, SIB, and disruptive behavior
- good tolerability (attention to risk of metabolic disorders)

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**ARIPIPRAZOLE**

is approved for the treatment of irritability associated with autistic disorder in children and adolescents (ages 6-17 years), including

- symptoms of aggression,
- self-injury,
- tantrums,
- quickly changing moods
ARIPIPRAZOLE

Prospective open label study, 12 weeks
12 young participants (6-25 aa) with FXS
daily mean dose: 9.8 mg

Significant improvement (CGI and ABC)
2 discontinuations:
  1 for akathisia and tiredness
  1 for tiredness

4 cases with psychotic disorder
1 case with PB and ASD
good efficacy and tolerability

ASENAPINE

- 15 cases (26-45 yrs; ID from mild to moderate)
- 14 monotherapy; 1 in combination with valproate and escitalopram
- 11 bipolar disorder; 4 schizophrenia
- 5 drug naive, 10 switched from clozapine, olanzapine, valproate, clotiapine, delorazepam, clorpromazine, carbamazepine
- clinical improvement (CGI at 1, 3, 6 months)
- minor side effects i.e (vomit, nausea, headache, sedation)
ZIPRASIDONE

- prevalent use on PBs
- some evidence of efficacy in case series
- good tolerability (weight neutral)

40 persons with ID and PB, overweight and dyslipidemia (total cholesterol, HDL, LDL, TG)
- efficacy on PB
- weight and dyslipidemia improvement

THE CONCEPT OF EFFECTIVENESS OF INTERVENTION

Efficacy
Tolerability and Safety
Effectiveness
Adeherence/Stay on treatment

OUTCOME MEASURES IN PSYCHOPHARMACOTHERAPY OF ASD

**Risperidone** (1)

Meta-analysis was possible for three outcomes. Some evidence of the benefits of risperidone in irritability, repetition and social withdrawal were apparent.

**Tricyclic Antidepressants** (2)

The objectives are to determine if treatment with tricyclic antidepressants:
- improves the core features of autism, including restricted social interaction, restricted communication and stereotypical and repetitive behaviours
- improves non-core features such as challenging behaviours
- improves co-morbid states, such as depression and anxiety
- causes adverse effects.

**SSRIs** (3)

The objectives are to determine if treatment with SSRIs:
- improves the core features of autism (social interaction, communication and behaviour problems)
- improves non-core aspects of behaviour or function such as self-injurious behaviour
- improves the quality of life of children and their carers
- has short and long term effects on outcome
- causes additional harms.

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THE CONCEPT OF EFFECTIVENESS OF INTERVENTION

Efficacy

Tolerability and Safety

Effectiveness

Adeherence/ Stay on treatment

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New Research Findings Comparing Atypical to Typical Antipsychotic drugs

- Blockade of NMDA antagonists
- ↑ Levels of GABA neurosteroid allo pregnanalone
- ↑ Neurotrophic factors (ie, BDNF)
- ↑ Neurogenesis
- Preservation of ACh neurons & cognitive function
- ↑ Anti-apoptotic vs pro-apoptotic proteins
- ↑ Levels of antioxidant defense enzymes
- Preservation of mitochondria respiration
- ↑ Neuronal glucose supplies

EFFECT OF 90 DAY TREATMENT WITH HALOPERIDOL OR OLANZAPINE ON RAT CORTICAL CHAT^ LEVELS

ChAT is an abbreviation for choline acetyltransferase which is a marker for cholinergic neurons that are highly involved in cognitive processes. ChAT is labeled as bright green dots.

ASSESSMENT OF METABOLIC SYNDROME IN PEOPLE WITH ID ON ANTIPSYCHOTIC MEDICATION

Figure 4 Assessment of the four aspects of metabolic syndrome within the last year

![Bar chart showing assessment of metabolic syndrome aspects]


Research

Monitoring for metabolic syndrome in people with intellectual disability on antipsychotic medication

Regis Ilabas and Mohamed B Tahat

Abstract

Purpose - People with intellectual disability are at risk of increased health complications compared to the general population. The purpose of this study was to assess the risk of metabolic syndrome in people with intellectual disability on antipsychotic medication.

Methods - A cross-sectional study of people aged 18 years and older with intellectual disability on antipsychotic medication at two local intellectual disability services in the UK was conducted. Body mass index, waist circumference, blood pressure, fasting plasma glucose and total cholesterol were measured.

Results - The mean age of the participants was 54.2 years, and the majority were male (78%). The prevalence of metabolic syndrome was 21.4% (n=25). The most common metabolic syndrome component was elevated waist circumference (48.8%).

Conclusion - The findings suggest that people with intellectual disability on antipsychotic medication are at risk of metabolic syndrome. Further research is needed to investigate the potential mechanisms and interventions to prevent metabolic syndrome in this population.

Keywords: Intellectual disability, antipsychotic medication, metabolic syndrome, prevention, intervention.
MONITORING FOR METABOLIC SYNDROME IN PEOPLE WITH ID ON ANTIPSYCHOTIC MEDICATION

Table I  Prior to initiation

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<tr>
<td>Glucose</td>
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<td>40.625</td>
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<td>Lipids</td>
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<tr>
<td>BP</td>
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Table II  Monitoring – three months

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The British Journal of Psychiatry
bjp.rcpsych.org

RESEARCH ARTICLES

Safety of antipsychotics in people with intellectual disability

Valeria Frighi, MD

- metabolic indices were the same or more favourable in the ID group than in the general population control group
- overweight/obesity and type 2 diabetes were more prevalent in the women in the ID group than the control group
- a total of 100% and 70% of participants on amisulpride/sulpiride and risperidone respectively had hyperprolactinaemia, with secondary hypogonadism in 77% and 4% of affected women and men.
THE CONCEPT OF EFFECTIVENESS OF INTERVENTION

- Efficacy
- Tolerability and Safety
- Adeherence/Stay on treatment

SCHIZOPHRENIC PATIENTS COMPLETING THE TREATMENT HAVE A QoL IMPROVEMENT


Number of patients at each time point:

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<th>Weeks on Antipsychotic Therapy</th>
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<td>83</td>
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*p<.05
Quality of life in pharmacological intervention on autism spectrum disorders

Marco Bertelli, Michele Piazza, Stefano Liao, Annamaria Bianco and João Correia


**Summary**

- Although the international scientific community shows increasing interest on QoL and other person-centred measures in psychopharmacological practice, in respect to ASD considerable research efforts are needed to make these measures applicable and their usefulness actually proved.
- In fact our mapping indicates a considerable lack of studies and the few contributions present in the literature show significant conceptual and methodological limits.
- The literature does not allow any comparison of effectiveness between neither classes of drugs nor single compounds with respect to QoL.
- Since the important implications that QoL assessment may have for resource allocation in healthcare, it is to be hoped that current state of research will rapidly improve.

### ANTIPSYCHOTIC MEDICATION (% by sample and dosage by time)

<table>
<thead>
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<th>COMPOUND</th>
<th>N</th>
<th>%</th>
<th>MEAN DOSAGE (mg/day)</th>
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<td></td>
<td></td>
<td></td>
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<tr>
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<td>Clopromazine</td>
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<td>18,18</td>
<td>200,00</td>
</tr>
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<td>Levomepromazine</td>
<td>3</td>
<td>13,64</td>
<td>91,67</td>
</tr>
<tr>
<td>Promazine</td>
<td>2</td>
<td>9,09</td>
<td>210,00</td>
</tr>
<tr>
<td>Perphenazine</td>
<td>2</td>
<td>9,09</td>
<td>16,00</td>
</tr>
</tbody>
</table>

Wing’s Handicap Behaviours and Skills schedule (HBSs)

Temperamento bizzoso
Rumorosità
Distruttività
Iperattività
Mancanza di cooperazione
Comportamento in luoghi pubblici
Comportamento aggressivo
Vagare
Abitudini personali negative
Altri problemi del comportamento
Rompere o gettare oggetti
Gridare o piangere

Behaviour rated for:
Severity (consequences)
0 = Not at all a problem
1 = the behaviour is a problem, but SLIGHT in degree
2 = the problem is MODERATELY SERIOUS
3 = the problem is SEVERE in degree

Frequency (n/day)
1 = <1
2 = 1-3
3 = 3-5
4 = >5

OVERALL QoL-IP SCORE by TIME

BECOMING SUBAREA SCORES by TIME

QoL-IP ‘BEING - PSYCHOLOGICAL’ SCORE by TIME


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We are delighted to invite you to the 10th European Congress of Mental Health in Intellectual Disability to be held in Florence, Italy from the 9th – 11th September 2015.

In collaboration with and hosted by our Italian partners CDA and Misericordia, we look forward to meeting you in Florence, Italy!

Together we will create a place for reflection to exchange research, experiences and good practice. We will also bring new perspectives and support networking in the field of Mental Health and Intellectual Disability.

For all plenary sessions and many workshops and symposia we will provide simultaneous translation from English into French and Italian.

Add these dates to your agenda and be our guest in the beautiful surroundings of Florence. I look forward seeing you all in Italy!

Dr. Marco Botelli
President of the European Association for Mental Health in Intellectual Disability 2013-2015 – Psychiatrist, CREA (Research and Clinical Centre) della Fondazione San Sebastiano, Florence, Italy

Stefano Lassi
Vice-President of the European Association for Mental Health in Intellectual Disability 2013-2015 – Psychiatrist, Fondazione CDA Firenze Oulus of Florence, Italy