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'Lots of Black people are on meds because they're seen as aggressive': STOMP, COVID-19 and anti-racism in community learning disability services

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Abstract

Background: The STOMP agenda (Stopping Over-Medication of People with learning disabilities, autism, or both) drew focus to individuals with a diagnosis of a learning disability being prescribed psychotropic medication to manage 'behaviours that challenge'. The following study is an audit of two community learning disability services in the London boroughs of Westminster and Kensington and Chelsea for compliance with national guidance on the use of medication in this population, the impact of the COVID-19 pandemic, and equality, diversity and anti-racism.

Method: Routinely collected data were audited relating to clients identified in each service, totalling 54 participants. Data were audited against five standards: minimum effective dose, medication reviews, alternative multidisciplinary input, the impact of the COVID-19 pandemic and equality, diversity and anti–racism. Comparisons were made to the overall caseload ($N = 365$) where appropriate.

Results: Evidence demonstrated a greater risk of receiving psychotropic medication to manage behaviours that challenge for service users from racialised backgrounds, further evidencing institutional and/or individualised racism within practice for this population. Prescriptions also increased in dosage during the COVID-19 pandemic exacerbated by insufficient provision of alternative input and regular multi-disciplinary review as required by national guidance.

Conclusions: Community learning disability teams require dedicated, co-produced STOMP pathways to review those at risk of over-medication. Additional research is required to explore individual and systemic factors contributing to ethnic disparities in medication prescription for behaviours that challenge among people with learning disabilities. Further recommendations are considered around developing data collection, service user involvement, and future directions.

KEYWORDS
clinical psychology, learning (intellectual) disabilities, psychopharmacology

Accessible summary

- Abuse at care home (Winterbourne View) led the NHS to start a campaign known as STOMP to make sure people with learning disabilities and/or autism got the right medication.
- We looked at the medications people with learning disabilities in our area were given. We looked at how often these medications were checked by a doctor. We looked at what other support people were given.
- We also looked at how people with learning disabilities were affected by COVID-19. We also looked at differences between people from different racial backgrounds.
- We found that some people were given more medications to manage their behaviour. We found that the medications were not checked as often as they should be. This happened most for Black, Brown, and Asian people.
- We spoke to a local service user project about our findings. They said they think racism is one of the reasons for more medications. They also said it is bad that people are on too much medication and that people should get more support.

1 | INTRODUCTION

Behaviours that challenge represent a spectrum of behaviours that may pose a risk of harm to an individual, others, or the environment and are common in individuals with a diagnosis of learning disability (McGill et al., 2020). Understandings of behaviours that challenge are often individualised, leading to restrictive practices including physical restraint and over-medication (McGill et al., 2018; Raghavan & Patel, 2010). This is despite evidence for approaches which contextualise behaviours that challenge (Harvey et al., 2009).

Up to 35,000 people with learning disabilities in the UK receive psychotropic medications (antipsychotics, antidepressants, mood stabilisers and sedatives) to manage behaviours that challenge without a relevant mental health diagnosis (Glover et al., 2015). This is contrary to research which has demonstrated many behaviours that challenge arising due to environmental factors and inappropriate or insufficient support (Olivier-Pijpers et al., 2018). This shift in understanding, particularly in the fall out of the Winterbourne View case (Department of Health, 2012), led to the emergence of the STOMP campaign (Stopping Over-Medication of People with learning disabilities; National Health Service England, 2017) to raise awareness of over-medication and poor review processes. There is particular emphasis on the health consequences of long-term over-medication, especially considering the learning disability mortality review (LeDeR; National Health Service England, 2019) programme.

This led the National Institute for Clinical Excellence [NICE] to develop guidance (NICE, 2017) outlining the following criteria for the use of psychotropic medications in managing behaviours that challenge people with learning disabilities and/or autism:

- If psychological interventions or other input have failed.
- If treatment for co-existing conditions (mental or physical) has not reduced the behaviour.
- If the risk to self/others is high.
- Only in conjunction with alternative input—for example, psychology, speech and language therapy, occupational therapy.
- At the minimum effective dose.
- To be reviewed at 3–4 weeks and stopped at 6 weeks if there is no benefit.
- With a full multi–disciplinary team (MDT) review at 3 months, followed by every 6 months.

However, little evaluation has taken place on the subsequent impact on prescribing and alternative input (Branford et al., 2019). A recent study conducted by Naqvi et al. (2022) found psychotropic prescribing increased during the COVID-19 pandemic for individuals meeting STOMP criteria (Challenging Behaviour Foundation, 2023). Reviewing the NICE (2017) guidance, recent findings (e.g., Naqvi et al., 2022), and emerging STOMP projects (e.g., MC-STOMP; Mahmood et al., 2022) produced the following standards. These standards were approved by the Clinical Effectiveness Group (CEG) within the associated NHS trust (Table 1).

2 | METHOD

2.1 | Study design

This study is a cross-sectional audit of psychotropic prescribing and alternative multidisciplinary input across two London-based

TABLE 1 Audit standards, rationale and expected levels.

Standard	Guidance
(1) Minimum effective dose	*Guidance:* Medications to be prescribed at the minimum effective dose. *Evaluated as:* The proportion of service users in receipt of a single prescription, the proportion in receipt of polypharmacy, and the proportion in receipt of PRN (pro re nata) medication. *Expected level:* The majority of service users (>80%) to be in receipt of a single prescription.
(2) Medication reviews	*Guidance:* Medication review every 6 months. *Expected level:* For 100% of service users to have a medication review within the last 6 months.
(3) Alternative multidisciplinary team (MDT) input	*Guidance:* Medication to only be used in conjunction with alternative input. *Expected level:* 100% of service users to receive input from at least one MDT discipline alongside medication.
(4) Impact of the pandemic	*Previous findings:* Naqvi et al. (2022) found an increase in psychotropic prescribing during the lockdown in urban settings for individuals meeting STOMP criteria. This bears relevance to the densely populated London boroughs within which this audit is located. *Expected level:* *Dosages:* For there to be no significant differences between dosage change scores when comparing prepandemic (2019) and pandemic (2020). *Alternative MDT input:* For there to be no significant difference in the proportion of service users in receipt of alternative MDT input when comparing prepandemic and pandemic. *MDT Reviews:* For there to be no significant difference in the number of MDT reviews per person/year when comparing prepandemic and pandemic.
(5) Equality, diversity and antiracism	*Guidance:* Multicultural STOMP (Mahmood et al., 2022) is a project set up to explore the impact of prescribing for individuals with learning disabilities from an ethnic minority background that meets STOMP criteria. *Expected level:* For there to be no significant differences between the STOMP sample demographics and the overall caseload in each borough (age, gender, ethnicity).

community learning disability teams in the Royal Borough of Kensington and Chelsea and the City of Westminster. These services represent health MDTs co-situated with local authority social care services, comprising psychiatrists, nurses, occupational therapists, speech and language therapists and psychologists. Quantitative analyses were conducted on routinely collected data using nonparametric tests.

2.2 | Participants

Service users receiving the psychotropic medication without a relevant mental health diagnosis were identified by the lead psychiatrist and/or wider MDT. Those who had a mental health diagnosis and/or did not display behaviours that challenged were not included. This led to the identification of 27 service users in each borough. Demographic information for the audit samples compared to the overall caseloads is presented in Table 2. Where possible, gender and ethnicity are determined by service users, those in their network, or staff.

2.3 | Data collection

For each service user, the following information was collected:

- *Demographics:* age, gender, ethnicity
- *Medication:* medication prescribed, change in dosage pre- (2019) and during the height of the COVID-19 pandemic (2020), last review date, mean medication reviews per year/person
- *Alternative input:* date of last MDT review, MDT input offered pre- (2019) and during the COVID-19 pandemic (2020; e.g., occupational therapy).

2.4 | Procedure

Demographic and clinically relevant data were collected from existing data sets and clinical documentation. The anonymised data set was analysed in Statistical Package for Social Sciences (SPSS). Findings were summarised and discussed with MDT colleagues across both boroughs and were also shared with a local service user group for

TABLE 2 Demographic information for the audit samples compared to the overall caseloads across each borough (N represents the number of service users).

Demographic	Kensington and Chelsea				Westminster				Total			
	STOMP sample		Caseload		STOMP sample		Caseload		STOMP sample		Caseloads	
	N	%	N	%	N	%	N	%	N	%	N	%
Age												
16–24	6	22.2	39	15.7	6	22.2	28	8.5	12	22.2	67	18.4
25–34	9	33.3	63	25.4	9	33.3	22	20.0	18	33.3	85	23.3
35–44	5	18.5	32	12.9	4	14.8	16	13.0	9	16.7	48	13.2
45–54	3	11.1	35	14.1	3	11.1	16	13.0	6	11.1	51	14.0
55–64	2	7.4	39	15.7	2	7.4	22	18.8	4	7.4	61	16.7
65–74	1	3.7	26	10.5	2	7.4	10	23.9	3	5.6	36	1.0
75+	1	3.7	14	5.65	1	3.7	3	2.5	2	3.7	17	0.5
Gender												
Woman	7	25.9	87	35.1	7	25.9	43	36.8	14	25.9	130	35.6
Man	20	74.1	160	64.5	20	74.1	74	63.2	40	74.1	234	64.1
Other	0	0.0	1	1.5	0	0	0	0	0	0	1	0.3
Ethnicity												
Black British/Other	6	22.3	56	22.6	8	29.6	14	12.1	14	25.9	70	19.2
Asian British/Other	4	14.8	16	6.4	4	14.8	18	15.5	8	14.8	34	9.3
White British/Other	13	48.1	144	58.1	9	33.3	56	47.7	22	40.7	200	54.8
Arabian British/Other	2	7.4	22	8.9	5	18.5	12	10.3	7	13.0	34	9.3
Mixed background	2	7.4	10	4.0	1	3.7	9	7.8	3	5.6	19	5.2
Unknown	0	0	0	0	0	0	8	6.9	0	0	8	2.2

Abbreviation: STOMP, Stopping Over-Medication of People.

people with learning disabilities. Feedback was collected and key quotes have been included.

2.5 | Ethical approval

The project was registered with the CEG based within the NHS trust. They advised that ethical approval was not required as this project falls within the clinical audit and service evaluation. However, the CEG felt that analysing service user feedback would tip the project into the research field. Key quotes have been included, nonetheless.

2.6 | Data analysis

To increase statistical power during analysis, the data sets for the two boroughs were combined. To compare differences in the demographics of the STOMP and caseload samples, chi-square tests of independence were used. To compare the mean number of MDT reviews per person/year, and the proportion in receipt of alternative

MDT input pre- and during the pandemic, a Wilcoxon signed ranks test was used due to not meeting parametric assumptions. Significance was accepted at $p < 0.05$.

Reflecting the Naqvi et al. (2022) paper, percentage dosage changes were calculated prepandemic (2019) and during the pandemic (2020). This involves calculating the dosage given as a fraction of the max dosage according to the British National Formulary (British National Formulatory, 2022) oral guidance. A Friedman's test was used to compare differences due to not meeting parametric assumptions ($p < 0.05$).

3 | RESULTS

3.1 | Standard 1: Minimum effective dose

3.1.1 | Single prescription, polypharmacy and PRN

For Kensington and Chelsea, 33.3% of service users received a single prescription and 66.6% received multiple medications.
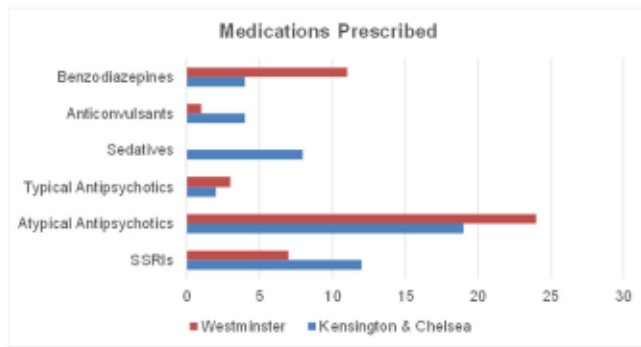
FIGURE 1 Medications prescribed in each borough.

FIGURE 2 Alternative multidisciplinary team input across each borough.

Of these, 33.3% received PRN medication either singularly or alongside another medication. In Westminster, 74.1% received a single prescription, 25.9% received multiple prescriptions, and 51.9% received PRN either singularly or as part of a multi-prescription. It was expected that >80% would be on a single prescription in line with guidance on the minimum effective dose. Standard 1 of this audit has therefore not been met in either borough.

3.1.2 | Medications prescribed

In Kensington and Chelsea, the most prescribed medications were atypical antipsychotics (41.3%), followed by selective serotonin reuptake inhibitors (26.1%). In Westminster, atypical antipsychotics were also the most prescribed (63.9%), followed by benzodiazepines (30.6%)— see Figure 1.

3.2 | Standard 2: Medication reviews

It was expected that 100% of service users would have a medication review within the last 6 months in line with NICE (2017) guidance. In Kensington and Chelsea, only 26% had a medication review within 6 months, compared with 84.6% in Westminster. Neither borough has therefore met the criterion for Standard 2.

3.3 | Standard 3: Alternative MDT input

In Kensington and Chelsea, 81.4% of service users received alternative input in conjunction with prescribed medication, compared to 66.8% in Westminster. The most frequent input in both boroughs was psychology (85.1% and 70.3%, respectively)— see Figure 2. It was expected that 100% of service users would be in receipt of alternative input. It can therefore be concluded that Standard 2 has not been met in either borough.
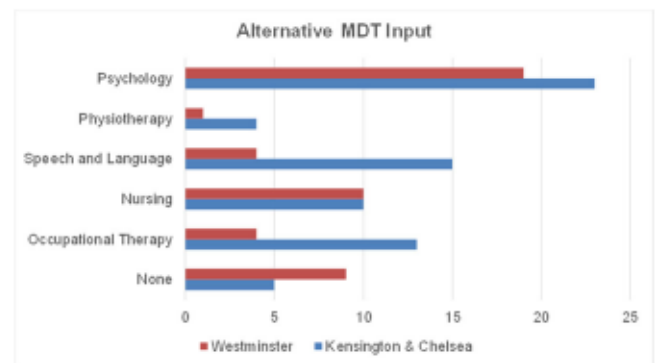
3.4 | Standard 4: Impact of the COVID-19 pandemic

3.4.1 | Dosages

A Friedman test found a significant difference between the percentage dosage changes prepandemic (2019) compared to during the pandemic (2020) when comparing the combined STOMP samples, X^2 (1, 54) = 8.76, $p < 0.05$. This was consistent for Kensington and Chelsea ($X^2 = 6.25$, $p < 0.05$), but not in Westminster ($X^2 = 6.25$, $p = 0.059$). However, there is a considerable likelihood that this represents a false negative (Type II error) given the significance value (p) is very close to 0.05. It was expected that there would be no significant differences found. This aspect of *Standard* 4 has therefore *not* been met.

3.4.2 | Alternative MDT input

There was little impact of the pandemic on the proportion of service users in receipt of alternative input. Prepandemic (2019), those in receipt of alternative MDT input stood at 61.1%. During the pandemic (2020), this stood at 64.8%. A Wilcoxon signed ranked test found no significant difference between the number of service users receiving alternative input prepandemic (2019) compared to during the pandemic (2020), $Z = -0.177$, $p > 0.05$. This was consistent for Kensington and Chelsea ($Z = -1.0$, $p > 0.05$) and for Westminster ($Z = -5.63$, $p > 0.05$) when analysed separately. The expected outcome of this aspect of Standard 4, of no significant change in alternative MDT input, has therefore been met.

3.4.3 | MDT reviews

There was an increase in the mean number of MDT reviews per person per year during the pandemic (2020) compared to prepandemic (2019), standing at an average of 4.2/year and 2.3/year, respectively. A Wilcoxon signed ranked test found no significant
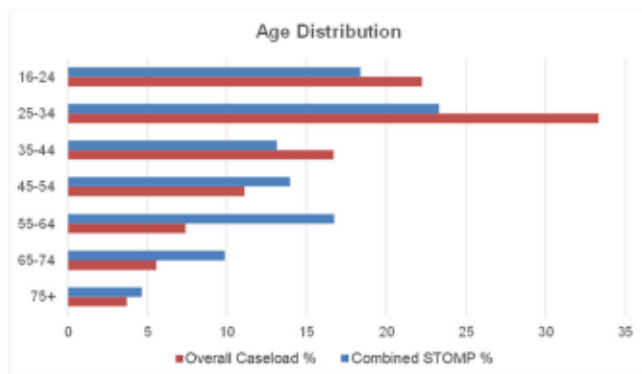
FIGURE 3 Age distribution across the combined Stopping Over-Medication of People (STOMP) samples and overall caseload.
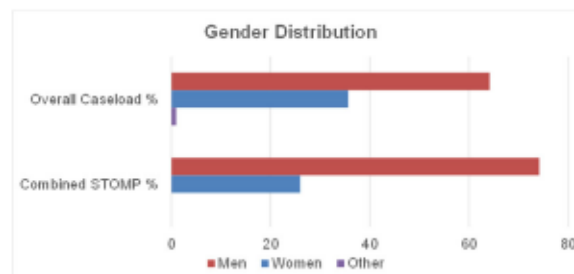

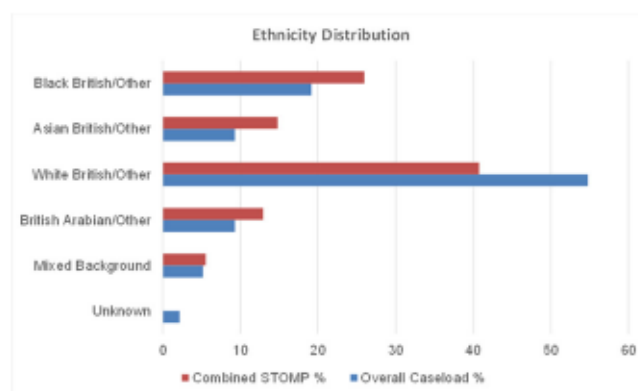FIGURE 4 Gender distribution across the combined Stopping Over-Medication of People (STOMP) samples and overall caseload.

FIGURE 5 Ethnicity distribution across the combined Stopping Over-Medication of People (STOMP) samples and overall caseload.

differences in the number of MDT reviews per year when comparing the combined STOMP samples and overall caseload ($Z = -1.8$, $p > 0.05$). As further confirmation of this, the outcome was consistent for both Kensington and Chelsea (1.2/year in 2019, 1.6/year in 2020; $Z = -1.29$, $p > 0.05$) and for Westminster (3.4/year in 2019 and 6.81/year in 2020; $Z = -0.563$, $p > 0.05$). The expected outcome of this aspect of Standard 4, of no significant change in MDT reviews, has therefore been met.

3.5 | Standard 5: Equality, diversity and antiracism

3.5.1 | Age

The distribution of age (Figure 3) in the combined STOMP sample is skewed towards the younger categories, whereas there is a greater representation of older service users in the overall caseload. Applying a chi-square test of independence did not yield a significant difference when comparing the combined STOMP sample and overall caseload ($X^2 = 6.07$, $p > 0.05$). This outcome was maintained when separating into Kensington and Chelsea ($X^2 = 4.85$, $p > 0.05$) and Westminster ($X^2 = 4.14$, $p > 0.05$), respectively. There are therefore no significant differences in age when comparing the sample and overall caseload; this aspect of Standard 5 has therefore been met.

3.5.2 | Gender

A chi-square test of independence revealed that there were no significant differences in gender distribution between the combined STOMP sample and overall caseload, $X^2(1, 419) = 2.06$, $p > 0.05$. Men were overrepresented in every group (see Figure 4), as is common within learning disabilities disability services, although this seemed to be slightly more pronounced in the STOMP samples. This pattern was consistent for both Kensington and Chelsea ($X^2 = 0.96$, $p > 0.05$) and Westminster ($X^2 = 1.13$, $p > 0.05$), respectively. The expected outcome of no significant

differences in gender between the overall caseload and the STOMP sample has therefore been met for Standard 5.

3.5.3 | Ethnicity

Service users from racialised backgrounds were significantly over-represented in the combined STOMP sample (59.3%) compared with the overall caseload (45.2%)—see Figure 5. A chi-square test of independence demonstrated that the proportion of service users in each ethnic group did not differ significantly between the STOMP sample and the overall caseload. However, when comparing racialised service users collectively with those categorised as White, racialised service users were significantly overrepresented in the STOMP sample relative to the overall caseload, $X^2 (1, 419) = 3.73$, $p < 0.05$.

These results were consistent when comparing specific boroughs, with neither Kensington and Chelsea ($X^2 = 5.83$, $p > 0.05$) nor Westminster ($X^2 = 9.13$, $p > 0.05$) producing significant results when comparing specific ethnic group differences. Interestingly, when combining service users from racialised backgrounds, this produced a significant outcome in Kensington and Chelsea ($X^2 = 3.35$, $p < 0.05$), but not in Westminster ($X^2 = 1.87$,

$p = 0.17$). However, there is a risk of a false negative here (Type II error), given the significance value (p) is close to 0.05. This may be due to lower representation among some racialised groups (e.g., Arabian British/Other; Mixed Background).

These results suggest that there is a greater risk of medication for the purposes of managing behaviours that challenge the racialised people with a learning disability relative to their White counterparts. This effect does not appear to relate to a specific racialised group (e.g., Black British), but rather is generalised and across racialised groups to an extent that produces a significant overall difference. These differences, and the findings within each borough, will be considered in the discussion.

3.6 | Service user feedback

Having analysed the data, we shared our findings with a local service user project for feedback. The findings were shared via easy-read materials and telephone consultations were conducted with service users living in one of the two boroughs with the support of the lead for the local project. We were unable to analyse service users' responses due to conditions attached to ethical approval; however, key quotes have been included below. These have been unsystematically grouped into themes by the authors loosely in line with the standards of the audit (see Table 3).

4 | DISCUSSION

This audit aimed to evaluate two community learning disability teams in London for their compliance with national guidance for the use of psychotropic medication to manage behaviours that challenge people with learning disabilities. The impact of the COVID-19 pandemic on prescribing and prescribing across demographics was also evaluated. Five standards were developed to guide this. According to the findings of this audit, the service fell short of many of these standards. This will be explored in the following.

4.1 | Standard 1: Minimum effective dose

In Kensington and Chelsea, 33.3% of service users were in receipt of a single dose, compared to 74.1% in Westminster. It was expected that >80% would meet this criterion and so both boroughs fell short; however, the Westminster service was much closer. It could be hypothesised that there is a greater level of complexity in the Kensington and Chelsea caseload, leading to greater levels of polypharmacy. This may be supported by findings relating to increased dosage during the COVID-19 pandemic. However, it could also be argued that there is insufficient exploration of alternatives to medication, leading to overprescribing.

Importantly, however, it is worth acknowledging that the 'minimum effective dose' for a given client is difficult to quantify,

particularly as prescribing within this population is 'off-licence'—that is, medications being prescribed for purposes beyond their licensed and intended use. Single versus multiprescription was employed as a crude measure to capture this, and so may be limited in its usefulness. The level for this—and other standards—was what was considered by the MDT to represent compliance with national guidance. Future evaluations, and the services in question, would benefit from involving stakeholders in the process of establishing standards to ensure these are pertinent to those impacted by STOMP.

4.2 | Standard 2: Medication reviews

The expectation for medication reviews was for a review to occur every 6 months in line with NICE (2017) guidance. In Kensington and Chelsea, 26.0% had a review within 6 months, compared to 84.6% in Westminster. Neither borough, therefore, met the criterion for Standard 2; however, there was a substantial disparity between the two boroughs. This could suggest a difference in resources between the two boroughs, although this is speculative. Regardless, this emphasises the need for a dedicated review pathway for individuals that meet STOMP criteria, ensuring all receive a medication review within 6 months. Findings for Standard 3 will inform the need to incorporate full MDT reviews within this.

4.3 | Standard 3: Alternative MDT input

The expected level for Standard 3 was for all service users to be in receipt of alternative MDT input in conjunction with medication. This stood at 81.4% in Kensington and Chelsea and 66.8% in Westminster, meaning both boroughs fell short once again. Interestingly, however, this would suggest that service users in Kensington and Chelsea were supported more holistically. This may suggest that previous failings in this borough may indeed represent greater complexity, leading to a galvanisation of MDT resources. Although, again, this remains speculative. These findings reinforce a clear need to incorporate full MDT reviews into a dedicated pathway for service users meeting STOMP criteria, occurring at least semiannually in line with the NICE (2017) guidance. This would enable a thorough review of input received, the identification of further avenues for support, and sharing of responsibility for complex cases as a team.

4.4 | Standard 4: Impact of the COVID-19 pandemic

It was expected that there would be no significant differences in either borough across dosage changes, alternative input and MDT reviews when comparing pre–pandemic (2019) and during the pandemic (2020). This criterion was met for alternative input and MDT reviews both when combining the STOMP samples and overall caseload, and when analysing within the specific boroughs,

Theme	Quote
Medication	'I feel stressed taking too much medication. It's good to take one but not too many'.
	'It's like having an overdose – might make you feel drowsy or have side effects'.
	'It's a bad thing that people are on more medication than they need to be'.
	'Lots of people taking lots of medication, for some people it helps and heals the pain but not if it is too much it is not suitable for the body'.
COVID-19	'Everyone's been hibernating, put on medication, getting bored and sicker'.
	'It was hard during Covid because there was no support here'.
Alternative Input	'It is short-staffed [where I live] and not enough support; I would like more activities'.
	'In the lock down everything closed down. It's all about getting people together and socialising together over a cup of tea'.
	'It's a good thing to have support workers come and visit'.
	'I found my psychology support helpful; I made a book'.
	'Back home [abroad] I have no key worker, but in England it's good. I get to go far in the car'.
Racism	'My Asian friend is a zombie now'.
	'A lot of Black people are on meds because they're seen as aggressive'.
	'People aren't given a voice or an opinion'.
	'It's a shame. People should be given the same [treatment]'.

TABLE 3 Service user feedback on the findings of this audit, unsystematically grouped into themes.

suggesting a successful rousing of resources during this period—if still below NICE recommended levels in terms of review frequency.

In terms of dosage changes, however, percent dosage change scores were significantly different when comparing pre- (2019) and during the pandemic (2020) across combined samples and individual boroughs. It could be hypothesised that this reflects difficulties managing behaviours that challenge as resources became less available during lockdowns, leading to a greater reliance on medication for managing behaviours that challenge. It is important for further research to explore the pattern of prescribing psychotropic medications for this population as the COVID-19 pandemic decreases in intensity. A further consideration is also required for what forms of alternative input are most beneficial for contributing to a reduction in prescribing for this population.

These findings also raise important ethical considerations in terms of dissemination. The COVID-19 pandemic has been and continues to be an unprecedented period for staff, with a well-documented impact on well-being (Wong et al., 2021). Audits can cause staff to feel that their work is being evaluated, adding to this pressure (Burgess & Moorhead, 2020). Efforts were made to mitigate this by discussing how best to share these findings with the wider MDT before proceeding. Future research should hold these considerations in mind. The services audited here may also benefit from professional development spaces for considering the key issues relating to STOMP, including the impact of prescribing and alternative approaches already available within the MDT. Similarly,

feeding back these findings to service users, especially those who have not had a medication review recently and/or hold racialised identities had the potential to cause distress. Future research contributors may benefit from warnings around content and space for support following consultation—or indeed for more authentic and thorough involvement throughout.

It is important to note that these findings reflect previous research conducted by Courtenay and Perera (2020), underscoring the impact of the pandemic on people with learning disabilities. They emphasise the impact of reduced activity, increased distress, escalating behaviours that challenge, and placement breakdown as factors that contribute to the increased likelihood of medication being prescribed for behavioural management. These findings constitute important lessons for future pandemics but also for the importance of a contextual approach to behaviours that challenge.

4.5 | Standard 5: Equality, diversity and anti-racism

Across the STOMP samples and overall caseload, there was an overrepresentation of men, those from younger age groups, and those from racialised backgrounds. However, only the disparities in terms of ethnicity were found to be statistically significant when comparing the combined and separated STOMP samples with the overall, and respective, caseloads. It is important to note that the

result was not statistically significant for the Westminster service; however, given the significance (p) value produced was close to 0.05, it is considered likely that this represents a false negative (Type II error) as a reflection of lower representation among some racialised groups—especially Arabian British/Other and Mixed Backgrounds. Given the stability of the STOMP samples and overall caseloads over time, more robust conclusions can be drawn.

It is difficult to infer whether the disparities found in prescribing for those from racialised backgrounds are affected institutionally or individually, and it could be hypothesised to be some combination of both. Steps taken to address ethnic disparities should therefore reflect this. It could be argued that behaviours are more likely to be understood as challenging in racialised service users (Pestana, 2011), leading to a greater likelihood of medication being prescribed. It could also be argued that there is a need to consider systemic factors such as a lack of racialised representation within the MDTs, and senior leadership roles, and how this may contribute to the found disparities in prescribing and warrants exploration. Nonetheless, evidence of substandard care for service users from racialised groups underlines an urgent need to determine the factors contributing to this disparity and to develop systems, processes and policies to directly address this.

It is also important to note that the ethnic disparities found reflect the previous findings by Naqvi et al. (2022). This suggests that this is an issue that extends beyond the services audited within this paper and requires investigation across community learning disability services for the benefit of racialised service users.

4.6 | Implications

Despite difficulties in drawing causal conclusions and making comparisons over time, the findings of this audit point to a need for developing review processes and data collection around the five standards of this audit. This would ensure compliance with national guidance and key service priorities and could be achieved by establishing a dedicated STOMP pathway with semiannual, full MDT reviews of *all* input for this client group.

Focus needs to be paid at both an individual and institutional level to the factors contributing to ethnic disparities within the STOMP sample compared to the overall caseload. Priorities should include staff training, outreach work with racialised service users and their networks, and reviewing recruitment processes that may encourage/discourage recruitment of racialised team members—especially in senior leadership roles.

The findings from this audit reflect a specific point in time for a relatively small sample of service users ($N = 54$). Generalising findings to other services should therefore be made with caution. A point of note is the greater proportion of service users meeting STOMP criteria despite a smaller overall caseload within Westminster (23.2%) relative to Kensington and Chelsea (10.9%). The factors contributing to this warrant exploration. Further, direct comparisons were not

made between service users with/without a diagnosis of autism. Given the significance of STOMP to this population, this also requires additional exploration.

4.7 | Recommendations and future directions

The following recommendations have been identified based on the findings of this audit, with a mind to the limitations outlined:

- Hold a review of the five standards with service users, family members and other key stakeholders
- Coproduce a dedicated review pathway for service users meeting STOMP criteria including 6-monthly reviews
- Review data collection to enable comparisons over time
- Establish a post-pandemic baseline with which to compare data, including direct comparisons of those with/without an autism diagnosis
- Establish an anti-racist working group to consider the utility of staff training, review processes, hold important MDT discussions, conduct outreach work with service users from racialised backgrounds, and further investigate causes of ethnic disparities (e.g., team diversity, social context).

DATA AVAILABILITY STATEMENT

Data that support the findings of this study are subject to permission from Central London Community NHS Trust. Data relevant to this paper is available upon request at the discretion of the relevant local authorities and NHS trust.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

ETHICS STATEMENT

This study was registered as a service evaluation project with the relevant NHS trust. This enabled limited quantitative analysis for the purpose of service development.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.