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EVALUATION BRIEF

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Medication Use Among Children and Youth Entering the Albany County System of Care

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Introduction

The use of medication to treat children's mental health disorders has increased over the past several decades. There is debate in the field whether this reflects a true increase in the frequency with which medications are prescribed for children, or is a result of an increase in the number of children diagnosed with mental health disorders requiring medication. Concerns also abound regarding over-medicating children and prescribing medications without sufficient research trials on children. This evaluation brief presents our preliminary analysis of medication use by children enrolled in the Albany County, NY system of care, and determines relationships between medication use and age, gender, race/ethnicity, and diagnosis. Whether medications are used as part of an overall coordinated service plan is also explored.

Data Sources

Data for this analysis are derived from intake forms and baseline and follow-up caregiver interviews. The Enrollment and Demographic Information Form (EDIF) is completed during intake and provides demographic information as well as presenting problems and diagnoses. The Caregiver Information Questionnaire (CIQ) is administered to adult caregivers during baseline and all follow-up interviews. Caregivers are asked whether their child has taken medications for his/her emotional and behavioral problems during the preceding 6 months, and if so, to specify the name of the medication(s). The Multi-Sector Services Contacts (MSSC) is administered starting at the 6-month follow-up interview and collects detailed information on services received. The dataset used in this analysis contains 161 baseline and 87 6-month follow-up cases.

Findings

Nearly two-thirds (N=100, 62%) of youth enrolled in the longitudinal evaluation are taking medications for emotional or behavioral issues at baseline. This is higher than SAMHSA's national evaluation findings of 47%. Nearly equal proportions of boys and girls take medications, 66% and 61%, respectively. Similarly, there are no significant differences in racial categories: 67% of African American or biracial youth and 63% of White youth enrolled at baseline are taking medications (13 cases do not have race indicated). Elementary age children (5-12) receive medication as frequently as youth age 13-21 (69% and 67%, respectively). No child under age 5 is taking medication. In terms of caregiver characteristics, we have found that children of caregivers with some post-high school education are more likely to be taking medication, but household income did not significantly impact medication use. Among children with private insurance, 73% are taking medications compared to 68% for children with Medicaid or Child Health Plus.

Table 1. Medication Use by Diagnostic Category

	Total # of Children within Diagnostic Category	Number of Children with Dx Taking Medication	% of Children within Dx Category Who Take Medication
Mood Disorders Depression, bipolar	77	65	84%
Attention Deficit/Hyperactivity Disorders (ADHD)	51	40	78%
Adjustment Disorders Psychological response to stressor(s)	21	6	29%
Post-Traumatic Stress Disorder (PTSD) Symptoms related to exposure to extreme trauma	20	14	70%
Oppositional Defiant Disorder (ODD) Negative behavior towards authority	18	12	67%

****NOT A FINAL ANALYSIS – DATA COLLECTION IS CONTINUING****

The diagnoses listed in Table 1 are the five most common diagnostic categories among children in the sample, with Mood Disorders (depression and bipolar) being the most common diagnostic category among children who take medications. Of course, children can have more than one diagnosis, or "co-occurring disorders", for example Mood Disorder and ADHD. Having more than one mental health diagnosis is related to medication use, but this could also be a function of which diagnoses tend to stand alone. For example, children with Adjustment Disorder are least likely to have a co-occurring disorder and least likely to use medications, whereas children with Mood Disorders are more likely to have a co-occurring disorder and to be taking medications.

Drug Categories

There are six primary drug categories for the range of medications prescribed for children: antipsychotics, antidepressants, anxiolytics (anti-anxiety), mood stabilizers, noradrenergics (to offset side effects), and stimulants (primarily for ADD/ADHD).

Table 2. Frequency of Medication Use by Drug Category

Category	*Number of Children Taking*
Antipsychotics • Abilify, Haldol, Orap, Risperdal, Seroquel, Zyprexa	67
Mood Stabilizers • Carbamazepine (Tegretol), Depakote, Limictal, Lithium, Neurontin, Trileptol, Topiramate (Topamax)	40
Stimulants/Strattera* • Adderall, Concerta, Dexadrine, Ritalin	30
Antidepressants • Celexa, Desyrel, Effexor, Lexapro, Paxil, Prozac, Strattera, Symbyax, Wellbutrin, Zoloft	29
Noradrenergics • Catapres, Cogentin, Minipress, Tenex	24
Anxiolytics • Benzodiazapam, Clonopin, Xanax	4

* This category of medications is typically used for ADD/ADHD.

The majority of youth take medications from two or more categories, with the most common two category combination being antipsychotics and mood stabilizers. Almost no child is taking more than one medication within a category. In terms of specific medications, the most frequently prescribed medications are: Risperdol (27%), Abilify (20%), Seroquel (20%), Catapres/Clonidine (18%) and Concerta (17%).

Service Use

Children taking medications are significantly more likely to receive one or more of the following services: medication monitoring (N=54), case management (N=53), family therapy (N=28), and crisis stabilization (N=16). We are looking at differences in service constellations between children who take medications and those who do not.

Next Steps

We presented these and other data related to medications at a recent research conference in Tampa. The Evaluation Advisory Group was instrumental in helping us decipher the medication data in preparation for this presentation. We are now exploring some other relationships with medications, such as:

- The effect of caregiver empowerment on medication and service use – for example, are children of empowered caregivers more likely to use medications? More likely to engage in family therapy or other services?
- The effect of type of health insurance on medication use and service access.
- The effect of medications on housing stability and clinical outcomes.
- Side effects and their influence on medication compliance and quality of life.

If you are interested in joining the Evaluation Advisory Group to help us explore these and other questions, please contact LuAnn McCormick. Anyone is welcome to join – family members are particularly encouraged to come to help us put a real-life lens on the data we are collecting.

For more information on the Evaluation Program, please contact
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