



## Youth at entry to residential treatment: Understanding psychotropic medication use

Annette K. Griffith <sup>a,\*</sup>, Gail Smith <sup>b</sup>, Jonathan C. Huefner <sup>b</sup>, Michael H. Epstein <sup>c</sup>, Ronald Thompson <sup>b</sup>, Nirbhay N. Singh <sup>d</sup>, Laurel K. Leslie <sup>e</sup>

<sup>a</sup> Momentum Behavioral Health, United States

<sup>b</sup> Boys Town, United States

<sup>c</sup> University of Nebraska-Lincoln, United States

<sup>d</sup> ONE Research, United States

<sup>e</sup> Tufts Medical Center, Floating Hospital for Children, United States

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### ABSTRACT

Youth entering residential treatment often present with complex mental health and behavioral needs. As a result, it is not surprising that many of these youth have active prescriptions for psychotropic medications. What is surprising, however, is that very little is known about how psychotropic medications are used for youth who enter residential treatment. Therefore, the purpose of this study was to gain a better understanding of psychotropic medication use for youth at their time of entry to residential treatment through the examination of archival data. Data suggested that the youth in this sample had high levels of emotional and behavioral difficulties and that many had active psychotropic prescriptions. Patterns of use differed slightly from those identified with previous samples, but several clinical and non-clinical factors were identified that were predictive of psychotropic medication use. Findings and implications are discussed in detail.

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### 1. Introduction

Over the past decade, research in the field of pediatric psychopharmacology has increased at a significant rate (Vitiello, 2008). The increase of research in both the pharmaceutical industry and academia has been encouraged by the enactment of federal legislation focused on establishing safety and efficacy data in child samples and a burgeoning interest by federal agencies such as the National Institute of Health (Connor & Meltzer, 2006; Vitiello, 2008). The result has been several promising studies examining the use of psychotropic medications for youth with a variety of emotional and behavioral disorders. For example, research on the use of medications for youth with ADHD has shown that psychostimulants can be effective in reducing behavioral symptoms such as impulsivity and hyperactivity (e.g., Schachter, Pham, King, Langford, & Moher, 2001). For youth with depression, selective serotonin reuptake inhibitors have been shown to be more effective than usual care when used either alone or in combination with psychosocial treatments (March, Silva, Vitiello, & The TADS Team, 2006). In addition, second generation antipsychotics have been shown to reduce levels of aggression for youth with both developmental delays and autism spectrum disorders (Stigler & McDougle, 2008; Van Bellinghen & De Troch, 2001). However, despite emerging evidence for the effectiveness of some

psychotropic medications, widespread and frequent use of psychotropic medications for pediatric populations remains a controversial issue (Correll et al., 2006; Vitiello, 2007).

While research examining the effects of psychotropic medications for youth has been continually increasing over the past decade (Connor & Meltzer, 2006; Vitiello, 2008), there remain questions about the appropriateness of current psychotropic prescribing practices for youth. Many researchers and clinicians have argued that the empirical evidence currently available is not adequate to fully understand and support the current level of psychotropic prescribing among pediatric populations (e.g., Correll et al., 2006; Greenhill et al., 2003; Vitiello, 2007). Rates at which psychotropic medications have been prescribed for youth have far outpaced research supporting their use (Dean, McDermott, & Marshall, 2006). The majority of research on psychotropic medications has occurred with adults and there are many reasons to suspect that the findings from adult studies may not generalize to youth (Vitiello, 2007). Specifically, concerns have been raised due to differences in physiology, an increased risk for adverse health effects, and the potentially disruptive impact of these agents on developing body systems (Correll et al., 2006).

#### 1.1. Youth in residential treatment

While the use of psychotropic medications is a controversial issue for all youth, it is particularly concerning for youth involved in residential treatment. Residential treatment centers across the United

\* Corresponding author.

E-mail address: [agriffith@behavioralmomentum.com](mailto:agriffith@behavioralmomentum.com) (A.K. Griffith).

States currently provide mental health interventions to approximately 200,000 youth (Child Welfare League of America, 2009), who present with significant and complex emotional and behavioral disorders (Duppong Hurley et al., 2009). Of these youth, as many as 90% typically enter treatment with severe impairments in emotional and behavioral functioning (Duppong Hurley et al., 2009; Pottick, Warner, & Yoder, 2005). In addition, at the time of admission a large proportion of these youth have two or more psychiatric diagnoses, problems with substance abuse, academic difficulties, and histories of abuse, neglect, and suicidal behaviors (Duppong Hurley et al., 2009; Handwerk et al., 2006; Pottick et al., 2005). Due to the significant treatment needs of these youth, it is not surprising that many have active prescriptions for one or more psychotropic medications at the time of admission (Connor & McLaughlin, 2005; Handwerk, Smith, Thompson, Spellman, & Daly, 2008). Due to the vulnerable nature of youth in residential treatment (e.g., many are wards of the state, many have experienced multiple out-of-home placements, many lack an involved adult advocate), it is especially important to understand the issues related to the use of psychotropic medications in this population.

Only a handful of studies have been conducted examining the use of psychotropic medications by youth in residential treatment (e.g., Breland-Noble et al., 2004; Connor & McLaughlin, 2005; Handwerk et al., 2008), and, hence, the knowledge base regarding psychotropic medication use for this group is based on only a few samples. Despite this, it has been reported that up to 80% of youth who enter residential treatment have active prescriptions for psychotropic medications (Connor & McLaughlin, 2005; Handwerk et al., 2008), and that as many as 55% of youth taking medications have three or more concurrent prescriptions (Connor & McLaughlin, 2005; Griffith et al., 2010). Despite these advances in knowledge, many questions remain. For instance, it is unknown why, in spite of high psychotropic medication rates in this population prior to admission to a residential treatment program, these youth still demonstrate high levels of problem behavior and significant impairments in emotional and behavioral functioning (Duppong Hurley et al., 2009; Griffith et al., 2010). Additionally, it is not known why some youth enter residential care with active prescriptions while other, similarly functioning youth do not. The role of specific demographic or clinical characteristics in determining psychotropic medications use prior to admission to residential treatment has also not been adequately explained.

### 1.2. Factors associated with the use of psychotropic medications

Previous research with non-residential youth has indicated that while there are several clinically indicated factors that are associated with the use of psychotropic medications (e.g., presence of one or more diagnosed mental health disorders, high levels of aggression, disabling social adjustment, history of abuse, history of suicide; Dean et al., 2006; Safer, Zito, & dosReis, 2003), there are several non-clinical factors that are also highly correlated with psychotropic medication use (e.g., gender, race/ethnicity, ward status, insurance type; dosReis et al., 2005; Martin, Van Hoof, Stubbe, Sherwin, & Scahill, 2003; Zito, Safer, Zuckerman, Gardner, & Soeken, 2005). Research involving youth in the child welfare system has suggested that, even when clinical factors such as behavioral and mental health status are controlled for, youth in child welfare tend to have higher rates of psychotropic prescriptions than youth not involved in child welfare (Raghavan et al., 2005).

While it is not known whether psychotropic medications are prescribed excessively or inappropriately for youth in residential care, the American Academy of Child and Adolescent Psychiatry (2005) has raised concerns that for youth in out-of-home care this is potentially the case and has suggested that an improved understanding of the factors associated with psychotropic prescribing is necessary. These concerns emphasize the importance of research that will

increase our knowledge of the youth who are prescribed psychotropic medications and how these youth differ from those who do not receive medications. This information will be helpful in understanding how appropriate current prescribing practices may be and will help to identify groups who may be over- or under-medicated.

Thus, the primary purpose of this study was to gain a better understanding of reported psychotropic medication use for youth at the time of entry into residential treatment. Archived data from youth admission files were examined to: (a) describe the levels and patterns of psychotropic medication use on entry, and (b) determine if specific youth characteristics could be identified that were predictive of psychotropic medication use.

## 2. Method

### 2.1. Participants

Archival data were obtained for 1010 youth consecutively admitted to a large, Midwestern residential group care program. The program serves youth aged 8 through 18 who present with significant impairments in emotional and behavioral functioning. Youth with psychotic disorders and/or mental retardation are excluded from admission to the program.

### 2.2. Procedure

An administrative database was queried to obtain information on youth demographics, placement history and mental health/behavioral functioning. Youth data obtained from the administrative database were initially collected by admissions counselors at the time of youths' entry to the program. Data were collected for treatment purposes using a standard admissions protocol that is administered to all new youth and their families (or guardians) during the initial intake interview. The admissions protocol collects information regarding placement history, physical and mental health status, educational status, family history, and basic demographic information. At the time the admissions protocols were completed, caregivers also completed a rating scale of youth behavior (i.e., Child Behavior Checklist [CBCL], Achenbach & Rescorla, 2001) and youth completed screenings of mental health functioning (i.e., Diagnostic Interview Schedule for Children-IV [DISC-IV], Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000; Suicide Probability Scale [SPS], Cull & Gill, 1988). All data were stored in youth files and were entered into the administrative database.

### 2.3. Measures

Youth data were collected using both formal and informal procedures. For organizational purposes the data collected have been divided into two domains: 1) demographic characteristics and placement history and 2) mental health and behavioral functioning.

#### 2.3.1. Demographic characteristics and placement history

Nine demographic and placement variables were extracted from the administrative database. The variables included: (a) gender, (b) age at admission, (c) race/ethnicity, (d) legal status, (e) referral source, (f) ward of the state, (g) age at first placement, (h) number of prior placements, and (i) placement setting prior to program entry (as measured by the Restrictiveness of Living Environment Scale [ROLES]; Hawkins, Almeida, Fabry, & Reitz, 1992). The ROLES is a widely used measure that has shown promise to be psychometrically sound, with adequate levels of reliability when used with youth in out-of-home settings. The ROLES was used to determine placement setting prior to admission. The ROLES identifies 25 categories, which range from high (e.g., jail, state mental hospital) to low (e.g., home of natural parents, independent living) levels of restrictiveness.

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