Children's Hospital of Philadelphia PolicyLab

The Numbers of Youth on Antipsychotics: What Does it All Mean?

Health Equity

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By 2008, 1 in 5 youth who were receiving stimulants (presumably for ADHD), and 1 in 3 youth who were receiving antidepressants (presumably for depression or anxiety), also received antipsychotics as part of their treatment regimens. Such was the report out this week in our most recent manuscript on the use of antipsychotics by the more than 1/3 of youth in this country who receive health insurance through the Medicaid program. Ponder those numbers for a moment. And now let's try to unpack what they mean.

To some degree, a first reflection might be, "Hey, I'm not surprised; we knew that antipsychotics were being used a lot in recent years." However, did you know that 85% of the time antipsychotics are used, the use is in combination with other more traditionally prescribed psychotropic medications, and that this combination treatment approach is no longer on the margins? Rather, we are seeing an emerging clinical practice that is increasingly reaching less impaired youth who were never hospitalized for behavioral or psychiatric concerns, who did not spend time in foster care, or had simpler diagnostic classifications (like ADHD alone) in their medical claims. When these medications are started, they are also not short-term; instead, they are being used for long durations, much like the stimulants and antidepressants with which they are so often paired.

A more important reflection to be made is this: what do the findings say about the challenges of treating the complex problems many of our youth face? In some ways, the reliance on antipsychotics as an emerging norm of clinical practice indicates a lack of comfort either with the underlying diagnosis a youth receives or with the perceived effectiveness of the primary medications, such as stimulants or antidepressants, which have been historical mainstays of the treatment approach. Stated another way, this trend reveals the great challenge of

clinicians in responding to disruptive and challenging behaviors in youth that don't neatly fit common diagnostic categories or respond to traditional treatment approaches. There is a growing body of research to suggest that many of these behaviors in a population of low-income youth may stem from traumatic experiences during childhood, which are internalized and later return as the disruptive behaviors that are so challenging in clinical practice. In public systems that rarely offer other, non-pharmacologic services to respond to these behaviors, we should not be surprised by how quickly the use of antipsychotics has grown.

So why should we care? Aside from the question of appropriate treatment to respond to the unique needs of youth that don't neatly fit diagnostic categories, or of the lack of non-pharmacologic alternatives with which we might be better poised to respond to trauma, is the reality that there is very little efficacy or safety data for antipsychotics in most youth, and much less so when the antipsychotic is used in combination with other medications. The potential for drug-drug interactions in youth should raise concern. At the very least, we will need to make sure we are closely monitoring youth who are on these treatment regimens for potential side effects, like weight gain and development of diabetes. And we should be wondering what trade-offs we are making through the use of these powerful sedatives and the potential long-term consequences if we fail to confront the underlying issues our youth are facing.

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