



Children in Child Welfare are More Likely to be Prescribed Psychotropic Medication than Other Children on Medicaid: Findings from Florida and Kentucky

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KEY POINTS

- Children on Medicaid and involved with the child welfare system were more likely to be prescribed psychotropic medications in comparison to children just on Medicaid. Using data from Kentucky and Florida, this includes both psychotropics overall and specifically for antidepressant, antipsychotic, and stimulant prescriptions.
- Children ages 12 to 17 across the sample had a higher percentage of psychotropic medication prescriptions relative to younger children, with boys receiving more prescriptions than girls.
- Among children in foster care, those placed in congregate care facilities or group homes were more likely to be prescribed a psychotropic medication than children in family foster homes. Children in non-relative family foster homes were more likely to be prescribed a psychotropic medication than children in relative family foster homes.

BACKGROUND

The use of psychotropic medications in children is a complex issue for parents, caregivers, health care professionals, researchers, and policymakers. Psychotropic medications are used to treat behavioral health conditions. When these medications are prescribed appropriately, they can be effective in managing behavioral health symptoms.¹

However, policymakers and program administrators have expressed concerns about prescribing of psychotropics for children in foster care.² It is well documented that children in the foster care system are overprescribed psychotropic medications, and are often on two or more medications at the same time.^{3,4,5} Children involved with the child welfare system have a higher prevalence of behavioral health conditions in comparison to the general child population, but their behavioral health needs may not always necessitate the use of psychotropic medications.^{6,7}

This brief looks at psychotropic prescribing patterns for children in the child welfare system and on Medicaid in two states. The objectives are to quantify differences in prescribing between children involved child welfare systems and a comparison group of children on Medicaid, but who were not involved in child welfare. Analyses looked at three groups – children in foster care, children with child welfare involvement but no foster care

placement, and children without any child welfare involvement. The analysis uses data from the [Child and Caregiver Outcomes Using Linking Data \(CCOULD\)](#) project, which contains linked child welfare and Medicaid administrative data from Florida and Kentucky. The analysis focused on children receiving services between January 2017 to September 2020. Details on the data and methods can be found in the Technical Appendix at the end of this brief.

The Child Welfare System includes groups of services designed to promote child well-being through safety and permanence, including foster care and adoption services. While the federal government supports states through legislation and funding, the primary responsibility for child welfare services resides with the states.⁸

Medicaid helps cover medical costs for some people with income or resource restrictions. While the federal government provides rules for state Medicaid programs, each state runs their own program, which means that eligibility and benefits vary.⁹ The Children's Health Insurance Program (CHIP) is managed by states according to federal requirements. Children may be eligible for CHIP if their families cannot afford private health coverage, but their family income is too high for Medicaid.¹⁰ Data cannot easily distinguish between children on Medicaid and CHIP, and for this analysis, references to Medicaid include CHIP. Practically all children in foster care are eligible for Medicaid.

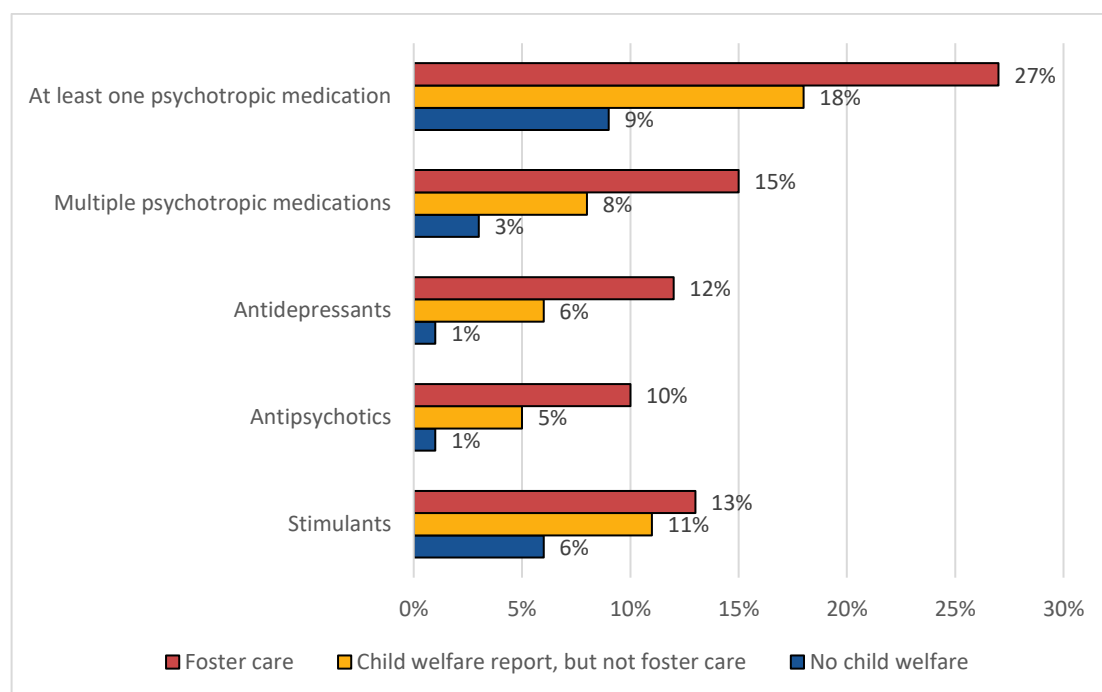
Since the data in this analysis only includes two states, findings may not be generalizable to other states or national trends but provide an important view into how prescription rates for psychotropic medication may differ between children involved or not involved in the child welfare system. While no common characteristics their child welfare systems or measurable child welfare outcomes are different enough to cause concern that either Florida or Kentucky would have fundamental differences related to prescription rates, in depth analysis around prescribing practices, availability of other behavioral health services, and specifics around services covered by Medicaid are outside the scope of this brief and may warrant follow on study.

FINDINGS

Children Involved with the Child Welfare System were More Likely to be Prescribed Psychotropic Medications in Comparison to Children without Child Welfare Involvement

Psychotropic prescribing was more common as children were more involved in child welfare systems. Figure 1 shows the percent of child Medicaid recipients in each group that were prescribed at least one psychotropic medication or multiple classes of psychotropic medication in the same month (polypharmacy). Nine percent of children without any child welfare involvement were prescribed at least one psychotropic medication, in comparison to 18 percent of children involved with child welfare and without a foster care placement, and 27 percent of children in foster care. Furthermore, there was substantially higher polypharmacy use for the child welfare groups. Three percent of children without any child welfare involvement were prescribed multiple classes of psychotropic medications, in comparison to eight percent of children involved with child welfare and no foster care placement, and 15 percent of the foster care group.

Figure 1. Percentage of Children Prescribed Psychotropic Medications by Child Welfare Involvement, 2017-2020



Source: Children and Caregiver Outcomes Using Linked Data (CCOULD) data from Florida and Kentucky, 2017-2020. N=1,174,502

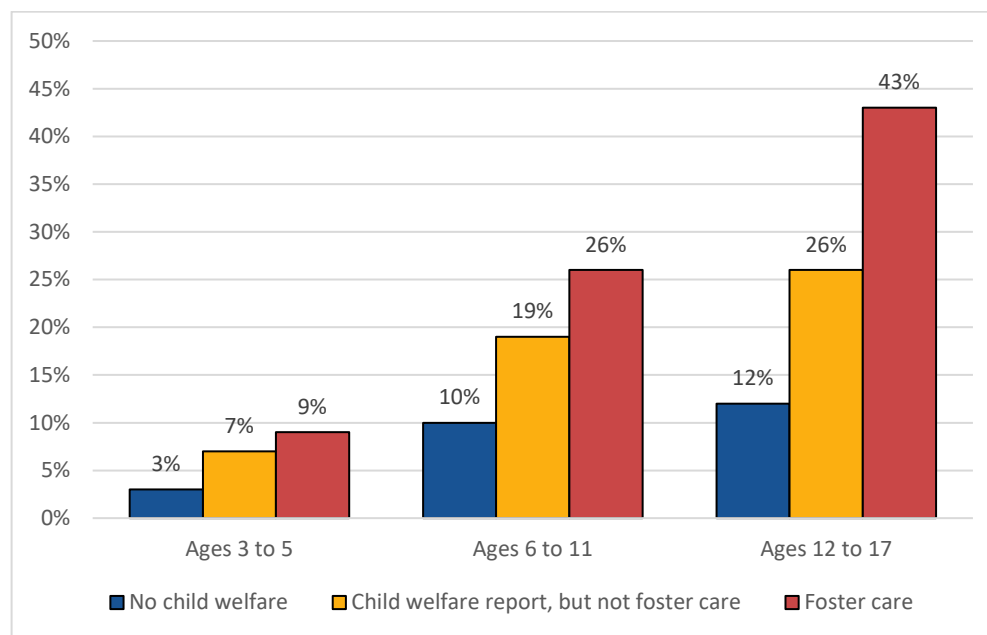
Children Involved with Child Welfare Had a Higher Percentage of Antidepressant, Antipsychotic, and Stimulant Prescriptions in Comparison to Children without Child Welfare Involvement

Figure 1 also shows the specific types of psychotropic medications prescribed across groups among child Medicaid recipients in Kentucky and Florida. The foster care group stood out as having the highest prescription percentages for three key psychotropic medication types: antidepressants, antipsychotics, and stimulants. Children in the foster care group were more likely to be prescribed an antidepressant than children without child welfare involvement (12 percent versus one percent). Children in the foster care group were also more likely to be prescribed an antipsychotic than children without child welfare involvement (10 percent versus one percent). Lastly, 13 percent of children in the foster care group were prescribed a stimulant in comparison to six percent in the non-child welfare group.

Children Ages 12 to 17 had a Higher Percentage Psychotropic Medication Prescriptions Relative to Younger Children

Figure 2 shows the percentage of prescriptions for psychotropic medications for children on Medicaid by age group. Children in the foster care group had the highest percentage of prescriptions across all age groups. The difference is most stark for children ages 12-17, with 43 percent of children in foster care prescribed a psychotropic medication, in comparison to 12 percent of children with no child welfare involvement. For children ages 6-11, 26 percent of children in foster care were prescribed a psychotropic medication in comparison to 10 percent of children with no child welfare involvement. For children ages 3-5, nine percent of children in foster care were prescribed a psychotropic in comparison to three percent of children without child welfare involvement. Consistent across age groups, children with child welfare involvement but no foster care were prescribed psychotropic medications at a higher rate than children with no child welfare involvement, but at a lower rate than children in foster care.

Figure 2. Percentage of Children Prescribed Psychotropic Medications by Age and Child Welfare Involvement, 2017-2020

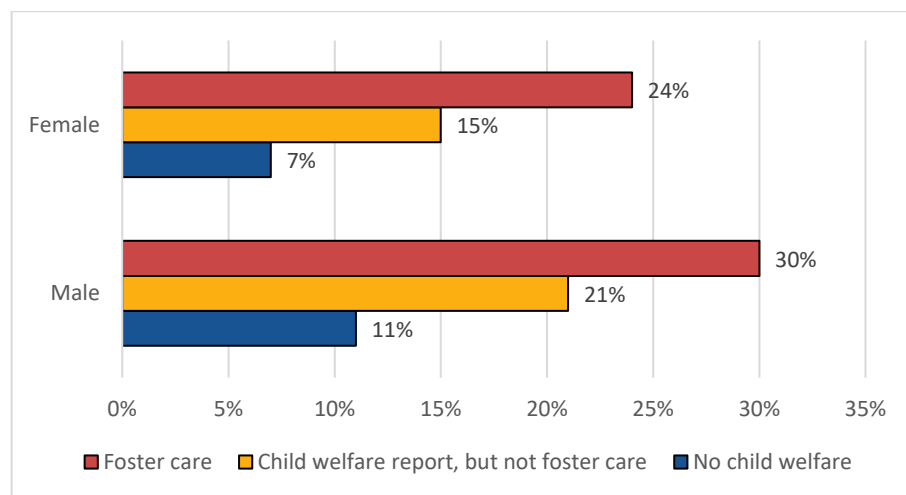


Source: Children and Caregiver Outcomes Using Linked Data (CCOULD) data from Florida and Kentucky, 2017-2020. N=1,175,502

Boys Were More Likely to be Prescribed Psychotropics than Girls

Figure 3 shows differences in psychotropic medication prescriptions by sex. Across groups, male children were more likely to have a psychotropic medication prescription regardless of child welfare status. For female children, 24 percent of children in foster care were prescribed a psychotropic medication in comparison to seven percent of children with no child welfare involvement.

Figure 3. Percentage of Children Prescribed Psychotropic Medications by Gender and Child Welfare Involvement, 2017-2020

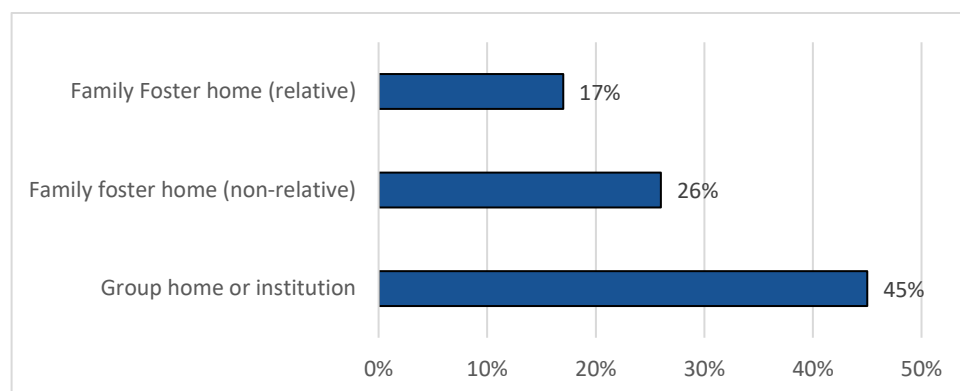


Source: Children and Caregiver Outcomes Using Linked Data (CCOULD) data from Florida and Kentucky, 2017-2020. N=1,174,502

Children Placed in Congregate Care Facilities were More Likely to be Prescribed a Psychotropic Medication Relative to Children in Family Foster Homes

Figure 4 shows the percentage of psychotropic medication prescriptions by foster care placement type. Across all placement types, the percentage of psychotropic medication prescriptions were highest among children living in group homes or residential treatment care settings. For children with a foster care placement, 45 percent of children living in a group home or residential treatment setting were prescribed psychotropic medications in comparison to 26 percent of children in a non-relative foster family home and 17 percent of children in a relative foster family home.

Figure 4. Percentage of Children Prescribed Psychotropic Medications by Foster Care Placement Type, 2017-2020



Source: Children and Caregiver Outcomes Using Linked Data (CCOULD) data from Florida and Kentucky, 2017-2020. N=36,075

DISCUSSION

Descriptive analyses highlight differences in the percentage of psychotropic medication prescriptions and polypharmacy across type of child welfare involvement, age and sex groups, and foster care placement type, for child Medicaid recipients in Kentucky and Florida from 2017 to 2020. Among children on Medicaid, those with child welfare involvement were consistently prescribed psychotropic medication at a higher rate than children with no involvement. For children in the child welfare system, those who were in foster care were prescribed psychotropics more frequently than children without a foster care placement. Children with child welfare involvement, both with and without foster care placement, were more likely to have a psychotropic medication prescription regardless of gender or age group we examined with foster children always having the higher proportion of children with a prescription. Boys were prescribed psychotropics more frequently than girls and older children more frequently than younger children. The analysis also found that children in group homes are more likely to have a prescription than children in family foster homes and children in non-relative foster homes were more likely to have a prescription than children placed with relatives. The findings also show differences in the percentage of psychotropic medication prescriptions across groups for classes of psychotropic medications, specifically antipsychotics, antidepressants, and stimulants with children in foster care having the highest rate of prescription across all classes. These findings are consistent with research on the prescribing of psychotropic medication for children on Medicaid and in foster care.

While several national organizations provide recommendations to reduce the prescribing of psychotropic medications for children in foster care, and several states have guidelines or policies to discourage overprescribing, it continues to be a pervasive issue that affects the health and well-being of children in our child welfare system.¹¹ Receiving proper mental health care is critically important for this population. Children

in foster care experience disproportionately high rates of trauma, mental health disorders, and behavioral challenges stemming from abuse, neglect, family separation, and placement instability.¹²

Non-medication mental health treatment options are critical tools for this population because they address the root causes of behavioral and emotional difficulties. Access to a broader array of behavioral health services reduces the possibility of pharmacology, promotes child and family preference, and better targets key presenting social and family problems. Additionally many psychosocial approaches have superior or equivalent evidence and may be a better option during central nervous system development. However, there are numerous potential barriers to providing these services to children in foster care. High placement instability makes it difficult to maintain the continuity of care that most therapeutic interventions require to be effective.¹³ The foster care system also faces persistent shortages of trained therapists, particularly in rural areas.¹⁴ Reimbursement structures under Medicaid, the primary insurer for most foster youth, have historically favored medication management over therapy due to lower cost and administrative simplicity.¹⁵ Additionally, caregivers and caseworkers may lack awareness of available non-medication options, and frequent changes in placement can disrupt relationships with providers, undermining therapeutic progress.¹⁶

Future research could examine the extent to which there are underlying differences in the prevalence of diagnosed mental health conditions between child Medicaid recipients with no child welfare involvement and those in the child welfare system. This would aid in understanding the reasons why child welfare recipients are more likely to have prescriptions for psychotropic medications than children with no child welfare system involvement. While children in the child welfare system may present with more severity behavioral health problems – and intensity of medication use likely covaries with the severity of a disorder – this is likely not the case for all children.

Key data decisions should promote efforts to ensure children in the child welfare system receive the highest quality and most appropriate care. To monitor the quality of care provided to children in foster care, states could compare Medicaid service and quality measures between children in foster care to those not. States already collect and report such measures through the [Medicaid and CHIP Adult and Child Core Sets](#). These include, for example, use of first-line psychosocial care for children prescribed antipsychotic medications and the receipt of follow-up care for children prescribed attention deficit/hyperactivity disorder (ADHD) medication. Although state submissions to the Centers for Medicare & Medicaid Services (CMS) do not currently distinguish children in foster care from other children, states may be able to collect, analyze, and report data in a manner that would allow comparisons between these groups. Such changes could help identify gaps in care, inform additional policy decisions, and guide improvements in the quality of care provided to children in the foster care system.

An additional area for action includes taking a more data informed approach to state Health Care Coordination and Oversight Plans for children in foster care, required under 42 U.S.C. § 622(b)(15)(A)(v). These plans include oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications, informed consent from youth, and compliance with professional practice guidelines. Among other requirements these plans must address (1) screening, assessment, and treatment planning mechanisms to identify children's mental health needs, including a psychiatric evaluation when necessary, to identify whether children need psychotropic medications; and (2) effective medication monitoring at both the client- and agency-level. Both GAO and HHS OIG reports have found that additional federal guidance may help improve these plans and encourage state compliance.^{18,19} Collaboration between the Administration for Children and Families and other key partners, such as CMS, could help states incorporate a more data informed approach for improvement and help target critical gaps that may require additional technical assistance.

An important limitation to the CCOULD data used in this analysis is that they only reflect two states, Florida and Kentucky. These findings may not be generalizable to other states or national trends. There is noteworthy variation between the two states. For children in Florida, about 20 percent of children in foster care were prescribed a psychotropic medication in comparison to about 44 percent of children in foster care in Kentucky. It is unknown how psychotropic medication usage varies across these groups in other states, as they are not included in the dataset. Future research could continue to examine differences across states to better understand the impact of guidelines and policies in preventing the overprescription of psychotropics for children on Medicaid and in foster care. States may also want to better understand within state variation, such as comparing urban versus rural differences in psychotropic medication prescriptions.

Future research can help better understand the factors driving higher psychotropic prescription percentages for children involved with child welfare and to understand the role and availability of non-medication therapies. Additional research can also help to clarify when psychotropic medication is appropriate for children in foster care and when non-medication alternatives may be better suited to align with the standard of care for behavioral health diagnoses.

TECHNICAL APPENDIX

This brief uses data from the [Child and Caregiver Outcomes Using Linking Data \(CCOULD\)](#) project, which contains linked child welfare and Medicaid (including CHIP) administrative data from state agencies in Kentucky and Florida. For all children in the sample, the analysis focused on January 2017 to September 2020, the time when child welfare and Medicaid records overlapped in both states. All children in the sample received Medicaid or CHIP.

This brief examines three mutually exclusive groups:

- Children with no child welfare involvement;
- Children with child welfare involvement, but no placement in foster care (e.g., children that reported to child welfare, but not placed in foster care), and;
- Children in foster care.

The sample contains 739,334 children with no child welfare involvement, 399,093 children involved with the child welfare system but no foster care placement, and 36,075 children in foster care. The brief examines demographic differences between groups (age and sex) and explores differences between foster care placement types. Children with no child welfare involvement come from a sample of all Medicaid enrolled children from each state

Claims for psychotropic medication classes were based on national drug codes for the following: Antidepressants, antipsychotics, anticonvulsants, antimanic, antiparkinsonian, anxiolytics-sedatives, benzodiazepines-barbiturates, central nervous system agents, hypnotics, and stimulants. The analysis focuses on medications prescribed and does not shed light on whether medications were dispensed, filled, or administered.

Defining Events

For each group, the analysis focused on the 12 months after the defining event for each group. For example, the foster care group focused on 12 months after foster care entry. For the group of children with child welfare involvement, but no placement in foster care, the focus is on the child's earliest child welfare report. For the group of children with no child welfare involvement, the focus is on the child's earliest Medicaid or CHIP enrollment record. Given that the analysis focused on January 2017-September 2020, ending with defining events in September of 2019 allowed for the full observations of prescriptions in the 12 months after the defining event for all children in the sample.

Analytic Sample

Several steps were taken to construct the analytic sample, including three sample restrictions. The sample excluded children with dual eligibility for Medicaid and Medicare, restricted benefits, and fewer than six months of continuous Medicaid enrollment. This allows the analysis to focus on children for whom Medicaid records capture most of their health care experiences. Dual insurance enrollment, such as through Medicare or another private insurer, could impact the ability to review all health records, as Medicaid is the payer of last resort; In that case, Medicare or another insurer would pay for covered services first, rather than Medicaid. The sample also only includes children and adolescents ages 3 to 17 at the time of their defining event because children as young as three years old have been shown to be prescribed psychotropic medications.²⁰ Appendix Table 1 shows the process for determining the sample.

Appendix Table 1. Number of records remaining in the data after applying each sample restriction, by group of children and adolescents

Sample restriction	Number of records in the data after applying sample restrictions		
	Foster care	Child welfare report, but not foster care	No child welfare involvement
Raw data ^a	105,104	1,841,908	62,267,071
Drop events before January 2017 or after September 2019	61,708	1,256,609	37,372,402
Drop events for each child that occurred after the defining event, creating a child-level file ^b	58,734	818,097	1,495,284 ^c
Drop children with a foster care record to create mutually exclusive groups	n.a.	761,763	n.a.
Drop children with dual insurance, restricted benefits, or fewer than 6 months of continuous Medicaid enrollment in the 12 months after the event	54,613	512,852	1,317,782
Drop children younger than 3 years old or older than 17 years old	36,075	399,093	739,334

Source: Child and Caregiver Outcomes Using Linked Data ; n.a. = not applicable.

^a The raw data file differed for each group and each raw file was structured at a different level. The counts in this row represent the total number of records in the files and not the number of unique children. The raw data files were: (1) CCOULD_CH_FC_EPISODES for the foster care group, structured at the child-by-foster care entry level; (2) CCOULD_CH_WELFARE_REPORT for the child welfare report, but not foster care group, structured at the child-by-report level; and (3) CCOULD_MDCD_ENROLLMT_COMPGRP for the no child welfare involvement group, structure at the child-by-month of Medicaid enrollment level.

^b For example, for the foster care group, this step retains the child's earliest foster care entry and drops records from any subsequent foster care entries that occurred during the sample timeframe.

^c The large decrease in records for the group with no child welfare involvement is because the raw file is structured at the child-by-Medicaid enrollment month level. This step collapses the file to the child level.

Measures

Appendix Table 2. Measures used in the analysis

Measures	CCOULD file for groups with any child welfare involvement	CCOULD file for group with no child welfare involvement	Data elements	Approach to construct the measures
Psychotropic medications	MDCD_RX_LINE	MDCD_RX_LINE_COMPGRP	NDC	Binary variable equal to 1 if in the 12 months after the defining event, the child had at least one claim for a psychotropic medication class ^a
Demographic characteristics	CH_CG_CROSSWALK	MDCD_ENROLLMT_COMPGRP	GENDER YOB SUBMTG_ST	- Child sex: Male if sex is male and female if sex is female. For the purpose of this analysis, we classify gender by sex. - Child age: Difference between the child's year of birth and the year of the defining event - State: Florida if the record is from Florida and Kentucky if the record is from Kentucky.
Medicaid enrollment-related sample restrictions	MDCD_ENROLLMT	MDCD_ENROLLMT_COMPGRP	RESTRCT_BNFT_DUAL_CYEAR_MONTH	Restricted benefits: Binary variable equal to 1 if the child had restricted benefits in any month in the 12 months after the defining event

				- Dual enrollment: Same as restricted benefits, but for dual enrollments 6 months of continuous Medicaid enrollment: Binary variable equal to 1 if child was enrolled in Medicaid for at least six consecutive months out of the 12 months after the defining event
Initial foster care placement setting for the foster care group	CH_FC_EPISODES	n.a.	FC_PLACEMENT_1_SETTING	Categorical variable equal to: (1) Foster family home (relative); (2) Foster family home (non-relative); (3) Group home or institution; or (4) Other, including pre-adoptive home, supervised independent living, runaway, trial home visit, or not collected or not applicable
Mental health conditions	MDCD_IP_HEDR MDCD_IP_LINE MDCD_OT_HDR MDCD_OT_LINE	MDCD_IP_HEDR_COMPGRP MDCD_IP_LINE_COMPGRP MDCD_OT_HDR_COMPGRP MDCD_OT_LINE_COMPGRP	All data fields that begin with DX	Binary variable equal to 1 if in the 12 months after the defining event, the child had any mental health condition ^b

^a We identified claims for psychotropic medication classes based on 53,332 national drug codes for the following medication classes: antidepressants, antipsychotics, anticonvulsants, antimanic, antiparkinsonian, anxiolytics-sedatives, benzodiazepines-barbiturates, central nervous system agents, hypnotics, and stimulants. The national drug code set was used for an analysis of behavioral health care in the child welfare population and the child mental health and suicidal activity analyses conducted under the Transformed Medicaid Statistical Information System (T-MSIS) Data Analyses. It has since been updated slightly to incorporate new codes and has been validated by Mathematica.

^b Mental health conditions include: attention-deficit/hyperactivity disorder, anxiety, behavior or conduct disorders, depressive disorders, mood disorders (including bipolar disorder), psychotic disorders (including schizophrenia), trauma disorders (including adjustment disorders, post-traumatic stress disorder, and other stress disorders), Tourette's syndrome and tic disorders, and other rarer mental health conditions (including dissociative disorders, eating and feeding disorders, obsessive compulsive disorders, personality disorders, sleeping disorders, somatic disorders, and some neurodevelopmental disorders). These conditions were calculated following a standardized approach for examining children's health conditions described in the Centers for Medicare & Medicaid Services' [Chronic Conditions Data Warehouse](#).

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