REDUCING THE OVERUSE OF PSYCHOTROPIC MEDICATIONS FOR CHILDREN IN FOSTER CARE

By Layla Nytes

EXECUTIVE SUMMARY

Children in foster care are prescribed psychotropic medications at significantly higher rates than other children, raising concerns about how these medications are being used and monitored. While medication can help treat serious mental health conditions, it should not replace trauma-informed care, stable support, or meaningful oversight. This report focuses on reducing inappropriate prescribing and unnecessary polypharmacy while ensuring foster youth still receive the treatment they need. To address this issue, Congress should strengthen oversight of higher-risk psychotropic prescribing, expand trauma-informed training for medical providers, and increase access to non-medication mental health services.

PERSONAL REFLECTION

I am passionate about this issue because I spent much of my childhood in the foster care system and experienced many of the same practices discussed in this report. When I entered care, my sisters and I immediately underwent psychiatric evaluations, were prescribed multiple medications, and received several behavioral diagnoses. Looking back, I believe medication was often used to treat behaviors that were actually trauma responses related to entering the foster care system. Like many children in foster care, I experienced separation from family, placement changes, and instability. Instead of receiving consistent support, the focus was often on managing behavior through medication.

THE PROBLEM & CURRENT LAW

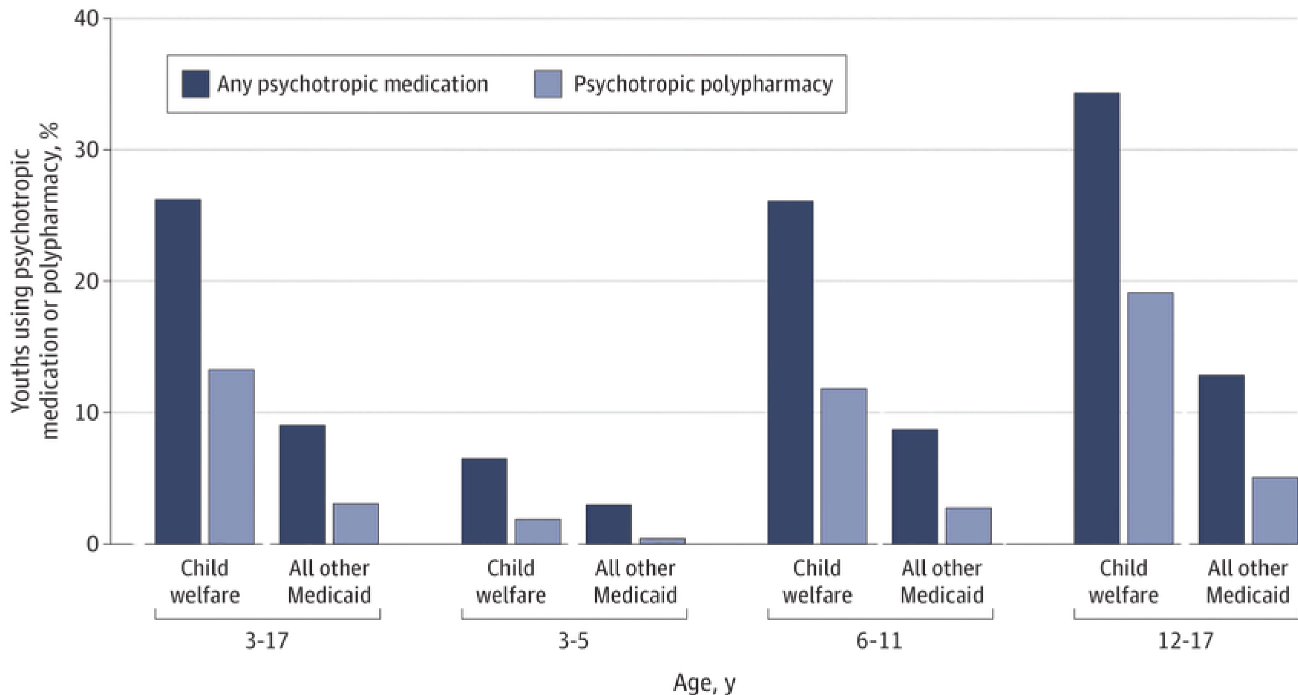
Mental health treatment for children in foster care often begins with diagnoses and prescription medication. In some cases, children are prescribed psychotropic medications, which can affect mood, behavior, or mental functioning and include antidepressants, antipsychotics, and stimulants. These medications can be appropriate for diagnosed conditions such as depression, anxiety, Attention-Deficit/Hyperactivity Disorder (ADHD), or other serious emotional and behavioral challenges. However, the high rate of psychotropic medication use among foster youth raises concerns that medication is sometimes being used too quickly or without sufficient trauma-informed support.

THE PROBLEM & CURRENT LAW *(CONTINUED)*

A study in JAMA Pediatrics found that 26.25% of children in the child welfare system were prescribed psychotropic medication, compared with 9.06% of other youth enrolled in Medicaid (Radel et al., 2023). This comparison is useful because nearly all children in foster care receive Medicaid coverage. The same study found that 13.27% of foster youth were prescribed multiple psychotropic medications at once, compared with 3.11% of other Medicaid-enrolled youth (Radel et al., 2023), meaning foster youth are nearly three times as likely to experience psychotropic polypharmacy. Former foster youth Kory Gonzales described being prescribed up to 16 pills a day and feeling “like a zombie,” while still experiencing unresolved emotional pain from abuse and abandonment (Henry, 2025). While not representative of all cases, these data and experiences raise concern about the need for consistent review when multiple medications are prescribed.

System fragmentation often prevents consistent medication review, as high caseloads, staff turnover, limited provider access, and poor coordination between child welfare and healthcare systems leave no single party with full oversight of a child’s history and treatment needs. These gaps increase the risk that providers focus on visible behavior without fully understanding the underlying trauma. Psychiatrist Dr. Petra Steinbuchel explains providers should do a “deeper dive” to understand “what’s driving them and not just use medication to treat behaviors” (Henry, 2025) and emphasizes that medication should be paired with therapy and environmental stability.

These patterns reflect a broader systemic issue. Foster youth behaviors are often shaped by trauma and instability but are frequently misinterpreted due to system inconsistency. Oversight is therefore inconsistent when children change placements or providers. The Child and Family Services Improvement and Innovation Act of 2011 requires states to monitor psychotropic medication use and establish oversight protocols, but leaves implementation largely to states, and no national standards exist. Some states have implemented stronger oversight. Texas uses Psychotropic Medication Utilization Parameters, and California requires judicial authorization for certain psychotropic medications (Texas Health and Human Services, 2026; California Courts Judicial Branch of California, n.d.). However, protections remain uneven. The Office of Inspector General of the U.S. Department of Health & Human Services found that in five states, one in three foster children on psychotropic medications did not receive required monitoring or treatment planning (HHS OIG, 2018). This highlights the need for consistent national standards; without stronger federal guidance, protections depend on geography.



POLICY RECOMMENDATIONS

To help address the overuse of psychotropic medication in treating children in foster care, Congress should:

- **Encourage states to require independent psychiatric reviews for foster youth prescribed higher-risk combinations of psychotropic medications, such as multiple medications, unusually high dosages, or medication without a clear diagnosis and treatment plan.** Independent reviews should be done by a licensed psychiatrist or qualified psychiatric specialist not involved in the child's treatment and should be triggered when a child is prescribed multiple psychotropic medications, dosages above U.S. Food and Drug Administration (FDA) pediatric guidelines, psychotropic medication at very young ages, or medication without a documented diagnosis and treatment plan. This recommendation builds on approaches already used in states like California and Texas and would help ensure more consistent oversight. States should track and publicly report psychotropic prescribing rates and high-risk medication combinations to improve transparency and accountability.

- **Require states receiving Title IV-E funding to expand trauma-informed training requirements to include medical providers treating foster youth.** Most existing trauma-informed child welfare training is directed towards caseworkers, foster parents, and child welfare staff rather than medical providers making prescribing decisions. Training should focus on recognizing trauma-related behaviors, understanding how

POLICY RECOMMENDATIONS (*CONTINUED)*

trauma can affect child development, recognizing risks and signs of overprescribing psychotropic medications, and considering alternatives to medication when appropriate. The federal government should establish baseline standards, while allowing states flexibility in implementation. Compliance could be tied to Title IV-E and Medicaid participation requirements, with training completed upon initial participation and renewed every two years to ensure providers remain informed on best practices for treating foster youth.

- **Increase funding for trauma-informed, non-medication mental health services for foster youth through Substance Abuse and Mental Health Services Administration (SAMHSA) grants, Medicaid behavioral health programs, and Title IV-E prevention services.** A portion of SAMHSA grant funding should be specifically directed toward expanding services in rural and under-resourced areas through telehealth programs, community mental health partnerships, and increased Medicaid provider participation. Funding should support services such as trauma-focused cognitive behavioral therapy (TF-CBT), family-based therapy, peer support programs, school-based counseling, and other community-based behavioral health services.