CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

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Developmental Challenges of Young Children in Foster Care: Clinical Report

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This clinical report and its accompanying policy statement review the developmental challenges of young children in foster care under the age of 5 years, including recent research on prenatal and postnatal environmental influences on early brain development, and the effects of severe or chronic stress on child development secondary to neglect, physical and sexual abuse. This report also highlights the impact of family disruption and child-parent attachment that occurs with foster care placement, the effects of structural and interpersonal racism, multigenerational poverty, and the more pervasive societal effects that are especially common among children in foster care. The report ends with a brief review of how interventions support resilience in the face of these challenges to child development.

INTRODUCTION

This clinical report and its accompanying policy statement[1] reflect advances in our understanding of both prenatal and postnatal environmental influences on early brain development, including the effects of alcohol and substance exposures prior to birth and the effects of severe or chronic stress on child development secondary to neglect, physical and sexual abuse, and family disruption. In addition, more pervasive societal effects that are especially common among children in foster care, including the effects of structural and interpersonal racism and multigenerational poverty, are discussed as important areas for intervention. This clinical report and the accompanying policy statement briefly review developmental challenges of young children in foster care under the age of 5 years and recent research on attachment, vulnerability, and resilience with the goal of guiding federal and state legislation and policy while providing recommendations for pediatricians.

abstract

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EPIDEMIOLOGY AND OVERVIEW OF DEVELOPMENTAL CHALLENGES OF YOUNG CHILDREN IN FOSTER CARE

Recent child welfare statistics in the United States highlight the risks to typical development faced by young children in foster care. In 2022, the foster care system provided care to 569 879 children, with 186 602 children entering foster care in 2022. Of children entering foster care, 20% were younger than 1 year, and 51% were 5 years or younger. Sixty-two percent of children were removed for neglect, 33% for parental substance use, 13% for physical abuse, 6% for parental alcohol use, and 4% for sexual abuse. Children younger than 1 year have the highest victimization rate, at 22.2 per 1000 children since data collection began in 1988.[2]

Of the 558 899 children who experienced child abuse and neglect nationally in 2022, more than one-quarter (27.3%) of survivors of child maltreatment were younger than 2 years, and 14.7% were younger than 1 year. American Indian/Alaska Native (AI/AN) children have the highest rate of victimization at 14.3 per 1000 children in the population, and Black or African American children have the second highest rate at 12.1 per 1000 children of the same race or ethnicity.[3] Given the large number of young children in foster care during the most critical period of early child development, this clinical statement focuses on developmental issues faced by young children in foster care from birth to 5 years of age.

The most common reasons for foster care placement are neglect and parental substance use, with infants and toddlers more likely than older children to enter foster care.[4] Of children referred to child protection in 2022, 89% were maltreated by one or both parents. Of all children of all ages referred to child protection, 23.8% had a caregiver with substance use and 15.2% had a caregiver with excessive alcohol use.[3] These figures likely underestimate the extent of parental substance and alcohol use, as child welfare assessment on entry to foster care often fails to screen for maternal alcohol or substance use.[5,6] Despite wide attention paid to prenatal opioid exposure, there has been little focus on the associated risk of isolated or concurrent prenatal alcohol exposure.[7] Evidence has found that of all substances, alcohol is by far the most damaging to the developing brain and that there is no known safe amount of alcohol use during pregnancy.[8,9] Given the prevalence of prenatal substance and alcohol exposure, discussion of developmental challenges among children in foster care must include the risks associated with prenatal substance and alcohol exposure in addition to the effects of child maltreatment.

Finally, children with disabilities are more than 3 times more likely than their peers to suffer all forms of maltreatment, and disability is an independent risk factor for abuse starting in the neonatal period and continuing through 10 years of age.[10,11] Although children with disabilities are 10.4% of the population, they represent 25.9% of children with a maltreatment allegation and 29.0% of those with a substantiated allegation.[12] Similarly, the disproportionate number of children referred for suspected abuse/neglect and subsequent foster care placement among families of American Indian/Alaska Native and Black or African American origin make systemic racism and negative implicit racial biases of workers throughout the child welfare system urgent areas to address in supporting the developmental health of all children across all racial backgrounds.

DEVELOPMENTAL DISABILITIES IN FOSTER CARE

Between 32% and 58% of young children in foster care have developmental delays, compared with 13% of peers who are not in foster care.[13] Several risk factors contribute to the association between foster care placement and developmental delays, including greater risk for prenatal alcohol and substance exposure, experiences of child maltreatment and neglect, disruption of attachments to caregivers, witnessing intimate partner violence, parental transgenerational trauma, parental stress or psychiatric illness, structural and interpersonal racism, concentrated poverty, and preterm birth.[14,15] Nearly half of children older than 3 years in out-of-home care in the United States have emotional, behavioral, and/or cognitive impairments.[16]

Despite the high prevalence of developmental delay among children in foster care, children 0 to 2 years of age in foster care are 2.4 times less likely to receive developmental services than preschool-aged children and 4.2 times less likely to receive services than school-aged children in foster care.[14] Although 35% to 50% of children with substantiated maltreatment cases are found to need developmental services, only 10% to 26% receive these services.[17] In many cases, early intervention programs restrict eligibility requirements with a percentage cut off based on age-expected developmental abilities.[18–20] Additional barriers to early intervention include lack of recognition of developmental delays because of fractured medical care, difficulties obtaining parental consent for evaluation and services, lack of coordination of care with foster care agencies, and lack of awareness of the importance of early intervention services among biological and foster parents.[21]

Risks associated with disability are further increased after foster care placement. Children with disabilities often have more foster care placements, spend more time in foster care with less placement stability, and have greater risk of being placed in congregate care.[22] Children with disabilities often require far greater care than children without disabilities. Many children are nonspeaking or reliant on others for extensive care needs that can easily exceed the ability of a parent or foster caregiver to provide care. These extensive care needs of a disabled child add excessive

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caregiver burden that, in itself, can be a risk factor for child abuse.[23] Children with multiple developmental delays have elevated rates of child maltreatment re-reports when compared with typically developing children.[24] Placement instability increases the risk for developmental, behavioral, and psychiatric challenges in addition to disrupting attachment, which is a cornerstone that supports child development.[25]

CHILD MALTREATMENT

Research over the past 50 years has led to greater awareness of the effects of traumatic experiences and pervasive toxic stress on brain architecture and function.[26] Research examining the impact of toxic stress and adversity on a child's developing neuroendocrine and immune system is a rapidly growing field of study. Prolonged exposure to toxic stress can contribute to dysregulation of the hypothalamic-pituitary-adrenal axis and cortisol levels over time, leading to decreased cerebral volumes in the prefrontal cortex and hippocampus with increased neurogenesis in the amygdala.[27,28] These neuroendocrine changes increase the risk of developmental delays and later difficulties in learning, attention, and self-regulation as well as risk for affective disorders.[29] Studies examining immune system responses to toxic stress and adversity in children show higher levels of biomarkers for chronic disease compared with nonaffected peers.[30] In contrast, secure positive attachments results in increases in oxytocin that improves ongoing attachment and brain development.[31]

Young children are dependent on a nurturing, responsive caregiver to act as a critical buffer against threats to healthy development.[32] A healthy attachment to a responsive adult supports the development of social interactions, executive function, and self-regulation.[33] Early childhood stress, especially if frequent or unremitting without the presence of a nurturing caregiver, affects the neurobiology and architecture of the brain in an experience-dependent response to environmental stress.[34] Child maltreatment can lead to chronic or severe stress responses that elicit physiological and behavioral adaptation that, over time, can lead to brain-based changes and emotional/behavioral dysregulation.[35] The relatively new field of epigenetics studies the influence of the social and physical environment in shaping the brain through experience-dependent adaptation or maladaptation.[36] The potentially deleterious sequelae that accompany child maltreatment not only result in adverse consequences during infancy and childhood but also often initiate a negative developmental cascade that can reach across the lifespan.[37] For example, early childhood physical abuse may impact the epigenetic regulation of the stress response system.[38]

Early childhood neglect, although often the most clinically difficult form of maltreatment to recognize, has a profound effect on development. Children experiencing neglect over the first 4 years of life show a progressive decline in cognitive functioning and a significantly reduced head circumference at 2 and 4 years of age, and child maltreatment, particularly emotional abuse and neglect, is associated with a wide range of long-term adverse health and developmental outcomes.[39] Neglect disrupts brain development, not only through the persistent absence of responsive care that reinforces neurodevelopment, but also through activation of the body's stress response.[40] Thus, for children at the peak of development, the effects of child abuse and neglect can last far beyond childhood.

Intergenerational trauma is common among parents of children in foster care.[41–43] Extensive research documents the effects of maternal childhood traumatic experiences on child development.[44,45] Intergenerational trauma may cause epigenetic changes in DNA, the maternal stress response, and the interplay of parenting with child developmental and behavioral challenges, although studies have not yet conclusively demonstrated epigenetic transmission of trauma effects in humans.[46] A maternal history of childhood trauma can also affect the nature of the parent-child relationship secondary to parental emotional stress dysregulation and altered parent–child interactions that can lead to intergenerational trauma through social learning, behavior of caregivers toward children, and maternal negative cognitions about their children.[47] Maternal childhood trauma is linked with negative parenting behaviors, including less sensitivity, more negative affect, difficulties with attachment, decreased parenting confidence, increased harsh discipline, and a child's inability to manage frustration and stress, placing children at risk for child welfare referral.[48]

Child maltreatment, thus, poses substantial risk for undermining the broad spectrum of developmental domains including emotional/behavioral regulation, development of attachment relationships, self-organization and self-esteem, peer relations, and adaptation to school.[49] Early exposure to child abuse or neglect, family turmoil, neighborhood violence, extreme poverty, racial discrimination, or other hardships can prime biological systems to become hyperresponsive to adversity.[50,51] Early identification and referral of children at risk of developmental delays and maltreatment can markedly change the trajectory of development by working to establish a safe, nurturing environment, which is one of the primary goals of foster care placement.[52]

FETAL ALCOHOL SPECTRUM DISORDERS

Because prenatal alcohol exposure is especially prevalent among children in foster care, specific history taking for prenatal alcohol and substance exposure history is imperative in identifying children at greatest risk for developmental challenges as well as supporting parent substance use treatment and recovery.[53] Screening for maternal

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depression and anxiety can provide pediatricians information to allow ongoing surveillance for parental well-being while acknowledging that pregnant adults who experience frequent mental distress are at twice the risk of alcohol use and 3 times more likely to binge drink during pregnancy.[54]

Although the prevalence of fetal alcohol spectrum disorders (FASDs) in the general population is 1.1% to 5%,[55] the estimated prevalence of FASDs among infants and children in foster care is 18.8%.[56] Of children diagnosed with FASDs, 30.5% are placed into foster care, reflecting greatly increased risk of placement of infants and children with FASDs in foster care. Despite the high prevalence of FASDs in foster care, FASDs remain underrecognized in the child welfare system. A study of 547 children in foster or adoptive care found 28.5% of children met criteria for diagnosis of an FASD, while 80% of children with an FASD had never been diagnosed.[57]

Children with FASDs enter into foster care earlier and spend more of their life in out-of-home placement.[58] Most children with FASDs do not have the facial features, growth impairments, and neurodevelopmental challenges that meet criteria for a diagnosis of fetal alcohol syndrome (FAS), even in the absence of a documented history of prenatal alcohol exposure.[59] The prevalence of FAS is less than 1 in 10 of all children with an FASDs.[43] Because a diagnosis of an FASD other than FAS rests entirely on a history of prenatal alcohol exposure,[60] pediatricians have the opportunity of identifying children in foster care with FASDs and improving developmental outcomes by screening all children for prenatal alcohol exposure.[5,61,62] Screening for prenatal alcohol exposure can be efficiently obtained by weaving questions regarding alcohol use before, during, and after pregnancy recognition into questions related to the pregnancy history. The American Academy of Pediatrics (AAP) has designed an Implementation Guide for Screening for Prenatal Alcohol Exposure in general pediatric practice and recommends screening of all children (https://downloads.aap.org/AAP/PDF/FASD/FASD_PAE_Implementation_Guide_FINAL.pdf).

Because alcohol is a neurotoxin that readily crosses the placenta and blood-brain barrier, prenatal alcohol exposure affects fetal brain development including cell proliferation, migration, differentiation, and myelination.[63] Neurodevelopmental impairments stemming from altered brain development and function often manifest as developmental delays.[64] Referrals for evaluation include challenges in gross motor skills, speech, cognition, and social interactions and behavioral difficulties at home and school that are often the first indication of a diagnosis of an FASD.[65,66] In addition to developmental delays, young children with FASDs are commonly diagnosed with attention-deficit/hyperactivity disorder (ADHD) and oppositional defiant disorder.[67] The Society for Developmental and Behavioral Pediatrics has developed a practice guideline to facilitate diagnosis of complex ADHD, characterized by moderate to severe functional impairment, poor response to treatment, and diagnosis prior to 4 years of age.[68] Given the overlap of FASDs and ADHD symptoms, many young children diagnosed with complex ADHD are at especially high risk for having a concurrent undiagnosed FASD.[69] In addition to these developmental and behavioral challenges, the combined effects of prenatal alcohol and other substance exposure and traumatic experiences synergistically affect brain architecture and function and are manifested in greater developmental challenges than either risk alone.[70,71]

RACIAL INEQUITY AND DISPARITIES IN THE CHILD WELFARE SYSTEM

Racial disproportionality exists throughout the child welfare decision-making process. African American families are more likely to be reported of suspected maltreatment and investigated by child protective services than other families, although there is no evidence that African American parents commit more acts of child abuse or neglect than white parents.[72–74] AI/AN children are 4 times more likely to be removed by state child welfare systems than non-Native children and in 13 states are placed in foster care at a rate 14 times higher than their rate in the general population, with 56% of children adopted outside their families and communities.[75] AI/AN children continue to experience increased risk of both confirmed maltreatment and foster care placement.[76,77]

In addition to race-based inequities, poverty and higher income inequality is significantly associated with higher rates of child maltreatment.[78] Several studies document racial and poverty bias in newborn drug testing, a common entry point into the child welfare system.[79] The disproportionate placement of Black, Hispanic, and AI/AN children along with increasing awareness of the effects of experiences of racism on child development has given urgency to reforming the process of child welfare placement. Child welfare reform can working toward ensuring a child's safety while recognizing bias and discrimination that place specific populations at risk for removal to foster care and decreased likelihood for reunification with parents.[80–82] Historically, racially based family disruption and separation originated during colonialism and slavery including the genocide of the Indigenous American population, child removal to Indian Boarding Schools, and the separation of enslaved African American children from their parents. The history and future of child protection must be understood within this context.[83]

POVERTY, THE CHILD WELFARE SYSTEM, AND CHILD DEVELOPMENT

Decades of research have documented the association of poverty and antipoverty bias with child protective service

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involvement as well as the effects of poverty and stress on brain development.[84] Differences in development between children experiencing poverty and their peers tend to appear in the first year of life and persist into adulthood.[85] A disproportionate number of economically impoverished children of color are involved in child welfare as a result of antipoverty bias and historical and social barriers to services.[86] At the same time, income poverty explains some of the inequities of involvement with child protective services between Black and white families and highlights the importance of recognizing systemic racism as well as antipoverty bias.[87] Providing early access to resources such as early intervention can mitigate the effects of poverty on development.[88] Foster care payments play an important role in reducing the risk of poverty among children in foster care, yet in contrast to children in nonkinship foster care, children living with their grandparents in kinship care have a higher risk of poverty and are less likely to receive foster care or other income supports.[89] Financial support of both kinship and nonkinship families caring for children in foster care can ameliorate the damaging effects of poverty and remains an ongoing area for advocacy. Increased financial resources, such as income for economically impoverished families, the Supplemental Nutrition Assistance Programs (SNAP), and child tax credits, have been found to reduce the risk of contact with the child welfare.[90,91]

GOALS OF FOSTER CARE PLACEMENT: HEALTH, SAFETY, PERMANENCY, AND WELL-BEING OF CHILDREN

The intent of child welfare services is to ensure the safety of the child while developing a permanency plan that supports the ongoing well-being of the child. In many cases, the permanency plan seeks reunification with the biological parent. Even in cases in which the permanency plan is adoption, the biological parent remains an important part of a child's life while the child is in foster care. The medical home for children in foster care includes both biological and foster parents with additional input from the foster care agency. Pediatricians must mediate often-differing views of a child's developmental abilities with the need to address developmental challenges. This task is made especially difficult when states require consent from the biological parent before initiating evaluation for early intervention or school-based services. Children often enter foster care having experienced multiple past medical providers with lack of an integrated medical record required to accurately assess developmental challenges. For this reason, foster care placement is an opportunity to integrate medical and developmental care while providing consistency of care in the patient-centered medical home.[92]

The child welfare system is a critical point of contact for many infants and toddlers who have experienced or are at risk of child maltreatment and related developmental delays. Although federal laws mandate identification and intervention for young children in foster care, gaps persist in the steps between referral and ongoing receipt of services.[17] Foster care is an opportunity to identify children with developmental delays in the family-centered medical home. This includes screening and referral for developmental and behavioral challenges while ensuring the child's safety. The AAP recommends developmental surveillance at every health supervision visit as well as the administration of standardized screening tests at the 9-, 18-, and 30-month visits and screening for autism at the 18- and 24-month visits. Bright Futures recommends screening for behavioral/social/emotional screening at every well-visit.[93,94] Given the elevated risk for developmental challenges of children in foster care, a lower threshold for referral for further evaluation recognizes the complex relationship between child-parent attachment and development that is often disrupted by foster care placement. In addition to screening for delays across developmental domains, screening for child mental health and behavioral issues, assessment of a child's attachment to their caregiver, and screening for caregiver depression can guide intervention to support a child-centered environment while in foster care and beyond. This screening is especially important in working toward reunification with a child's biological parent.

Part C of the federal Individual with Disabilities Education Act (IDEA) establishes requirements for providing early intervention services to infants and toddlers with disabilities. In addition, the Child Abuse Prevention and Treatment Act (CAPTA), passed into law in 1974 and since amended, requires states to develop "provisions and procedures for referral of a child under the age of 3 who is involved in a substantiated case of child abuse or neglect to early intervention services."[88,95] The Comprehensive Addiction and Recovery Act of 2016 added requirements for states to provide data on the number of infants affected by substance use or FASDs and referrals and services for the affected parent or caregiver. More recently, The Family First Prevention Services Act of 2018 offers states the new opportunity to use federal funds to support children who are at risk of entering foster care and their families.[6,96] This support includes establishing a plan of safe care for infants affected by parental substance use to ensure ongoing developmental supports are in place.[97] Despite federal laws to facilitate support for children in foster care, a national study conducted in 2008–2009 found less than one fifth of all children in substantiated cases received a referral to developmental services (18.2%).[98] State policies and practices for maltreated infants and toddlers and their families have not changed significantly and few states have implemented policies or practices to support prevention of foster care placement. Given the risk for developmental, mental health, and behavioral challenges, young children in foster care should be eligible for early intervention

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services without regard to cut-off criteria often used to determine eligibility for services in the general population. Programs such as the Zero to Three Safe Babies initiative can help ensure that the urgent developmental and mental health needs of children in foster care are linked to services.[99]

Although the importance and cost-effectiveness of intervention in early childhood has been well documented,[100] barriers to diagnosis, referral, and developmental services exist within the foster care system.[101] Barriers include fragmentation of medical care, lack of information sharing across child welfare silos, inaccessible hospital birth records, lack of records describing the events leading up to foster care placement, lack of foster parent and caseworker awareness of a child's developmental history or current developmental status, and the need for consent by the birth parent for referral for early intervention or special education assessment.[102,103] Delays in referral and receipt of services can occur if the birth parent is not present at the visit, if there are difficulties locating and contacting birth parents, or if the birth parent does not agree with the need for referral for services.[17,104,105] Poor information exchange impedes care coordination.[106] Innovative ways to address these critical barriers utilizing information sharing systems suggest new means for collaboration between pediatricians, child welfare agencies, and the family court system.[107,108]

Each step in the early intervention process poses a risk for children to fail to receive services.[109] This process includes referral, eligibility determination, development of an individual family service plan, receipt of services, and transition to school-based services after 3 years of age if needed.[110] All too often, the time-sensitive referral process is delayed and places the child at risk of aging past 3 years and no longer qualifying for early intervention. States may have laws that limit foster parents serving as surrogates or otherwise acting as parents.[111] Although foster parents are often allowed to sign children into school, they are not given the same rights to ensure that children under their care receive early intervention evaluation or services.[112] In many cases, the support of a child's attorney or court-appointed special advocate (CASA) can advocate for overriding lack of parental consent.[111] In addition, some states have successfully used public health nurses to work with families when a family is reluctant to consent to a formal multidisciplinary assessment. These differences highlight the importance of developing consistent guidelines for processes such as obtaining consent, conducting evaluations, and appointing surrogate parents to integrate child welfare and early intervention services. Although it is important to retain parental involvement and respect parental decision making during foster care placement, access to early intervention services should be prioritized in the best interests of the child, even in the absence of parental consent. Standardization of consent for developmental evaluation and intervention from a child's parent or judge should be included in parental consent for medical services at intake to allow developmental evaluations and early intervention services to take place when a parent is unable or unwilling to sign consent for services.

Despite a mandate to determine placement planning in the best interest of the child, the judicial system all too often focuses on parental rights with an emphasis on maintaining family unity that may not necessarily be in the best interests of the child.[49] There are also times children are removed from homes when services to promote family preservation could have been put in place. Once placed in foster care, children may experience yearning for their birth parents, fear and anxiety because of separation from the birth parents, and minimization of the maltreatment perpetrated against them by the birth family.[113] The coparenting that occurs between foster parents and birth parents often results in conflicts between the role of foster parents and their emotional involvement with the child in their care and the perceived status of birth parents as "failed parents" (from the perspective of authorities) and their continuous aspirations to get their child home again.[114] Parental rights and family unity at times conflict with the best interests of the child. Current policies tend to focus on family reunification, even at the cost of prolonged stays in foster care or multiple placements.[115,116] The unique needs of young children's development and attachment deserve early permanency planning with the least number of placement disruptions.

RESILIENCE, PREVENTION, AND INTERVENTION TO PROMOTE DEVELOPMENT

Positive early experiences, support from responsive adults, and the early development of adaptive skills can counterbalance the consequences of adversity.[117] Child welfare systems can work with other systems to reduce environmental stress. For example, alleviating financial stress can help parents involved with the child welfare system by reducing their reliance on perpetrators of intimate partner violence or past child maltreatment.[118] Simple interventions such as earned income tax credits and child tax credits can function to alleviate the effects of child poverty among children in foster care while decreasing the risk of maltreatment.[119] Child welfare systems can strive to minimize the number of placements experienced by children and youth in foster care. Abundant evidence shows that placement disruptions are a potent source of stress and are associated with negative outcomes.[40] The basic principles of neuroscience indicate that providing supportive and positive conditions for early childhood development is more effective and less costly than attempting to address the consequences of early adversity later in life. A wide range of policies, including those directed toward early care and education, child protective services, adult mental health, and family economic

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supports can promote the safe, supportive environments and stable, caring relationships that children need.[120]

SUMMARY AND BARRIERS TO IMPLEMENTATION

Risks associated with loss of continuity in medical care and lack of developmental screening are magnified in children in foster care. Consent, history, and records are often difficult to obtain after foster placement.[107] Lack of continuity of medical providers often causes interrupted treatment plans and lost time in early intervention, leading to additional delays in achieving potential. Funding for CAPTA systemized data collection through the National Child Abuse and Neglect Data System to require collection for children of all ages in terms of number and types of disabilities of children entering the child welfare system can better define types of preventative resources needed for biological and foster families to lessen and decrease length of placement. These data help target high-risk children and families for early intervention services to maximize child development.

Significant responsibility is currently placed on the medical home, which lacks adequate resources to obtain medical and developmental information, prenatal exposure histories, and past traumatic experiences for children in the child welfare system. Systematic changes in information collection at intake and education of child protection intake coordinators to obtain medical, developmental, trauma, and substance exposure histories at intake are necessary to establish appropriate coordinated care for our most vulnerable children. Equally important is open communication between pediatricians, foster care agencies, child welfare authorities, and family court judges. Without comprehensive reforms, intervention initiatives may remain disjointed, jeopardizing the effective delivery of services. A collective responsibility to act in the best interests of the child to maximize child development remains a challenge for the future of child welfare.

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