POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

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Developmental Challenges of Young Children in Foster Care: Policy Statement

Douglas Waite, MD, FAAP,[1] Adiaha Spinks-Franklin, MD, MPH, FAAP,[2] Jessica Simkins, MD, MPH, FAAP,[3] and the Council on Foster Care, Adoption, and Kinship Care; and Section on Developmental and Behavioral Pediatrics

This policy statement updates a previous statement to 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, family disruption, poverty, and racism. The accompanying clinical report provides a detailed examination of the developmental challenges faced by children in foster care younger than 5 years.

BACKGROUND

Recent child welfare statistics highlight the risks to typical development faced by young children in foster care. Of children entering foster care in 2022, 20% were younger than 1 year and 51% were 5 years or younger. The most common reasons for foster care placement are neglect (63%) and parental substance use (33%), with infants and toddlers more likely than older children to enter foster care.[1,2] Between 32% and 58% of young children in foster care have developmental delays compared with 13% of peers who are not in foster care.[3] Several risk factors contribute to the association between foster care placement and developmental delays, including 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. Given the substantial number of young children in foster care during the most critical period of early child development, this policy statement focuses on developmental issues faced by young children in foster care from birth to 5 years of age.

Young children are dependent on a nurturing, responsive caregiver to function as a critical buffer against stress and threats to healthy

abstract

[1]Department of Pediatrics, Metropolitan Hospital; New York Medical College, New York, New York; [2]Adoption and Beyond Developmental-Behavioral Pediatric Clinic; Clinical Associate Professor, Baylor College of Medicine, Houston, Texas; and [3]Pediatrician and Newborn Hospitalist; WestMed/Summit Health and Greenwich Hospital; Assistant Professor of Pediatrics at New York Medical College, New York, New York

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The guidance in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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development.[4] A healthy attachment to a responsive adult supports the development of social interactions, executive function, and self-regulation. 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.[5] The child welfare system is a critical point of contact for children who have experienced or are at risk of child maltreatment and related developmental delays. Yet, although 35% to 50% of children with substantiated maltreatment cases are found to need developmental services, only 10% to 26% receive these services.[6,7] 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.[8] For children at the peak of development, the effects of child abuse and neglect can last far beyond childhood. 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.[9]

Caring for children in foster care within the context of the medical home allows pediatricians to integrate information pertinent to child development, including prenatal and postnatal influences on child development, while screening for developmental delays. The policy recommendations below and the background information in the accompanying clinical report[10] are meant to reach beyond this medical home toward a greater collaborative effort at securing a nurturing environment that can maximize child development and health. Such a collaborative includes not only pediatricians, but foster care agencies, child protection authorities, and family court judges. Further recommendations are given for future changes in state and federal policies.

RECOMMENDATIONS TO IMPROVE DEVELOPMENTAL OUTCOMES FOR YOUNG CHILDREN IN FOSTER CARE

1. Children in foster care should receive comprehensive care in a family-centered medical home that facilitates communication with the biological parent, the foster parent, and the child welfare agency caseworker in caring for the developmental needs of the child. Engagement of the biological parent is one of the most important tasks in obtaining family, birth, and developmental history and caring for a child in foster care. This presents a unique opportunity to acquire information that may otherwise become inaccessible with the passage of time. At the same time, navigating conflicts between biological and foster parents is challenging and often unresolvable by the pediatrician. In such cases, the foster care agency and family court can establish guidelines for biological and foster parents that ensure the safety of the child.
    a. Contact with biological parents should take into consideration the safety and emotional well-being of the child.
    b. Parental visitation is an important part of maintaining the integrity of the biological family even in the face of the family disruption that occurs with foster care placement. Family visitation ranges from supervised to unsupervised visitation.
    c. The effects of visitation with the biological parent can adversely affect a child's well-being, especially when visitation occurs in the aftermath of inflicted injury or abuse of a child by a parent. In such cases, visitation can trigger traumatic symptoms that hinder child well-being. Consideration of the best interests of the child should take precedence over parental visitation when there is straightforward evidence of a child's recurrent behavioral or developmental deterioration that occurs after parental visitation.
2. While recognizing the difficulties of obtaining and sharing information on prenatal and birth history, family history, and past exposures to traumatic experiences, pediatricians and other child welfare professionals can best identify young children at risk of developmental and psychological challenges by attempting to ensure each of the following is completed and documented in the medical record:
    a. Screening for developmental and social/emotional challenges as well as for caregiver depression and past traumatic experiences should be performed for all children in foster care as recommended for all children by the American Academy of Pediatrics.[11] If there is not a record of previous validated developmental screening, validated screening at the time of entry into foster care should be recorded in the child's medical record. Because children entering foster care may be new to the caregiver, developmental screening at a follow-up visit after the caregiver has had time to observe the child's abilities and behaviors may allow more accurate assessment. This includes the enhanced visit schedule outlined by Healthy Foster Care America (https://www.aap.org/en/patient-care/foster-care/health-care-standards/ [Accessed December 19, 2025]). Further information can also be found in Fostering Health: Healthcare for Children and Adolescents in Foster Care.[12]
    b. Children entering foster care should be assessed for prenatal alcohol and substance exposures. Although obtaining detailed histories of prenatal substance and alcohol use can be challenging, this information should be routinely shared with primary care and developmental pediatric specialists whenever possible.
    c. The implementation of systematic screening for prenatal alcohol exposure is necessary to enhance the

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identification of infants and children with fetal alcohol spectrum disorders (FASDs). Recognition that 1 of every 3 children with FASDs will enter foster care demonstrates the need for increased funding, enhanced training, and greater availability of services for families and children impacted by FASDs.[13] The American Academy of Pediatrics (AAP) has designed an implementation guide to help pediatricians integrate prenatal alcohol screening into their routine care (https://downloads.aap.org/AAP/PDF/FASD/FASD_PAE_Implementation_Guide_FINAL.pdf [Accessed December 19, 2025]). Obtaining this history is especially important when a child has developmental and/or behavioral challenges. The AAP offers an FASD Toolkit for pediatric health care providers with up-to-date recommendations for screening and interventions for children with FASDs and their families at https://www.aap.org/en/patient-care/fetal-alcohol-spectrum-disorders

   d. Children in foster care should be evaluated for traumatic experiences such as neglect, abuse, and exposure to violence and how these might impact their development and behavior. The Trauma Symptom Checklist for Children (TSC-C) and the Trauma Symptom Checklist for Young Children (TSC-YC) are validated trauma assessment tools that can facilitate the detection of trauma in the setting of an outpatient foster care evaluation clinic and increase identification of trauma symptoms.[14]
   e. A developmental history should be obtained to establish specific developmental trajectories across developmental domains to allow prompt referral of children who lag from age-expected milestones for further assessment.
   f. Information on developmental challenges, intellectual disability, autism, and psychiatric illness, history of traumatic experiences, and substance use disorders in a child's biological family should be assessed as it can provide critical information on additional risks to development and behavior.

3. Pediatricians can facilitate and ensure prompt developmental referral and streamline barriers to increase access to intervention services.
   a. Given the disproportionate number of young children in foster care with developmental and emotional/behavioral challenges, placement in foster care should be a qualifying condition for early intervention services just as children born prematurely are routinely referred for intervention services. Additional referrals can be made to infant and early childhood mental health programs (https://www.samhsa.gov/early-childhood-mental-health-programs [Accessed December 19, 2025]). Referral processes for early intervention services for children in foster care often vary by state. Awareness of state early intervention processes can help pediatricians caring for children in foster care to expedite referral and evaluation.
   b. While consent procedures vary widely among states, in many states, the birth parent/legal guardian at the time of entry to care retains guardianship and, thus, the right to consent to treatment on behalf of the child. The need for biological parent consent to refer, evaluate, and obtain early intervention services continues to be a barrier to obtaining services for children in foster care.[15] This barrier can be diminished by including developmental evaluation and intervention services in the parental consent for medical care and treatment at foster care intake.
   c. Pediatricians have an opportunity to provide ongoing education about a child's developmental abilities and progress at all well-child visits for young children in foster care. This information sharing serves to enhance foster parent and biological parent awareness of the importance of early intervention, which is especially important for children for whom developmental challenges are often seen as behavioral problems. Caregivers can also be referred to the Centers for Disease Control and Prevention's free milestone tracker located at https://www.cdc.gov/act-early/index.html.
   d. Attempts at seeking developmental evaluation and services may be hindered by biological parent and foster parent fears of stigmatization of their child and the feeling that providers are labeling their children as disabled. The medical home can be a site of family support that builds a relationship of trust focused on the shared best interests of the child's health and development.

4. Biological and foster parents should be educated about the specific developmental challenges of children in foster care. This education includes:
   a. Foster parent education and training in developmental and behavioral effects of traumatic experiences and manifestations in day-to-day life challenges. Further information for both pediatricians and parents can be found at the AAP website The National Center for Relational Health and Trauma-Informed Care (https://www.aap.org/en/patient-care/trauma-informed-care/ [Accessed December 19, 2025]) and the National Child Traumatic Stress Network (https://www.nctsn.org/).
   b. Foster and biological parent education and training in FASDs.

5. Children in foster care often have multiple providers. The need to integrate care extends from medical providers, foster care agencies, early intervention providers, and

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schools. Foster care placement can be an opportunity to integrate care across multiple providers in the child's medical record to guide both current and future diagnoses and interventions.

6. The transition from early intervention to school-based services is a time when services can abruptly end. This transition may be hindered by difficulties obtaining parental consent, changes in foster home placement, and the lack of biological or foster parent awareness of the importance of ongoing interventions. The medical home can help facilitate and ensure transition from early intervention services to preschool- and school-based services by guiding families through the transition process and emphasizing the importance of intervention in ongoing support of a child's development.
7. Pediatricians can collaborate with child welfare professionals to advocate for national and statewide policies to address historical structural and interpersonal racism in the intake, removal, permanency, and reunification process as well as the effects of poverty and racism on child development.
8. Specific policy recommendations for states and the federal government can dramatically improve the development of children in foster care or prevent placement in foster care. Specific areas of advocacy include adequate funding for early intervention programs to allow prompt evaluation and treatment of children in foster care with developmental delays, improvements in federal and public policy support for kinship families when children are unable to live with their biological parents,[16] and alliances with court-appointed advocates to assist in cases of abuse and neglect to improve prompt intervention, permanency outcomes, and length of placement in foster care.[17] Housing instability that threatens placement into foster care can be mitigated by improvements in the Family Unification Program (a federal initiative that connects inadequately housed families involved in child welfare with long-term rental subsidies to avoid foster placement).[18,19] In addition, racism and concentrated poverty continue to disproportionately affect children in foster care and kinship placement. Efforts to address these associated factors at the federal and local level offer hope for reduction in foster care placements.[20–23] For more information about advocacy engagement in your state on these issues, contact the AAP state advocacy team at stgov@aap.org.
    a. Earned income tax credits and child tax credits have been shown to reduce child poverty. The Transitional Aid for Needy Families (TANF) program and the effects of supplemental income during the COVID-19 pandemic have shown the possibility of reducing child poverty that is associated with foster care referrals. Pediatricians can collaborate with child welfare professionals to advocate for enhanced income for foster and kinship families that have been demonstrated to decrease foster care placement. These supports can mitigate the ongoing effects of racism and poverty on child development.[24]
    b. The need for the birth parent's consent to refer to, evaluate, and obtain early intervention services can be a barrier to obtaining services for children in foster care with developmental delays. Consent for medical treatment obtained from the parent for all children at the time of entry into foster care should be expanded to include consent for developmental evaluation and services. This consent facilitates the referral and evaluation process and acknowledges research that documents the complex interdependence of medical and developmental issues.
    c. Interdisciplinary care can be facilitated through sharing of information between the child welfare agency, child protective services, the family court system, and current and past medical homes. Many new initiatives have focused on sharing information across interdisciplinary teams while preserving confidentiality.[25,26] These efforts allow foster care placement to be an opportunity for developmental screening, integration of medical information, and intervention.
    d. Implementation of the Family First Prevention Services Act can help expand access to services to safely preserve families impacted by parental mental health and substance use disorders. Implementation of this act is imperative in addressing parental substance use and mental health issues as one of the primary causes for placement in the child welfare system.
    e. Supporting mental health access for children and their families involved in the child welfare system through community-based services via expansion of the Family First Prevention Services Act can serve to address racial disproportionality and inequity in the child welfare system while supporting a nurturing home environment to optimize child development.
    f. Improving implementation of "plans of safe care" under the Child Abuse Prevention and Treatment Act emphasizes a non-punitive public health approach to infants impacted by prenatal substance exposure and their families to prevent foster care placement. Expanding plans of safe care to include postnatal follow up and interventions with court oversight when needed can help ensure the safety and physical and developmental well-being of the child while supporting families. Although pediatricians can support child-based services, their ability to coordinate effective family-centered treatment

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services is limited and should be ensured by the family court and agencies responsible for safe care.

g. Children with disabilities can fail to receive services because of court and foster care agency inaction. Expeditious determination of parental rights status should be made for the benefit of infant and toddler developmental and mental health. The timelines established by the Adoption and Safe Families Act requires states to conduct a permanency hearing within 12 months of a child's placement in foster care and at least every 12 months thereafter for as long as the child is in foster care. Early permanency planning should focus on the best interests of the child's developmental and mental health. Court mandates are crucial in ensuring that child developmental and mental health interventions are timely to maximize child well-being.
h. Federal legislation is urgently needed to address systemic racism both in the child protection referral process and within the child welfare system. This needed legislation includes ongoing support for and adherence to the Indian Child Welfare Act to address the ongoing systemic racism and colonial trauma among American Indian/Alaska Native children and their families. Supporting kinship placement is a means of maintaining a child within the family and community while ensuring the safety of the child.[27] An emphasis on kinship placement and culture are both important when thinking about optimizing outcomes for American Indian/Alaska Native children.[28] Additional barriers for American Indian/Alaska Native children include navigating multiple legal jurisdictions (tribal, state, federal), the potential for out-of-home placement further from their home community because of the rural and urban distribution of tribes, and shortages of developmental specialists and services within Indian Health Services and tribal health systems.
i. Pediatricians and child advocates can advocate for policies and funding to ensure an adequate and well-trained workforce to provide early intervention services for children 0 to 3 years of age. In addition, advocacy for policies that provide payment for interdisciplinary care models (eg, integrated medical-behavioral health models and care coordination within the pediatric medical home) can promote access to integrated models of care.
j. Pediatricians and child advocates can promote ongoing up-to-date training for child welfare workers and case managers on the impact of trauma, attachment disruption, and prenatal alcohol and substance exposure on the development, behavior, and health of children. Child welfare workers are key professionals who can provide a link between the pediatrician, foster parents, and the child welfare system. Therefore, continuing education on the impact of trauma, prenatal exposures, and foster care placement on the children they serve is important to help them develop the knowledge and skills they need to provide quality care.[29,30]

LEAD AUTHORS

Douglas Waite, MD, FAAP
Adiaha Spinks-Franklin, MD, MPH, FAAP
Jessica Simkins, MD, MPH, FAAP

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REFERENCES

1. Williams SC, Sepulveda K. Infants and toddlers are more likely than older children to enter foster care because of neglect and parental drug abuse. Child Trends; March 2019. Accessed July 7, 2025. https://www.childtrends.org/publications/infants-and-toddlers-are-more-likely-than-older-children-to-enter-foster-care-because-of-neglect-and-parental-drug-abuse
2. US Department of Health and Human Services, Administration for Children and Families. Adoption and Foster Care Analysis and Reporting System (AFCARS) Report #30. Administration for Children and Families; March 2024. Accessed July 7, 2025. https://acf.gov/cb/report/afcars-report-30
3. McLeigh JD, Tunnell K, Lazcano C. Developmental status of young children in foster care. *J Dev Behav Pediatr.* 2021;42(5):389–400. PubMed doi: 10.1097/DBP.0000000000000906
4. Shonkoff JP. Building a new biodevelopmental framework to guide the future of early childhood policy. *Child Dev.* 2010;81(1):357–367. PubMed doi: 10.1111/j.1467-8624.2009.01399.x
5. Jones VF, Schulte EE, Waite D, et al; COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE. Pediatrician guidance in supporting families of children who are adopted, fostered, or in kinship care. *Pediatrics.* 2020;146(6):e2020034629. PubMed doi: 10.1542/peds.2020-034629
6. Munger KF, Stegenga SM, Storie SO, Wennerstrom EK. Addressing challenges at the intersection of early intervention and child welfare. *Child Abuse Negl.* 2023;142(Pt 1):105852. PubMed doi: 10.1016/j.chiabu.2022.105852
7. Meredith RM. Sensitive and critical periods during neurotypical and aberrant neurodevelopment: a framework for neurodevelopmental disorders. *Neurosci Biobehav Rev.* 2015;50:180–188. PubMed doi: 10.1016/j.neubiorev.2014.12.001
8. Shonkoff JP, Boyce WT, Levitt P, Martinez FD, McEwen B. Leveraging the biology of adversity and resilience to transform pediatric practice. *Pediatrics.* 2021;147(2):e20193845. PubMed doi: 10.1542/peds.2019-3845
9. Fisher PA, Leve LD, Delker B, Roos LE, Cooper B. A developmental psychopathology perspective on foster care research. In: Cicchetti D, ed. *Maladaptation and Psychopathology.* John Wiley & Sons; 2016:513–554. *Developmental Psychopathology.*
10. Waite D, Spinks-Franklin A, Simkins J; American Academy of Pediatrics, Council on Foster Care, Adoption, and Kinship Care, Section on Developmental and Behavioral Pediatrics. Developmental challenges of young children in foster care: clinical report. *Pediatrics.* 2026;158(1):e2026077418. doi: 10.1542/peds.2026-077418
11. Lipkin PH, Macias MM, Norwood KW Jr, et al; COUNCIL ON CHILDREN WITH DISABILITIES, SECTION ON DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS. Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening. *Pediatrics.* 2020;145(1):e20193449. PubMed doi: 10.1542/peds.2019-3449
12. Fostering Health. *Healthcare for Children and Adolescents in Foster Care. AAP Council on Foster Care, Adoption, and Kinship Care.* American Academy of Pediatrics; 2025.
13. Engesether B, Hoffner M, Johnson E, Klug MG, Popova S, Burd L. Prevalence of fetal alcohol spectrum disorder in foster care: A scoping review. *Alcohol Clin Exp Res (Hoboken).* 2024;48(8):1443–1450. PubMed doi: 10.1111/acer.15394
14. Forkey HC, Morgan W, Schwartz KA, Sagor L. Outpatient clinic identification of trauma symptoms in children in foster care. *J Child Fam Stud.* 2016;25(5):1480–1487. doi: 10.1007/s10826-015-0331-3
15. Szilagyi MA, Rosen DS, Rubin D, et al; COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE; COMMITTEE ON ADOLESCENCE; COUNCIL ON EARLY CHILDHOOD. Health Care Issues for Children and Adolescents in Foster Care and Kinship Care. *Pediatrics.* 2015;136(4):e1142–e1166. PubMed doi: 10.1542/peds.2015-2656
16. Rubin D, Springer SH, Zlotnik S, et al; COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE. Needs of Kinship Care Families and Pediatric Practice. *Pediatrics.* 2017;139(4):e20170099. PubMed doi: 10.1542/peds.2017-0099
17. Osborne C, Warner-Doe H, LeClear M, Sexton H. The Effect of CASA on Child Welfare Permanency Outcomes. *Child Maltreat.* 2020;25(3):328–338. Published online October 14, 2019 PubMed doi: 10.1177/1077559519879510

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18. Fowler PJ, Brown DS, Schoeny M, Chung S. Homelessness in the child welfare system: A randomized controlled trial to assess the impact of housing subsidies on foster care placements and costs. *Child Abuse Negl.* 2018;83:52–61. Published online July 17, 2018 PubMed doi: 10.1016/j.chiabu.2018.07.014

19. Fowler PJ, Marcal KE, Chung S, Brown DS, Jonson-Reid M, Hovmand PS. Scaling Up Housing Services Within the Child Welfare System: Policy Insights From Simulation Modeling. *Child Maltreat.* 2020;25(1):51–60. Published online May 16, 2019 PubMed doi: 10.1177/1077559519846431

20. Wulczyn F, Zhou X, McClanahan J, et al. Race, Poverty, and Foster Care Placement in the United States: Longitudinal and Cross-Sectional Perspectives. *Int J Environ Res Public Health.* 2023;20(16):6572. PubMed doi: 10.3390/ijerph20166572

21. Maguire-Jack K, Lanier P, Johnson-Motoyama M, Welch H, Dineen M. Geographic variation in racial disparities in child maltreatment: The influence of county poverty and population density. *Child Abuse Negl.* 2015;47:1–13. Published online June 27, 2015 PubMed doi: 10.1016/j.chiabu.2015.05.020

22. Kennedy RS, Potter MH, Font SA. A Meta-Regression of Racial Disparities in Wellbeing Outcomes During and After Foster Care. *Trauma Violence Abuse.* 2023;24(4):2711–2725. Published online June 30, 2022 PubMed doi: 10.1177/15248380221111481

23. Maguire-Jack K, Font SA, Dillard R. Child protective services decision-making: The role of children's race and county factors. *Am J Orthopsychiatry.* 2020;90(1):48–62. Published online May 13, 2019 PubMed doi: 10.1037/ort0000388

24. Gitterman BA, Flanagan PJ, Cotton WH, et al; COUNCIL ON COMMUNITY PEDIATRICS. Poverty and child health in the United States [reaffirmed April 2021]. *Pediatrics.* 2016;137(4):e20160339. PubMed doi: 10.1542/peds.2016-0339

25. Lutz NM, Greiner MV, Vaughn L, et al. Automated information sharing in foster care: perspectives on impact and expansion. *Front Pediatr.* 2025;13:1543076. PubMed doi: 10.3389/fped.2025.1543076

26. Beal SJ, Dynan L, Patzke A, et al. Impact of Automated Information Sharing on Health Care Delivery to Youths in Foster Care Beal. *J Pediatr.* 2022;249:111–113.e1. doi: 10.1016/j.jpeds.2022.06.001

27. Osborne J, Hindt LA, Lutz N, Hodgkinson N, Leon SC. Placement stability among children in kinship and non-kinship foster placements across multiple placements. *Child Youth Serv Rev.* 2021;126:106000. doi: 10.1016/j.childyouth.2021.106000

28. National Indian Child Welfare Association. Contemporary Attachment and Bonding Research: Implications for American Indian/Alaska Native Children and their Service Providers. Accessed July 7, 2025. Contemporary-Attachment-and-Bonding-Research-Final.pdf

29. Radey M, Schelbe L, King EA. Field Training Experiences of Child Welfare Workers: Implications for Supervision and Field Education. *Clin Soc Work J.* 2019;47(1):134–145. doi: 10.1007/s10615-018-0669-2

30. Radey M, Stanley L. Beginning the "never-ending" learning process: Training experiences of newly-hired child welfare workers. *Child Youth Serv Rev.* 2019;104:104378. doi: 10.1016/j.childyouth.2019.06.013

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