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Child Welfare Policies and Practices Regarding Children with Prenatal Exposure to Alcohol and Other Drugs: An Exploratory Study

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Abstract

Research indicates that there are more children with prenatal alcohol and other drug exposures in child welfare than in the general population. Using multiple forms of data from staff and caregivers from one urban agency, this exploratory study demonstrated opportunities to inform polices, practice, and data elements regarding this vulnerable group. Findings are discussed within the context of ensuring family preservation, equity and avoiding disproportional race/ethnicity within child welfare when identifying and caring for children with prenatal exposures.

Parental use of alcohol and other drugs is a major factor in bringing children and families to the attention of child welfare agencies in the United States. Studies have estimated that between 50% and 80% of child maltreatment cases involve substance misuse by a parent (Osterling & Austin, 2008; Radel et al, 2018). Many children of these families are also at risk for exposure to alcohol and other drugs in utero. Young and colleagues (2009) estimate

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that approximately 10% of infants born each year may be affected by prenatal substance exposure (PSE). Among child welfare populations, these percentages rise substantially, and concerningly, research has shown racial and socioeconomic disparities in reports of PSE to child welfare (Roberts & Nuru-Jeter, 2012). A meta-analysis of 33 international studies (11 in the United States) looking at children under state guardianship found that 17% of children in out-of-home care may be impacted by PSE, specifically alcohol, which is well above levels found in the general population (Lange, et al, 2013). However, historically, national datasets such as the National Child Abuse and Neglect Data System[1] (NCANDS) or the Adoption and Foster Care Analysis and Reporting System (AFCARS) have not obtained complete information on prenatal exposures. While recent attempts have been made to improve this, there is a lack of adequate information about children affected by PSE in the child welfare system as well as the services families may need.

PSE often results in adverse child outcomes (Preece & Riley, 2011) such as neonatal abstinence syndrome (NAS) or a fetal alcohol spectrum disorder (FASD). NAS is a neurological condition characterized by excessive crying, poor sleep and feeding regulation, as well as other behavioral issues as an infant experiences withdrawal from substances after birth. FASD is a term encompassing several diagnoses related to alcohol exposure during gestation. In the *general* population it is estimated that 2–5% of school aged children may have a FASD although most are undiagnosed or misdiagnosed (Chasnoff et al., 2015; May, et al, 2018).

Prenatal exposure to alcohol is of particular concern. A report from the National Academies of Science's Institute of Medicine stated, "Of all the substances of abuse (including cocaine, heroin, and marijuana), alcohol produces by far the most serious neurobehavioral effects in the fetus" (Stratton et al., 1996, p. 35). Negative effects associated with FASDs include delayed milestones, reduced IQ, learning/memory problems, attention deficits, self-regulation impairments, a range of behavioral issues, and poor adaptive functioning (Bertrand & Dang, 2012; Turchi & Smith, 2018). Unrecognized, or identified late in childhood, these negative effects may lead to severe lifelong consequences such as school failure, involvement with juvenile justice, inappropriate sexual behavior, poor health, and disrupted caregiving situations (Young, et al., 2009; Coles & Black, 2006; Streissguth et al., 2004); all adverse outcomes also associated with children involved with the child welfare system, which complicates identification and accurate diagnosis (Ringel et al., 2017).

If PSE, especially prenatal alcohol exposure (PAE), is not known, parents may misinterpret challenging behaviors as disobedience rather than brain-based impairments. Parents may become frustrated leading to an increased risk of child maltreatment as well as repeated cycles of abuse and neglect. This risk is increased if parents have alcohol or drug issues. Therefore, prenatal exposure history is an important consideration for parents, including foster parents, raising a child who has been affected (Petrenko, et al., 2016). Identifying children with PSEs and assessing the child's specific needs in combination with parent

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[1] In 2018, NCANDS began to include two questions: "Does the infant with prenatal substance exposure have a plan of safe care as specified by the CARA legislation?" and "Does the infant with prenatal substance exposure have a referral to Comprehensive Addiction and Recovery Act (CARA) appropriate services, including services for the affected family or caregiver?" However, these data elements are not yet available for analysis.

or caregiver education on PSEs can enhance the parenting dynamic, with the opportunity to prevent unnecessary foster care entrance and, when the child is already in foster care, promote faster reunification or greater placement stability (Leve, et al., 2012; Rhodes, et al., 2001). Child welfare professionals play a key role in obtaining this information for case families.

To better understand child welfare practices pertaining to identification, referral, and care of children with PSEs, it is helpful to examine the knowledge, policies, current practices and needs of child welfare agencies and professionals. To begin this process, in 2015, an exploratory study of a single child welfare agency in a mid-Atlantic urban center was conducted. The objective of this study was to explore ways to gather information about knowledge, policies, practices, and educational needs regarding children with PSE—particularly PAE—who are receiving child welfare services.

Methods

Three types of data were obtained: (a) semi-structured interviews with key informant staff; (b) review of a limited number of case files; and (c) a caregiver focus group. Data collection strategies were developed in collaboration with local child welfare agency staff to ensure completeness and validity. All procedures were reviewed and approved by the Institutional Review Board at ICF (FWA: 00000845). Signed informed consents were obtained. In 2015, the agency served 2,827 children, which included 62% receiving care in their homes and 38% in out-of-home care.

Key Informant Interviews

One-on-one interviews were conducted with 37 staff across major agency departments. Interviewers were trained to standard reliability and validity criteria. Additional information on interviewer and coder training is available from the first author. Participants included: administrators ($n = 9$); investigative and clinical staff ($n = 7$); ongoing management caseworkers ($n = 8$); trainers ($n = 7$); data managers ($n = 3$); and consulting medical professionals ($n = 3$).

Broad interview topics included: current knowledge of issues related to children with PSE, formal education regarding children with PSE, education and training needs (specifically continuing education or inservice courses), descriptions of any case involvement that included a child with PSE, and current or previous work with children who have special needs. Staff interviews lasted on average 47 minutes. All interviews were recorded and transcribed then analyzed in ATLAS.ti qualitative software applying content analysis and theme identification both within and across staff roles (Williams & Moser, 2019). A detailed description of the coding scheme is available from the authors.

Case Record Review

The objectives of case record review were to identify: (a) where in the case record staff routinely documented PSE information and (b) potential data elements that could accommodate routine reporting of PSE history.

After completing confidentiality agreements, research staff participated in on-site training of the agency's electronic data system. A sample of 75 case files were requested and provided by agency staff for review and abstraction for families involved with the agency between 2000 and 2016. To be considered for inclusion in case record review, cases needed to have a completed investigation and some form of ongoing agency involvement for at least 90 days (to ensure a minimum amount of data points for analysis). Requested case files included one referral, index child, per family and subsequent associated ongoing cases (i.e., siblings). Requested index cases included: cases involving a positive toxicology report at birth, cases involving substance abuse allegations, cases involving a child with an attention or behavior-related diagnoses (including an FASD), and cases chosen at random. An initial pilot review of eight case files led to the refining of data collection instruments and procedures and provided an opportunity to establish inter-rater reliability of abstraction coding before the full review of the remaining 67 case files.

The 75 cases examined included: 22 cases with a positive toxicology allegation or related medical diagnoses, 22 cases with a parental substance use-related allegation, 11 cases where at least one child had an attention or behavior-related diagnoses, and 20 cases selected from across the agency's data system, aligned with the study's inclusion criteria described above. Based on the small sample size, race-ethnicity data could not be effectively analyzed. Future work should include this information.

The abstraction rubric was divided into two primary sections based on the structure of the agency's data system: (a) Referral: This section recorded information from the initial hotline call or referral through the investigation findings from that referral and included reviews of six distinct reports related to the initial referral, collateral contacts, assessments (two forms), court documents, and the investigation; and (b) Ongoing Case: This section recorded data from the time a case was opened until it was closed due to family stability, child reunification, or child adoption and included reviews of nine reports related to case plans, collateral contacts, court documents (three reports), assessments, medical documentation (two forms), and case transfers.

Caregiver Focus Group

Seven current or previous foster/adoptive parents (including kinship caregivers) were recruited through their caseworkers at the local agency to participate in a two-hour focus group. Focus group participants completed a background information card with details about the type of caregiver they were, their length of caregiving experience, the number of children they had cared for, and the ages of those children.

The caregiver focus group was designed with an interactive framework to encourage participation and increase comfort levels. Throughout the focus group, participants responded to questions verbally, gave written responses, applied stickers to poster paper to indicate their responses, and held up rating cards to indicate priorities. Caregivers were asked analogous questions to those of agency staff, as well as about their personal experiences as a caregiver and perceptions of preparedness to care for a child with PSE. Topics addressed in the focus group included: background of caregiving (e.g., length of caregiving, number of children cared for); training and support received on PSE, developmental milestones, and caring for children with special needs; perceived information needs; knowledge of PSE and PAE; personal experiences as a caregiver of children with PSE/PAE; and broad opinions on the role of caregivers in treatment, education, and support of children in their care.

The focus group discussion was audio recorded and transcribed with detailed notes taken by a researcher observer. Participants' individual responses via rating cards, post-it notes, and stickers were entered into an Excel matrix along with their background information which were analyzed using descriptive statistics. This analysis explored the salience or differences among themes by type of caregiver, years of experience, or age of the child in care (e.g., infant). These findings were synthesized with the aggregate thematic coding conducted in ATLAS.ti (as previously described).

Results

Results for staff interviews, case records, and the caregiver focus group are presented separately.

Staff Interviews

Because this was an initial, exploratory study with a small number of staff interviews, especially at the staff specific-role level, primarily qualitative results are presented. The following terms are used to reflect intentional approximations of frequency: few (about 10 to 25% of participants), some (about 26 to 50% of participants), many (about 51 to 75% of participants), and most (about 76 to 90% of participants).

Staff estimated that 10-30% of their caseloads involved PSE cases. This range widened when specifically queried about PAE (range=0-90%). Results from interviews are organized into three areas: (a) previous education or training; (b) knowledge of PSE; and (c) current policies/practices (including obtaining referrals and treatment).

Previous Education or Training

Most interviewees reported no training or formal classes related to PSE. A few participants indicated minimal training or education. Several staff participants mentioned knowing of only one training on PSE ever offered by the agency. Nonetheless, training staff noted an optional inhouse training on children with FASDs and in background research for the project, researchers found several trainings on the topics of children with PSE and FASDs that were available to agency staff. A few participants further indicated that they gained knowledge through trainings that discussed FASDs, which focused on the adverse effects of PAE with little information provided about other drug exposures.

Most participants indicated that they obtained knowledge of PSE through "on-the-job experience" from mentors or co-workers. Every participant discussed the need for training and education in at least one area within the topic of PSE. The most frequently cited topics for further training were short-and long-term effects of PSE and how to identify PSE symptoms in children. Needing information on available services, resources, and treatments were frequently mentioned.

Knowledge of PSE

Participants were asked to rate their knowledge of PSEs as beginner, intermediate or advanced. Most participants rated themselves as having an “intermediate” level of knowledge of PSE. The remaining participants rated themselves as “beginner,” with very few rating their knowledge as advanced.

Participants reported varying opinions about the types of substances that they thought were most harmful to use during pregnancy; the most mentioned substances were alcohol and phenylcyclohexyl piperidine (i.e., PCP). In general, participants correctly expressed that PAE would have more harmful long-term effects compared to other substances. A few participants also noted that some drugs (such as marijuana and K2, a synthetic marijuana) need more research to determine their long-term effects on children since use of these drugs appears to be on the rise. Relevant to all these findings may be that some staff inadvertently became aware of the fact that the researchers were interested in studying alcohol which could have raised their attention and awareness of alcohol as an issue.

In addition to types of PSEs, participants were asked about acceptable levels of exposure. Many participants indicated that there is no acceptable use of alcohol in pregnancy regardless of the trimester, with some also indicating that there was no acceptable use of any substance at any stage of pregnancy. Many mentioned that exposures could occur before pregnancy recognition. A few participants were hesitant to indicate acceptable levels of exposures citing the fact that they were not medical professionals. Finally, although their advice to clients would be not to consume alcohol at all during pregnancy, some participants indicated that this may be unrealistic for women and stopping some substances (e.g., opioids/methadone) could result in high risk of harm for the mother or baby.

Current Policies and Practices

Policies and practices regarding children in care with PSE for (a) identification and (b) ongoing care or service referrals were examined. When asked about formal agency policies regarding identification, participants reported that there was no established policy regarding how caseworkers were supposed to identify PSE. In discussing actual practices, there was consensus across participants that it would be ideal to systematically determine PSE history during the initial investigation as part of obtaining a child’s health history. It was noted that such information is more likely obtained for infants and young children under the age of three years or children who had known birth complications (e.g., prematurity) compared to older children or children with no complications at delivery. The most common way that agency staff reported identifying children with PSE was through a positive toxicology report at the birth of the child (either the mother’s or the infant’s). However, many staff noted that positive toxicology reports to child welfare were at the discretion of local hospitals. One participant further described differences in PSE reporting frequency by hospital, based on the socioeconomic status of the population served.

Participants also were asked about situations when PSE history was not obtained during the initial phases of a case. In these cases, participants indicated that several data sources other than direct maternal reports may be accessed including medical/birth records, school records, criminal records, and interviews with collateral contacts. Caseworkers who were responsible for ongoing case management also indicated that although they utilized a standard assessment which included items about the mother's pregnancy and complications at birth, targeted questions about PSE were not included in this required list. A few respondents indicated that they had their own informal questions about PSEs, although they acknowledged inconsistency in using them. Participants mentioned several barriers to identifying PSE in children already known to the agency: reliability/validity of maternal report due to reluctance to disclose, access to records, focus on immediate safety, and limited time to evaluate developmental and behavioral issues in the child.

None of the participants described any specific agency policies related to referring children to specific assessments or services based on suspected or known exposures.[2] Most participants reported that the process to identify needed services was similar across cases whether children were prenatally exposed to substances or not. Participants described various assessments used to determine the service referrals that caseworkers would recommend for both mothers and children. Assessments may be formal, such as standardized developmental assessments, or informal such as contact notes from parental or collateral contact interviews and caseworker observations. Participants also noted that while there were no formal processes for sharing records between medical professionals and agency staff, medical providers routinely shared the outcomes and findings from appointments and evaluations. Finally, many caseworkers responded that service referral was dependent on the child's age. They noted an urgency for younger children to access early intervention services, but also expressed knowing that some impairments, especially educational or neurodevelopmental impairments, do not emerge until after infancy. However, most staff did not focus on possible ongoing impacts of PSE on a child's development, which would be particularly relevant for alcohol exposure. A theme that emerged across participants was that children will not be referred for a formal relevant assessment unless and until an agency staff member has determined some reason to suspect that a child may have a problem related to PSE. How the staff member comes to that decision was unclear based on the information available in this study.

An important observation was that throughout the interviews, when asked about treatment or services for children with PSEs, most participants defaulted to responding about efforts to provide and support parental substance abuse treatment. In addition, a few permanency caseworkers clarified that a main focus of their work was to support the mother in addressing her substance abuse issues as a way to facilitate child reunification.

Case Record Review

A total of 75 case files were reviewed yielding a total of 231 children in the reviewed sample. Eighty-five percent of the reviewed case files reported maternal substance use with 59% having indications of PSE for a child, although these high percentages are most likely an artifact of the sampling method.

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[2] This study took place prior to the Comprehensive Addiction and Recovery Act of 2016 and the reauthorization of CAPTA, which mandated the development of Plans of Safe Care for substance-exposed newborns. Public Law No 114-198, § 503 (2016). See https://www.cadca.org/comprehensive-addiction-and-recovery-act-cara.

Within the referral and investigation sections of the records, 52% had at least one child with a report of PSE. Relevant information was most commonly found in investigation summaries (51%) or contact reports (45%), both of which were primarily narrative. Aligned with caseworker reports, most of these reviewed cases relied on positive toxicology tests (45%) or a positive maternal drug test during pregnancy or at the birth of the child (43%) as their source of information. A much smaller percentage of referral and investigation sections (3%) included a medical diagnosis of exposure (e.g., FASD or withdrawal) for any child. Just 1% of reviewed referral and investigation sections included a PSE report that was discovered for a child older than 1 or where the timing of discovery was unclear.

Information in ongoing case documentation (e.g., visitation notes) were similar to those seen in the referral and investigation sections, with 55% of ongoing case documentation recording at least one child with PSE. This documentation was also primarily narrative, found in contact reports (53%), case plans (37%) or court disposition reports (25%). In addition to frequent reports from positive toxicology and material drug tests, three contextual categories provided higher percentages of pertinent information within the ongoing case documents as compared to the referral and investigation sections: parental report (32%), collateral report (15%), and medical diagnoses (4%).

Caregiver Focus Group

Caregivers described receiving general information about developmental milestones, special needs, and broad PSE effects. Four of the seven focus group participants reported receiving information on PSE from the agency prior to receiving children in care; six recalled receiving this information after a child had been placed in their care; and one had never received information about PSE (some participants received information multiple times). When asked to think about children in their care who had PSEs or had suspected exposure, only two of the seven participants recalled receiving specific information about the medical, behavioral, or developmental background of that child. Most participants reported that they received little or no information about that child’s background from the agency prior to placement. In some cases, this information delay was because PSE was not a known issue that the child faced. One kinship caregiver had never received information from the agency about her child’s PSE. Because she was a family member, she speculated that the agency staff assumed that she did not need any background knowledge about the child regarding PSE, developmental indicators, or other factors.

In addition to receiving information from the agency, focus group participants reported receiving information about PSE from private agencies, support groups through social media, personal research, and family members with specialized training (e.g., a relative who is a substance abuse counselor and a relative who runs a trauma center). Personal research was cited by several foster and adoptive participants as a key source of knowledge. Caregivers noted that this included “online seminars where you get techniques and strategies,” information on developmental delays received from pediatricians, research articles, and conversations with professionals. Finally, all participants reported that prior to receiving the child, they did not feel prepared to support the child through challenges related to PSE. Despite reporting a lack of complete and specific information from their agency, these caregivers reported that based on trainings received, additional personal research, and skills learned through having to navigate these challenges, they felt prepared to support the children currently in their care, as well as any future children who might be placed with them. There were no observable differences in the information received by participants regarding length of caregiving experience, number of children cared for, or the type of caregiving background.

Discussion

This exploratory study examined the knowledge, policies and practices, and educational needs regarding children with PSE receiving child welfare services in a single, urban, child welfare agency. It is important that findings from this exploratory study be understood within the context that the high percentage of minority children in child welfare may be an artifact of these families being disproportionally targeted for alcohol and drug issues (Child Welfare Information Gateway, 2021). For example, minority and/or disadvantaged women and their infants may be more likely to be administered a toxicology screen at birth or during child welfare investigations (Roberts & Nuru-Jeter, 2012). The Children’s Bureau is especially concerned that child welfare professionals ensure equity regarding race/ethnicity when encountering children who may have been prenatally exposed to alcohol and other drugs. Changes in training and agency guidance can improve the process agencies use for screening and providing needed services to all families as well as address the implicit bias that may contribute to the imbalance of race/ethnicity in child welfare.

The study revealed several important insights. First, participants, both staff and caregivers, strongly expressed a need for specific information on PSE for each child as they came into care. Staff reported, and case records confirmed, that cases with documented PSE are most commonly those with a positive toxicology report of mother and/or baby at birth. Yet an overreliance on these hospital reports to identify PSE among children in care may be problematic; research has shown racial and socioeconomic disparities in hospital screening of PSE and subsequent reports to child welfare (Ellsworth, et al., 2010; Roberts & Nuru-Jeter, 2012). In addition, both staff and caregivers indicated significant barriers to identifying PSE during the ongoing case, including diagnosis confusion and a lack of historical data. This has unique implications for children with PAE, as they often have ongoing future developmental and educational issues (Young, et al., 2009; Coles & Black, 2006). Second, staff frequently defaulted to discussions of parental substance abuse rather than prenatal substance exposure. This finding suggests that *current* parental substance abuse may be more salient to staff as a pressing concern than uncovering and providing services for the children’s potential problems related to prenatal exposures.

Additionally, the information gathered in this exploratory study highlighted opportunities for additional training and the need for consistent data reporting procedures. Specific agency policies regarding required training on PSE or identification of children with PSE were not identified, a finding consistent with a pre-study review of agency policies on this topic. Further, staff education regarding children with PSE was primarily through “on-the-job” experiences, rather than formal training. Staff consistently expressed a desire to learn more about the impacts of different substances. Staff reports and case record reviews both indicated that, if assessed, PSE was documented in a variety of locations within the electronic case file system making it difficult to communicate the information among various staff who interact with case children/families in various capacities or over time. This may further limit the ability of staff to make the most informed recommendations for child services or family supports. Finally, caregivers indicated that they have a need for exposure information on each child in their care as well as training on care of children with PSE.

Importance of Identifying PAE

As indicated by the Institute of Medicine statement, PAE is the most harmful prenatal exposure (Stratton, et al., 1996). Further, findings across a variety of studies indicate that that PAE is a much bigger problem than most people have suspected; alcohol is legal, readily available, socially acceptable, widely promoted, and along with tobacco, is the most commonly co-used substance (England, et al., 2020; Singer & Minnes, 2011). Any child found to be prenatally exposed to other drugs is highly likely to be at risk for PAE as well.

Identifying children with PAE can be difficult; unlike children with many types of prenatal drug exposures, children with PAE generally do not experience withdrawal or NAS at birth (Preece & Riley, 2011). Further, reliance on toxicology screens, such as those seen in this study, is problematic in identifying PAE, given that alcohol is not generally included in such panels and alcohol metabolites are usually eliminated from the mother's system within 12 hours of consumption. Thus, toxicology screens likely miss most instances of PAE (Drescher-Burke, 2007).

For older children, impairments due to PAE are not readily apparent because many meet milestones within normal age limits and have good basic language skills (e.g., vocabulary & syntax) leading adults to believe that there is no problem. However, their poor executive functioning skills and difficulty understanding the intentions of others can lead to increased risks and serious problems. For example, a young teen might be encouraged to engage in dangerous or illegal activity because the FASD-affected young person is trying to be friendly but does not recognize the malign motives of the "friend," (such as asking the youth to carry a paper bag across the street, when it actually contains drugs).

Importance of Identifying Children in Child Welfare with PSE to Strengthen Services and Supports, Mitigate Re-maltreatment, and Promote Permanency

Children with PSE, especially PAE, can be difficult to parent with increased risk for child maltreatment due to a child's propensity towards challenging behaviors such as impulsivity, hyperactivity, and distractibility (Bertrand & Dang, 2012; Turchi & Smith, 2018). But identification of PSE and PAE alongside relevant education about exposure impacts and parenting strategies can alter the parent-child dynamic, potentially reducing future harm (Burry & Wright, 2006). Reframing understanding of the child's difficult behaviors from "won't" to "can't" is a low-cost intervention with immediate benefits for safety and family functioning. Child welfare service plans for families with substance use issues tend to focus on discouraging inappropriate substance use by parents in conjunction with teaching general parenting skills. However, these service plans may be strengthened by also factoring in children's prenatal exposure history and its impact on the parenting dynamic and ability to effectively parent an affected child.

Referral and evaluation for an accurate diagnosis is important, but not universally done. A recent study showed that over 80% of children with an FASD were not diagnosed (or were misdiagnosed) when they came into foster care (Chasnoff, et al., 2015). The most common misdiagnosis was Attention Deficit/Hyperactivity Disorder (ADHD) only, with no co-occurring diagnoses. Such misdiagnoses can contribute to over-medication or inappropriate medication, which may not appropriately impact the challenging behaviors, further frustrating parents or caregivers. Identifying if the child has a prenatal exposure, particularly to alcohol, can inform physician medication decisions greatly and has the potential to reduce parental or caregiver stress through improved understanding of the cause of child behaviors. This may, in turn, allow children to safely remain in their homes, lead to greater placement stability or fewer subsequent child welfare removals (Leve, et. al, 2012; Rhodes et al., 2001).

This approach of providing adequate information to the parents on the needs of the child also supports the mandate of the Families First Prevention Services Act (FFPSA). FFPSA specifically focuses on keeping families together to prevent children and youth from entering the foster care system. Identification of a child with PAE or other drug exposures combined with education on the implications of those exposures allows for reframing of parenting situations which may work in concert with substance use treatment for the parent(s)s. Such reframing combined with traditional interventions could provide the opportunity to greatly reduce the risk of maltreatment and increase the chances for the family to remain intact or to be reunified.

Summary

Findings from this exploratory study indicate that establishing an agency-level policy regarding obtaining and documenting information on PAE and PSE may be beneficial for children and families in the child welfare system. Specific practices and guidance would facilitate caseworkers' ability to obtain prenatal exposure histories for all children, which may reduce disparities in identified PSE resulting from overreliance on hospital reporting and promote more equitable service plans and recommendations for all families. Ongoing educational opportunities also would facilitate this practice. And caregivers would benefit from education and information about the exposure history of individuals in their care to support more appropriate service needs, rather than learning or discovering these facts on their own.

This exploratory study provides initial insight into PSE-related policies, practices, and needs of child welfare agencies, staff, and caregivers. However, the findings represent only one agency in one location. The study does serve as a springboard for a larger effort in multiple child welfare systems that looks at geographically and demographically diverse agencies. To address this research gap, the Children's Bureau of the Administration for Children and Families, in collaboration with the National Center on Birth Defects and Developmental Disabilities at the Centers for Disease Control and Prevention, are currently working on such a study. Using findings from these studies to inform policies, practices and trainings may help improve developmental outcomes for children and improve family functioning, thereby reducing the risk for cycles of child maltreatment.

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