CONDITIONS OF CHILDREN IN OR AT RISK OF FOSTER CARE IN ILLINOIS

AN ASSESSMENT OF THEIR SAFETY, STABILITY, CONTINUITY, PERMANENCE, AND WELL-BEING

A report by the
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TABLE OF CONTENTS

Introduction: Accountability for Child Welfare Outcomes I-1
Child Protection and Placement in Illinois I-1
Accountability for Outcomes I-2
Background on Child Welfare Reform in Illinois I-3
Future Challenges I-5

Chapter 1: Child Safety: At Home and in Substitute Care 1-1
Child Protective Services in Illinois 1-2
Child Safety in Illinois 1-2
National Comparison: Children Not Investigated for Maltreatment 1-3
Preventing Maltreatment Recurrence: The Role of Safety Assessment 1-6
Risk of Maltreatment Recurrence 1-9
Observations on Child Safety 1-11

Chapter 2: Stability of Family Life: At Home and in Substitute Care 2-1
Preserving the Stability of Family Life 2-1
Keeping Families Intact 2-2
Stability in Substitute Care 2-4
Measuring Placement Stability 2-4
National Comparison: Rate of Child Non-Removal 2-5
Current Status of Placement Stability in Illinois 2-5
Kinship Care and Placement Stability 2-6
Youth Who Run Away From Substitute Care 2-9
Observations on Stability in Illinois 2-11

Chapter 3: Continuity: Kinship, Community, and Sibling Ties 3-1
Least Restrictive Care 3-1
Kinship Foster Care 3-4
National Comparison: Percentage of Children in Substitute Care Living With Kin 3-5
Preservation of Community Connections 3-6
Conservation of Sibling Ties 3-8
Observations on Continuity in Illinois 3-10

Chapter 4: Legal Permanence: Reunification, Adoption, and Guardianship 4-1
Legal Permanence in Illinois 4-2
Permanence Post-ASFA 4-6
The Changing Significance of Kinship for Permanence 4-9
Stability of Permanence 4-11
The Rising Demand for Post-Permanency Services 4-14
Post-Permanency Survey Results 4-15
Length of Time in Substitute Care 4-15
Observations on Permanence in Illinois 4-16

Chapter 5: Well-Being: Children in Out-of-Home Care 5-1
Child Well-Being 5-1
Child Well-Being Outcomes Illinois & National Comparison 5-4
Mental Health 5-5
Physical Health 5-9
Education 5-12
Observations on Well-Being in Illinois 5-14

Appendix A: Outcome Data Broken Down by Region, Gender, Age and Race Over Seven Years A1-21

ACCOUNTABILITY FOR CHILD WELFARE OUTCOMES

Parenthood is a relationship of care, commitment, and trust that is bestowed on most children at birth. While it is expected that parents will naturally protect and permanently care for their children, there is no guarantee that this expectation will always be honored. Care is sometimes neglected, commitments can be broken, and trust may be violated. Whenever deviations from norms of parental solicitude are chronic or serious enough to jeopardize the safety of the child, public authorities have the responsibility to intervene and to work towards remediation of the conditions in the home, or when family preservation or reunification is not possible, to promote alternative permanent relationships through adoption and guardianship.

Child Protection and Placement in Illinois

Approximately 260,000 calls of alleged parental neglect and abuse are phoned in each year to the Illinois Department of Children and Family Services (DCFS, the Department). One out of four of these calls are determined to warrant further action and are referred for formal investigation by local offices. These approximately 67,000 reports of suspected abuse or neglect involving about 110,000 children set into motion a sequence of decisions by DCFS and the courts that commence with the question of ***safety***: Is there credible evidence to find that a child has been maltreated as defined under the Illinois Abused and Neglected Child Reporting Act.[1] In 2006, in slightly more than one out of four investigations of reported abuse and neglect, DCFS investigators found credible evidence to indicate approximately 27,000 children for maltreatment. This is down from approximately 53,000 indicated cases of abuse or neglect in FY 1995.

For children indicated for abuse or neglect, child protective services (CPS) investigators must next make a decision about ***stability***: Can the child be safely left or served in the home, or must he or she be removed and taken into state protective custody? In approximately four out of ten cases of indicated child maltreatment, DCFS will refrain from any further involvement with the family. This can happen because the investigator determines that the children are no longer at substantial risk as a result of changed circumstances. For example, an indicated perpetrator (such as a baby-sitter or ex-partner) may no longer be present in the home or be involved in the child's care. In the remaining 60 percent of indicated cases, if it is desirable that the indicated perpetrator (mostly birth parents) stay involved in the care of the children and if it is determined that it is safe for them to do so, DCFS will make "reasonable efforts" to prevent removal and instead supervise the children in the home as an "intact family" case. In recent years, approximately ten thousand family cases with 20,000 children were opened for intact family services by DCFS and private agencies.

Sometimes safety considerations necessitate that a child be removed from the home and be taken into state protective custody. Investigators, police, and medical personnel make this decision with approximately 5,700 children. DCFS then has 48 hours to make its case before a juvenile court judge that there is an "urgent and immediate" necessity for retaining them longer in temporary state custody. In about ten percent of child removals, DCFS allows protective custody to lapse and the child is returned home. The remaining children are retained in foster care.

Disruption of regular parental care, even if it is abusive and neglectful parenting, can be extremely stressful to children. To minimize the trauma, best practice favors making out-of-home placement decisions that conserve ***continuity***: Can a suitable relative be found to care for the child and siblings, or if kin are not available, can the child and siblings be placed in a foster family in close proximity to their home of origin, school, and neighborhood? DCFS places approximately 45 percent of entering children with relatives who pass home safety standards and criminal background checks (up from one-third in 2000). The remaining children are placed in family foster care, group homes and residential treatment facilities. Approximately one-third of all foster children in Illinois are placed within five miles of their parents' home, and 40 percent of children in sibling groups of all sizes are placed together in the same home.

1 Abused and Neglected Child Reporting Act, 325 ILCS § 5.

After removal, DCFS and the courts immediately begin deliberating the question of ***permanence***: Can the circumstances that led to removal be successfully ameliorated so that the child may be returned home, or if family reunification is not possible, can alternative permanent homes be found with caring relatives, adoptive parents, or legal guardians? Since 1997, Illinois has answered this question by reunifying approximately 35 percent of children entering fostering care, discharging another 20 percent to the adoptive care or legal guardianship of relatives, and finding alternative permanent homes for another 20 percent with non-related adoptive parents or legal guardians, mostly former foster parents. The remaining 15 percent leave before 18 years or age out of foster care at 18 or a few years later.

For children under 18 awaiting permanence, DCFS as their public guardian has the obligation to oversee the promotion of ***well-being***: What measures can be taken to ensure that children's developmental opportunities for leading a healthy and productive life aren't unduly compromised by state intervention? The funneling down of 100,000 annual child investigations to 5,000 annual child removals means that DCFS and the courts are looking after the most vulnerable of the vulnerable. The child well-being challenge is further heightened by the fact that the residual group of foster children who are unlikely to attain family permanence constitute an increasingly older segment of public wards with special health, emotional, and educational needs.

Accountability for Outcomes

DCFS and the courts have the ultimate responsibility for safeguarding the welfare of abused and neglected children at each decision stage of child protective intervention and placement. The B.H. consent decree is a formal agreement between DCFS and the federal court, which establishes a system for assuring that children are afforded minimally adequate protection and care. Under this agreement, the plaintiffs' attorneys and DCFS have charged the Children and Family Research Center (CFRC, the Center) at the University of Illinois at Urbana-Champaign with the task of reporting to the federal court on the state's performance in achieving the outcomes of safety, stability, continuity, permanence, and well-being.

The Center has, each year since its inception in 1996, produced a report examining a multitude of factors and conditions affecting the welfare of children in or at risk of foster care in Illinois. The work of the Center is conducted within a framework of results-oriented, evidence-based accountability that builds on a common foundation of clinical practice and social administration and conceives of public oversight as progressing through successive stages of monitoring, data analysis, and evaluation. Outcomes monitoring begins with the question of whether the state is on target in achieving desired goals established by federal and state statutes, consent decrees, and other goal-setting processes. Where progress toward specific targets is being achieved, the monitoring process continues another round of review. Where targeted goals are not being met, efforts are made to analyze the underlying conditions and trends that may need to be addressed to steer the system back on course. Wherever possible, we attempt to highlight promising practices and muster the best possible evidence showing whether current interventions are having their intended impact or not.

The report is organized by outcome area. Although there are variations in definitions, considerable consensus exists in practice, policy and law about the importance of the following outcomes of child protective intervention and placement:

- ***Safety:*** Children's safety is the primary concern of all child welfare services, particularly the safety of children who have been identified as maltreatment victims.[2]
- ***Stability:*** Children are entitled to a stable and lasting family life and should not be deprived of it except for urgent and compelling reasons.[3]
- ***Continuity:*** Children should be placed in a safe setting that is the least restrictive (most family like) and in close proximity to the parents' home.[4]
- ***Permanence:*** Every child is entitled to a guardian of the person, either a natural guardian by birth or adoption or a legal guardian appointed by the court.[5]

2 U.S. Department of Health and Human Services. (2004). *Child welfare outcomes 2001: Annual report. Safety, permanency, well-being*. Washington, DC: U.S. Government Printing Office.

3 First White House Conference on the Care of Dependent Children, January 25, 1909.

4 U.S. Social Security Act, Sec. 475. [42 U.S.C. 675].

5 U.S. Children's Bureau (1961) Legislative guides for the termination of parental rights and responsibilities and the adoption of children, No. 394, Washington, DC: U.S. Department of Health, Education, and Welfare.

- ***Well-Being:*** Children should receive adequate services to meet their educational, physical and mental health needs.[6]

In each of the following chapters, we present statistical data and other information on how well the state is achieving the above outcomes. Appendix A presents detailed breakdowns by child gender, age, race, and region of service delivery. ***To facilitate interpretation, we chart statewide indicators so that increases correspond to improvement and decreases correspond to a worsening performance.*** Although this convention sometimes leads to unfamiliar or awkward wording, e.g. percent not maltreated, percent not removed, we find that charts are more easily interpreted when downward consistently means lack of improvement and upward means progress.

The good news is that there has been upward progress since 1998 in most areas as measured by statistical outcome indicators. Illinois shows continuing improvement, with only a few exceptions and warning signs. Reconciling this assessment, however, with the results of the last federal Child and Family Services Review (CFSR), which enumerated Illinois among sixteen states that did not meet any of the seven federal standards used to assess state child welfare performance, requires explanation. In the 2005 report, Appendix B was devoted to explaining the limitations of the federal standards and made a strong case for using longitudinal statistical indicators to track child outcomes prospectively from case entry to discharge as an alternative to the retrospective measures now used in the Child and Family Services Reviews (CFSR). This year, however, the federal government announced a new set of indicators by which all states are to be judged. At the time this report went to print we did not have time to adequately address the new federal indicators. The 2007 report will again address this issue.

Background on Child Welfare Reform in Illinois

The turnabout in Illinois' performance can be linked to reforms initiated in 1995. At that time the state registered the highest per-capita rate of out-of-home placement in the nation—17.1 per 1000 children under age 18. The problem largely arose from policies adopted in the late 1980s to address the protection and care of children living apart from their parents in the homes of relatives. Between 1985 and 1995, the number of children in state custody rose at an average annual rate of 13% from 13,850 to 49,000 children. The rapid build-up of children in "out-of-home care" reflected a peculiar bent in Illinois policy that permitted and encouraged the taking into public custody of children who were living informally with extended kin.

Many of these children had been left voluntarily in the custody of kin by birth parents who made private arrangements with extended family members to look after the children until the parents could get back on their feet. As these informal arrangements lengthened into months and sometimes years because of parental drug addiction or continued absence, the relatives (mostly grandparents) eventually ran into legal difficulties when it came time to enroll the children in school or to obtain medical treatment. Because they lacked formal legal authority to consent on the children's behalf, many were counseled to seek assistance by phoning in an allegation of parental neglect to DCFS.

Because in most cases the legally responsible parent was absent from the home, DCFS investigators could indicate the child for lack of supervision (by the parent) under the definition of neglect in effect at the time. Once indicated, state attorneys could exercise their discretion to screen these children into state custody. In many of these so-called "grandmother cases," the child was retained in the custody of the relative who had made the "hotline" call. In this way, most of the growth in foster care between 1985 and 1995 was accommodated by the placement of children with kin, which grew at an average annual rate of 22% from 3,690 to 27,070 children.

Addressing the rapid build-up of children in kinship foster care required a more nuanced approach to handling the needs of children in informal kinship care. So DCFS proposed and the General Assembly passed in 1995 sweeping Home of Relative (HMR) Reform legislation that changed the way the state dealt with relatives in two important ways:

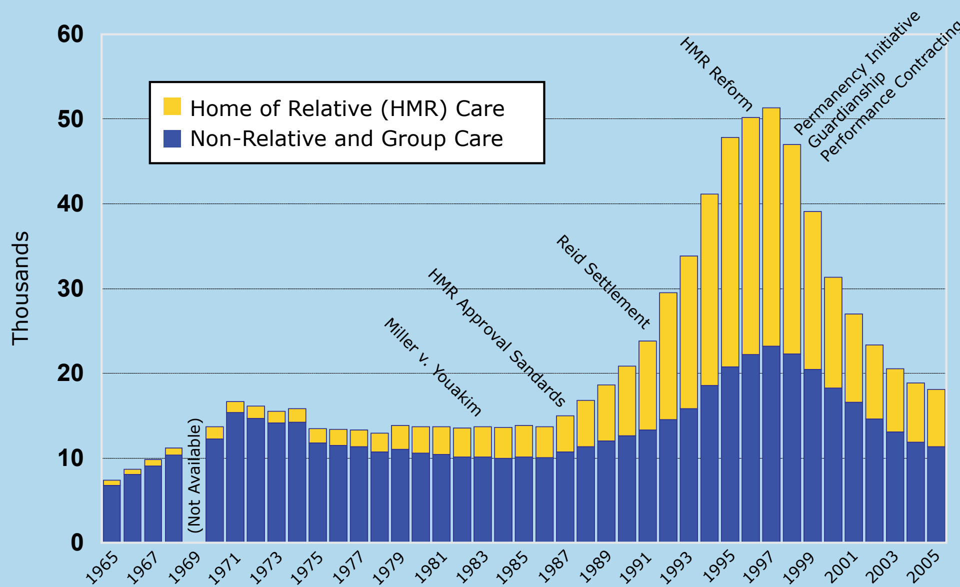
(1) DCFS stopped taking into foster care those children in pre-existing kinship care arrangements where no safety concerns existed.[7] Instead, it offered alternative Extended Family Support services to grandparents, aunts and uncles to help stabilize these informal kinship arrangements; and

6 U.S. Department of Health and Human Services. (2003). *Child and Family Services Reviews onsite review instrument and instructions.*

7 The change in statute reads as follows: "A child shall not be considered neglected for the sole reason that the child's parent or other person responsible for his or her welfare has left the child in the care of an adult relative for any period of time."

Box I.1—**Changes in End-of-Year DCFS Caseload**

The history of kinship foster care in Illinois provides an important backdrop for understanding the changes in the number of children in publicly-supported foster care in Illinois. The U.S. Supreme Court ruling, *Miller v. Youakim*, stipulated in 1979 that relatives who met state licensing standards could not be denied federal foster care benefits. But it was not until Illinois established separate home approval standards for kin in 1986 that the size of the HMR program took off. In 1992, DCFS entered into the Reid Consent Decree that effectively closed off guardianship and kinship custody as discharge options. The implementation of HMR Reform in 1995 reduced the intake of children into kinship foster care but did not impact the large backlog of children in long-term state custody. Follow-up legislative changes ("Permanency Initiative"), the federal subsidized guardianship waiver demonstration, and performance contracting promoted the discharge of foster children to permanent homes. As a result, the number of foster children in state custody declined from a peak of 52,000 to under 17,000 today.



(2) DCFS implemented a single foster home licensing system in which relatives are eligible to participate if they apply and meet the standards. The Department continued to place children in non-licensed kinship care if the home passed basic safety and criminal checks. Children in these homes are supported at 100 percent of the IV-A Aid to Families With Dependent Children (AFDC) "child only" standard of need.

As a result of HMR Reform, the number of children indicated for lack of (parental) supervision (many of whom were living safely with kin) dropped and intake into DCFS custody sharply declined.

Although the runaway growth in foster care intake was curtailed, changes at the front-door were not enough to "right size" the system. Children were staying far too long in the custody of the state. The median length of time in out-of-home care had lengthened from 10 months for children entering foster care in 1985 to 46 months for those entering care in 1994. Research commissioned by the Department showed, however, that many of these children were, for all practical purposes, "already home." Reunification had been ruled out, and many of the children in relative care had been living since birth with their extended family. The state's challenge was converting these stable substitute care arrangements into legally permanent homes.

Turning stable placements into legally permanent homes was accomplished through a series of steps. First, state laws were changed so that undue hesitancy about terminating parental rights was removed as a barrier to adoption. In 1997, the Illinois General Assembly passed comprehensive legislation ("Permanency Initiative") which anticipated the federal reforms of the Adoption and Safe Families Act (ASFA) and eliminated long term foster care as a permanency goal, reduced permanency planning time

lines to one year, and directed the Department to engage in concurrent planning. Second, the state opened up a new pathway to permanence for children for whom adoption was not recommended. Illinois' federally approved IV-E Subsidized Guardianship Waiver Demonstration was begun in 1997. It extended subsidies to families assuming private guardianship of children who otherwise would have remained in substitute care. Third, DCFS implemented performance contracting in 1998 for its largest caseload, the HMR program in Cook County. Under the arrangement, performance contracting exchanged increased resources for improved results—providers received increased fees to purchase specific supports, but they had to more than triple their permanency rates. The majority of providers were able to meet these goals, and the result was the first significant decrease in kinship care caseloads, which were followed a year later by reductions downstate when performance contracting was extended statewide.

As a result of these three permanency initiatives, the substitute care caseload in Illinois declined from a peak of 52,000 children in 1997 to under 17,000 today (see Box I.1). Permanency rates jumped from 10 percent of children ever served in foster care in 1995 to 26 percent in 2000. The median duration of care for new entrants dropped from 46 months in 1994 to 23 months in 2003. In mid-2000, the number of children in state-supported adoption and guardianship surpassed 31,000 children, exceeding for the first time the number of children in substitute care. In 2002, this milestone was reached by the nation as a whole for children in federally-assisted foster care and adoption. There are currently 41,000 former foster children in publicly-assisted permanent homes in Illinois, compared to fewer than 18,000 children in state-funded foster care. By 2008, it is projected that the number of children in nationally federally-assisted adoptive homes will exceed the number in federally-funded foster homes by an order of 2 to 1.

Future Challenges

Meeting future challenges calls for innovative twenty-first century partnerships between states and the federal government, which can both fulfill traditional foster care obligations and support and strengthen newly formed families. Illinois' success in preventing child removal and moving thousands into permanent homes does not mean that follow-up work with the smaller number of remaining foster children grows simpler. The residual group in state custody comprises an increasingly older population of foster youth with complex developmental, educational, and mental health needs. Similarly, the shift from foster care to family permanence does not mean that the work of supporting and strengthening these new families necessarily ends. Even though regular casework and judicial oversight are no longer required, these homes still need occasional support to ensure child well-being and sometimes more intensive interventions to preserve family stability.

To meet the complex needs of current foster youth, DCFS has unveiled a "lifetime" approach that commits the state to investing in the lives of each child under its custody *as if* the Department were going to be responsible for the child until he or she becomes a young adult. Even if a child's time in state custody is eventually shortened by family reunification, adoption or private guardianship, no child can afford to miss critical developmental opportunities for social and emotional growth and educational progress, transitions which if neglected are difficult to make-up in later years. In addition, the challenges posed by the newer forms of adoptive kinship and legal guardianship will require additional investments in extended family support to grandparents raising grandchildren, post-permanency services to adoptive parents and legal guardians caring for adolescents, and innovative approaches to conserving the rights of association of siblings whose ties have been severed by termination of parental rights.

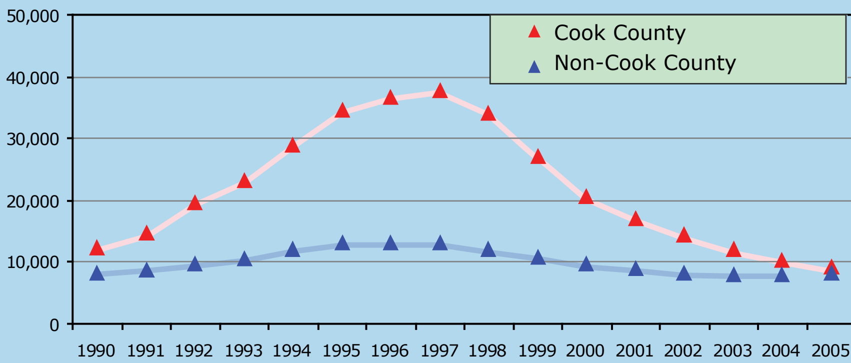
A major impediment to states fulfilling traditional and new child welfare responsibilities is the inheritance of a twentieth century federal financing structure that is seriously out of alignment with the emerging post-permanency system of child protection and placement. The bulk of federal entitlement dollars and discretionary state funds are still restricted to children who come into foster care and remain in the legal custody of the state. Funding caps on preventative services for families of children at risk of removal seriously limit the ability of states to ameliorate underlying trauma and problems that compromise healthy growth and development, some of which are initiated before a child's birth (e.g. early parenthood and intrauterine drug exposure) and are located as well in external community conditions (e.g. chronic joblessness, poor schools, and lack of neighborhood resources). The tendency of abused and neglected children to concentrate geographically in a common set of neighborhoods gives rise to a characteristic pattern in Illinois' largest county (Cook County), and this trend is identifiable as far back as the early 1900s.[8]

8 Testa, M., & Furstenberg, F. (2002). The social ecology of child endangerment. In M. Rosenheim, F. Zimring, D.S. Tanenhaus, & B. Dohrn (Eds.), *A century of juvenile justice* (pp. 237-263). Chicago: University of Chicago Press.

Box I.2—**Changing Caseload Dynamics in Illinois**

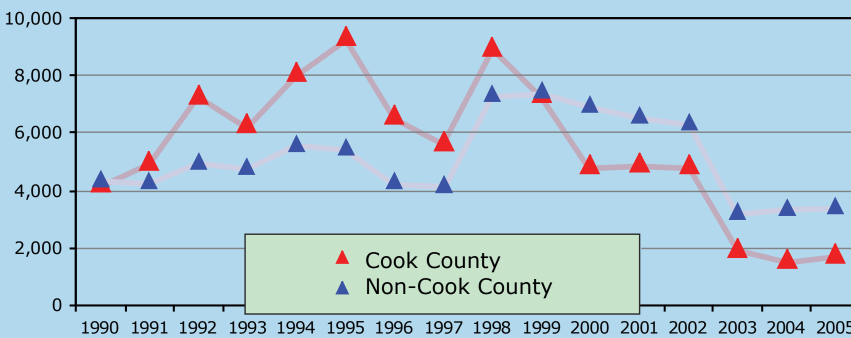
Throughout the early to late 1990s, and even in the early part of this century, the issue of children in substitute care could have been characterized as primarily a "Cook issue" – far more children were in substitute care in Cook County than in the entire rest of the state. At its height in 1997, there were 45,000 children living in substitute care in Illinois, of which three-quarters (35,000 children) were children from the greater Chicago area. In recent years, this picture has changed dramatically so that in 2005 the children in substitute care from Cook County are about equal to the number of children in care throughout the remainder of the state. (To put this in perspective, 23 per 1,000 children living in Cook County were in substitute care, as compared to 5 per 1,000 children living in non-Cook. Currently 6 per 1,000 Cook County children are in care compared to 4 per 1,000 in the rest of the state.)

Figure I.1 **Children in Substitute Care at the End of the Year**



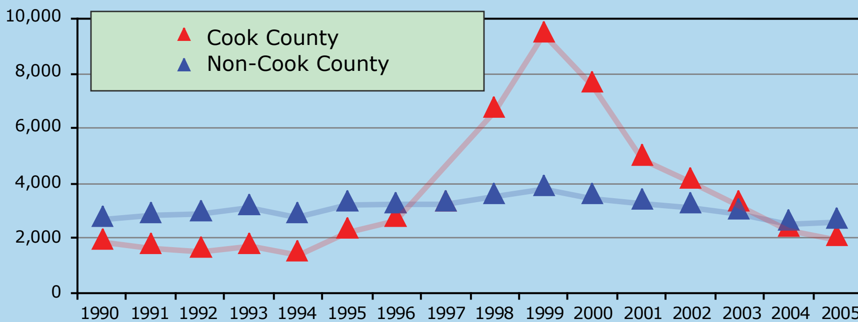
The number of children in substitute care at the end of a fiscal year is the result of the count of children in care at the start of the fiscal year *plus* the number of children who enter care *minus* the number of children who exit care (Figure I.1). To further understand this new caseload picture, we looked at entries into foster care and exits to permanencies from foster care.

Figure I.2 **Children Entering Substitute Care**



The number of children entering care from Cook County and the remainder of the state was about equal in 1990 (Figure I.2), but then the entries into care from Cook County jumped to over 8,000 in 1995 while Non-Cook cases remained around 5,000. Cook County entries dropped to under 6,000 in 1997 and then both areas saw a big increase in 1998. In 1999 entries were just over 7,000 in each region. Since then entries have decreased in both Cook and Non-Cook cases, but Non-Cook cases have remained greater than the number of children entering care in Cook County.

Figure I.3 **Children Exiting Substitute Care to Permanence**



Significant changes in the numbers of children exiting the system from Cook County highlight the largest difference in the two populations – the permanency initiatives of the late 1990's had a significant impact on children in Cook County, but very little impact on children in the rest of the state. Exits from care for non-Cook children have remained remarkably stable over the past 15 years (Figure I.3).

Lags in funding post-permanency services to children in kinship, adoptive and guardian homes threaten the long-term stability of these new living arrangements. Recently published federal regulations eliminate matching federal dollars for thousands of foster children living safely and stably with kin. The absence of a federal subsidized guardianship program continues to deprive foster children of the permanency opportunities piloted in Illinois of financially assisting relatives and foster parents who become legal guardians. The cut-off of federal independent living benefits to older youth taken into guardianship or adopted from foster care deprives them of an important safety-net just when they are beginning their transition to self-sufficient adulthood. Unless federal and state governments adapt existing funding mechanisms to the new realities of twenty-first century family life, Illinois is in danger of sacrificing many of the gains it achieved over the past decade in bringing safety and permanence to the lives of thousands of former foster children.

The future challenges of the child protection and placement system in a post-permanency world are only now coming into view. In FY 2005, the School of Social Work at the University of Illinois at Urbana-Champaign was commissioned by the Illinois DCFS to prepare a report for submission to the Illinois General Assembly. This study looked at the post-permanency needs of adoptive and subsidized guardianship caregivers and found that the majority of caregivers surveyed (81%) reported no unmet service-related needs. Yet those that comprised the 19 percent with needs had significant unmet service needs. The study found that the services for these families were either not available or were not intensive enough to meet the child's needs.[9] If support for these families cannot be found, families are faced with the potential of further disruption in their lives, and the state could see an increase in children re-entering foster care after adoption or guardianship. Illinois is seen as a national leader in the area of adoptions and subsidized guardianship. It was among the first in the country to implement a subsidized guardianship program, and ranks among the highest in the nation in terms of children adopted from the child welfare system. Illinois should lead the nation in designing a system of service delivery that meets the needs of children after they have exited the foster care system to adoption or guardianship.

Illinois has a unique opportunity to shape national policy since the state is at the leading edge of many key changes and reforms. In the following chapters, we chart indicators of improvement and flag warning signs of potential problems. What is often absent in statistical reports of child welfare performance, however, are the voices of those who are the subjects of child protective intervention—the children themselves. Since 2004, the Children and Family Research Center has operated a writer's workshop, *Project FYSH: Foster Youth, Seen and Heard*. As part of the program, former and current foster youth are encouraged to write stories and personal recollections of their experiences in foster care. Because their stories and memoirs have influenced both the Center's research agenda and the way we think about potential solutions, we include a selection of their stories and recollections in the various chapters. This year four youth were involved in Project FYSH. The four youth, Kim Brown-Riley, Rebekah Childers, Latricia Johnson, and Montriece Wade, have given us permission to use their real names, and real stories as a way to help put the real numbers into perspective. You will see their words of hope, frustration and experience throughout this volume (see Box I.3 on next page).

Holding our child protection and placement systems accountable for assuring the safety, stability, continuity, permanence and well-being of the children who have come, briefly or long-term, under our public guardianship is arguably the most important collective responsibility we in Illinois exercise as a citizenry. In the following chapters, the experiences of the four FYSH writers are tabulated along with the individual experiences of 104,000 other children to provide a composite statistical profile of key trends and conditions of children in and at risk of foster care in Illinois.

9 Fuller, T.L., Bruhn, C., Cohen, L., Lis, M., Rolock, N. & Sheridan, K. (2006). *Supporting adoptions and guardianships in Illinois: An analysis of subsidies and spending*. Urbana, IL: Children and Family Research Center.

Box I.3—**Project FYSH: Foster Youth Seen and Heard**

During the 2004–2005 academic year, four foster youth were involved with Project FYSH at the Center. These authors have given us permission to use their stories and reflections in this report. What follows are their introductions to themselves, prepared for this report. We want to thank these young writers for their contributions to this report, and their insights that drive our research agenda at the Center.

In the June 19, 2006 issue of *People*, these four foster youth involved with Project FYSH were featured. Reporter Barbara Sandler and photographer Marc Asnin spent time with these youth and their photographs and samplings of their personal writings appeared in the magazine. We would like to thank Marc Asnin for allowing us to use his photograph in this report.

Photo by Marc Asnin

Kim Brown-Riley

I am 19 years old and, 18 years ago, I entered the Department of Children and Family Services as a foster child. My mother allowed physical abuse as a well as sexual abuse to happen to my siblings and me. In fact, it was my mother that tried to kill me and now I have permanent body marks to constantly remind me of the event, as well as other scars from different incidents. The sister who was next to me in age, and I, went to the same foster home but my brother was sent to another home. I visited him annually in appointed supervised meetings. My oldest sister stayed with my biological family. She suffered from MS. I didn't see her again until I went to her funeral two years ago. I am an orphan now and now my older sister has died also. I am the youngest of my biological family and now there are only 3 of us left from this family. Three of us left...

During the beginning of foster care, when I first entered, I didn't talk - I was unresponsive. It took me until age 3 to finally say a word and of course by then, I had developed a speech impediment. My biological sister who had first joined me in the foster home slept with a knife under her pillow and hid the keys at night - this was the first reason why we were split up. She came back years later and we were reunited, but then she went away again; this happened constantly throughout both our childhoods. She was always in and out of my foster home. I never had a chance to really know her and develop a deep relationship. I only had enough time to remember her face and name. She was just another foster child. I quickly adapted to this situation but I always wondered what was outside - in the place where foster children went when they left my foster home. I never got the opportunity to find out. The one foster home I was placed in as a one-year old baby became my adoptive home at age 11.

Now, eight years later, at age of 19, I am a junior at the University of Illinois, majoring in Psychology with a minor in Afro American studies. I want to continue advocating for kids in the DCFS system, as I do now with the *Project FYSH* program. I plan to go to graduate school, concentrating on behavioral psychology in adolescents and young children. I want to develop research that seeks to understand what can best be done for teenagers and youth who enter the Children and Family Services system. *I want things to improve…I want things to change…*

continued on next page

*Box I.3—**Project FYSH: Foster Youth Seen and Heard (continued)***

Rebekah Childers

Intelligent, resilient, and beautiful – these are three words that best describe me. I am an 18-year-old junior at the University of Illinois at Urbana-Champaign, where I am currently pursing a bachelor's degree in Advertising. I am a sister of 4 girls and 2 boys. My siblings are very important to me, as are other family members and the boyfriend I have managed to hang on to. I was born in Detroit, Michigan, the third child of seven. I grew up in various homes with relatives, foster parents, and my biological parents as well. Growing up without stable parents and strong family relationships was hard for me, but it has made me who I am today. I am a person that is forever striving to build relationships and family for myself, a person that believes kindness is a treasure to be shared.

Latricia Johnson

I entered the child welfare system when I was just 6 weeks old, because of my mother's drug abuse. I am now 20 years old. I am the proud mother of a 5-year old son and a 5-month old daughter. I am currently enrolled at Parkland College where I'm majoring in pre-pharmacy. I am a hard-working mother and student who has worked at the Children and Family Research Center for the past 2½ years as both a Young Researcher and a Writing Specialist for *Project FYSH*. Although my main goal in life is to be a pharmacist, I love to help educate members of child welfare organizations and caseworkers everywhere. My experience with DCFS was a fair experience but in working for the Children and Family Research Center, I have learned about the more difficult system experiences others have faced and I have explored the ways in which I can help improve those experiences. I know that no matter what my career goal is, I will always volunteer to help improve the child welfare system. I know I have a voice and I want to share my message with the world.

Montriece Wade

On April 1, 1986, I was born at 9:04 p.m. in Michael Reese Hospital located in Chicago, Illinois and as a newborn infant I was placed immediately into the child welfare system. As a little girl, I was closely attached to my foster parents and their families. At age seven, my biological grandmother took custody of my older two siblings and me. I still remember the cold winter night when I literally broke down while hiding in the attic of my foster home, before I was found and then carried to the unfamiliar van which transported me to my new home. In both homes, my experiences of always being the youngest, ironically, forced me to become strongly independent. Even though I was a "problem child" during middle school, I somehow defeated that label upon entering high school and graduated as Valedictorian of my class. Fortunately my journey of "beating the odds" has continued here at the University of Illinois, where I am an Advertising major and *Project FYSH* Writing Specialist. As far as my professional future goes, after I graduate from college, I plan on joining a pharmaceutical company as a commercial sales representative and later, want to become a part-time real-estate investor.

CHAPTER 1

CHILD SAFETY

AT HOME AND IN SUBSTITUTE CARE

Children's safety is the primary concern of all child welfare services, particularly the safety of children who have been identified as maltreatment victims.[1]

Child safety is the paramount concern of today's public child welfare system. However, interfering in private family life in order to protect the physical and emotional safety of children has not always been recognized as an appropriate responsibility of state and federal governments. Early government interventions on behalf of children were mostly concerned about meeting the physical needs of dependent and abandoned children rather than mitigating the effects of child abuse and neglect. Over the past 100 years, changing beliefs about family autonomy and the role government should play in the protection and care of abused and neglected children has evolved the child welfare system into a child protection system.[2]

The identification of the "battered child syndrome" in the 1960s[3] ushered in a new era of thinking and reform regarding child abuse and neglect, leading to an expanded federal role in child protective services. The expansion of the federal government's influence has been shaped by several ideological debates, one of the most significant of which centers on the rights of the parents versus the interests of the child. When the pendulum of public opinion swings toward parental rights, the goal of family preservation is emphasized. Conversely, swings toward the interest of the child result in greater legislative emphasis on ensuring child safety and well-being above other concerns.[4] Best practice attempts to strike a balance by emphasizing that children's interests can best be served by supporting and strengthening families' capacity to care for their own children.

During the past two decades, two key pieces of federal child welfare legislation illustrate the challenges of striking a balance between the opposing extremes of this ideological continuum. Reacting to concerns about the dramatic increases in the number of children entering foster care in the mid-1980s, Congress established the Family Preservation and Family Support Services Program as part of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66). This program provided flexible funding for community-based services to prevent the occurrence of child abuse and neglect and help families whose children were at risk of being removed. A bit over a decade later, perceptions of the public child welfare system once again shifted over concerns that the system was biased toward parental rights at the expense

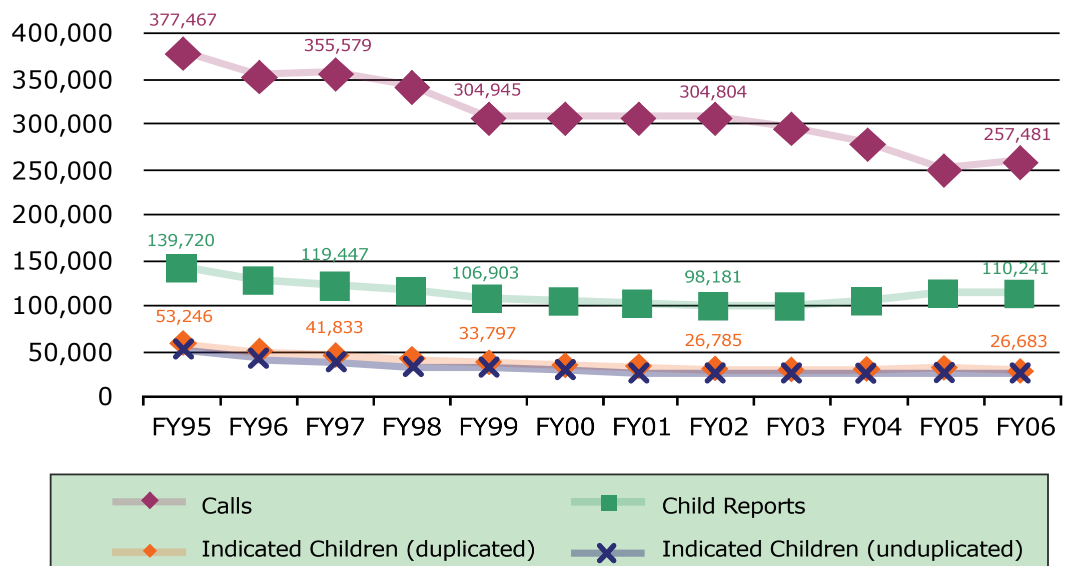
1 U.S. Department of Health and Human Services. (2004). *Child Welfare Outcomes 2001: Annual Report. Safety, Permanency, Well-being*. Washington, DC: U.S. Government Printing Office.

2 Murray, K.O., & Gesiriech, S. (n.d.). A brief legislative history of the child welfare system. Retrieved May 2, 2005, from http://pewfostercare.org/research/docs/Legislative.pdf

3 Helfer, R., & Kempe, C. (1968). *The battered child*. Oxford, England: University of Chicago Press.

4 Murray & Gesiriech, *supra* note 2

Figure 1.1 **Child protective services caseload volume**



Source: Illinois Department of Children and Family Services

CHILD SAFETY AT A GLANCE

We will know children are safer:

If more children are protected from abuse or neglect:

Of all children living in Illinois, the number that did not have an indicated report of abuse or neglect increased by 2 children per 1,000, from 991 per 1,000 in 1999 to 993 per 1,000 in 2005.

If more children are safe from abuse or neglect after an initial investigation:

Of all children with initial reports, the percentage that did not have an indicated report within 60 days has increased from 98% in 1995 to 99% in 2004.

If more children are protected from repeated abuse or neglect:

Of all children with a substantiated report of abuse or neglect, the percentage that did not have another substantiated report within a year has improved from 85% in 1998 to 89% in 2004.

If more children are protected from abuse or neglect while at home:

Of all children who were served at home in an intact family case, the percent that did not have another substantiated report within a 12-month period has increased from 86.5% in 1998 to 90% in 2001, and decreased to 89.5% in 2004.

If more children remain safe from abuse or neglect while they are in foster care:

Of all children ever served in substitute care during the year, the percentage that did not have a substantiated report[a] during placement has remained constant at 99% over the past seven years.

[a] DCFS administrative data does not distinguish between report date (the date the incident was reported to the Department) and incident date (the date the incident occurred), so the effects of retrospective reporting error must be estimated. The most common "retrospective reporting" errors are reports of sexual abuse. We have, therefore, excluded recurrence reports of sexual abuse from this indicator.

of child safety and well-being. In response, Congress passed the Adoption and Safe Families Act of 1997 (Public Law 105-89) that made child safety the paramount concern in any child welfare decision.[5]

Child Protective Services in Illinois

In 2006, approximately 257,000 calls were made to the Illinois State Central Registry and screened for suspected abuse and neglect (see Figure 1.1). This is down from a peak of over 377,000 in 1995. A little over one-fourth of these approximately 257,000 calls (26.8%) are determined to warrant further action and are referred for investigation by local Department of Children and Family Services (DCFS, the Department) offices. These investigations involved approximately 110,200 child reports of suspected abuse and neglect during the fiscal year 2006.

In slightly less than one out of four child reports of abuse and neglect (24.3%), DCFS investigators find credible evidence a child has been maltreated. This is down from the mid-1990s when 38% of child maltreatment reports were indicated by DCFS investigators. In 2006, approximately 27,000 children in Illinois were indicated for abuse or neglect compared to a peak of 53,000 in 1995.

Child Safety in Illinois

Prevalence of Child Maltreatment

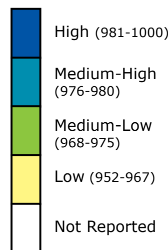
Even when examined through the lens of the child welfare system, child safety exists in a variety of contexts. Thus, to obtain a comprehensive understanding of child safety in Illinois, several indicators must be examined. The first context is the safety of children under 18 years from child abuse and neglect, or the prevalence of maltreatment.

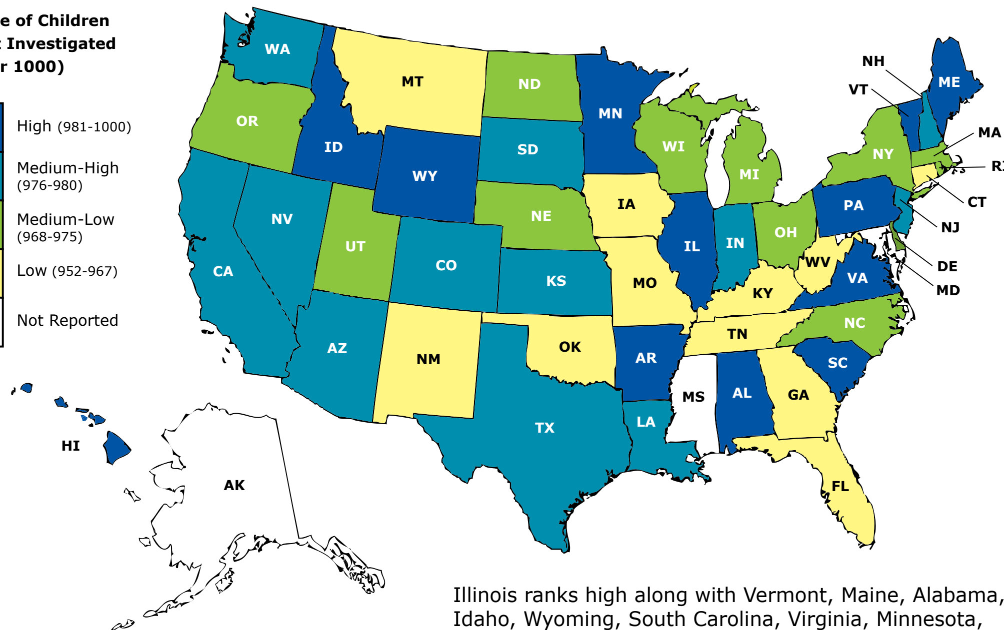
Figure 1.2 reveals that the number of children *without* an indicated report of child abuse and/or neglect has slowly but steadily increased over the past seven years, from 990.7 per 1,000 children in 1999 to 992.6 per 1,000 in 2005. When this data is examined by DCFS region, the rate of children without an indicated report was higher in Cook

5 Ibid

Map 1.1— **National Comparison: Children Not Investigated for Maltreatment, 2004**

County and the Northern region than in the Central and Southern regions. Much of this improvement has occurred in Cook County – rates have increased from 992.9 per 1,000 in 1999 to 995.4 per 1,000 in 2005. In addition, rates of non-maltreatment have significantly improved among African-American children – from 980.3 per 1,000 in 1999 to 986.5 per 1,000 in 2005. Despite this increase, rates of non-maltreatment among African-American children are considerably lower than those for children of other ethnicities (see Appendix A, Indicator 1.A).



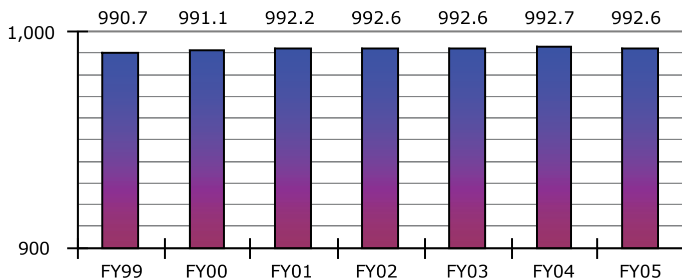


Illinois ranks high along with Vermont, Maine, Alabama, Idaho, Wyoming, South Carolina, Virginia, Minnesota, Arkansas, Hawaii and Pennsylvania

Source: NCANDS data: http://www.acf.hhs.gov/programs/cb/pubs/cm04/table2_4.htm Note: Alaska, Maryland and Mississippi did not report data for this indicator.

National comparisons of the rate of child non-maltreatment are difficult. Differences in state definitions of child abuse and neglect, investigation disposition categories (e.g., substantiated, inconclusive, unsubstantiated), and the level of evidence required for disposition decisions all influence the rate of substantiated child maltreatment. With this in mind, the most recent national data suggest that rates of children not investigated for maltreatment vary widely among states, from a high of 992 per 1,000 children in Pennsylvania to a low of 952 in West Virginia and Kentucky.[6] The non-maltreatment report rate in Illinois in 2004 was 980 children per 1,000, ranking high along with Vermont, Maine, Alabama, Idaho, Wyoming, South Carolina, Virginia, Minnesota, Arkansas, Hawaii and Pennsylvania (see Map 1.1).

Figure 1.2 **Number of Children (per 1,000) Without Indicated Report of Abuse or Neglect**



Maltreatment Recurrence

Once a child becomes involved in an indicated report of child abuse or neglect, the child welfare system assumes partial responsibility for the safety and protection of the child from additional abuse or neglect (e.g., maltreatment recurrence). Maltreatment recurrence is therefore viewed as the primary indicator through which child safety can be assessed. However, definitions of maltreatment recurrence vary widely among reporting sources, often making it difficult to compare results from one report or evaluation to the next.

The most common definition of recurrence is a substantiated report following a prior substantiation that involves the same child or family.[7] However, some studies have included all subsequent reports (sometimes called re-referrals) following an initial report, regardless of the substantiation status of the report.[8] Another important dimension along which definitions vary is the length of time over which recurrence is monitored; common follow-up periods range from 60-120 days (short-term recurrence), six months, 12 months, and 24 months.

The federal Child Welfare Outcomes Reports produced by the U.S. Department of Health and Human Services include

6 U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2004). *Child Maltreatment 2002*. Washington, DC: U.S. Government Printing Office. NCANDS data available at: http://www.acf.hhs.gov/programs/cb/pubs/cm04/table2_4.htm Note: Alaska, Maryland and Mississippi did not report data for this indicator.

7 Fluke, J.D., & Hollinshead, D.M. (2003). *Child maltreatment recurrence*. Duluth, GA: National Resource Center on Child Maltreatment.

8 English, D., Marshall, D., Brummel, S., & Orme, M. (1999). Characteristics of repeated referrals to child protective services in Washington State. *Child Maltreatment, 4,* 297-307.

a measure of maltreatment recurrence: For all children who were victims of substantiated or indicated child abuse and/or neglect during the first 6 months of the reporting period, what percentage had another substantiated or indicated report within a 6-month period?[9] Initially, the federal indicator of maltreatment recurrence measured the percentage of children who had a subsequent indicated report within 12 months of an initial report, but the indicator was modified to allow measurement using a single year of data.

The indicator of maltreatment recurrence included in this report defines recurrence as the number and rate of children with an indicated maltreatment report that did not have another indicated report within 12 months (Figure 1.3; see Appendix A, Indicator 1.B).

Figure 1.3 **Percent of Children With a Substaintiated Report of Abuse or Neglect That Did Not Have Another Substaintiated Report Within a Year**

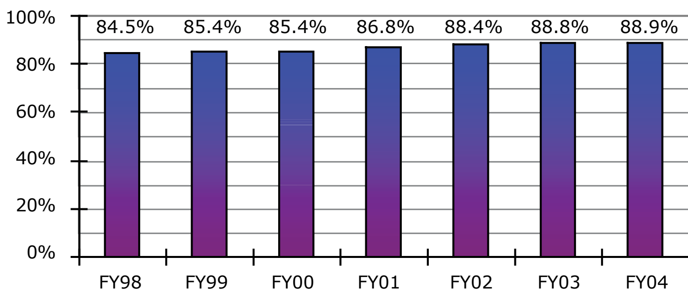


Figure 1.4 **Percent of Children Served at Home in Intact Families That Did Not Have a Substaintiated Report Within 12 Months**

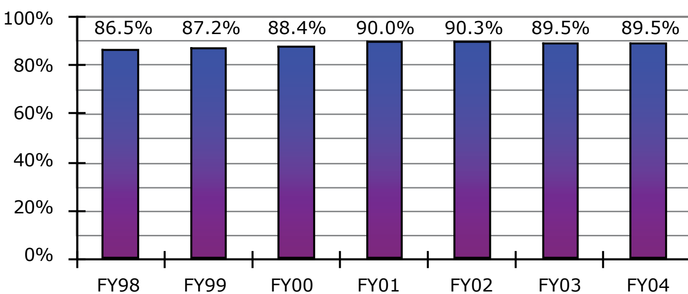


Figure 1.3 reveals that the number of children who do not experience maltreatment recurrence within 12 months of an initial substantiated report has increased slightly after several years at a constant level, from 84.5% in 1998 to 88.9% in 2004. This indicates that more children were safe from repeat maltreatment in 2004 than in 1998. Examination of 12-month maltreatment recurrence rates by region reveals that Cook County has the highest rate of non-recurrence, followed by the Northern region, Central region, and then Southern region. The Northern region has shown the greatest improvement in 12-month maltreatment recurrence rates – the percentage of children who do not experience recurrence increased from 83% in 1998 to 90% in 2004.

Maltreatment Recurrence Among Intact Family Cases

In some instances, the Department will indicate a family for child maltreatment, but decide that it is in the best interest of the child and family to receive services at home rather than place the child into substitute care. These cases, known as "intact family cases," are of special interest to the Department because their history of indicated maltreatment places them at higher risk of repeat maltreatment. The next indicator therefore examines maltreatment recurrence among children served at home in "intact family" cases (Figure 1.4; see Appendix A, Indicator 1.C).

In 1998, 86.5% of the children living at home in an intact family case did not experience a substantiated report within a year. This rate increased to 90.3% in 2002 and has fallen slightly in the last two years. Additional analysis reveals that African-American and Hispanic children in intact families have significantly higher rates of non-recurrence than Caucasian children. Rates of non-recurrence among intact families increase with child age – older children are less likely to experience recurrence than younger children (see Appendix A, Indicator 1.C).

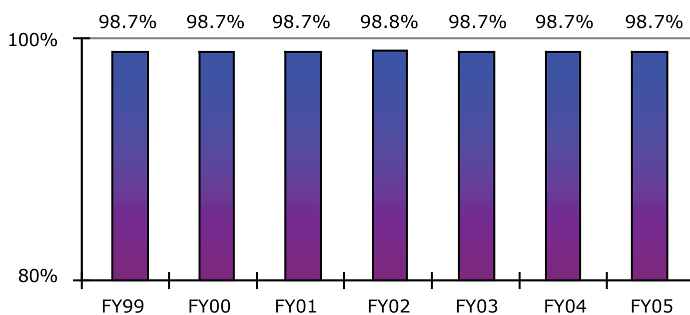
Maltreatment Recurrence in Substitute Care

If children are taken from their home of origin and placed into substitute care for protective reasons, the expectation is that their new living arrangement will provide them with safety from additional abuse or neglect. The following indicator examines the safety of children in substitute care, i.e., the number of children who *do not* experience a substantiated report of maltreatment during placement.

9 U.S. Department of Health and Human Services, Administration for Children and Families. (2004). *Child welfare outcomes 2001: Annual report*. Washington, DC: U.S. Printing Office.

The percentage of children living in substitute care who have not had a substantiated report of abuse or neglect while in placement has remained stable over the past several years at about 98.7% (Figure 1.5; see Appendix A, Indicator 1.D). This consistency is notable in light of the significant reductions in the number of children served in substitute care over the past several years. This data excludes reports of recurrence that involve sexual abuse because of the problems with determining dates of occurrence. Recurrence rates are calculated using data that contains the date the incident was reported to the Department (report date) rather than the date the incident occurred (incident date).

Figure 1.5 **Percent of Children Served in Substitute Care That Did Not Have a Substantiated Report During Placement**



Note: Sexual abuse has been excluded.

Research conducted by the CFRC has revealed that use of the report date rather than the incident date results in an overestimation of abuse and neglect in substitute care.[10] According to this research, a portion of the maltreatment that is reported while children are in substitute care actually occurred prior to a child's entry into care, i.e., the incident occurred prior to entry but the report occurred during substitute care. The most common "retrospective reporting" errors are reports of sexual abuse. DCFS administrative data does not distinguish between report date and incident date, so the effects of retrospective reporting error must be estimated. We therefore exclude recurrence reports of sexual abuse from this indicator.

10 Tittle, G., Poertner, J., and Garnier, P. (2001). *Child maltreatment in foster care: A study of retrospective reporting*. Urbana, IL: Children and Family Research Center.

Box 1.1— **New Initiative Update: "Strengthening Families" in Illinois**

In January 2005, the Center for the Study of Social Policy (CSSP) announced that Illinois is one of seven states chosen to participate in a national pilot program aimed at reducing the number of children who are abused or neglected. The pilot program, called "Strengthening Families," engages early child care and education settings in carrying out child abuse and neglect prevention program strategies.

The Strengthening Families approach to maltreatment prevention is somewhat unique in that it focuses on building protective factors for children and their families rather than identifying parents at risk of maltreatment and providing interventions such as home visiting. The protective factors identified in this approach are:

- parental resilience
- social connections
- knowledge of parenting and child development
- concrete support in times of need
- social and emotional competence of children

Illinois' approach to implementing the Strengthening Families Initiative includes:

- the development of five regional learning networks of early childhood centers implementing the approach
- an awareness campaign aimed at ensuring that 80% of licensed early childhood centers are aware of the connection between protective factors and child abuse and neglect prevention
- collaboration with the Illinois Children's Mental Health Partnership to advocate for mental health resources in the pilot sites and statewide
- ensuring that all foster children have access to quality early care and education placements
- infusing the Strengthening Families approach in state-level decision-making and prevention activities across state agencies

In addition, the DCFS training department is revising its Foundation and Enhanced Training for caseworkers to include the Strengthening Families practices; it will also be included in training materials for licensing staff and foster parents. For more information about the Strengthening Families Initiative and Illinois' implementation of the program, visit the CSSP website at: http://www.cssp.org/doris_duke/index.html.

YOUTH VOICES

Coming to Terms

It is my belief, that in order to live a fulfilling life, it is necessary to make peace within your self, whether it is about your decisions, relationships or important life experiences. But that can be one of the hardest things to do. I would say that being able to come to terms with a major life issue has more to do with success than any other factor. A person can be intelligent, have all the resources they need, or at least the means to find them, and still be hindered greatly if they don't have peace of mind.

It's even harder to make peace within yourself, when you may be torn between different thoughts and feelings on significant life issues. For example, it is considered natural to love your parents, in fact, one is suppose to honor "thy mother and thy father" according to some religious views points. But the truth is, that is way too simple a thought.

Holding on to destructive parents, or bad relationships can inhibit a person from working to their fullest potential. What if something were to affect my whole outlook on life so much so, that I was unable to function appropriately? For many children in the foster care system, some relationship that they haven't come to terms with is still lingering within, hovering above them, preventing them from being all that they can.

Destructive family relationships breed more destructive family relationships. Coming to terms offers a way out of the cycle. 'Coming to terms' means being able to evaluate your situation in a way that is acceptable to you, but is also about being realistic. That is, being able to understand the past, but also move forward.

I realize that I could have never had a normal or happy upbringing with my parents, and that I was born to my parents through no fault of my own. I must make it in this world the best way I can, building my own family as I go along.

—Rebekah

Preventing Maltreatment Recurrence: The Role of Safety Assessment

In 1997, the Adoption and Safe Families Act (ASFA) placed legislative emphasis on child safety by indicating that safety takes precedence over other social policy interests such as family preservation. In response to this increased demand for accountability, child welfare agencies devoted considerable effort toward improving safety decision-making. Fundamental steps in this effort included the articulation of the concepts of safe and unsafe, their differentiation from the concept of risk (which looks at the likelihood of harm over a longer time span), and the development of structured safety assessment protocols for use during the initial weeks of family contact and investigation. To date, 42 states have implemented some form of structured safety assessment protocol into their practice.[11] However, only a handful of states have evaluated the implementation or impact of their safety assessment instrument on child safety.

Evaluating the Impact of Safety Assessment in Illinois

In 1994, the Illinois Senate passed PA 88-614, which required the Department to develop a standardized child endangerment risk assessment protocol and to implement its use by training staff and certifying their proficiency. This act also required DCFS to provide an annual evaluation report to the General Assembly regarding the reliability and validity of the safety protocol, known as the CERAP (Child Endangerment Risk Assessment Protocol).

To evaluate the impact of CERAP on child safety in Illinois, CFRC has conducted an extensive program of research examining short-term maltreatment recurrence rates both before and after its implementation in December 1995. Although only a true experimental design with random assignment of subjects to treatment (CERAP) and control (no CERAP) groups can definitively "prove" the effectiveness of an intervention, these designs are rarely feasible in natural settings. In such instances, observational designs which compare naturally-occurring groups that did and did not receive the intervention are often used.

The CERAP assesses child safety, defined in Illinois as the likelihood of immediate harm of a moderate to severe

11 U.S. Department of Health and Human Services, Administration for Children, Youth, and Families. (2003). *National study of child protective services systems and reform efforts: Review of state CPS policy.* Washington, DC: U.S. Government Printing Office. Available online at: http://aspe.hhs.gov/hsp/cps-status03/state-policy03/

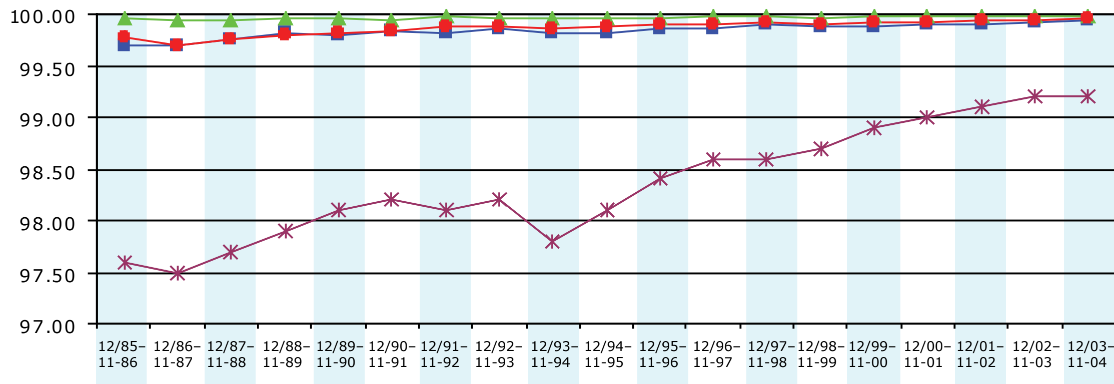
Figure 1.6 **Percent of Children Safe From Repeated Maltreatment**

Moderate Physical Abuse

Sexual Abuse

Severe Physical Abuse

All Maltreatment Types



nature. Thus, the indicator of child safety in this context must reflect two important dimensions: 1) the threat of harm to the child must be "immediate" and 2) the potential harm to the child must be of a "moderate to severe nature." Thus, child safety was defined in terms of the occurrence (i.e., recurrence) of an indicated report of moderate to severe maltreatment within 60 days of an initial report. Because DCFS policy does not include a specific definition of "moderate to severe harm," three mutually exclusive groups were defined using allegation codes included in the Illinois Child Abuse and Neglect Tracking System (CANTS) database. *Moderate physical abuse* included allegations of cuts, welts, and bruises, human bites, and sprains/ dislocations. *Severe physical abuse* included indicated allegations of brain damage/skull fracture, subdural hematoma, internal injuries, burns/scalding, poisoning, wounds, bone fractures, and torture. *Severe sexual abuse* included indicated allegations of sexually transmitted diseases, sexual penetration, sexual exploitation, and sexual molestation.

The following analyses examine the number of children who did not experience maltreatment recurrence within 60 days of an initial maltreatment report (i.e., the number who remained safe during this period). Results of the analysis for all maltreatment types are shown in Figure 1.6, as are the results for moderate physical abuse, severe physical abuse, and severe sexual abuse. The results indicate that very few children experience a recurrence of moderate to severe maltreatment within 60 days of their initial report, and that the short-term safety rate has increased over time for all maltreatment types, moderate physical abuse, severe physical abuse, and sexual abuse. Safety rates for all maltreatment types increased from 97.6% in 1986 to 99.2% in 2004, rates for moderate physical abuse increased from 99.7% to 99.9%, rates for severe physical abuse increased from 99.95% to 99.98%, and those for sexual abuse increased from 99.8% to 99.96%.

YOUTH VOICES

My Earliest Memories...

September 1986 — Laying face up I begin to cry ...
Mom walks past the bathroom, sees me, and takes the bottle from me. She tightens the top. She shakes it and pushes the bottle in my chest. I sleep on a blanket between a pillow and the wall. Our house is small, but a lot of people come over, sometimes people sleep with my mom. Sometimes we spend the night with grand-mom. Grandmom lets me help her around the house. I like doing chores. My mom lets me help out a lot too, but sometimes she screams at me. She screams at all of us.

Crying and screaming I am helpless ...
My sister cries all the time. "Shut up. Come and shut your sister up!" Mom says. Mom leaves the house say-ing, "I am going out for a smoke. Your sister better be quiet when I get back or ELSE!" Mom comes back. She says "You still crying? I brought you into this world and I can take you out." Mom is grabbing me by my leg as I cry. She takes me to the stove. The stove is on, blue flames burn. I scream. I am crying. "HELP! SOMEBODY HELP!" My legs and hands swing at mom as my uncle runs into the house. My sister is still crying as she is be-ing taken away from mom.

I am sleeping in an all-white room. I am warm and feel better ...
The Nurse says: Why would some one *do that to their own child? This is one of the worst cases I have ever seen and I have been working here for 15 years. "Baby girl - sleep, sleep the pain away. We can make you better; just let us take care of you. Keep fighting."*

—Kim

Box 1.3—**Warning Signs: Do CERAP Safety Plans Protect Children From Maltreatment Recurrence?**

The intended purpose of the Child Endangerment Risk Assessment Protocol is to provide Child Protective workers with a mechanism for quickly assessing the potential for moderate to severe harm in the immediate or near future and for taking quick action to protect children from harm. This action takes the form of a safety plan designed to control the safety factors placing the children at risk of immediate harm. In theory, a well-designed and implemented *safety plan* should mitigate the risks posed by the threats to child safety identified in the CERAP so that children in "unsafe" households are no more likely to experience maltreatment recurrence than those in "safe" households. To test this assumption, we looked to see if the child continued to be safe from maltreatment 60 days after the initial CERAP, and we looked to see if there was a difference in homes where the initial outcome was 'safe' and compared them to homes where the initial outcome was 'unsafe'. For the purpose of this analysis, CERAP assessments were broken into two distinct groups: those for children with one (initial) CERAP, and those with multiple CERAP assessments. The first (those with an initial CERAP only) found that children in 'safe' homes were very likely to continue to be safe (99% were 'safe' after 60 days), but those children whose original CERAP finding was 'unsafe' were less likely to continue to be safe (97%). (See Table 1.1).

To further understand this dynamic, we looked at children who had a subsequent CERAP assessment. Subsequent CERAP assessments are completed for the following reasons: 1) a child's safety may be in jeopardy, 2) every five days following an 'unsafe' determination when a safety plan is in place, 3) at the conclusion of a formal investigation when a case is not opened, or 4) at CWS intake within 24 hours of seeing the child(ren).

For each case, the safety decision contained in the initial CERAP assessment was selected for analysis. Results are presented in Table 1.2.

Cases with a CERAP safety decision of 'unsafe' are less likely than those with a 'safe' decision to continue to be safe from repeat maltreatment. However, the difference is smaller for cases in which a subsequent CERAP was completed during the investigation. For example, in 2004, 99.16% of 'safe' outcomes continued to be 'safe' after 60 days while 98.74% if 'unsafe' outcomes were 'safe' after 60 days.

Previous research has shown that certain characteristics, such as child age and type of maltreatment, are significantly associated with maltreatment recurrence. Thus, an alternative argument could be made that these factors, rather than the safety assessment decision, account for the difference in short-term recurrence seen in safe and unsafe cases. To examine this hypothesis, additional analyses using propensity score matching (PSM) were completed that control for the effects of these demographic and maltreatment characteristics.

For this analysis the population of children to be included is matched so that the two samples of children (those with a safe outcome and those with an unsafe outcome) are similar (not exactly matched) in terms of certain demographics (the child's gender, race/ethnicity, age, type of allegation, maltreatment reporter, year of initial report, and geographic region). Prior to this type of analysis, unsafe cases were 102% more likely than safe cases to experience short-term maltreatment recurrence. This analysis shows that after controlling for these demographics, children considered to be unsafe were 85% more likely to experience maltreatment recurrence compared to children considered safe. Thus even after controlling for these demographics, children living in households considered to be 'unsafe' on the CERAP assessments are at increased risk of short-term maltreatment recurrence.

tables continue on next page

The results presented in Figure 1.6 also highlight another important finding – short-term safety rates for moderate to severe physical and sexual abuse are extremely high when compared to rates for all types of maltreatment combined. The vast majority of short-term maltreatment recurrence consists of allegations outside the category of "moderate to severe harm," and includes allegations that fall into neglect categories (e.g., inadequate supervision, food, shelter, clothing, medical neglect, educational neglect, malnutrition, etc.) as well as substance exposed infants, emotional abuse, and substantial risk of harm. Additional analysis of recurrence patterns among these "less serious" neglect allegations would add to our overall understanding of safety and risk assessment in Illinois.

Risk of Maltreatment Recurrence

In addition to the analyses which examined recurrence rates over time, multivariate logistic regression analyses were conducted to examine the relationships between specific child and maltreatment report characteristics with recurrence. The predictor variables examined in this analysis were limited to those reliably available in the DCFS administrative database, and included: 1) child gender, 2) child race, 3) child age group, 4) geographical region, 5) maltreatment allegation, and 6) maltreatment reporter. The dependent variable was substantiated maltreatment recurrence within 60 days of an initial maltreatment report. Included in this model is safety data from 1986 through 2004.

Before computing the logistic regression model, the bivariate relationship between each predictor variable and maltreatment recurrence was explored, as well as several theoretically-meaningful interaction effects. The results of these preliminary analyses revealed that the relationship between child race and maltreatment recurrence interacted with several other variables – that is, the relationship between child race and recurrence was different depending on what region the child lived in, the type of maltreatment experienced by the child, and who reported the maltreatment to DCFS. Since these interactions can make the results of

Box 1.3— Warning Signs: Do CERAP Safety Plans Protect Children From Maltreatment Recurrence? (continued)

Table 1.1—**Children Safe From Maltreatment 60 Days After Initial CERAP**

	CERAP Decision:	Safe	Unsafe	Total
2003	Number Investigated	58,225	2,081	60,306
	Number Safe From Recurrence	57,656	2,026	59,682
	% Safe	99.02%	97.36%	98.97%
2004	Number Investigated	55,003	2,023	57,026
	Number Safe From Recurrence	54,559	1,971	56,530
	% Safe	99.19%	97.43%	99.13%
2005	Number Investigated	55,265	1,151	56,416
	Number Safe From Recurrence	54,782	1,127	55,909
	% Safe	99.13%	97.91%	99.10%

Table 1.2—**Children Safe From Maltreatment 60 Days After Subsequent (two or more) CERAP Assessments**

		Safe	Unsafe	Total
2003	Number Investigated	24,565	3,584	28,149
	Number Safe From Recurrence	24,345	3,533	27,878
	% Safe	99.10%	98.58%	99.04%
2004	Number Investigated	19,529	3,797	23,326
	Number Safe From Recurrence	19,365	3,749	23,114
	% Safe	99.16%	98.74%	99.09%
2005	Number Investigated	20,113	4,290	24,403
	Number Safe From Recurrence	19,967	4,242	24,209
	% Safe	99.27%	98.88%	99.21%

Table 1.3—**Predicting 60-day Maltreatment Recurrence: Percent Difference in Rates**		
Variable	**African-American**	**Other Race/ Ethnicity**
Geographical Region		
Cook County	-11%	-21%
Comparison is non-Cook County		
Maltreatment Type		
Lack of Supervision	+107%	+68%
Environmental Neglect	+64%	+72%
Substantial Risk of Harm	+19%	+14%
Other Neglect	n.s.	n.s.
Substance-Exposed Birth	n.s.	n.s.
Physical Abuse	+18%	+14%
Comparison is sexual abuse		
Maltreatment Reporter		
Law Enforcement	-4%	+36%
Social Services	+45%	+44%
DCFS	n.s.	n.s.
Medical Personnel	n.s.	n.s
School Personnel	n.s.	n.s.
Child Care	n.s.	n.s.
Comparison is family/friend		
Age at Initial Investigation		
Under 3	+96%	+119%
3 to 5 years	+51%	+60%
6 to 8 years	+51%	n.s.
9 to 11 years	n.s.	n.s.
12 to 14 years	n.s.	n.s.
Comparison is 15-18 year olds		
Note: This model controls for the year of the initial investigation, data is from 1986-2004.		

logistic regression analysis difficult to interpret, separate analyses were computed for African-American children and those of all other races combined (see Table 1.3).

Geographical Region: Geographical region was significantly related to maltreatment recurrence in the multivariate models – African-American children in Cook County were 11% less likely to experience recurrence than those in the rest of the state, while children of other racial groups in Cook County were 21% less likely to experience recurrence than those in non-Cook regions.

Maltreatment Type: This variable was significantly related to maltreatment recurrence in the multivariate model for both African-American children and children of other ethnicities. Compared to those who experienced sexual abuse, children who were indicated for lack of supervision were at increased risk of recurrence (+107% among African Americans, +68% among other racial groups), as were those who were indicated for environmental neglect (+64% and +72%, respectively), substantial risk of physical injury (+19% and +14%, respectively), and physical abuse (+18% and +14%, respectively).

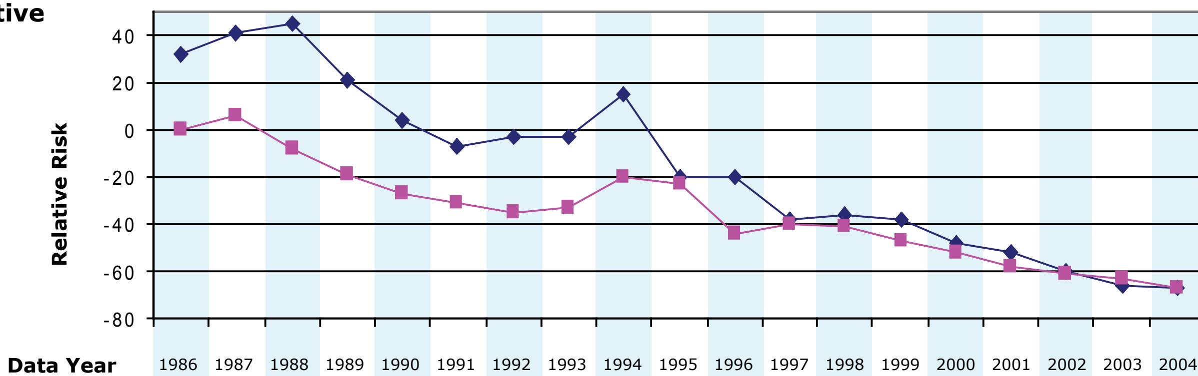
Maltreatment Reporter: Risk of maltreatment recurrence was also related to the source of the initial maltreatment report, although the effects of the reporter differed for African-American and non-African-American children. African-American children reported by law enforcement were 4% less likely to experience recurrence than those reported by family/friends, while non-African-American children reported by law enforcement were 36% more likely to experience recurrence than those reported by family/friends. Children reported by social service personnel were more likely to experience recurrence compared to those reported by family/friends (+45% African-American, +44% other groups).

Child Age: Results of the multivariate analyses revealed that the risk of maltreatment recurrence decreases with age for both African-American children and those of other racial groups. African-American children age 0 – 3 were 96% more likely to experience recurrence than those between 15 and 18; non-African-American children in this group were 119% more likely to recur than those between 15 and 18 years. Children between 3 and 5 years in both groups were also at elevated risk – they were 51% to 60% more likely to experience recurrence than 15 – 18 year olds. The elevated risk of recurrence continued among African-American children through age 8.

Figure 1.7 **Relative Risk Ratio of Recurrence**

African-American

Other Race/ Ethnicity



Child Gender: There were no significant differences in the risk of maltreatment recurrence between males and females.

Child Race: Figure 1.7 shows the relative risk of maltreatment recurrence for successive cohorts of African-American children and children of other ethnicities. The comparison group is children of other ethnicities investigated in 1986 (arbitrarily anchored at zero). The risk of 60-day maltreatment recurrence for both African-American and other racial groups has been declining fairly consistently over the past 15 years. However, in earlier cohorts, African-American children were at a higher relative risk of recurrence compared to children of other racial backgrounds. Since 1997, the differences between the groups have been negligible.

Observations on Child Safety

Child safety is the paramount concern of child welfare services. By all accounts, children in Illinois are safer than ever before. The number of children investigated for potential abuse or neglect has decreased 25% in the past decade, and the number of children indicated for maltreatment has declined an even greater 47%. This trend is mirrored throughout the nation – most states are indicating fewer children today than in the past.

The true litmus test of child welfare performance, however, is the rate of maltreatment recurrence after a child is indicated. Illinois' performance in this area is consistently strong. The number of children that do not experience maltreatment recurrence has remained constant or increased on each of the three indicators examined in this report – all children with an indicated report, children served in intact families, and children living in substitute care.

Many have attributed the increased safety of children in Illinois to the implementation of a structured safety assessment protocol in December 1995. Indeed, annual evaluation of this protocol (the Child Endangerment Risk Assessment Protocol) has indicated that rates of short-term maltreatment recurrence (e.g., within 60 days of an initial report) have decreased or remained constant each year since 1995. The decline in short-term maltreatment recurrence appears to have begun prior to CERAP implementation, however, which introduces the possibility that rates would have continued this decline without intervention. Our analysis of "unsafe" and "safe" determinations on the CERAP, however, shows that children living in households considered to be "unsafe" on the CERAP assessment remained at an increased risk of short-term maltreatment recurrence compared to children considered "safe". Attention should be paid to determining how we might better serve those families and reduce the likelihood that recurrence will occur.

The successes Illinois has experienced in the area of child safety should not breed complacency, however. Compelling evidence exists that the children most likely to experience maltreatment recurrence are those most unable to protect themselves – children under three years of age. In addition, children who experience an indicated report of neglect are around 100% more likely to experience recurrence than children who experience certain other types of maltreatment. Continued monitoring and innovation in the area are still needed to ensure that the successes achieved in this area are maintained and extended to all children in Illinois.

STABILITY OF FAMILY LIFE
AT HOME AND IN SUBSTITUTE CARE

Home life is the highest and finest product of civilization.
Children should not be deprived of it except for urgent and compelling reasons.[1]

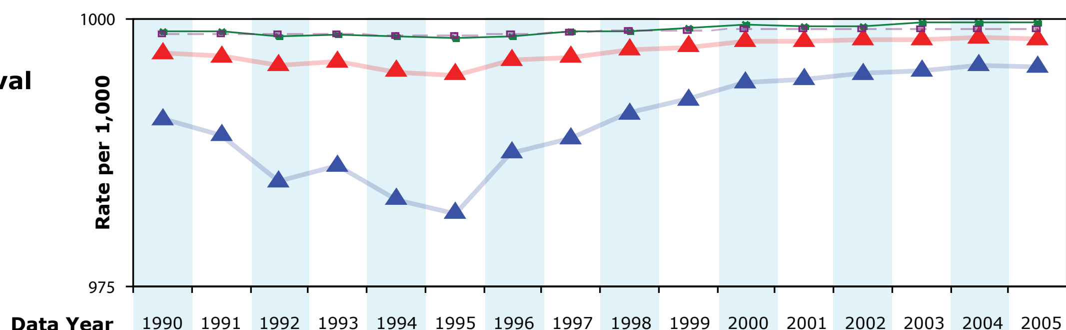
For as long as government has taken a role in safeguarding the welfare of children, there has existed a tension between ensuring safety by depriving children of their home life versus preserving family stability by serving children in their own home. In the late 19th century, public and voluntary agencies routinely removed dependent and neglected children from their indigent or neglectful homes and placed them in institutional asylums. Later on, dissatisfaction with the quality and cost of institutional care led to placing dependent and neglected children in substitute homes with foster families, many far away from their homes of origin. This practice in turn generated a reaction against the injustice of removing children from their families for reasons of poverty alone.

At the 1909 White House Conference on Dependent Children, child welfare practitioners and policy makers advanced the principle of maintaining the stability of children's family life. This principle found expression in the Mother's Pensions programs that Illinois pioneered in 1911 and subsequently in the federal Aid to Dependent Children program that Congress established in 1935 to maintain needy children in the homes of parents and relatives. It continues to be evidenced in family preservation programs, where the underlying assumption is that abused and neglected children should remain at home whenever their safety can be assured. It is also evidenced in permanency planning laws that focus on reuniting foster children with their parents and shortening the timeframe for making permanency decisions. More recently, this idea has been extended to the stability of children's placements while in foster care. The federal Child and Family Service Review process establishes outcome measures and seeks to hold states accountable for reducing placement instability among foster children.

Preserving the Stability of Family Life

Once a determination has been made by child protective services that intervention is necessary to safeguard the welfare of a child, the next choice that child welfare workers must make is whether the child can be safely served in the home or should be taken into protective custody and placed in foster care. The preference is to prevent removal and DCFS supports a system of intervention in which families can be referred for "intact family services" in lieu of placement into the foster care system.

This preference can be quantified as the rate of child non-removal; that is, for every 1,000 children in Illinois, the number that has *not* been removed from their home. This rate has increased substantially since the mid-1990s, primarily because of dramatic increases in the rate of non-removal among African-American children (see Figure 2.1). Despite the increase in non-removal, overrepresentation of African-American children in substitute care is still cause for concern (see Box 2.1).

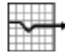


1 First White House Conference on the Care of Dependent Children, January 25, 1909.

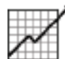
CHILD SAFETY AT A GLANCE

We will know children have more stability:

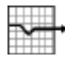
If more children remain with their family while they are served in their own home after a child maltreatment finding:


Of all children served in intact family cases, the percentage that did not experience an out-of-home placement within a 12-month period remained constant between 93% and 95% over the past seven years.

If more children do not move from home to home while they are in foster care:


Of all children entering foster care and staying at least one year, the percentage that had no more than two placements within 12 months from the date of entry into foster care increased from 72% in 1998 to 78% in 2003.

If more children do not run away while they are in foster care:

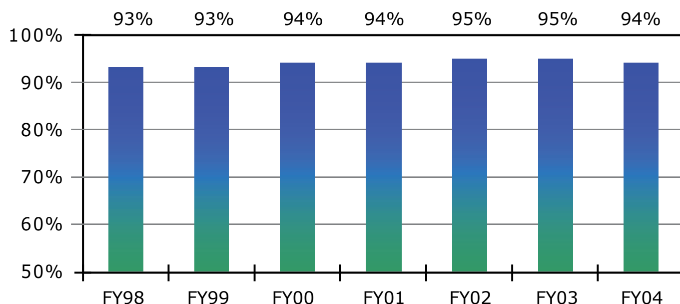

Of all children entering substitute care at the age of 12 or older, the percentage that did not run away from a foster care placement within their first year in care has fluctuated between 75% and 78% over the past seven years.

A national comparison of child non-removal rates reveals that Illinois ranks among the highest in the country – more children remain at home and are not in foster care in Illinois than in most states (see Map 2.1 on p. 2-5). Illinois' rate of child non-removal is comparable to that among the southern states of Texas, Louisiana, Alabama, and North Carolina. Among the northern states, only New Hampshire and New Jersey rank as high as Illinois.

Keeping Families Intact

Another measure of how well the state is doing in preserving family stability is the number of children served in intact family cases that do not experience a substitute care placement within a year of initial report (see Appendix A, Indicator 2.A). Examination of Figure 2.2 shows that the number of children not removed from home increased slightly, from 93% in 1998 to 94% in 2004. Additional

Figure 2.2 **Children Served in Intact Families That Did Not Experience an Out of Home Placement Within a Year**



Box 2.1—**Disproportional Representation of African-American Children in Child Welfare in Illinois**

Table 2.1 shows that the rate of non-removal among African-American children has changed dramatically since the mid-1990s. In Illinois, the decrease in the child welfare population can clearly be attributed to this increase in non-removals – more African-American children today remain at home with their families than ten years ago. However, African-American children continue to represent the largest population of children in care, and the differential in non-removal rates in Illinois among African-American and Caucasian children persists.

In an effort to better understand this disproportionate representation, a tool developed by the Center for Social Services Research at the University of California at Berkeley was used to arrive at a disproportionality index for Illinois, with breakouts for Cook County and the remainder of the state. This tool's usefulness is that it expresses the rate at which children of different ethnicities encounter the child welfare system as a proportion to their perspective size of the child population. In this calculation, the denominator changes with each stage of child involvement, beginning

continued on next page

Table 2.1–**Illinois Disproportionality Index**			
Reports	**1995**	**2000**	**2005**
Black	2.3	2.1	1.9
White	0.7	0.7	0.8
Hispanic	0.5	0.6	0.3
Substantiated Reports			
Black	2.6	2.1	1.8
White	0.6	0.7	0.9
Hispanic	0.5	0.5	0.4
Entries			
Black	3.7	3.1	2.7
White	0.3	0.5	0.6
Hispanic	0.4	0.3	0.3
In Care on June 30			
Black	4.2	4.0	3.4
White	0.2	0.3	0.5
Hispanic	0.3	0.3	0.3

Table 2.2–**Cook County Disproportionality Index**			
Reports	**1995**	**2000**	**2005**
Black	2.2	2.0	1.9
White	0.3	0.3	0.5
Hispanic	0.5	0.6	0.4
Substantiated Reports			
Black	2.3	2.1	1.9
White	0.3	0.3	0.5
Hispanic	0.4	0.6	0.5
Entries			
Black	2.6	2.5	2.4
White	0.2	0.2	0.3
Hispanic	0.2	0.3	0.3
In Care on June 30			
Black	2.7	2.7	2.5
White	0.1	0.1	0.2
Hispanic	0.2	0.2	0.2

Table 2.3–**Non-Cook Disproportionality Index**			
Reports	**1995**	**2000**	**2005**
Black	3.8	2.9	2.8
White	0.7	0.8	0.8
Hispanic	0.9	0.7	0.4
Substantiated Reports			
Black	3.6	3.3	2.8
White	0.7	0.8	0.8
Hispanic	0.7	0.6	0.4
Entries			
Black	5.1	4.9	4.2
White	0.6	0.6	0.7
Hispanic	0.6	0.3	0.3
In Care on June 30			
Black	6.3	5.6	4.7
White	0.5	0.6	0.7
Hispanic	0.5	0.4	0.3

Box 2.1— Disproportional Representation of African-American Children in Child Welfare in Illinois (continued)

with child reports and ending with the population of children in foster care. By looking at the stages of foster care in this manner, it puts in perspective the rate at which children of different ethnicities progress through the child welfare system, taking into consideration the numbers of children of that ethnicity in the state. Please note the example at the bottom of this box for further explanation.

What this shows is that, in Illinois, African-American children are 1.9 times as likely as all children to have a maltreatment report. While this has declined somewhat, the overall state disproportionality is still high. If we look at the next level of intervention, the decision to substantiate a report, we see that compared to the previous stage of intervention the disproportionality persists and increases for African-American children. As the system is penetrated at each step towards increased child welfare involvement, this disproportionality increases. There has been some improvement over time – in 1995 African-American children were almost four times (3.7) as likely to enter substitute care, and that is down to 2.7 percent.

Policies and practices that drive disproportionality often differ depending upon the community in which they are practiced. This holds true in Illinois as well. When these rates are broken down by Cook County and the remainder of the state (Tables 2.2 and 2.3), what is revealed is that Cook County follows similar patterns to the state, albeit with slightly lower numbers and that the remainder of the state has a much larger rate of disproportionality. Outside of Cook County, African-American families were 3.8 times as likely to be reported to the child welfare office in 1995, and that is down to just under 2.8 percent today. In 1995, African-American children were 5.1 times as likely to enter foster care, and 6.3 times as likely to be in care. While these numbers have decreased, to 4.2 and 4.7 respectively, significant differences persist.

This index was developed by staff at the Center for Social Services Research at the University of California at Berkeley. The calculation is, using Black Reports as our example: (number of reports for black children/total black children) / (total reports for all children/total children).

analyses reveal that the age of the child at the time of intervention is important – older children are less likely to enter substitute care from intact family cases than their younger counterparts. The regional differences show a slight improvement in Cook, but no clear trends in the remainder of the state. While African-American children in intact families have experienced a slight increase in stability, Caucasian children's stability has remained constant; there is little difference between the two ethnic groups in recent years. There is virtually no gender difference in this indicator.

Stability in Substitute Care

Research on child development upholds the importance of stable parental care and attachments in children's lives. Recent research reveals the damage that having multiple foster homes inflicts on a child's sense of well-being and capacity to form trusting and emotionally satisfying relationships. A CFRC study of youth involved in the subsidized guardianship program found that frequently-moved children are significantly more likely to convey depressive attitudes, express less happiness with their current home, and feel a weaker sense of belonging than children with fewer moves. In addition, frequently-moved children are more likely to have their current placement disrupt and are less likely to be adopted or taken into private guardianship.[2] Specifically, a child who experiences four separate homes within the first year of foster care (10% of newly placed youth) is only 60 percent as likely to be adopted or taken into guardianship as a child with only one placement. After eight separate placements, the chances of adoption or guardianship fall to less than a third of those children with only one placement.

Measuring Placement Stability

While the notion that stability of family, school, and neighborhood is important to children's successful development is uncontested, there is tremendous variation in how stability is defined operationally. Measurements of placement stability often focus on the *number of placements* that a child experiences while in care. However, there is no uniformly agreed upon number of placements used to indicate placement instability. Several studies count three moves, or four placements, as the threshold for placement instability.[3,4] The federal government measures placement stability as "two or fewer placements within a year,"[5] which implies placement *instability* once the child experiences three placements. While the ideal may be to have a child experience only one placement, the threshold of two placements acknowledges the reality of initial emergency or diagnostic homes when the child is first taken into state protective custody. A few studies do define stability as one placement and any move as placement instability.[6]

In addition, the *definition of placement* or type of placement included in definitions of stability varies from source to source, as does the *timeframe* under examination. These variations can make a substantial difference in the analysis of placement stability data. The CFRC, in conjunction with the Child Welfare League of America, produced a discussion paper that details the specific types of placements that may be counted or not in defining placement or placement move.[7] State policies regarding placement in emergency or assessment shelters, for instance, varies greatly across the country; some jurisdictions view this as a necessary first step prior to a true foster care placement in which a child can be evaluated and the best placement found for him/her, while other states rarely use emergency placements and instead place a child immediately into a foster care setting. There is also great variation in the use of trial home visits, where a child may be returned home for a period of time, but under custody or supervision of the child welfare agency. Detention, incarceration and institutional settings are used differently by child welfare agencies across the country and may or may not be included among the types of placement moves included in definitions of instability.

While measuring the aggregate number of placements for a particular child provides useful information, others

2 Testa, M.F., Cohen, L., & Smith, G. (2003). *Illinois subsidized guardianship waiver demonstration: Final evaluation report*. Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

3 Hartnett, M.A., Leathers, S., Falconnier, L., & Testa, M. (1999). *Placement stability study*. Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

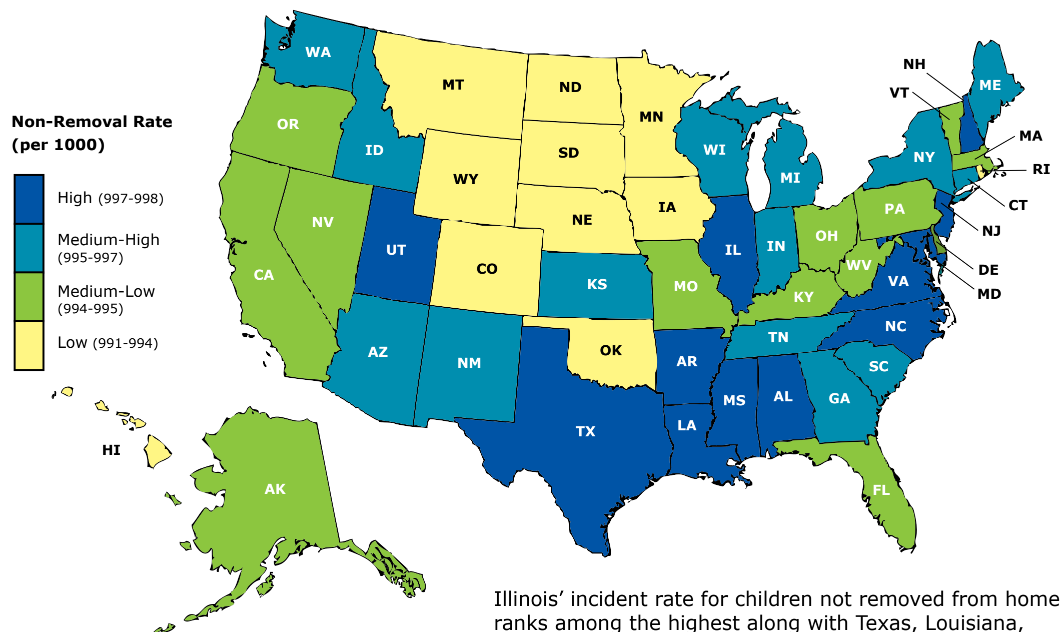
4 Webster, D., Barth, R., & Needell, B. (2000). Placement stability for children in out-of-home care: A longitudinal analysis. *Child Welfare, 79*, 614-632.

5 U.S. Department of Health and Human Services. (2004). *Child welfare outcomes 2001: Annual report. Safety, permanency, well-being*. Washington, DC: U.S. Government Printing Office.

6 Barber, J.G., Delfabbro, P. H., & Cooper, L. (2001). Predictors of the unsuccessful transition to foster care. *Journal of Child Psychology and Child Psychiatry, 42*, 785-790.

7 Children and Family Research Center. (2004). *Research brief: Instability in foster care*. Unpublished manuscript, University of Illinois at Urbana-Champaign.

Map 2.1— **National Comparison: Rate of Child Non-Removal**



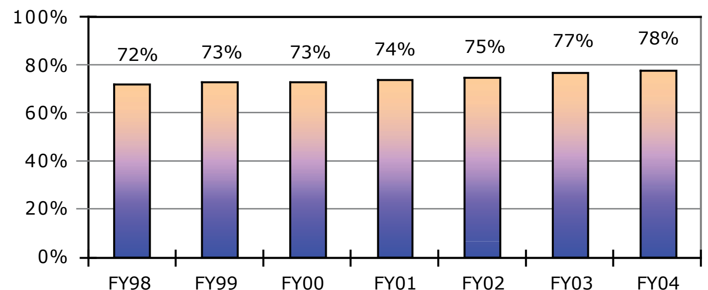
Illinois' incident rate for children not removed from home ranks among the highest along with Texas, Louisiana, Alabama, North Carolina, New Hampshire, Utah, Maryland, Mississippi, Arkansas, Virginia and New Jersey

Source: AFCARS data from the U.S. Department of Health and Human Services (http://www.acf.dhhs.gov/) Note: a three year average non-removal rate was calculated from this data

suggest that the more critical element is the manner in which children move through care: from restrictive to less-restrictive placements and the timing and duration of the longest placement in care. This second research view categorizes spells in foster care into early or later stability.[8]

Reaching a common definition of placement stability that will provide both useful and reliable data is imperative. As it stands currently, each time a community, research institution, or governmental body looks at placement stability, a different set of conclusions will be drawn. The CFRC, in conjunction with the Child Welfare League of America, is leading the efforts to develop such standards.

Figure 2.3 **Children in Substitute Care for at Least One Year Who Had No More Than Two Placements Within a Year of Removal**



Current Status of Placement Stability in Illinois

When a child is removed from home and placed in substitute care, it is incumbent upon the state to provide a stable environment for that child. In this report, stability in substitute care was defined using the AFCARS standard of "no more than two placements." Unlike AFCARS, however, the definition was changed to follow only children that have been in care for at least one year, excluding children in care only a few days or months. As with the AFCARS definition, the following types of placements were excluded from the calculation of placement stability: run away, detention, respite care (defined as a placement of less than 30 days where the child returns to the same placement), hospital stays, and placements coded as "unknown whereabouts."

Results of the CFRC analysis are presented in Figure 2.3, and reveal that placement stability in substitute care has increased slightly over the past several years (Appendix A, Indicator 2.B). In 1998, 72% of the children had two or fewer placements in their first year of care. This increased to 78% in 2004. Examination of trends in specific subgroups of children reveals that the increases observed in placement stability have occurred primarily among Caucasian children, whose rate of stability increased from 69% in 1999 to 81% in 2004. Stability among African-American children has remained around 75% during the same period. A similar pattern holds true for geographical region: stability rates in Cook County have remained constant while other regions have seen increases in stability. In addition, the data shows that children under 12 years of age experience greater placement stability than teens. There is little difference in placement stability by gender.

Results presented here differ significantly from those in a recent report from Chapin Hall Center for Children[9] on

8 James, S., Landsverk, J., & Slymen, D. J. (2004). Placement movement in out-of-home care: Patterns and predictors. *Children and Youth Services Review, 26*, 185-206.

9 Zinn, A., DeCoursey, J., Goerge, R., & Courtney, M. (2006). *A study of placement stability in Illinois*. Chapin Hall Center of Children at the University of Chicago.

Box 2.2—**The Race Matters Consortium**

Throughout the country, black children are overrepresented in state child welfare systems. Native American children – Indians, Hawaiians and Alaskans – are all overrepresented in the jurisdictions in which they reside. Latino children are overrepresented in over 10 states. But this information does not fully describe the disproportionality of minority children in the child welfare system. Asians and Pacific Islanders tend to be underrepresented in the child welfare system. And, if we look more closely at Latino representation throughout the country, we see that Latinos are overrepresented in some jurisdictions and underrepresented in others.

What are the reasons for this disproportional representation of minority children in the child welfare system throughout the country? What is the "most appropriate" representation of any group of children in the child welfare system? These are very complex issues that are heightened by the understanding that definitions of abuse and neglect in the child welfare system differ from state to state, which means that the states define who should be within their child welfare systems differently.

The Race Matters Consortium (*The Consortium*) works to understand the disproportional representation of children of color in the child welfare system and to inform the larger child welfare community of their findings. In our examination of the child welfare system we recognize that each of the following factors impact child welfare systems: 1) federal and state policies guide all child welfare efforts; 2) program administration affects casework practice; 3) community configurations are diverse; 4) individual and family factors are unique. To better understand the complicated nature of disproportional representation we need to closely examine each of these aspects.

We hypothesize that systems and programs that are developed at the federal level are designed uniformly, ultimately to serve children of various races and ethnicities in the same way. Training and other practice-related efforts are often designed to mimic the guidelines of the federal programs. The error in this thinking is that people are unique, with different cultures, histories, strengths and needs, and when we provide services in a uniform way, we omit important characteristics of the children and families for whom the services are intended.

Many federal policies are designed to meet the needs of the mainstream. For example, the Urban Institute's recent report on federal child care policies found that current federal child care policies and programs better meet the child care needs of white families than black and Hispanic/Latino families.[a] While one would argue these policies are developed on national child care patterns, when child care patterns are examined by race, as they are in this report, they do not hold among black families. Additionally, the national patterns for Hispanic/Latino children and families tend to follow the identified national patterns more closely, but not identically. Ultimately, these types of differences need to be understood and addressed. *The Consortium* is committed to understanding these differences and developing policies and practices that reflect the diversity of the child welfare population, in the community in which it operates.

The Consortium began as a project at the CFRC and is now a national initiative housed at the research firm, Westat. For more information please visit: http://www.racemattersconsortium.org/

This box was written by Dennette Derezotes, Executive Director of Race Matters Consortium. Ms. Derezotes was formerly with the Children and Family Research Center.

[a] Capizzano, J., Adams, G., & Ost J. (2006). *Caring for children of color: The child care patterns of White, Black, and Hispanic children under 5.* Occasional Paper Number 72. Washington: The Urban Institute.

children in substitute care in Illinois. The report from Chapin suggests that stability for children in foster care in Illinois is getting worse. Part of the difference in the two findings seems to be definitional – the Chapin report counts placement in detentions and hospital stays differently than the Center does. But, from our initial analysis of this data, these placement types do not seem to account for all of the differences. The ACLU of Illinois has called for a study of these differences so that they can be understood and transparent. Study of this issue will be a priority in the upcoming year.

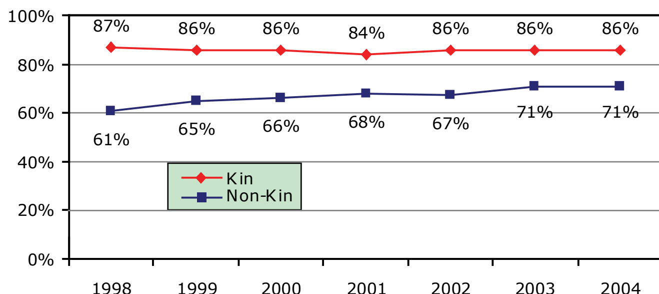
Kinship Care and Placement Stability

CFRC's program of research on kinship foster care shows that placement with kin, after appropriate safety checks, is the most stable form of substitute care available to children who are removed from parental custody.[10] [11] This finding has been confirmed by researchers in California who found

10 Garnier, P.C., & Poertner, J. (2000). Using administrative data to assess child safety in out-of-home care. *Child Welfare, 79*, 597-613.

11 Testa, M. (2002). Kinship care and permanency. *Journal of Social Service Research, 28*, 25-43.

Figure 2.4 **Percent of Children With No More Than Two Placements During Their First Year in Care by First Placement Type**



that children in kinship care had greater stability than those placed with non-kin.[12] Placement with grandparents, aunts and uncles helps reduce the trauma of separation that accompanies child removal from the home and preserves important connections to siblings, family, and local community. Figure 2.4 shows that children initially placed with kin are much more likely to experience placement stability than those placed with non-kin. It also indicates that the improvement seen in placement stability in Illinois has occurred primarily among children placed with non-kin.

A study of placement stability funded by the CFRC found that unmet child behavioral need was the most significant reason for placement changes in non-kin foster homes.[13] Forty-five percent of foster parents and nearly forty percent of caseworkers reported that the foster home's inability to deal with the child's behavioral problems, such as physical aggression, property destruction, disobedience, and police involvement, was either the first or second most crucial factor for a placement ending. A comparison of stable with disrupted placements suggested that specialized foster care, receipt of therapy, and foster parent empathy and tolerance were important predictors of stability in non-kin foster homes.

Research indicates that the timing of the first placement change can predict the likelihood of multiple moves for children in care. The Illinois data shows that of the children that do move, 81% of those placed with non-kin experience their first move within the first 90 days of entry into substitute care compared with 56% of children placed with kin. This suggests that not only do children initially placed with kin experience greater overall stability than those placed with non-kin (see Figure 2.5), they are more likely to experience at least 90 days of stability when first placed into care.

12 Webster, D., Barth, R.P., & Needell, B. (2000). Placement stability for children in out-of-home care: A longitudinal analysis. *Child Welfare, 79*, 614-632.

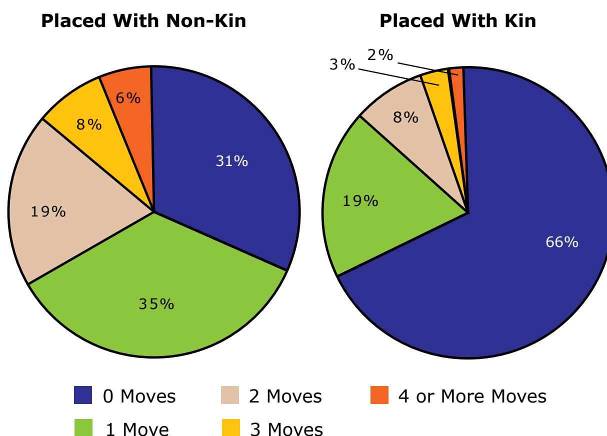
13 Hartnett, M.A., Leathers, S., Falconnier, L., & Testa, M. (1999). *Placement stability study*. Urbana, IL: Children and Family Research Center.

Box 2.3— **Innovative Programs: Child and Youth Investment Teams**

In June 2005, DCFS announced a new initiative aimed at streamlining decision-making processes and service delivery to youth experiencing multiple moves and youth for whom a more restrictive placement setting is considered (i.e. a move to residential care, specialized foster care or independent living). Child and Youth Investment Teams (CAYIT) bring together a multi-disciplinary team to make a recommendation for placement that involves input from significant players in the youth's life. The intention is to make better decisions and bring stability to the youth and families involved. A key component is that the youth, biological parents, their advocates and community supports, current foster parents and service providers meet to collectively make a decision. This model allows all voices to be heard – youth, families, professionals and advocates.

CAYIT teams make recommendations for placement of the child/youth who is the subject of the meeting. Each team includes a Clinical Reviewer, a Facilitator and an Implementation Coordinator who is responsible for writing and monitoring the implementation of an action plan. In addition to soliciting the opinion of the youth and people involved in the life of the youth (natural parents, foster parents, GAL, school personnel, therapists, coaches, etc.), the Clinical Reviewer completes a formal assessment using the Child and Adolescent Needs and Strengths (CANS) assessment tool. Based on case records and group discussion, the CANS instrument calculates a score that is translated into a recommendation for a specific type of placement. The CAYIT process seeks a consensus recommendation, however when there is disagreement DCFS retains decision authority. Between July, 2005 and June 2006, approximately 2,250 CAYIT staffings were held.

Figure 2.5 **Number of Moves Within One Year**



Box 2.4—**The Impact of Parent Methamphetamine Abuse on Foster Children in Illinois**

Over the past three years researchers from CFRC have collaborated with child welfare professionals in Charleston, Illinois to better understand the growing and urgent problem of methamphetamine abuse and its effects on children. Our research describes the experiences and the mental health status of Illinois children in foster care because of parent methamphetamine abuse. We conducted approximately 90 hours of fieldwork over a six month period "shadowing" child protective investigator's visits of rural homes. We also interviewed 35 knowledgeable adults in the community: child welfare professionals, law enforcement professionals, educators, foster parents. We asked them to describe their experiences with methamphetamine involved families, beliefs about the effects of methamphetamine on school-aged children, and appropriate strategies for intervention. We also interviewed 18 children involved in the public child welfare system because of parent methamphetamine abuse about their experiences in their families. We administered a variety of standardized assessments to describe children's developmental functioning and mental health.

> *13-year-old: "...you just grow up and you don't know anything better. You just know that your family does drugs. And there's like, nothing you can do about it... you're just so used to hollering and screaming... You're used to everything that you grew up around... All the people I knew were drug addicts."*

Both children and knowledgeable adults reported children's exposure not only to their parents' and non-kin adults' methamphetamine and other substance abuse, but to a constellation of activities related to drug use or drug seeking behavior including violence within their homes and other criminal behavior. Children responded to the contexts in which they were reared in a variety of ways, including accepting or actively resisting socialization messages that normalized substance abuse.

The majority of children described involvement with law enforcement and child welfare as a "sad" and "scary" time in their families. Children reported intense shame, especially in small towns where they feel that everyone knows and gossips about the parents they love. Far from embracing their placement within safe and stable families, many children continued to express sadness, distress and resistance to legal and child welfare interventions even after months in foster care. Children reported feelings of emotional pain within their families, the absence of social support for understanding and coping with what was happening in their families, and a belief that talking about parents' methamphetamine abuse is taboo.

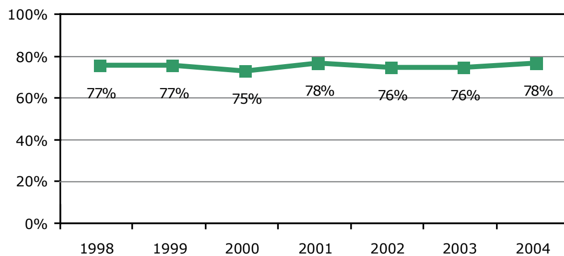
> *Children reported intense shame, especially in small towns where they feel that everyone knows and gossips about the parents they love.*

We have used the results of our study to develop a clinical intervention for rural children involved with the public child welfare system because of parent methamphetamine abuse that provides a bridge between the time of a child's entry into foster care and the time he/she enters long term therapy. This allows children to tell their stories to a supportive adult who can help them to interpret experiences in a way that will facilitate healthy development. Our ongoing research evaluates this intervention. If the intervention is successful, we hope to implement the strategy in other rural areas of Illinois.

For additional information please read, "'In these bleak days': Parent methamphetamine abuse and child welfare in the rural Midwest" by Wendy Haight, Teresa Jacobsen, James Black, Linda Kingery, Kathryn Sheridan, Cray Mulder, (2005). *Children and Youth Services Review, 27*, 949-971.

This box was written by Wendy Haight. For additional research by Dr. Haight visit the Center's website at: http://cfrcwww.social.uiuc.edu/.

Figure 2.6 **Percent of Children 12 or Older Who Did Not Run Away During the Year Following Entry**



Youth Who Run Away From Substitute Care

Another way to measure stability in substitute care is to look at the number of children who run away from their foster home. In an effort to examine the population of foster children most likely to run away from placement, this indicator examines only those children who enter care at the age of 12 or older. Figure 2.6 displays the number of children 12 or older who did not run away from substitute care during the first year of placement, and reveals that this outcome has fluctuated between 75% and 78% over the past seven years. The age group most likely to run is children entering care at age 15 or older. When looked at by race, African-American children and Caucasian children experience very different stability rates: more African-American children are unstable, as the number of African-American children that do not run away from foster care decreased from 77% in 1998 to 73% in 2004. While the trend for Caucasian children has been the opposite – from 78% not running away in 1998 to 86% in 2003. Children residing in Cook County are much more likely to run away than children in the remainder of the state, and teen girls run away more frequently than their male counterparts (see Appendix A, Indicator 2.C).

An evaluation of youth who run away from substitute care suggests that youth with placement instability are more likely to run than youth who have experienced placement stability.[14] In addition, youth who have run away from at least one placement are more likely to run again, particularly during the period immediately after return to care. Children

14 Courtney, M.E., Skyles, A., Miranda, G., Zinn, A., Howard, E., & Goerge, R.M. (2005). *Youth who run away from out-of-home care*. Chicago, IL: Chapin Hall Center for Children.

YOUTH VOICES

Just 4

a poem by Latricia

1.
Talking to someone
in the same
situation as me:
foster kid
19
emancipated
on her own
alone

I asked her:
how many placements have
you had in foster care?
She said just 13.
Just 13.
How could she say just 13?
like 13
Isn't so many placements.

I just had 4.
Just 4.
Like 4
isn't so many placements.

2.
Talking again
to one of the top
big shot
salary paid
DCFS workers.

She asked me
how many placements have
you had in foster care?
I said just 4.
Just 4,
How could you say just 4?

Just 4.
That's a lot,
she said.

3.
DCFS
Taking us
from our only home
From our parents
giving us a life
in a beige-colored folder.

The state becomes our parent
File folders our home
and yeah,
we get a little allowance
but they can never keep an eye on us

So they send
a woman with our file
our aunts and uncles from the state
better known as the caseworker
but they have
their own lives to live
so they find us
the first babysitter that they can find
that gets all the money:
our foster parents.

4.
I said just 4.
Just 4.
How could you say Just 4?

Just 4.
That's a lot
she said.

Just 4?

What about
Just 13?
What about
Just 20?
Just 30?

What about
State becomes our parent?
File folder our home?
What about
Caseworker-aunts and
Babysitter-foster parents?

I just had 4.
Just 4.
Like 4
isn't so many placements.

Box 2.5—**Variation in Child Well-Being Between Kin and Non-Kin Providers**

Well-being of children continues to emerge as a significant consideration with regard to assessment of outcomes, and kinship care has been associated with the enhanced well-being of children. According to several studies, children living in kinship care are less likely to be identified as having behavior problems than children in other placement types. The percentage of children in out-of-home care that have developmental disabilities has also been found to vary by placement type – fewer children living in kinship care than in either traditional or specialized foster care are identified as having developmental disabilities.[a] Current research and theories for understanding these findings will be briefly reviewed here. The discussion is organized along lines suggested by Keller et al.[b]

Selection effects: It is possible that children in kinship care demonstrate relatively better functioning as a consequence of preferential placement to children having more intensive service needs with traditional foster care providers. Alternatively, availability of kin may indicate a more functional social support system. Grogan-Kaylor[c] demonstrated that children initially placed with kin differ from children placed in other settings. Children placed in kinship care were more likely to be African American or Latino, to be free of observed health problems, to be placed due to neglect, to be from families that were not receiving AFDC payments, and to be between the ages of one and twelve. These findings suggest that some component of the variance in observed well-being outcomes for children in kinship care may be attributable to differences at the outset.

Rater effects: Alternatively, some element of the variance in child well-being by placement type may be a consequence not of actual variation in well-being but of some type of reporting bias. In a study by Shore, Sim, Le Prohn, and Keller,[d] teachers, kinship care providers, and non-kin providers were asked to complete child behavior rating scales. The correspondence between teacher ratings and kinship care provider ratings was found to be greater than that between teacher ratings and non-kin provider ratings. Non-kin tended to rate children as having more severe emotional problems.

Kinship effects: Kinship effects may have a preventative or ameliorative effect with regard to emergence or maintenance of various types of health, mental health, and developmental problems. Findings from Fox, Fransch, & Berrick[e] indicate that children living in kinship care have more contact with their biological families (also reported by Berrick, Barth, & Needell[f]) and are more likely to indicate that, as teenagers, they expect to be living with their current caregivers. Children in kinship care also report greater caregiver support for school-related issues of well-being.

At present, some support exists for each of the broad hypotheses that have been offered to explain identified differences between the well-being of children in kinship care and that of children in other care types. Evidence suggests that these differences persist. As findings from Round 1 of the Illinois Study of Child Well-Being demonstrated, children in kinship foster homes are identified as having problems with mental health, behavior, and education at lower rates than children in other types of care (Hartnett & Bruhn[g]). Moreover, data from the most recent wave of the National Survey of Child and Adolescent Well-Being indicate that only 30% of children in formal kinship care are rated by caregivers as having borderline or clinical level behavioral concerns, whereas 48% of children in traditional foster care placements are so rated (unpublished finding). The implication is that disparities in well-being by care type remain a salient concern needing additional research that addresses the underlying reasons for the disparities.

This box was written by Christina Bruhn of the CFRC staff. Dr. Bruhn researches well-being issues at the Center.

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[a] Bruhn, C.M. (2003). *Impact of disability on case planning for youth children in foster care.* Unpublished doctoral dissertation, University of Illinois at Chicago.

[b] Keller, T.E., Wetherbee, K., Le Prohn, N.S., Sim, K., & Lamont, E.R. (2001). Competencies and problem behaviors of children in family foster care: Variations by kinship placement status and race. *Children and Youth Services Review, 23*, 915-940.

[c] Grogan-Kaylor, A. (2000). Who goes into kinship care? The relationship of child and family characteristics to placement into kinship foster care. *Social Work Research, 24*, 132-141.

[d] Shore, N., Sim, K.E., Le Prohn, N.S., & Keller, T.E. (2002). Foster parent and teacher assessments of youth in kinship and non-kinship foster care placements: Are behaviors perceived differently across settings? *Children and Youth Services Review, 24*, 09-134.

[e] Fox, A., Frasch, K., & Berrick, J.D. (2000). *Listening to children in foster care: An empirically based curriculum*. Berkeley, CA: Child Welfare Research Center.

[f] Berrick, J.D., Barth, R.P., & Needell, B. (1994). A comparison of kinship foster homes and foster family homes: Implications for kinship foster care as family preservation. *Children and Youth Services Review, 16*, 33-63.

[g] Hartnett, M.A., & Bruhn, C. (2005). *The Illinois study of child and adolescent well-being, round 1: Final technical report*. Urbana, IL: The Children and Family Research Center.

placed with kin and children placed with siblings in care were less likely to run away than those placed in unrelated homes or placed separately from siblings in care.

Observations on Stability in Illinois

The rate of child non-removal from home of origin into substitute care has increased substantially since the mid-1990's, particularly among African-American children. Although the rate of non-removal among African-American children has risen dramatically over the past decade, it is still substantially lower than that of any other group of children. This racial disproportionality in removal rates is a cause for concern. Policies and practices that drive disproportionality often differ depending upon the community in which they are practiced. This holds true in Illinois where African-American children living outside of Cook County are three times more likely to be reported to child welfare authorities, four times more likely to enter foster care, and almost five times more likely to be in care, compared to children of other ethnicities. Additional attention and resources are needed to adequately address these issues.

Illinois' non-removal rates rank among the highest in the country – more children remain at home and are not taken into foster care in Illinois than in most states. Furthermore, the vast majority of the families served at home with intact family services do not experience an out-of-home placement within a year. It appears then that the relatively high non-removal rate in Illinois has not had an adverse effect on child safety among intact families.

Measurements of placement stability vary greatly – reaching a common definition that provides both useful and reliable data is imperative. Using a modified AFCARS definition of stability, Illinois has seen improvement in the number of substitute care placements a child experiences within the first year of care. The differences in stability reports produced by Chapin Hall Center for Children and the Center need to be better understood, and a

YOUTH VOICES

Letter to a Foster Parent

Dear Ms. N,

When I met you, I was just fifteen years old and already had a baby – only nine months old. I was told I was going to be staying with you for only two weeks, so not knowing what was coming next, I came into your home with my baby in my arms: a child raising a child. You welcomed me with all of my excess baggage: trash bags, a teen pregnancy and a failed placement. And I knew almost right away that we would get along just fine. Well, weeks turned into months and trash bags turned into a dresser of my own. As time went on, we grew to love and live with one another.

Ms. N., you nurtured and loved my baby and me. We grew up together in your home. You showed me how to be a mom, with patience and love. Do you remember when you used to teach my little boy to sing "Jesus Loves Me?" I would never sing because, well, I just can't sing! You said, "If you can talk, you can sing." You always encouraged and supported me like that.

When my family let me down, you got me right back up, encouraging me to keep my head up and gave me that extra push to actually do something with my life. You taught me to be patient and wait for the good things to come. And, sure enough, they did.

When the opportunity to move to another town arose, everyone was telling me not to go. Do you remember what you told me? You told me to do what I think I should do, and not what everyone else was saying I should do. Even in this experience, you taught me something, Ms. N.

At seventeen years old, I made the decision to move away and start on my own road to independence. It was time for me to leave and though I was told that I would live with you for only two weeks; that two weeks turned into a lifetime.

When I left your home, I was a young woman and my son was a healthy, rambunctious two-year-old, holding my hand and walking on his own. And while I came with all that baggage, I left with a lighter load. You gave me suitcases to replace my trash bags and so much more. I was a different person: more patient, confident and knowledgeable.

I know it was hard for me, just as it was for you; we are still close. I try not to miss a night calling you to pray together, to talk and seek your wisdom as I navigate young adulthood and motherhood.

Thank you for being so easy on me. Thank you for being so hard on me. Thank you for being there for me. I love you, Momma.

Love always,
Latricia

Box 2.6—**National Mobility and Stability of Placement Study**

Child welfare policy makers have historically struggled with responding to potentially conflicting values concerning substitute care placements for children. Specifically, placement workers must often decide whether to prioritize a child's kinship/community continuity over other considerations such as material security and educational advances outside the child's home community. CFRC staff analyzed nationally representative survey data to get a better understanding of this issue. The study examined the stability of placement arrangements for children either reported to or investigated by child protective authorities for abuse or neglect and who participated in both Wave 1 (initiated in October of 1999) and later in Wave 4 (36 months later) of a nationally representative survey (the National Survey of Child and Adolescent Well-Being (NSCAW).

CFRC staff confirmed previous studies that found placement stability declines the less family-like (more restrictive) the placement setting is. Children placed with a biological parent at Wave 1 were most likely to be in the same placement, and to have never moved during the three years of the study. Of all the children residing with their birth families at baseline, 90 percent are still with or back with their birth families at Wave 4. Most of these children, 84 percent, stayed with their biological family across all three years of the study.

Table 2.1 Mobility and Stability of Children by Placement Status: A Comparison of Wave 1 and Wave 4 NSCAW Data

Placement Type (Wave 1)	Same Placement at Wave 4	Never Moved
Birth family	90%	84%
Adoptive family	63%	53%
Informal kin care	4%	65%
Informal non-kin care	39%	30%
Formal kinship care	45%	47%
Foster family care	31%	18%
Group or Institutional care	13%	2%

Particularly noteworthy is the low percentage of children in informal kinship placements in Wave 1 and Wave 4 (4 %). This is not because informal kin placement is any less stable than other forms of substitute care. Two-thirds (65%) of the children who were in informal kin care are still in the same home at Wave 4 that they were residing in at Wave 1. The major difference is the change in the "out-of-home" status of the baseline home. Of the 65 percent of children in informal kin care who never moved out of their baseline home, the vast majority (82 %) are now designated as living in formal kinship care at Wave 4. This change is consistent with the hypothesis that children informally placed with kin are gradually absorbed into the formal system. By contrast, very few of the 30 percent of children in informal non-kin households who never moved out of their baseline homes are designated as living in formal foster care (13%) at Wave 4. Most maintain their same "in-home" status as at Wave 1.

In this study, a model of stability was tested using logistic regression with presence or absence of a placement move(s) as the dependent variable and a combination of demographic variables (age and race of child and caregiver, number in household, and marital status), various forms of 'bridging social capital' (caregiver education, employment, and income), 'bonding social capital' (emotional support and relationship to caregiver), and type of placement at baseline as independent variables. A child located on the lower ends of both 'bonding' and 'bridging' social capital were found to have a significant correlation to an increased likelihood of a placement move. Additionally, a child placed in a formal non-kin placement (i.e. traditional foster care) at baseline were 18 times more likely to experience a placement move than a child in the home of a birth parent at baseline, while a child in a formal kinship placement was less than three times (2.6) times more likely to experience a move.

This is a summary of the findings that will be published in a chapter entitled "Comparative safety, stability, and continuity of the living arrangements of children at elevated risk of abuse and neglect," by M. Testa, C. Bruhn and J. Helton, expected to be published in a volume of findings related to NSCAW in 2007.

Box 2.7—**African-American Males in Foster Care and the Risk of Delinquency**

Juvenile delinquency remains a significant problem for child welfare systems throughout the United States. Victims of child abuse and neglect are more likely to engage in delinquency relative to children in the general population. Although the magnitude of this relationship is not fully understood,[a] the risk of delinquency is particularly high for African-American males and for children in substitute care settings.[b] Debate continues regarding the factors that connect these two phenomena. To improve understanding of juvenile delinquency in the child welfare system, research at CFRC tested aspects of social control theory within the context of foster care for African-American males, focusing on the level of attachment with foster care providers, commitment to education and religion, and perceptions of permanence.

Healthy development is dependent upon parents and other socializing agents making consistent investments in the care, education, and supervision of children. Such investments help instill a sense of attachment, commitment, and obligation that tie children to family and conventional role models. When confronted with opportunities to engage in nonconforming or undesirable behaviors, children with extensive and strong social bonds have a greater stake in conformity and are less likely to engage in delinquent behavior that might jeopardize those relationships.[c d] Attachment and commitment represent two key components of the social bond.

Using a sample of nearly three hundred African-American males in Cook County between the ages of 11 and 16, survey data were used to estimate the strength of social bonds. Official delinquency petitions were used as the dependent measure. Measures related to the commitment to education (school suspension and participation in after-school activities) and religion decreases the risk of delinquency. This work explores not only the effects of placement instability, but also how one's perception of future instability may impact problematic behavior. Perceptions of placement instability appear to increase the likelihood of delinquency (17% of the children that perceived themselves as likely to move from their current foster home had a delinquency petition, compared with 8% of children who perceived their current placement as stable and unlikely to change). Finally, reported levels of attachment are also associated with subsequent delinquency – children reporting a more positive relationship with their foster care provider were less likely to enter the juvenile justice system.

These findings emphasize the need for child welfare professionals to facilitate and maintain attachment between foster youth and foster parents, to facilitate and maintain youth involvement with important social institutions (e.g. schools), and to secure a stable home for all foster youth.

This is excerpted from: Ryan, J. P., Testa, M. F., & Zhai, F. (in press). African-American youth in foster care and the risk of delinquency: The value of social bonds and permanence. *Child Welfare*.

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[a] Zingraff, M., Leiter, J., Myers, K., & Johnsen, M. (1993) Child maltreatment and youthful problem behavior. *Criminology 31*, 173-202.

[b] Ryan, J. P., & Testa, M. F. (2005) Child maltreatment and juvenile delinquency: Investigating the role of placement and placement instability. *Children and Youth Services Review, 27*, 227 – 249.

[c] Furstenberg, F., & Hughes, M.E. (1995). Social capital and successful development among at-risk-youth. *Journal of Marriage and the Family, 57*, 580- 592.

[d] Hirschi, T. (1969). *Causes of delinquency*. Berkeley, CA: University of California Press.

better understanding of this issue should be a priority in the upcoming year. Previous studies, as well as the current findings, show that placement with kin is the most stable form of substitute care available to children. However, as the proportion of foster children living with kin in Illinois decreases, there may be associated increases in placement instability. Furthermore, with the new legislation that prohibits placement with unlicensed kin, Illinois needs to monitor these changes closely.

CONTINUITY

KINSHIP, COMMUNITY, AND SIBLING TIES

Children should be placed in "a safe setting that is the least restrictive (most family like) and most appropriate setting available and in close proximity to the parents' home"....[1]

When substitute care is necessary to foster or protect children, federal and state policy favor placement in settings that conserve children's existing kinship, community, and sibling ties. The Adoption Assistance and Child Welfare Act of 1980 promulgated this preference under its "least restrictive" clause that prioritized foster family care over group homes, institutions, and other forms of congregate care. At the time, most foster families recruited by the state were unrelated to the children taken into custody. Only in the late-1980s did formal placement with kin become a prominent feature of the foster care system after states passed "kinship preference" laws that encouraged placement with relatives over non-relatives. Federal law subsequently incorporated this preference in 1996 when Congress amended the IV-E state plan requirements to provide that states "shall consider giving preference to an adult relative over a non-related caregiver when determining a placement for a child, provided that the relative caregiver meets all relevant State child protection standards."[2] As of 2003, data reported to the federal government showed that kinship foster care accounted for 23 percent of all substitute care in the United States.

The emphasis on keeping foster children in close proximity to their parents' home was initially intended to facilitate regular visitation between parents and children, which research suggested was conducive to family reunification.[3] Out-of-state placement was discouraged unless the state could demonstrate that it was in the child's best interests. As attention turned to the emotional well-being and educational attainment of foster children, greater emphasis was put on preserving the continuity of children's connections to school, local neighborhood, and other social institutions familiar to the child.

Relationships with siblings are frequently the longest lasting and most dependable source of support that people can draw on over their lifetime. Despite the importance of sibling connections, many foster children are unnecessarily kept apart from their brothers and sisters, and may even lack any contact with them or knowledge about their whereabouts. While sibling placement or visitation is a "best interest" factor in deciding where children should be placed after removal from the home, state and federal courts have generally stopped short of recognizing a right of sibling association. Illinois is one of the few exceptions. In *Aristotle P. v. Johnson*, the federal district court found a constitutional right to sibling association for children who had a strong, pre-existing relationship. But this right does not extend to siblings who had not grown up together prior to placement and does not extend to siblings whose ties had been legally severed by termination of parental rights. Adoptive parents may permit ongoing contact between children and their unadopted siblings, but currently there is no legal recourse for biological siblings denied such opportunity. In June 2004, Illinois formed a Governor's Joint Task Force to examine the rights of sibling association after termination of parental rights and post-adoption.

Least Restrictive Care

Historians of the Illinois juvenile court record that its founders considered institutional care to be a viable dispositional option although they saw little reason for committing most dependent, neglected, and delinquent children, especially first-timers.[4] As an alternative, they developed family-based services, such as probation, mothers' pensions, and foster family care, to avoid institutional care if possible. Most child welfare professionals at the time looked upon institutional care, especially large congregate-care facilities, as a somewhat

1 U.S. Social Security Act, Sec. 475. [42 U.S.C. 675].

2 U.S. Social Security Act, Sec. 471. [42 U.S.C. 671].

3 Fanshel, D., & Shinn, E. (1978). *Children in foster care: A longitudinal investigation*. New York: Columbia University Press.

4 Schlossman, S. L. (1977). *Love and the American delinquent: The theory and practice of 'progressive' juvenile justice, 1825-1920*. Chicago: The University of Chicago Press.

CONTINUITY AT A GLANCE

We will know if continuity is preserved:

If more children are placed in less restrictive settings than institutions or group homes:

Of all children placed into their current placement setting before the age of 12, the percentage that is not placed into institutional or group home care has remained constant at 97% over the past six years and is now 98%.

If more children are placed with kin:

Of all children entering foster care, the percentage placed with kin in their first placement increased from 35% in 2000 to 44% in 2005.

Of all children in substitute care, the percentage living with kin at the end of the year decreased from 47% in 1999 to 36% in 2003, and then increased to 38% in 2005.

If more children in group homes or institutions are placed inside the state:

Of all children living in institutions or group homes at the end of the fiscal year, the percentage placed within the state increased from 96% in 1999 to 99% in 2005.

If more children are placed in or near their community of origin:

Of all children entering traditional foster care, the percentage placed within five miles of their home of origin decreased from 26% in 1999 to 21% in 2005.

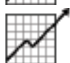
For those children entering kinship care, while this percentage is initially substantially higher than traditional care, it has decreased from 44% in 1999 to 40% in 2005.

If more children are placed with their siblings:

Of all children living in foster care at the end of the year, the percentage of sibling groups that were placed together in the same home:

For sibling groups of two or three:

increased for siblings in traditional foster care, from 45% in 1999 to 57% in 2005, and


is higher for siblings in kinship foster care, and has increased from 65% in 1999 to 69% in 2005.

For sibling groups of four or more:

increased for siblings in traditional foster care, from 9% in 1999 to 14% in 2005, and

while higher for siblings in kinship foster care, has decreased from 33% in 1999 to 31% in 2005.

disreputable last resort. After World War II, however, professional attitudes shifted, and social workers began to accept institutional care as a specialized service appropriate for some groups of children as part of a continuum of care.[5]

Government commissions called for the expansion of residential treatment programs to treat incorrigible, "acting-out," and emotionally disturbed youth. Voluntary child welfare agencies took the lead. At the time of the incorporation of the child welfare functions of the Cook County Public Aid Department into DCFS in 1969, almost half (47%) of the foster children served by voluntary agencies and 16 percent under public supervision were housed in residential facilities.[6] After the consolidation, approximately 30 percent or 4,130 children in publicly supported substitute

5 Kadushin, A. (1967). *Child welfare services.* London: Macmillan.

6 Illinois Department of Children and Family Services. (1970). *Statistical handbook: Available data—1949 through 1969.* Springfield, IL: State Printing Office.

care in Illinois were in child-care institutions or group homes.[7] Plans were underway to expand the use of institutions from placements of "last resort" to "therapeutic options of choice,"[8] however, were overtaken by a revitalized deinstitutionalization movement that spilled over from mental health and corrections into child welfare.

Between May of 1973 and June of the following year, the number of institutionalized children in publicly supported substitute care in Illinois dropped by one-third from 3,160 residents to 2,067 residents.[9] The drop coincided with the policies inaugurated by DCFS director Jerome Miller (1973-74), which commenced with the return of some 500 wards from out-of-state residential placements in the summer of 1973. Most of the returned children were not re-institutionalized but instead placed in foster homes, independent living, or released back to the custody of their parents. Similar restrictions on institutionalization were also extended to children referred to in-state voluntary agencies and resulted in the closing or size-reduction of several large custodial facilities. While Miller's anti-institutional stance brought him into conflict with the state's child welfare establishment and hastened his resignation, his policy of deinstitutionalization persisted after his departure. Between 1974 and 1980, the number of children in publicly-supported institutions and group homes in Illinois further declined from 3,286 to 2,195.[10] During this period, professional interest in extracting institutional care from a hierarchy of placement preferences also waned, and federal law enshrined the preference for family care over institutional care in the least-restrictive-care clause of the Adoption Assistance and Child Welfare Act of 1980.

Application of the "least restrictive" clause continued to divert children from institutions and group homes during the early 1980s. The trend line turned, however, after 1985 as the size of the substitute care population grew in Illinois and older wards began entering residential programs after exhausting less restrictive options. Between fiscal years 1985 and 1995, the numbers in institutions and group homes rose from 1,998 to 4,015 residents. But as a proportion, the institutionalization rate continued to slide from 15 to 10 percent of all out-of-home placements.

7 Testa, M., & Lawler, E. (1985). *The state of the child: 1985*. Chicago, IL: Chapin Hall Center for Children.

8 Bush, M. (1980). Institutions for dependent and neglected children: A therapeutic option of choice or a last resort? *American Journal of Orthopsychiatry, 50*, 239-255.

9 Testa, M. (1983). *Child placement, deinstitutionalization, and social change*. Chicago, IL: Department of Sociology, University of Chicago.

10 Testa & Lawler, (*supra* note 7).

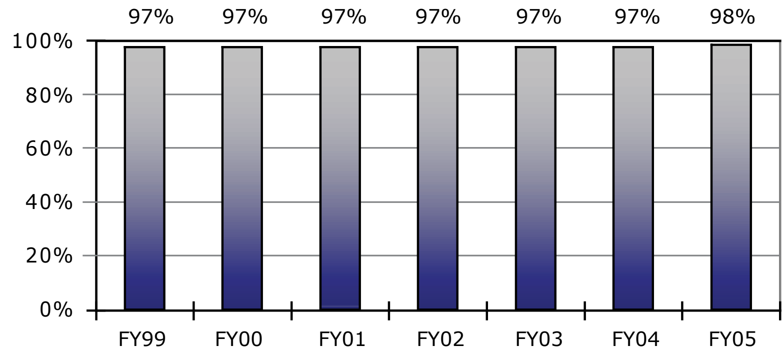
Box 3.1—**Innovative Programs: Integrated Assessment**

Recognizing the value of a comprehensive assessment of the needs and strengths of families, the DCFS Integrated Assessment program combines the engagement skills of the permanency worker with the clinical skills of trained screeners. The initial integrated assessment, completed within the first forty-five days after temporary custody, addresses the emotional, physical, educational and social needs of clients as well as the safety factors that brought the child(ren) into placement.

Integrated Assessment identifies the needs of a child using a standardized assessment as they enter the child welfare system, and guides the development of the service plan to support out of home placement. The assessment considers all life domains of the child, and involves the natural parents, child(ren) and the foster parents. Initial assessments are completed at the time of opening for all children that are entering care, except for children removed from families receiving intact family services and children that have siblings already in out-of-home placement. For children whose families have previously received child welfare services, the permanency worker completes the comprehensive assessment independently.

The integrated assessment program strives to aid early reunification of families by: ensuring that families are engaged as quickly as possible after temporary custody; identifying necessary services up front; and developing a strong service plan with clear goals for families. Another goal is increased stability for children, as service needs are identified and addressed upon initial placement. In addition, the IA program models strong engagement skills for permanency workers through joint interviews and family meetings. An evaluation of the program, conducted by Chapin Hall Center for Children, will consider the impact of the program on timely permanency and placement stability.

Figure 3.1— **Percent of Children Under 12 Not Living in Institutions or Group Homes at Year End**



Even though institutional care was targeted at older children who had exhausted less restrictive options, research conducted in the mid-1990s suggested nonetheless that many institutionalized children could be stepped back down to less restrictive settings.[11] In response, DCFS implemented a series of gate-keeping policies to restrict entries into residential care and to step youth down to non-residential placements, which produced a 58 percent reduction in the size of the institutional population from 4,015 to 1,683 residents at the end of fiscal year 2003.[12]

Although best practice recognizes a need for residential treatment for a residual segment of older wards that cannot be appropriately served in a family setting, there is general consensus that the institutionalization of young children interferes with normal developmental growth. Illinois made concerted efforts in the 1990s to prevent the institutionalization of young children. The percentage of foster children under the age of 12 years old that is not placed in a group home or institution has remained above 97 percent since 1999 (see Figure 3.1 and Appendix A, Indicator 3.A). Whether further increases in the proportion of young children served in less restrictive settings are possible will depend on the availability of trained foster parents as well as "wrap-around" services to children in kinship foster care.

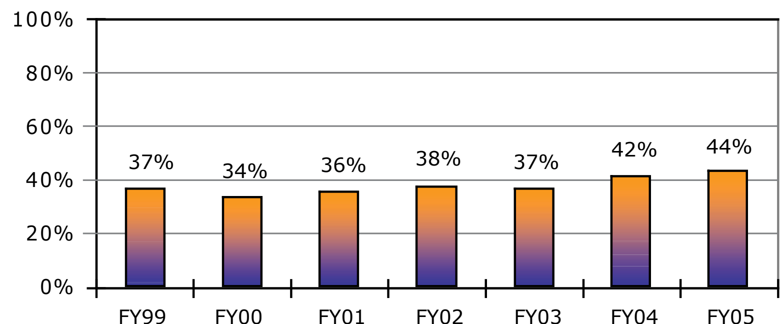
Kinship Foster Care

In 1996, Illinois registered the highest per-capita rate of kinship foster care in the nation at nine per 1,000 children in the population. New York was a distant second at 3.5 per 1,000 children and the median rate stood at one per 1,000 children for the nation as a whole. The atypically high involvement of kin in the Illinois formal foster care system arose from both a statutory preference for kinship foster care and an overly broad definition of neglect that labeled children living apart from their parents as neglected even if they were safely residing with relatives. The Illinois General Assembly amended state law in 1995 to exclude such children from the definition of neglect and instead fund a package of extended family support services to help relatives with financial, medical, or legal problems they had in looking after their younger family members. As a result, thousands of children who previously would have entered the foster care system were instead diverted and supported in the informal custody of relatives. Children who needed to be removed from family custody for reasons of abuse or neglect could still be placed with kin who met basic safety standards or became licensed foster parents.

As a result of these changes in 1995, both the numbers of children taken into foster care and the percentage initially placed with kin dropped immediately. The number placed with kin declined to its lowest level in 2000 before rebounding slightly. Although the total number of children taken into foster care continued to drop after 2000, the percentage placed with relatives as their first placement rose from 35% in 2000 to 44% in 2005 (see Figure 3.2).

Prior to 1995, there were distinct differences in the levels of regional reliance on relatives as foster parents. The fraction placed with kin was highest in Cook County and lowest in the Southern Region. After 2000, these

Figure 3.2— **Percent of Children Entering Care and Initially Placed With Kin**

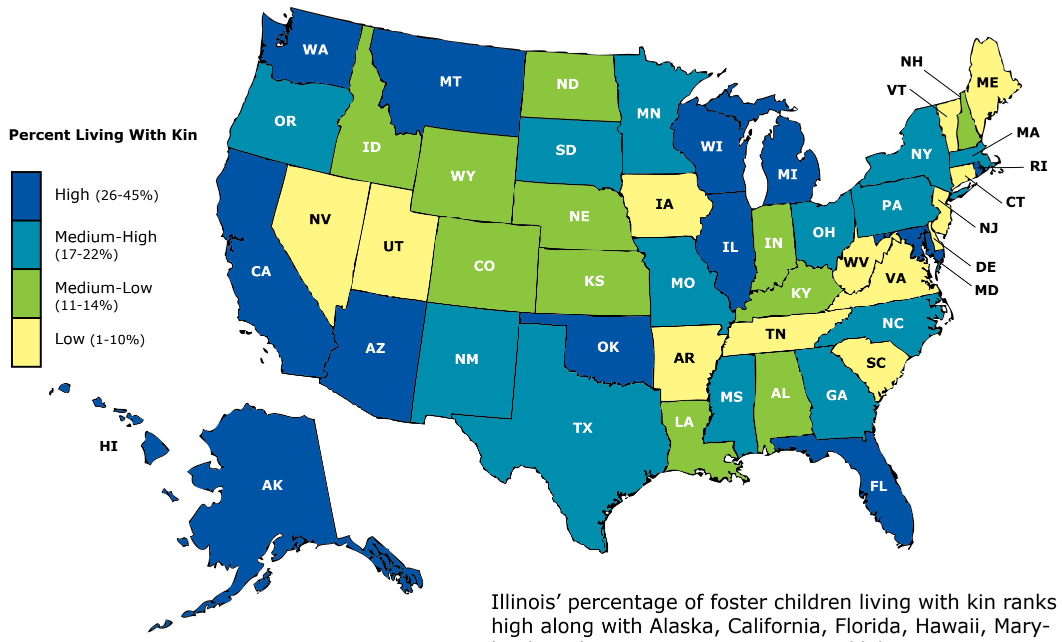


11 Lyons, J. S., Libman-Mintzer, L. N., Kisiel, C. L., & Shallcross, H. (1998). Understanding the mental health needs of children and adolescents in residential care. *Professional Psychology: Research and Practice, 29*, 582-587.

12 Budde, S., Courtney, M., Goerge, R., Dworsky, A., & Zinn, A. (2004). *Residential care in Illinois: Trends and alternatives interim report*. Descriptive findings from analysis of DCFS administrative data. Chicago: Chapin Hall Center for Children.

differences narrowed with Cook placing 37% with kin in 2003 and Southern region placing 35% with kin (see Appendix A, Indicator 3.B.1). The latest data, however, shows an overall increase in children placed with kin. Central region has the highest rate (48%) and Cook County has the lowest (43%). The regional convergence in reliance on relatives as foster parents most likely reflects continued public outreach to relatives to become temporary caregivers of their minor kin as well as a statewide drop in the supply of non-related homes available to become licensed foster homes.

Map 3.1— **National Comparison: Percentage of Children in Substitute Care Living With Kin (2001–2003)**



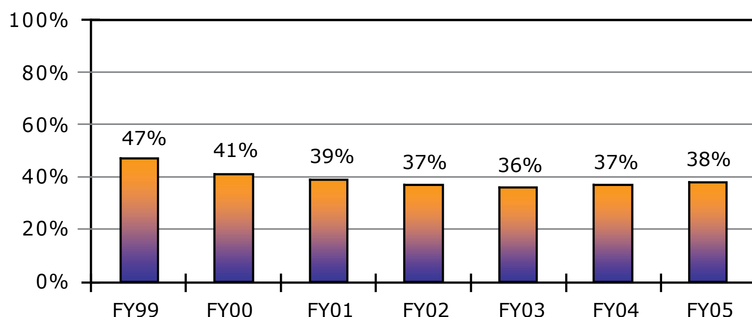
Illinois' percentage of foster children living with kin ranks high along with Alaska, California, Florida, Hawaii, Maryland, Michigan, Arizona, Montana, Oklahoma, Wisconsin and Washington

Source: AFCARS data from the U.S. Department of Health and Human Services (http://www.acf.dhhs.gov/) Note: a three year average non-removal rate was calculated from this data

The percentage of children in substitute care who were living with kin declined from a peak of 57% at year-end in 1995 when 27,071 children were in kinship foster care to a low of 36% at year-end in 2003 when 7,278 children were in kinship foster care (see Figure 3.3). Although the year-end count of children in kinship foster care continued to decline to 6,734 in 2005, the rebound in first placements with kin helped push up the year-end proportion to 38%. Despite the decline, Illinois' percentage of foster children living with kin still ranks among the highest in the nation (see Map 3.1).

The same regional convergence reported for initial placements with kin also holds for the year-end proportions. In 1998, Cook County ranked highest at 58% of all foster children living with kin and Southern Region lowest at 30%. In 2004, the proportions for Cook County, Southern and Northern Regions clustered around 38 to 39% with Central Region lowest at 34% (Appendix A, Indicator 3.B.2).

Figure 3.3— **Percent of Children Living in Kinship Foster Care at Year End**



The sharpest decline in the year-end proportion residing with kin occurred among African-American children. In 1999, 52% of all African-American foster children were looked after in the homes of relatives. In 2005, 39% of all African-American foster children were living with kin. This change should not be interpreted as a tilt away from kinship care. Rather it reflects Illinois' success in converting long-term kinship foster homes among African Americans into legally permanent homes.

Whether the proportion of children cared for by relatives ever will rise again to the levels of the mid-1990s will depend on how well DCFS makes concerted efforts to locate and assess relatives as potential placement resources. While Cook County has dropped slightly in initial placement with relatives since 1999, Non-Cook County has shown consistent improvement in this area (see indicator 3B.1). The Child and Family Services Review conducted by the federal government in 2003 rated locating and assessing relatives as resources for kin-care as an area in need of improvement, particularly in regards to the location and assessment of paternal relatives. DCFS addressed this concern in the Program Improvement Plan through the implementation of the Integrated

YOUTH VOICES

A Foster Child

Left with nothing, the state paying someone to care for me. Nothing was given for free. Home chores and 'child labor' equaled money in my hands, food in my belly, blankets on my bed. I was thankful, no matter how little I had. I was thankful because, according to my foster mom, I could have been dead, a street kid, someone without morals, without a home. After all, my own mom tried to take my life and I am an off-spring of all that is bad, all that is evil.

I was not thought of by my father, unloved by my mother, uncared for by my family.
I was a foster child.
I was without.

My older foster sister was an important person in my life because she showed me she had potential as she forced open the doors of opportunity. She gave me a feel for what I could do in the future, as she colored on the canvas of her own life – without anyone else's dark grays or blues. She showed me how to be resourceful – and she wasn't a case manager, a foster mom, or an employer. She was someone like me, someone I could identify with....a foster child.

—Kim

Assessment Program (see box 3.1), by improving the use of the diligent search process as a mechanism for locating and engaging parents, through expansion of the Intensive Relative Search Program in Cook County for children with the goal of independence, and by statewide implementation of Fatherhood Engagement Training. In the Children and Family Services Review, relative placement was rated as a strength in 76% of cases reviewed, despite weakness in locating and assessing kin for caregiving. In the ongoing DCFS Outcome Enhancement Review, each region has consistently met or exceeded the PIP goal of 79%.

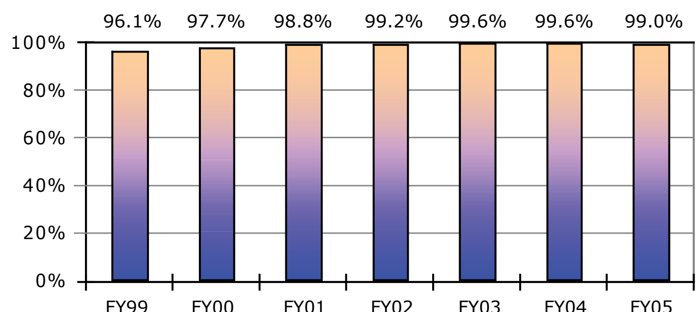
The Home of Relative Reform that Illinois implemented in 1995 gives families who meet safety standards the choice between providing care as an extended family member or becoming a licensed foster home. One of the reasons behind the 1995 legislation was to motivate relatives to become licensed relative caregivers. Even though there is higher reimbursement available to relatives who operate a licensed facility, over 70% of families elect to receive the slightly lower reimbursement as a non-licensed relative caregiver. Children in non-licensed care received the same services as children placed with licensed providers and the federal government reimbursed for these services. In 2006 congress passed legislation that disallows payment to non-licensed caregivers. One of the reasons for the new legislation is to motivate states to license relative homes. This assumes that licensing improves the quality of care provided foster children. Not only is the assumption untested, but the risk is that requiring all relatives to abide by the same room-size, training, and assorted standards required of non-relatives will hamper the state's ability to involve kin in the foster care of their family members. Furthermore, in Illinois, safety has increased for children in relative care placements despite the fact that a large percentage of these children are placed in unlicensed homes. Illinois applied for a federal IV-E waiver in 2002 to test the advantages of licensed versus non-licensed kinship care but was turned down. This is an area that warrants close attention as the new federal legislation is implemented (see Box 3.2 Warning Signs).

Preservation of Community Connections

Federal law mandates that foster children be placed in close proximity to the parents' home unless their best interests would be better served by a more distant setting. The federal Child and Family Services Review assessed whether Illinois made concerted efforts to ensure that children are placed in foster care placements that are in close proximity to the family and community of origin. They found this to be an area of strength.

Illinois' record of out-of-state residential placements is in accord with the CFSR's assessment. The percentage of children in group homes or institutions that are not located out of the state rose from 96.1 percent in 1999 to 99 percent in 2005 (see Figure 3.4 and Appendix A, Indicator 3.C).

Figure 3.4— **Percent of Children Living in Institutions or Group Homes at Year End Placed Within Illinois**



Box 3.2—**Warning Signs: New Legislation to Impact Licensing Requirements for Kin**

Illinois' continued ability to involve kin from either the maternal or paternal side in the care of children will be hampered by recent legislation passed in congress in February 2006 (the Deficit Reduction Omnibus Reconciliation Act of 2005). Prior practice permitted states to claim federal reimbursement for administrative costs, such as the costs of casework and paperwork, for children in non-licensed kinship foster care. Under the new legislation, states are no longer permitted to claim these costs except for cases where the relative caregiver meets all state licensing requirements within 12 months of placement, or within the average time it takes to license foster parents in that state, whichever is less. These changes directly impact the ability of grandparents and other relatives to care for abused and neglected children who cannot live safely with their parents. To date, Illinois has not changed its policies or practices with regards to placement in licensed or unlicensed homes. The loss of financial reimbursement will have some impact down the road. The financial impact of these decisions have not been realized and the effects if this legislation warrants close monitoring in Illinois and the nation.

Box 3.3—**New Findings: Do Children Placed in Kinship Homes Have Better Outcomes?**

Illinois' use of relatives to care for children ranks it as having one of the highest percentages of children living with kin in the nation (see Map 3.1), consequently much attention has been paid to the outcomes of children in kinship foster homes in Illinois. Many believe that this reliance on kin to care for foster children comes at a great risk – that children actually fare better when placed in licensed foster homes with non-relatives. Prior research has shown that children in kinship foster homes are less likely to achieve permanence. On the positive side, prior research also shows that children placed with kin are just as safe, and are less likely to move than those placed with non-kin.

Previous studies, however, have not controlled for pre-existing differences in children and caregivers' demographic characteristics between kinship and non-kinship foster homes. Therefore, it is not certain whether the different outcomes of kin and non-kin placements are due to the type of placement or to certain characteristics of children and caregivers. Research currently underway at CFRC examines these issues, taking into consideration the demographics of the caregivers and the children placed with them that distinguish the types of children that go into kin and non-kin homes.

This study uses data submitted by DCFS to the federal Adoption and Foster Care Analysis Reporting Systems (AFCARS) between March 1998 and September 2004. A sample of 21,914 kin children and 10,108 non-kin children was created for the analysis of legal permanence and stability outcomes, and another sample of 29,344 kin children and 20,749 non-kin children was generated to analyze the outcome of foster care re-entry. For each sample, a random sub-sample of 1,500 children in non-kinship care was matched to the kinship sample to correct for pre-and post-placement mean differences between children in kinship and non-kinship foster homes. The permanency outcomes of children in kin and non-kin foster care in the matched sample of 3,000 are compared to test for differences in rates of permanence, placement stability, and re-entry into foster care.

Contrary to prevailing wisdom, this new research shows that once demographics of the caregivers and children are controlled, children in kinship homes are just as likely to find permanent homes as those in non-kinship homes. The two groups of children also are not significantly different in their likelihood of foster care re-entry.

This research also confirms previous research that children in kinship foster homes are more stable. Kin placements are less likely to experience an initial placement disruption.

These findings suggest that future research should identify specific factors that prevent or promote stability and permanence for children in kin and non-kin foster care, providing guidance on child welfare policies and practices.

This box was written by Eun Koh, doctoral student at the School of Social Work at the University of Illinois at Urbana-Champaign. Ms. Koh also works for the Center.

YOUTH VOICES

My Fate, My Destiny, My Path...

Growing up feeling suppressed, forgotten, and vulnerable made me desire to obtain certain goals in life, to do certain things with myself. These things will help me develop and define myself separately from my past experiences, from my parent's mistakes, and from the stereotypes presented against me. I want to be an activist to defend myself, a mother to love myself, and a writer to express myself. As a poor Black former foster youth female, I started from the 'bottom' and had to climb to reach the status that I hold today. I am still climbing and battling stereotypes - racism, ageism, sexism, and economic classism.

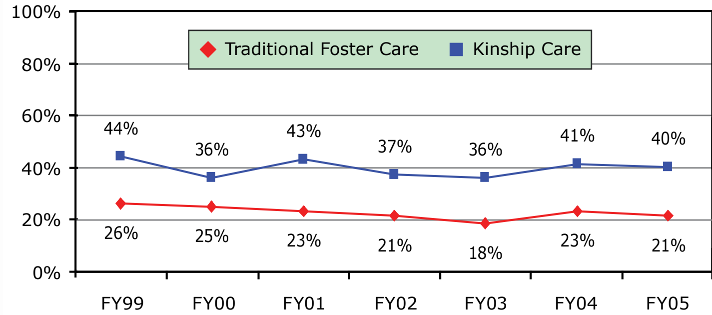
As I remember stories of how my real mom tried to kill me as a baby, or remember the day my real sister put a knife to me when I was a teenager, or even recall my adoptive mom saying I would die before the age of 24, I now know that nothing can stop me. Staying in school is a piece of cake, compared to what my life has been. Growing up part of my life as an orphan, and then being adopted at age eleven, I realized how important family can be. My heart is already driven for a future with children. I really want to be a mother when the time is right. I want to adopt and also have my own biological children.

Right now I write to express myself and my feelings. When there is no one around to listen, I can still express myself through writing. I am learning I have powers with writing, an ability to change lives. Hopefully, writing a book about my life will be an inspiration to many people. I know my stories will outlast me, my stories can be read by more people than I could ever talk or lecture to. I feel I will finally be seen and heard.

—Kim

The results are mixed, however, for children in less restrictive settings. Between 1999 and 2005, the proportion placed in traditional foster homes within five miles of their home of origin dipped from 26 percent in 1999 to 21 percent in 2005. While children placed with kin are more likely to live closer to the home of their parents, the proportion living within five miles has also dropped, from 44 percent in 1999 to 40 percent in 2005 (see Figure 3.5 and Appendix A, Indicator 3.D).

Figure 3.5— **Children Placed Within Five Miles of Their Home of Origin**



It remains to be understood whether the lengthening distances between the homes of parents and substitute care homes are damaging to patterns of regular family visitation and school continuity or instead represent an improvement in community opportunities made available to children who are unlikely to be reunified with their birth parents.

Conservation of Sibling Ties

As fewer children are taken into state custody and more are served in their own homes, the residual group removed from parental custody will likely require an alternative approach to the guardianship of their person and property than children who can be kept at home or reunified quickly. Although there is always a hope that a child taken into state custody can be reunified, the prospects are less promising especially after efforts to serve the child safely in his or her own home have already proved unsuccessful. Because predicting the likelihood of reunification is more prone to error the rarer the probability, it is imperative that public authorities plan concurrently for alternative permanent guardianship arrangements to reunification.

Guardianship of the person and property of children removed from parental custody is more complicated in today's modern world than in the past. Authorities can no longer be held accountable solely for meeting the physical needs of the child. Instead they must also be charged with the responsibility of securing foster youths' future development by providing them with sufficient educational opportunity and holding their financial and social assets in trust so that these investments are available to them when they become adults. Economists call these three sorts of assets, human, financial, and social capital respectively, because they can be conceived of as inputs to a young person's future economic productivity and social well-being.

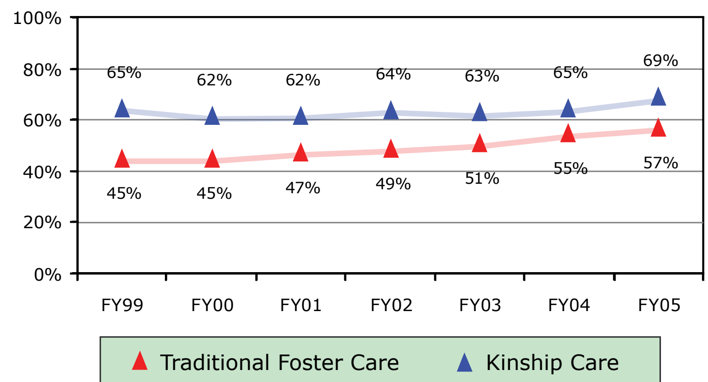
Although the procedures for safeguarding a public ward's financial assets have been around for decades, the procedures for safeguarding the human and social capital of foster youth are only now being developed. An important but until recently overlooked source of social capital are the resources that arise from sibling bonds. Research shows that sibling relationships play a major role in how children develop and learn to interact with other people.[13] Sibling bonds, just like parent-child bonds, influence children's developing sense of attachment.[14] Siblings are an important source of emotional comfort during childhood, and in adulthood, siblings can also become a vital source of material and financial assistance.[15]

Despite the significance of sibling relationships for childhood development and well-being in adulthood, the importance of conserving sibling ties has been ignored until recently in child welfare practice. Because of this inattention, foster children are potentially deprived of an important source of social capital both during their childhood and later in their adult lives.

The opportunities for sibling association while in foster care are related to the type of care into which children are placed (see Appendix A, Indicator 3.E). Figure 3.6 shows that sibling groups of varying sizes are more likely to be placed together when they are living with relatives than when they are in unrelated foster care. This pattern holds for 2005, but it is important to note that the proportion of siblings placed together has remained level and increased recently for kinship care and it has improved significantly in unrelated foster care settings for sibling groups of all sizes. While the increase in the proportions of siblings placed together in foster homes is to be applauded, the drop off in sibling placements among kin also needs to be understood. The extent to which it is an artifact of the aging of the residual population still in care, the placement of newborns in non-kin homes, or a decreased willingness by kin to accept all siblings into their home, requires further investigation. In addition, the new legislation requiring kin placements to be licensed is likely to impact this outcome as well. The impact of adoption and guardianship on patterns of sibling association also deserves scrutiny.

One of the more vexing issues raised by the permanency initiatives of the late 1990s is: What are the effects on the sibling association rights of foster children whose younger

Figure 3.6 **Sibling groups of 2 or 3 placed together**



Box 3.4—**New DCFS Initiative: Tracking School District at Entry**

Beginning July 2006, DCFS implemented a policy that takes school continuity into consideration when deciding the initial foster home placement for a child(ren). Every effort is made to ensure that children entering traditional foster care in Chicago remain in their current school, and outside of Chicago, that children remain in the same school district. Baseline data from DCFS shows that in FY2005, approximately one-third of initial traditional placements were in the same school district and, in Chicago, very few placements were in the same school boundaries.

The identification of homes and school areas is made by staff at the statewide Case Assignment Placement Unit (CAPU). Geo-code computer programming allows staff to identify the local school and/or school district boundaries based on the address from which the child(ren) were removed. Available, licensed foster homes are identified within a one, two and ten mile radius from the local school/school district. With this information, the licensing agency is contacted to determine if the home is an appropriate match for the child or sibling group.

The database of available homes includes information on available capacity, language skills, and age preferences. POS agencies and DCFS resources update the database weekly to indicate any changes in availability. DCFS provides POS agencies with data on new protective custodies, hoping to encourage agencies to develop recruitment strategies in communities where the need is the greatest.

13 Begun, A.L. (1995). Sibling relationships and foster care placements for young children. *Early Child Development & Care, 106*, 237-250.

14 Hegar, R. (1988). Sibling relationships and separations: Implications for child placement. *Social Service Review, 62*, 446-467.

15 Cicirelli, V.G. (1991). Sibling relationships in adulthood. *Marriage & Family Review, 16*, 291-310.

Box 3.5—**Continuity: Staying Connected**

For the past 3 years CFRC hosted the Young Researcher's Program. This program, run by two emancipated foster youth – April Curtis and Onie Riley – provided youth in care with a research internship at the Center. While at the Center, April and Onie were instrumental in advocating for change in policies and practices surrounding sibling visitation. The YR program has now ended, and April and Onie have moved on. This is their summary of where they are now.

Since leaving CFRC in September 2005 we have been working for Uhlich Children Advantage Network (UCAN). At UCAN we run the High School to College program for youth in care. Through this program we assist DCFS youth with academic and professional skills that they need to be successful in high school and academic pursuits beyond. We use our experience as former foster youth and as researchers at CFRC to assist others as they navigate the world of early adulthood.

In addition to this program, we conduct public presentations. We work inside Chicago public schools speaking on violence prevention. We also travel around Illinois and the country to speak at conferences on youth advocacy, education, youth empowerment, programs offered to youth in care and the importance of sibling bonds, as well as preparing youth to do the same.

We are still passionate advocates for the rights of siblings. We are working on an initiative at UCAN to educate the public around the importance of sibling bonds. In addition, we both serve on several committees and councils working to improve child welfare, during foster care and after care.

YOUTH VOICES

As If I Was Alone

"As if I was alone, in the dark, in a place where no could see me, not even myself," could be the statement best describing my sense of identity as a foster youth. When you realize your home is different, along with your life, you start looking at things differently. Living a life that threatens to always be changing, you adjust to quick changes - denying 'normal', but always wanting it.

During my pre-teen years and all the way to the college, my only personal goal has been to understand people; perhaps understanding them would give me secrets to myself. I felt early in life that I was not like most people in life. I couldn't identify with my foster mom or her family for the most part - they hurt me and each other. My biggest problem of life was the house I called home - where the ground moved with violence, the air was thick, and people once so close became so distant. In my foster home, many people came, a few stayed and even fewer ever came back to visit.

The person I should have resented, I felt sorry for. She was my real mom and, after all, how could you hate a person who is dead? Knowing her pain, I forgave my real mother for giving into drugs, allowing them to control her, to end her, and to cause so much damage in my life.

—Kim

siblings have been adopted out of foster care? Termination of parental rights turns biological siblings into legal strangers unless they are adopted into the same home. Although some adoptive parents may permit ongoing contact between adopted children and their unadopted biological siblings, there is no legal recourse for siblings who are denied such opportunity (see Box 3.7, p. 3-11).

Observations on Continuity in Illinois

When substitute care is necessary to foster or protect children, federal and state policy favor placement in settings that are most family like and that conserve children's existing kinship, community and sibling ties. While historically the conservation of family and community ties has not been a priority of child protective intervention, recent research reveals that kinship care and placement with siblings are valuable social assets for ensuring family permanence and promoting child well-being.

Illinois' reliance on kin foster placements ranks it as having one of the highest percentages of children in substitute care living with kin in the nation. Research in Illinois has well-documented the fact that children fare better when placed with kin. This report shows that children placed with kin are much more likely to be placed close to home, therefore increasing the likelihood of parental visits. In addition, children placed with kin are more likely to be placed with all their siblings in care. Relationships with siblings are frequently the longest lasting and most dependable source of support that people can draw on throughout their lives, and it

is incumbent upon the state to foster this whenever possible. Kinship has also proved to be a previously untapped source of family permanence through adoption and guardianship. By building on the cultural traditions of informal adoption and kinship care among African Americans, Illinois was able to transform placement with kin from a permanency barrier to a permanency asset. In addition the recent work at the Center that compares kin and non-kin providers suggests that future research should identify specific factors that prevent or promote positive permanency outcomes of children in both kin and non-kin foster care, providing guidance on child welfare policies and practices.

With the current focus at the Department on older wards, it would be remiss not to pay close attention to preserving sibling and kin ties that can provide the foundation for support to youth as they age out of the system and as adults, long after they leave foster care. Although the procedures for safeguarding a public ward's financial assets have been around for decades, the procedures for safeguarding the human and social capital of foster youth are only now being developed. Attention should be given to preserving these bonds while children are in foster care, so that as adults, former foster youth have family to rely upon. Attention should be paid to the pending Illinois legislation on sibling visitation and on the new federal legislation that mandates increased licensing standards for kinship providers. These new laws have the potential to significantly impact the lives of families involved with the child welfare system. In addition, the Governor's Task Force charged with monitoring post-adoption sibling visitation should be encouraged to seek legislation that would assist adopted children visit their biological siblings.

At the same time, it is important not to treat "least restrictive care" as a panacea. Research indicates that for some children initially placed into an institution and later released into foster care, these children are likely to have stable reunifications and placement histories when compared to children that experience several failed foster care placements prior to an institutional setting. These findings, documented in 1982 and again in 2004, need to be examined further to ascertain whether the least restrictive principle actually protects children against unnecessary confinement or needlessly exposes them to further discontinuity. In addition, the introduction of CAYITs has changed the manner in which placement decisions are made, directly impacting the use of more restrictive care. The impact of these new policies needs to be closely monitored and evaluated.

Box 3.6—**Warning Sign: Post-Adoption Sibling Visitation at Risk**

The Sibling Post-Adoption Continuing Contact Governor's Joint Task Force was charged with making recommendations about the rights of sibling association after termination of parental rights and post-adoption. The options range from leaving the decision of post-adoption contact solely to the discretion of the adoptive parents, to developing a sibling registry that permits contact after children reach adulthood, to permitting continued sibling visitation, contact via telephone, letters, or e-mail. Recent legislation was drafted that would establish sibling visitation rights. To the best of our knowledge, this legislation is currently pending and should be closely monitored to ensure it is acted upon.

Box 3.7—**Sibling Visitation Post-Permanence**

In a recent survey of caregivers of children that had entered Subsidized Guardianship or had been adopted, in Illinois (see chapter 4, or the Center's website, for more information on this survey), caregivers were asked about the contact their adopted or guardian children had with their biological families. Just over half of the caregivers surveyed (52%) had a biological relationship to the child, either directly or through their spouse, (typically a grandparent or an aunt or uncle). Slightly less than half (42%) reported contact with the biological mother, and 27% reported contact with the father. Approximately half of the children had contact at least once a month, while the other half saw a biological parent a few times a year. Caregivers reported that, of the children with biological siblings, about half (47%) had contact with their biological siblings. Caregiver reports also revealed that children with a biological relationship to their caregivers are more likely to have sibling visitation (62%) than those not related to their caregivers (30%). For children that have contact with their biological siblings, 60% of the time it is at least monthly.

CHAPTER 4

LEGAL PERMANENCE

REUNIFICATION, ADOPTION AND GUARDIANSHIP

Every child is entitled to a guardian of the person, either a natural guardian by birth or adoption or a judicially appointed guardian.[1]

In the 1960s, child welfare practitioners began advancing the principle of legal permanence. Studies had uncovered that far too many children were languishing in foster care without the protection of either a natural or legal guardian who could safeguard their interests, make important decisions in their lives, and with whom they could have a personal relationship.[2] Psychologists underscored the concern by documenting the emotional damage inflicted on children who grew up without secure attachment relationships to parents or substitute caregivers.[3] These findings provided a strong evidence base in favor of policies that conserved children's birth home through family preservation and reunification or found a substitute permanent home through adoption or guardianship when reunification was not a safe possibility.

In 1980, Congress passed the federal Adoption Assistance and Child Welfare Act (AACWA). The legislation made permanency planning the guiding principle of child welfare services. It promulgated procedural guidelines to reduce the amount of time children spent in foster care and created a new funding entitlement to support families adopting children with special needs. By the mid-1980s, permanency planning was in full swing as child welfare agencies and the courts sought to conserve or find permanent homes for children as an alternative to retaining them in long-term foster care.

A decade after the passage of AACWA, however, optimism over its potential for bringing stability and security to the lives of foster children began to wane. Despite early gains made in reducing the numbers of children in out-of-home care after the law's passage, by the late 1980s foster care caseloads were once again on the rise. In the early 1990s, more than 500,000 children were in foster care nationwide – the highest number recorded up to that time. To address this surge in foster care caseloads, Congress passed the Adoption and Safe Families Act (ASFA) of 1997. The legislation endorsed adoption as the primary solution for the backlog of children in foster care who could not or should not return home. It also narrowed the criteria for making "reasonable efforts" to reunify families in circumstances of aggravated abuse and neglect (e.g. torture, prior child death, and previously terminated parental rights).

In anticipation of ASFA, the Illinois General Assembly passed a package of laws that sought to quicken the movement of children from public custody into permanent homes. Because adoption did not always meet the permanency needs of children already in safe and stable kinship care who could not be reunified with their parents, Illinois applied for and received federal waiver authority in September of 1996 to extend federal IV-E subsidies to families assuming private guardianship of children who otherwise would have remained in substitute care. The USDHHS granted Illinois an extension to the IV-E waiver that continues the standard guardianship program and creates an expanded program that targets the needs of older youth (see Box 4.1). To better align financial incentives with permanency outcomes, DCFS implemented performance contracting in July of 1997 for its largest caseload, the kinship care program in Cook County. Under performance contracting, private agencies serving foster children must balance entering new cases with those exiting to permanence in order to ensure payment and caseload parity. These changes were codified into law by the Illinois General Assembly through legislation that eliminated long term foster care as a permanency goal, reduced permanency planning time lines to one year, and directed DCFS to engage in concurrent planning with families. Concurrent planning involves the pursuit of family reunification and another permanency goal, such as adoption or guardianship,

1 U.S. Children's Bureau. (1961). *Legislative guides for the termination of parental rights and responsibilities and the adoption of children, No. 394*. Washington, DC: U.S. Department of Health, Education, and Welfare.

2 Henry S.M., & Engler, R.E. (1959). *Children in need of parents*. New York: Columbia University Press.

3 Bowlby, J. (1973). *Attachment and loss. Volume II, Separation: Anxiety and anger*. New York: Basic Books.

LEGAL PERMANENCE AT A GLANCE

We will know if children have permanent homes:

If children are reunified with their parents more quickly:

Of all children who entered substitute care during the year and stayed at least 7 days, the percentage reunified within 12 months from the date of entry into care increased steadily from 15% in 1995 to 20% in 2004.

If children who cannot be reunified within 12 months find a permanent home in a timely fashion:

Of all children who entered substitute care during the year and stayed for longer than 7 days, the percentage attaining permanence through reunification or adoption within 24 months from the date of entry into foster care increased from 23% in 1995 to 38% in 2003.

Of all children who entered substitute care during the year and stayed for longer than 7 days, the percentage attaining permanence through reunification, adoption, or subsidized guardianship within 36 months from the date of entry into foster care increased from 32% in 1995 to 56% in 2002.

If more children who have attained permanence are not displaced from home:

Of all children who attained permanence during the year (excluding placements of less than 8 days) the percentage that did not experience a rupture in permanence within two years increased from 82% in 1990 to a high of 94% in 1999 but decreased recently to 91% in 2003.

Of all children who attained permanence during the year (excluding placements of less than 8 days) the percentage that did not experience a rupture in permanence within five years increased steadily from 73% in 1990 to 89% in 2000.

Of all children who attained permanence during the year (excluding placements of less than 8 days) the percentage that did not experience a rupture in permanence within ten years increased from 66% in 1990 to 74% in 1995.

If children spend less time in foster care:

Of all children entering care for the first time, the median number of months a child stays in care has become shorter: from 32 months in 1997 to 22 months in 2003. The largest decrease has been among African-American children.

simultaneously in case the preferred option of reunification can not safely be achieved in a timely fashion.

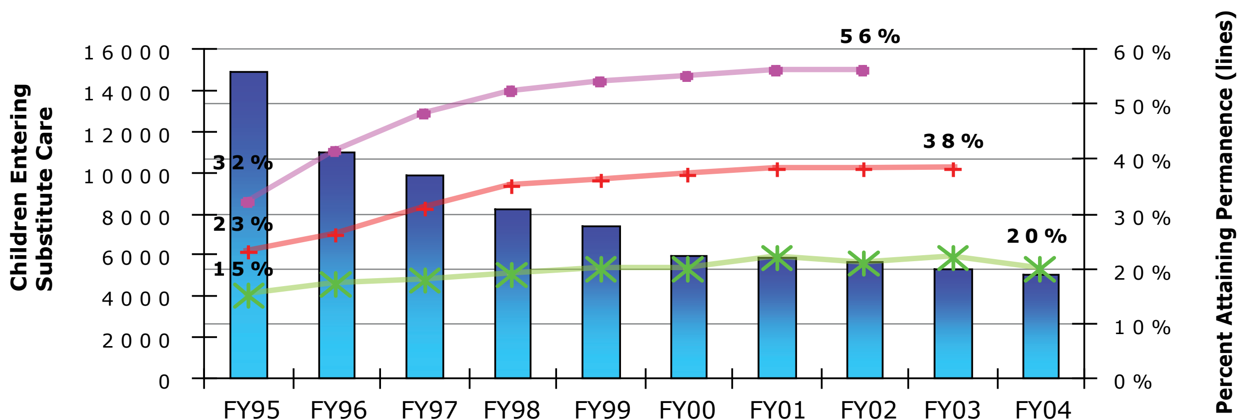
Legal Permanence in Illinois

Statistics show that large numbers of children moved into permanent homes after Illinois implemented its three permanency initiatives in 1997. Between 1998 and 2002, approximately 33,000 children were adopted or taken into private guardianship—twice as many children as were discharged to adoption or guardianship during the entire decade from 1987 to 1997. Although these increases in adoption and guardianship have earned Illinois national recognition, concerns linger that Illinois' permanency initiatives negatively impacted children's chances for reunification. To address this concern, it is important to track results from the time children enter foster care (entry cohorts) to the point they exit care (exit cohorts). Tracking children prospectively in this manner offers a complete view of what happens to children after they enter foster care in a given year, subsequently exit through reunification, adoption or guardianship, or else remain in care until they age out. This longitudinal approach is endorsed by the Pew Commission on Children in Foster Care and in

Without a place of permanency,
I have often felt lost, and alone.

—Rebekah

Figure 4.1 **Children Moving to Permanent Homes Increases One (Purple), Two (Red) and Three (Green) Years After Entry***



*Note: Permanence at one year is reunification only, at two years reunification and adoption and at three years reunification, adoption and sudsidized guardianship.

the recommendations of the committee charged by the Administration of Children and Families to review the Children and Family Services Review (CFSR) process.[4]

Longitudinal data show that the reunification rate at the 12-month milestone for children who entered foster care in Illinois increased from 15% to 20% between 1995 and 2004.[5] Reunification rates at the 24-month milestone also showed improvement, increasing from 22% for the 1995 entry cohort to 31% for the 2003 entry cohort. At the 36-month milestone, reunification rates improved from 27% in 1995 to 35% in 2003.

Research suggests that race is a strong predictor of the length of time to reunification. A recent study of reunification in Illinois[6] found that African-American children take longer to reunify than other children and that the slower reunification times are correlated with living in Cook County. That is to say, African-American children in Cook County are slower to reunify than other children in the state, including African-American children from Non-Cook Counties. These findings are corroborated in the current report (see Appendix A, Indicator 4.A). Twelve-month reunification rates in Cook County (8% in 2004) are much lower than those in the Northern, Central, and Southern regions of the state (21%, 27%, and 38% in 2004, respectively). In addition, African-American and Hispanic children are much less likely to be reunified within 12 months (13 and 12% in 2004) than Caucasian children (29%).

While reunification accounts for the majority of permanencies within 36 months in Illinois, the post-ASFA push on adoptions and the introduction of subsidized guardianship in 1997 widened the permanency pathway for children. As a result, overall rates of permanence have risen steeply. At the 24-month milestone, the rate of permanence[7] increased from 23% in 1995 to 38% in 2003 (see Figure 4.1 and Appendix A, Indicator 4.B). At the 36-month milestone,[8] the permanency rate increased from 32% in 1995 to 56% in 2002 (see Figure 4.1 and Appendix A, Indicator 4.C).

Although the trends show that permanency rates have increased for all forms of permanence since Illinois implemented its three permanency initiatives in 1997, the common perception is that *reunification* rates were adversely affected by these reforms. This impression perhaps arises from familiarity with the history of reunification in Illinois. As illustrated in Figure 4.2, 40 to 50 percent of children who entered care in the late 1980s were reunified within three years of entry, compared to one-third of children in recent years. Although recent reunification rates are lower than those of the late 1980's, rates were at their lowest in the early 1990s and have *improved* considerably since the implementation of the permanency initiatives.

Another explanation of the impression that reunifications are declining despite the rebound in rates after 1995 is that they now account for a smaller proportion of the overall number of children attaining legal permanence. With increased adoptions and guardianships, reunifications have shrunk as a percentage of the total number of children attaining permanence from 87% in 1990 to 71% in 1995 and currently to 45% in 2005. The greater success in moving

4 Child and Family Services Review Workgroup. (2004). Summary of recommendations. Unpublished manuscript.

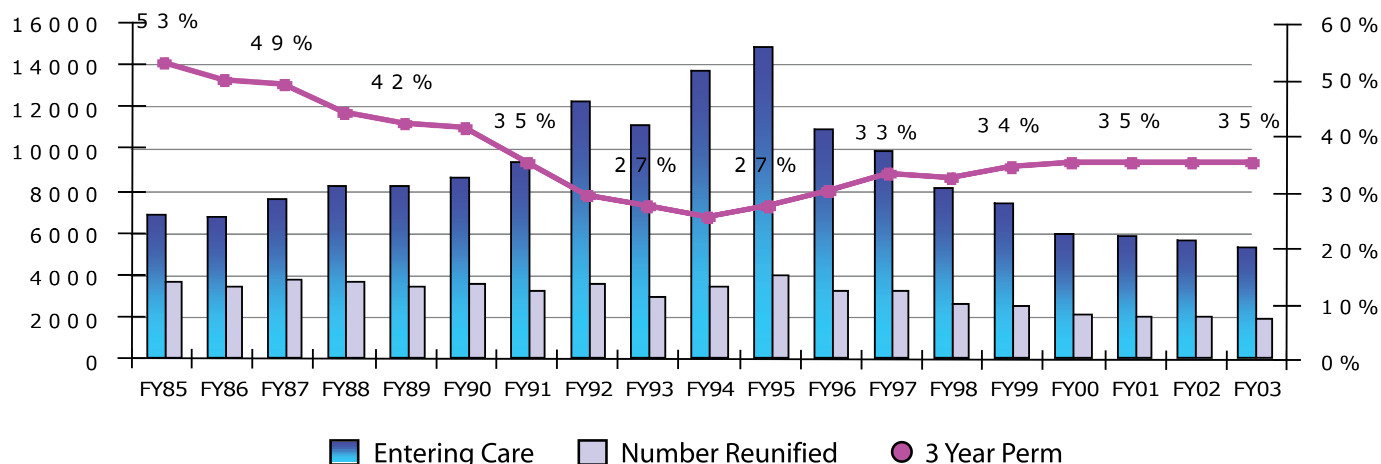
5 These numbers exclude children who entered substitute care and stayed less than 7 days.

6 George, R.M., & Bilaver, L.M. (2005). The effect of race on reunifications from substitute care in Illinois. In D.M. Derezotes, J. Poertner, & M.F. Testa (Eds.), *Race matters in child welfare* (pp. 201-214). Washington, DC: Child Welfare League of America.

7 At the 24-month milestone, reunification and adoption are the two permanency options available to children in substitute care.

8 At the 36-month milestone, three permanency options are available to children in substitute care – reunification, adoption, and subsidized guardianship.

Figure 4.2 **Children Reunified Within Three Years of Entering Foster Care**



Box 4.1—**Subsidized Guardianship in Illinois and Other States**

From April 1997 to March of 2002, the subsidized guardianship program achieved great success in improving permanency outcomes for many children and youth in Illinois. As a result, the USDHHS granted Illinois an extension to the IV-E waiver until December 31, 2008, that continues the standard guardianship program and creates an expanded (enhanced) program. The program expansion, the *Enhanced Subsidized Guardianship and Adoption Program* builds on the established success of the standard program by enabling Illinois to rigorously evaluate innovative strategies for pursuing permanence for older wards.

Specifically, the waiver will enable the state to test the efficacy and impact of the offer of post-permanency transition programs to youth who are adopted or enter subsidized guardianship at or after the age of 14. Under current policy, youth are only eligible for transitional services if they remain in care and age out of the system. Youth are ineligible for such services if they exit the system as a result of achieving permanence. In addition to a medical card and a monthly stipend, the enhanced service package available to eligible youth includes: Youth in College, Vocational and Life Skills Training, Education and Training Vouchers, Employment Incentive Program, and Housing Cash Assistance. The enhanced program is critical to better understanding barriers to permanence for older wards that were identified during the first five years of the Subsidized Guardianship Waiver Demonstration. On July 1, 2005, the enhanced program was implemented in three demonstration sites: the East St. Louis sub-region, the Peoria sub-region, and Cook Central. The program was implemented in the remainder of the state on April 1, 2006.

As a result of the success of the Subsidized Guardianship Waiver Demonstration in Illinois, the states of Wisconsin and Tennessee have contracted with CFRC and Westat to evaluate their subsidized guardianship waiver demonstrations. This opportunity allows CFRC to continue to evaluate the efficacy of the program, as well as determine the effectiveness of the program beyond the state of Illinois. The state of Wisconsin's waiver was implemented in October of 2005 and the state of Tennessee began its waiver demonstration in the winter of 2006.

This text box was written by Leslie Cohen, of the CFRC staff. Ms. Cohen has coordinated the Illinois Subsidized Guardianship efforts on behalf of the Center and is currently coordinating these efforts in Wisconsin and Tennessee.

children to adoption and guardianship obscures the more modest success in moving children to reunification.

The question remains whether reunification rates will ever rise again to levels that were once the norm in the 1980s. Perhaps with better drug addiction treatment and a broader array of social services to birth parents, reunifications will increase (see Boxes 4.2 and 4.3). Or maybe the decline in reunification rates is a permanent outgrowth of improvements in safety assessment and intact-family services which now bring fewer numbers of low-risk cases into state custody in Illinois. Last year our 2005 *Conditions* report looked at national reunification rates as they relate to national removal rates. Our analysis showed that states that remove comparatively few children on a per capita basis, such as Illinois, Nevada, New Hampshire, Texas, and Virginia typically reunify a smaller percentage of children within a year compared to states that remove a

Box 4.2—**Substance Abuse and Child Welfare: Findings From the AODA Waiver**

Alcohol and other drug abuse are major problems for the children and families involved with public child welfare. Substance abuse compromises appropriate parenting practices and increases the risk of child maltreatment. It is estimated that one-half of children taken into foster care in Illinois are removed from families with serious drug problems. Because untreated substance abuse delays reunification, children removed from such families tend to remain in care for a long time. As a result of this delay, as many as 70 percent of children in foster care on any given day are from families in which alcohol and other drug abuse presents significant barriers to rehabilitation and permanence.

In 1999, the Illinois Department of Children and Family Services applied for a federal Title IV-E waiver to improve reunification and other family permanence, as well as safety outcomes for foster children from drug-involved families. Illinois received waiver authority to redirect IV-E dollars to fund Recovery Coaches to assist birth parents with obtaining needed AODA treatment services. Between April 2000 and June 30, 2004, 366 parents (representing 569 children) were assigned to the control group and 943 parents (representing 1,367 children) were assigned to the demonstration group. Recovery Coaches provide a proactive case management strategy that emphasizes continual and aggressive outreach efforts to engage and retain parents in treatment and other services needed for recovery. The primary goal for the Recovery Coach is to actively address the substance abuse problems of caregivers.

Summary of Key Findings

- Parents in the demonstration group accessed substance abuse service more quickly and were more likely to complete at least one level of care as compared with parents in the control group.
- Parents in the demonstration group were significantly less likely to be associated with a subsequent allegation of maltreatment (25% vs. 30%).
- The female caregivers in the demonstration group were significantly less likely to be associated with a subsequent SEI (substance exposed infant) (14% vs. 20%).
- Children in the demonstration group were more likely to achieve reunification relative to children in the control group (15.5% vs. 11.6%). This difference is statistically significant.
- On average, children in the demonstration group are reunified in 522 days as compared with 707 days for children in the control group. This difference is statistically significant.
- The vast majority of families are dealing with co-occurring problems. These problems and the lack of progress made within each problem area decrease the likelihood of achieving family reunification (see box 4.3).
- The AODA waiver demonstration saved $5,615,534.57 as of September 2005. Thus, the waiver remains cost neutral – more precisely – generating savings that the state can then reinvest in other child welfare services.

This box was written by Joseph P. Ryan of CFRC. These findings were excerpted from Dr. Ryan's final evaluation report submitted to the Illinois Department of Children and Family Services in January 2006 and accessible at http://cfrcwww.social.uiuc.edu/pubreports/MainPubs.htm

Box 4.3—**The Effects of Matching Services With Needs: Implications for the Completion of Substance Abuse Treatment**

The Alcohol and Other Drug Abuse (AODA) Waiver (see Box 4.2) provides enhanced treatment services to substance affected families served by DCFS. Prior research found that families facing substance abuse problems often have co-occurring problems -- such as domestic violence, mental health, and housing -- that obstruct recovery from substance abuse and interfere with positive permanency outcomes. As a part of a larger research effort to evaluate the five year AODA waiver, CFRC research staff is looking at how many mothers are experiencing co-occurring problems and whether the likelihood of substance abuse treatment completion is increased when services are provided to address these co-occurring problems. This analysis focuses on a subset of 269 mothers in the experimental group (those receiving the services of a recovery coach) from the AODA project.

Findings from this project confirmed the prevalence of co-occurring problems among study participants. Approximately 78% of mothers had at least four different types of service needs in addition to the issue of substance abuse. The most frequently stated needs were: parental training (89%), transportation (71%), family counseling (68%), housing (62%), job training (58%), and mental health (53%).

This research shows the importance of matching services to individual client needs. Subgroup analyses by each service area found that when services were directed at the co-occurring problems, participants were significantly more likely to complete substance abuse treatment. For example, mothers with matched housing services were almost four times more likely to complete their treatment compared to mothers with unmatched housing services. Similar findings were reported in service areas of transportation, housing, family counseling, job training, and mental health.

This study highlights the prevalent multiple needs for substance affected families involved with the child welfare system. In addition, this study suggests that success in substance abuse treatment is dependent upon service provision that address the families' co-occurring problems.

This box was written by Sam Choi of CFRC. Dr. Choi received her doctorate from the University of Illinois School of Social Work in 2006.

larger proportion of children, such as Iowa, Oklahoma, and Minnesota. One possible explanation is that states with low removal rates restrict foster care to the more difficult cases that cannot be safely served in the home, which reduces the proportion of removals that can be reunified quickly. States with high removal rates may bring less problematic cases into care, which increases the proportion of removals that can be returned quickly to the home.

Permanence Post-ASFA

Analysis of the impact of ASFA and an understanding of permanency trends in Illinois must begin with recognition of the policy changes implemented in Illinois prior to ASFA that impacted not only adoption, but also the alternative permanency options – subsidized guardianship and reunification. Despite lingering concerns over the negative impacts on children's chances for reunification, data show that the push on adoptions and the introduction of subsidized guardianship supplemented and expanded the permanency options available to families. As a result, the state has moved vastly more children into permanent homes by increasing the percent of children exiting the system to a permanent home.

The following tables (Tables 4.A and 4.B) look at the number of adoptions or guardianships (post -1997) in Illinois since 1990. By going back this far, we can track the impact of the permanency initiatives in Illinois, with a focus on the implementation of the ASFA legislation. The shaded areas of the tables are meant to highlight the impact of ASFA. These tables are presented in terms of cohorts of children that entered substitute care during the same year, and these tables follow these children, as a group, until they exit foster care. Take, for instance, Table 4.A, and the year 1994. In that year, 13,780 children entered foster care. Two years later, in 1996, 192 children (1%) had been adopted. None of these adoptions were the result of the permanency initiatives or ASFA because they had yet to be implemented. Five years later, in 1999, some of those 13,780 children had been adopted. If we look down to the 'five years or less in care' row we see that 2,912 children (or 21% from Table 4.B) had been adopted. These totals are cumulative – that is to say that the 192 children adopted within two years are included in the 2,912 children adopted within five years or less.

From a system performance perspective, the size of the entry cohort greatly influences the potential number of permanencies. For instance, a year that has few removals might find permanent homes for all the children that

Table 4.A Cumulative Number of Adoptions and Subsidized Guardianships by Time Since Entry

Children Entering Care	State Fiscal Year of Entry Into Substitute Care													
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
	8,695	9,435	12,373	11,181	13,780	14,941	10,968	9,915	8,197	7,426	5,969	5,827	5,636	5,297
Cumulative number of children that were adopted or entered Subsidized Guardianship after:														
2 years or less in care	192	171	162	169	192	218	272	448	614	544	412	549	562	413
3 years or less in care	365	346	384	404	493	860	1,281	1,555	1,599	1,501	1,189	1,244	1,223	
4 years or less in care	570	578	780	832	1,397	2,625	2,889	2,897	2,531	2,326	1,808	1,765		
5 years or less in care	799	922	1,199	1,659	2,912	4,448	3,830	3,563	3,182	2,791	2,149			
6 years or less in care	1,018	1,188	1,929	2,661	4,342	5,388	4,288	3,955	3,501	3,059				
7 years or less in care	1,213	1,584	2,844	3,556	5,002	5,946	4,610	4,184	3,644					
8 years or less in care	1,410	2,050	3,561	3,917	5,375	6,224	4,747	4,297						
9 years or less in care	1,655	2,342	3,867	4,143	5,581	6,371	4,823							
10 years or less in care	1,823	2,489	4,031	4,279	5,692	6,447								

Note: shaded area refers to the period of time since ASFA was passed.

Table 4.B Cumulative Percent of Adoptions and Subsidized Guardianships by Time Since Entry

Children Entering Care	State Fiscal Year of Entry Into Substitute Care													
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
	8,695	9,435	12,373	11,181	13,780	14,941	10,968	9,915	8,197	7,426	5,969	5,827	5,636	5,297
Cumulative number of children that were adopted or entered Subsidized Guardianship after:														
2 years or less in care	2%	2%	1%	2%	1%	1%	2%	5%	7%	7%	7%	9%	10%	8%
3 years or less in care	4%	4%	3%	4%	4%	6%	12%	16%	20%	20%	20%	21%	22%	
4 years or less in care	7%	6%	6%	7%	10%	18%	26%	29%	31%	31%	30%	30%		
5 years or less in care	9%	10%	10%	15%	21%	30%	35%	36%	39%	38%	36%			
6 years or less in care	12%	13%	16%	24%	32%	36%	39%	40%	43%	41%				
7 years or less in care	14%	17%	23%	32%	36%	40%	42%	42%	44%					
8 years or less in care	16%	22%	29%	35%	39%	42%	43%	43%						
9 years or less in care	19%	25%	31%	37%	41%	43%	44%							
10 years or less in care	21%	26%	33%	38%	41%	43%								

Note: shaded area refers to the period of time since ASFA was passed

Table 4.C Cumulative Number of Reunifications by Time Since Entry															
Children Entering Care	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
	8,695	9,435	12,373	11,181	13,780	14,941	10,968	9,915	8,197	7,426	5,969	5,827	5,636	5,297	5,039
Cumulative number of children that were reunified after:															
1 year or less in care	2,504	2,289	2,502	1,905	2,106	2,278	1,841	1,806	1,518	1,450	1,216	1,258	1,184	1,141	1,028
2 years or less in care	3,248	3,028	3,210	2,600	2,909	3,263	2,640	2,625	2,253	2,121	1,816	1,783	1,704	1,643	
3 years or less in care	3,590	3,292	3,560	2,965	3,495	3,989	3,254	3,234	2,637	2,495	2,112	2,034	1,949		
4 years or less in care	3,721	3,476	3,787	3,232	3,941	4,510	3,633	3,441	2,785	2,627	2,260	2,161			
5 years or less in care	3,779	3,590	3,962	3,438	4,258	4,753	3,748	3,550	2,879	2,698	2,317				
6 years or less in care	3,819	3,662	4,112	3,587	4,426	4,873	3,810	3,611	2,910	2,735					
7 years or less in care	3,860	3,732	4,220	3,662	4,507	4,919	3,852	3,640	2,928						
8 years or less in care	3,893	3,775	4,283	3,712	4,552	4,946	3,881	3,656							
9 years or less in care	3,917	3,805	4,318	3,723	4,571	4,958	3,893								
10 years or less in care	3,937	3,828	4,336	3,730	4,585	4,968									

Table 4.D Cumulative Percent of Reunifications by Time Since Entry															
Reunification	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Children Entering Care	8,695	9,435	12,373	11,181	13,780	14,941	10,968	9,915	8,197	7,426	5,969	5,827	5,636	5,297	5,039
Cumulative percent of children that were reunified after:															
1 year or less in care	29%	24%	20%	17%	15%	15%	17%	18%	19%	20%	20%	22%	21%	22%	20%
2 years or less in care	37%	32%	26%	23%	21%	22%	24%	26%	27%	29%	30%	31%	30%	31%	
3 years or less in care	41%	35%	29%	27%	25%	27%	30%	33%	32%	34%	35%	35%	35%		
4 years or less in care	43%	37%	31%	29%	29%	30%	33%	35%	34%	35%	38%	37%			
5 years or less in care	43%	38%	32%	31%	31%	32%	34%	36%	35%	36%	39%				
6 years or less in care	44%	39%	33%	32%	32%	33%	35%	36%	36%	37%					
7 years or less in care	44%	40%	34%	33%	33%	33%	35%	37%	36%						
8 years or less in care	45%	40%	35%	33%	33%	33%	35%	37%							
9 years or less in care	45%	40%	35%	33%	33%	33%	35%								
10 years or less in care	45%	41%	35%	33%	33%	33%									

entered care but if the entry cohort is small, this will not be accurately depicted in Table 4.A. It may also be the case that the number of adoptions is increasing simply because the number of entries in increasing. To compensate for this, Table 4.B looks at the cumulative percent of children adopted or in subsidized guardianship. The denominator is the same – the group of children that entered care during the same year (the entry cohort). The example used above shows that for the 1995 cohort of children 1% had been adopted within two years of entering foster care and 21% within five years of entering foster care. Prior to the permanency initiatives no more than 10% of children who had been in care for five years or less were adopted. After the permanency initiatives were implemented – five-year cumulative adoption rate increased to 21% of the 1994 cohort of children and to 39% for the 1998 cohort of children. Most recently the rate has dropped to 36% for the cohort of children have just recently reached the five year milestone.

As previously mentioned, concern has been raised that the focus on adoption and subsidized guardianship may have come at the expense of reunifying families. To shed light on this concern, the same tables were developed for reunification – using the same denominator as the base population – entry cohorts. At three years after entering substitute care we see that the number of reunifications is down – from 3,989 in 1995 to 2,637 in 1998. But if we look at the percentages we actually see an increase – from 27% in 1995 to 32% in 1998 (see Tables 4.C and 4.D.) This is a perfect example of why it is important look beyond the raw numbers to the associated percentages that take into account changes in the size of pool of potential reunifications. Fewer children are being reunified but these reunifications are happening among a smaller number of children entering care and the system is doing a better job of quickening the pace of reunification. Despite fears that the push towards adoptions has taken away from reunifications, the data indicate that this has not happened. With the additional focus on adoption, all forms of permanence have increased.

The Changing Significance of Kinship for Permanence

Another factor that affects reunification and other permanency outcomes is the extent of public reliance on relatives as foster parents. Research shows that children placed with kin are less likely to be reunified with their parents than children placed with non-kin. The speculation is that the availability of relatives as foster parents enables

YOUTH VOICES

My ID: Was I Really Who They Said I Was?

Everyone has one or more ID's. The most common are your driver's license, your health insurance and your library card. When we are born, we are given a social security number. When we enter the state's child welfare system, we are given Case ID numbers. When inmates become incarcerated, they are given ID numbers, which are stamped on their prison uniforms. We live in a world that requires we always show at least one form of identification. Ironically, showing a form of ID is always required of us, yet a person's real identity *is never revealed this way.*

For many years, I have pondered my identity. Was I really who they said I was? Just *a foster kid? Was I really "mean and disrespectful?" Would I be incarcerated, or have children, by age 16? Would my child be placed in foster care and be forced to ponder the same things I have? The answers to these questions have been answered through my actions. NO. No, I was* not *who they said I was! Yes, I was a foster kid. It only* appeared *that I was "mean and disrespectful" because I was angry, and shaken up by continuously being bounced around in life.*

All this is only part of my true *identity. I am 19 years old and have never been incarcerated and am not planning on having children until far in the future. Until then, I will focus on achieving my dreams, so that my children will not be stripped from me by an institution that will give them a Case ID.*

It is a point of pride that I chose my own path, that I discovered who I really am and what I can be. My personal discovery is the 'identity' that can never *be determined by my social security number, birth certificate number, driver's license number, or Case ID number – numbers that others assign my life.*

My identity lives within me and that is all that matters.

—Montriece

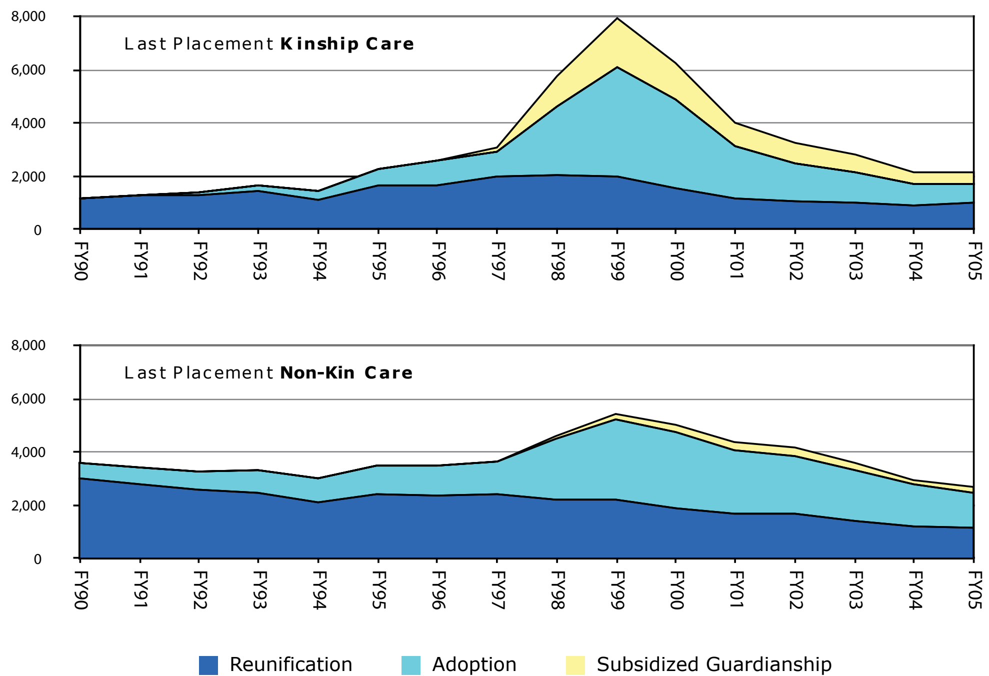


Figure 4.4 **Number of Children Attaining Permanence From Kin and Non-Kin Homes**

workers and the courts to shy away from making risky reunification decisions by retaining children in the safe custody of kin. There is also suspicion that some parents are less likely to comply with service and treatment plans because they are secure in the knowledge that their children are safely and stably placed with a relative. Whatever the explanation, many children in kinship foster care never return to the homes of their parents and instead grow to adulthood in the homes of grandparents, aunts, uncles and other kin.

In the past, growing up in the foster homes of kin meant joining the backlog of children in long-term foster care. Few foster children were adopted by kin, and practice wisdom held that kinship and permanence were incompatible. It was said that relatives were opposed to adoption, first, because they felt that they were already connected to the children by blood ties and, second, because they were reluctant to participate in the termination of the parental rights of close relatives.[9 10] To accommodate these concerns, Illinois and other states have pursued legal guardianship as a supplementary permanency option that is less disruptive of customary kinship norms than adoption.

Transfer of guardianship does not require the termination of parental rights, and birth parents can continue to play a supporting role in their children's upbringing. Caregivers also retain their extended family identities as grandparents, aunts and uncles instead of becoming mom and dad. Finally, sibling ties are conserved, unlike adoption in which these ties are legally severed once parental rights are terminated. For these reasons, many perceive guardianship as addressing the objections some voice against the idea of kin adopting their own family members.

When Illinois implemented its subsidized guardianship waiver in 1997, an unexpected discovery was that many relatives choose adoption over guardianship when both options were put on the table. In fact, a large share of the explosive burst in adoptions in Illinois occurred as a result of the conversion of kinship foster homes into adoptive homes. Figure 4.4 illustrates the growth in permanencies from kin and non-kin homes. In the late 1990s, the growth of permanencies from kinship homes was far steeper than that from non-kin homes.[11] Permanencies from kin homes spiked in 1999, due in large part to the adoption of children that had been in foster care for many years, and have since decreased as a proportion of permanencies. The number of children reunified from non-kin homes has steadily decreased since 1990, while the adoptions from non-kin homes began to increase in 1998 and have remained a fixed percentage of total permanencies.[12]

In retrospect, the perception that kinship foster care was a barrier to adoption appears to have been largely a self-fulfilling prophesy: workers acted on the belief that relatives were opposed to adoption and hence seldom asked. But

9 Thornton, J. (1991). Permanency planning for children in kinship foster homes. *Child Welfare, 70*, 593-601.

10 Burnette, D. (1997). Grandparents raising grandchildren in the inner city. *Families in Society, 78*, 489-499.

11 The kin vs. non-kin distinction is made based on the child's last placement type.

12 The percent of permanencies from kinship homes was approximately one-quarter in the early 1990s, was up to half of all permanencies in between 1998 and 2001, and in more recent years is approximately 40% of all permanencies. Historically, the percent of DCFS caseload living in kinship care was about half and since 2000 has been around 40%. Perhaps this decrease in kinship caseload can be explained in part by the fact that in recent years half the children exiting to permanent homes have been from kinship homes.

when the permanency question was broached, it turned out that far more relatives were willing to consider adoption than the field generally deemed likely. In a study of permanency trends in Illinois,[13] the evidence suggests that by restructuring permanency options in ways that built on the strengths of extended families and the cultural traditions of "informal adoption" among African Americans, Illinois was able to transform kinship care from a barrier into a positive asset for the timely achievement of permanence through adoption and guardianship.

Figure 4.5 **Post-Permanency Stability at Two (Diamond), Five (Star), and Ten Years (Circle) After Discharge**

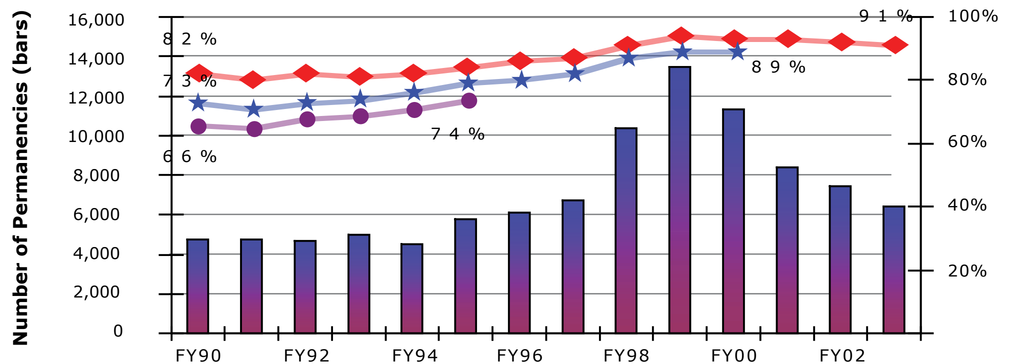
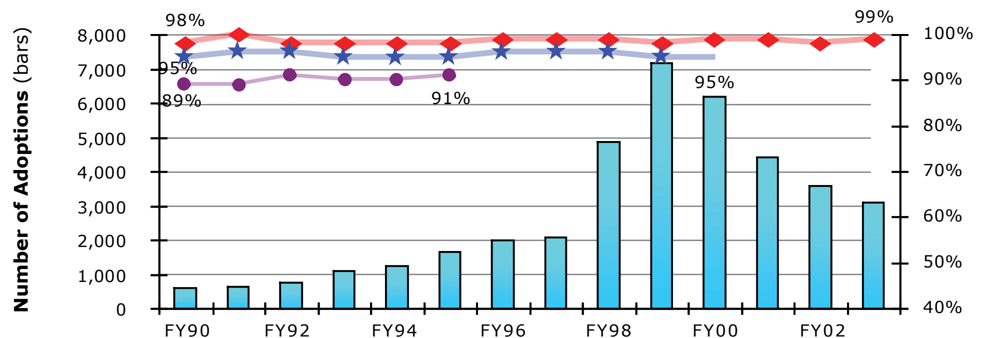


Figure 4.6 **Post-Adoption Stability at Two (Diamond), Five (Star) and Ten Years (circle)**



Stability of Permanence

The importance of permanent attachments and lasting family relationships for healthy child development is a central tenet of modern child welfare practice. However, the concern has been raised that the post-ASFA push for permanence may have forced families into making ill-considered commitments that will cause future placement ruptures.[14] Fortunately, the best available evidence to date shows that ruptures of adoptive and guardianship placements are rare, particularly when compared to re-entries from reunification and the instability that children experience when they remain in care.

Figure 4.5 illustrates the trend in the stability of permanent homes in Illinois. For the purpose of this analysis, rates for all types of permanent placements – reunification, adoption and subsidized guardianship – are grouped together. The data demonstrate that post-permanency stability has improved at two, five and ten years post-discharge. At the 2-year milestone, the percentage of children that remain at their permanent home without interruption increased from 82% in 1990 to 91% in 2003 (see Figure 4.5, Appendix A, Indicator 4.D). At the 5-year milestone, the percentage of children who remain at their permanent home without interruption increased from 73% in 1990 to 89% in 2000 (see Figure 4.5, Appendix A, Indicator 4.E), and at the 10-year milestone, the rate of post-permanency stability increased from 66% in 1990 to 74% in 1995 (see Figure 4.5, Appendix A, Indicator 4.F). Much of this increased stability can be attributed to children moving to adoptive homes and finding long-lasting permanence there. It is noteworthy that the majority of permanency ruptures occur within the first two years post-discharge.

The following sections look at each type of permanence to gain more insight into the stability of permanence.

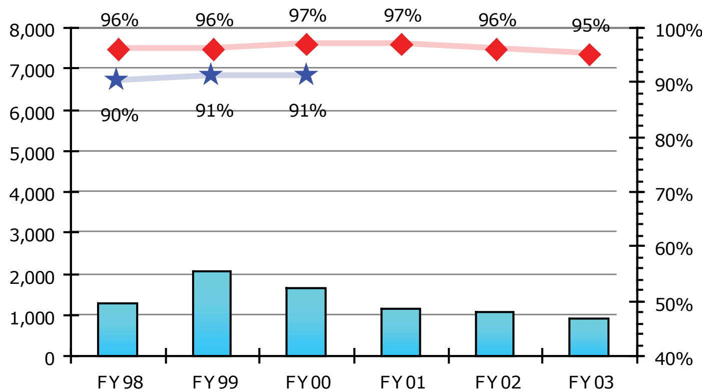
Adoption: Despite worries that the adoption push in the late 1990s would result in a greater percentage of failed adoptions, the percentage of children adopted and remaining with their parents remains quite high (Figure 4.6). For children who have been in adoptive placements for two years, 99% are in stable placements; after five years 95% are in stable placements; and after ten years 91% are in stable placements. This pattern of stable adoptions has

13 Testa, M. F. (2001). Kinship care and permanency. *Journal of Social Service Research, 28*, 25-43.

14 The term rupture will be used in this chapter to refer to a placement that does not last – a reunification, adoption or subsidized guardianship. Prior literature uses such terms as displacement, disruption or dissolution; the term "ruptured placement" includes any disruption in a permanent placement after permanence has been finalized.

persisted despite the dramatic increase in the number of consummated adoptions. In the early 1990s when 600 children were adopted through the peak adoption years of the late 1990s, when as many as 7,000 children were adopted in a year, the percentage of children that remained in stable adoptive homes remained consistently high.

Figure 4.7 **Post-Guardianship Stability at Two (Diamond), Five (Star) Years**

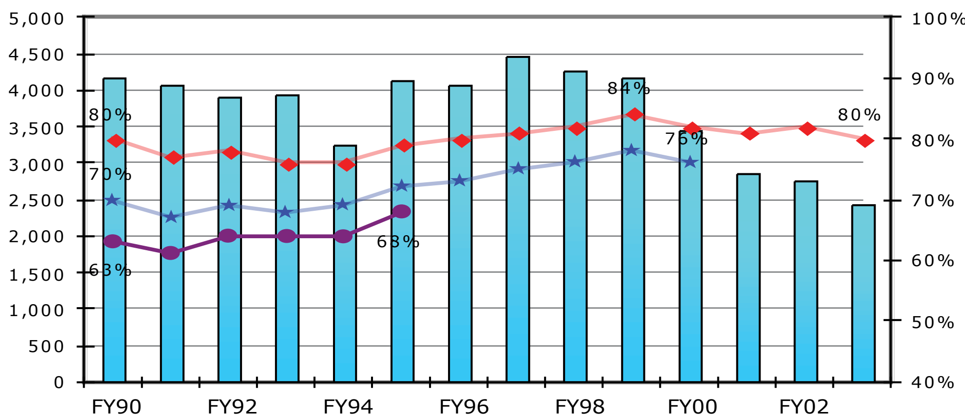


Subsidized Guardianship: Despite the relatively short follow-up period for observing stability post-guardianship, the rate has remained fairly constant (Figure 4.7). For each cohort of children that entered a subsidized guardianship between 1997 and 2003, the post-guardianship stability rate has remained high. Depending upon the year, between 95 and 97% of children that entered guardianship program remained in those guardianship homes two years later, and for these same cohorts of children the post-guardianship stability rate at five years after guardianship is 90%. While these percentages are quite high, they are slightly lower than the comparable rates among adopted children.

Adoption and Subsidized Guardianship Post-ASFA: Concern has been raised as to the 'quality' of permanencies after the permanency initiatives and post-ASFA. Tables 4.C and 4.D look at the trends in stability of adoptive and SG placements. These tables show very little difference in the stability of placements when 611 children were adopted in 1990 and when 9,245 children were placed in adoptive or guardian homes in 1998, for instance. Of the 611 children adopted in 1990, 580 children (95%) were in stable homes five years later, and of the 9,245 children adopted or in Guardianship in 1999, 8,690 children (94%) were in stable placements five years later.

Reunification: When compared to adoption and subsidized guardianship, children reunified with their parents experience significantly less post-discharge stability. However, this comparison should not obscure the improvements that have occurred on this measure as well (Figure 4.8). Although two-year post-reunification stability rates are at the same levels in recent years as those in the early 1990s, improvement has occurred at five years post-reunification – rates have risen from 70% for the cohort reunified in 1990 to 76% for the cohort that was reunified in 2000. At ten years post-reunification, with only five cohorts of complete follow-up data, 63 to 68% of children remain at home. This rate is lower than that reported in a study of reunification outcome data from across twelve states, including Illinois, which found a 72% post-reunification stability rate after 10 years.[15]

Figure 4.8 **Post-Reunification Stability at Two (Diamond), Five (Star), and Ten (Circle) Years**



15 Wulczyn, F. (2004). Family reunification. *The Future of Children, 14*, 95-113.

Table 4.E Number of Stable Adoptions and Subsidized Guardianships by Time Since Permanence															
Adoption/SG	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
	611	643	753	1076	1253	1649	2015	2274	6152	9245	7838	5534	4674	3990	3073
Number of Adoptions or Subsidized Guardianships That Remained Stable:															
1 year or less in care	606	641	748	1,068	1,250	1,633	2,006	2,255	6,098	9,166	7,781	5,494	4,626	3,947	3,039
2 years or less in care	600	641	741	1,059	1,227	1,622	1,987	2,242	6,041	9,047	7,712	5,439	4,562	3,904	
3 years or less in care	595	634	737	1,053	1,218	1,602	1,972	2,219	5,986	8,938	7,631	5,345	4,497		
4 years or less in care	589	625	730	1,041	1,206	1,581	1,953	2,196	5,901	8,837	7,529	5,262			
5 years or less in care	580	615	719	1,025	1,189	1,573	1,933	2,175	5,814	8,690	7,414				
6 years or less in care	571	607	716	1,013	1,172	1,559	1,918	2,141	5,732	8,605					
7 years or less in care	563	603	706	1,003	1,160	1,548	1,897	2,121	5,655						
8 years or less in care	555	598	700	986	1,145	1,538	1,879	2,100							
9 years or less in care	546	586	688	972	1,137	1,523	1,859								
10 years or less in care	544	572	684	966	1,126	1,508									

Table 4.F Percent of Stable Adoptions and Subsidized Guardianships by Time Since Permanence															
Adoption/SG	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
	611	643	753	1,076	1,253	1,649	2,015	2,274	6,152	9,245	7,838	5,534	4,674	3,990	3,073
Percent of Total Adoptions or Subsidized Guardianships That Remained Stable:															
1 year or less in care	99%	100%	99%	99%	100%	99%	100%	99%	99%	99%	99%	99%	99%	99%	99%
2 years or less in care	98%	100%	98%	98%	98%	98%	99%	99%	98%	98%	98%	98%	98%	98%	
3 years or less in care	97%	99%	98%	98%	97%	97%	98%	98%	97%	97%	97%	97%	96%		
4 years or less in care	96%	97%	97%	97%	96%	96%	97%	97%	96%	96%	96%	95%			
5 years or less in care	95%	96%	95%	95%	95%	95%	96%	96%	95%	94%	95%				
6 years or less in care	93%	94%	95%	94%	94%	95%	95%	94%	93%	93%					
7 years or less in care	92%	94%	94%	93%	93%	94%	94%	93%	92%						
8 years or less in care	91%	93%	93%	92%	91%	93%	93%	92%							
9 years or less in care	89%	91%	91%	90%	91%	92%	92%								
10 years or less in care	89%	89%	91%	90%	90%	91%									

YOUTH VOICES

Dear Someone Entering an Independent Living Program:

First of all, an independent living program is a branch of DCFS that take children between the ages 17-20 and help them get their own apartment while supporting them - educationally, emotionally, and financially.

I have been in an independent living program now for going on 3 years. I first entered as a child, really, having just turned 17 years old. I first heard about independent living programs when I was taking a life skills class that every ward has to take when they are 16 years old with DCFS. I thought it was a great idea to look into, considering I had a child of my own that was staying in a foster home with me. I loved my foster mother but I did want more for me and my child. I applied to a local independent living program and was accepted! But there was just one more thing - I was scared, not knowing what was to happen to me there. This was the first time I was going to be on my own. But it was my time to go.

As time went on, I began to get used to the program and understand what it was all about. Basically, the person that's a head of such a program wants the best for you. But it's up to you to go after it. The main goal of the program is to get you ready for that long road to independence. When you turn 21, you will no longer have the support that you get used to in the program, so you really must prepare yourself for that day. I have seen others that didn't take this program seriously and when they were about to turn 21 they panicked. They weren't ready. They didn't take the opportunity that was given to them and make the best out of it. You can just imagine what happened to them. When they did turn 21, either they moved back home with their biological parents - which soon became a disaster - or they ended up in prison.

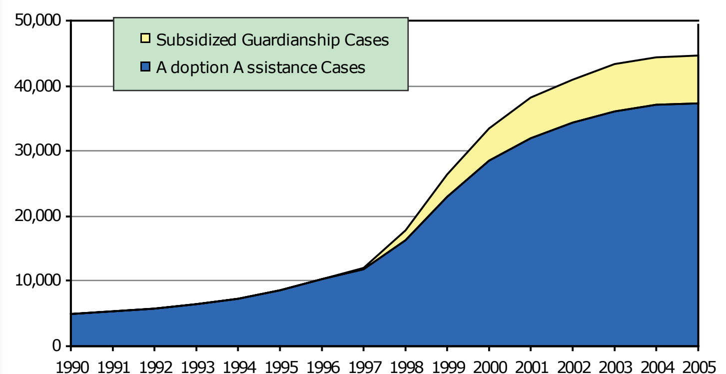
Once you turn 21, you are cut loose. You're on your own. You have to make your own decisions on how best to survive. That is why when you're in the program, you should use it to your best advantage. I tell you this because I care and I hope you will take my concerns into serious consideration.

—Latricia

The Rising Demand for Post-Permanency Services

Does the increasing number of permanency ruptures signal poor system performance? The raw number of ruptures from adoptive placements increased three-fold between 1990 and 2004. For some, this increase creates a perception that adoptions and guardianships are not permanent, stable homes for children. However, when interpreting this increase, it is vital to remember that these ruptures are occurring among a vastly larger pool of completed adoptions and subsidized guardianships (see Figure 4.9). In fact, the incidence rate of rupture from adoption and subsidized guardianship homes is rare. Of the 37,000 children ever adopted, 94.5% have never ruptured and 91.5% of the nearly 8,000 children in subsidized guardianship homes have not ruptured.

Figure 4.9 **Active Adoption Assistance or Subsidized Guardianship Cases**



Illinois has reached an important milestone – the number of children in state-assisted permanent homes with adoptive parents and legal guardians surpasses the number of children in state-funded foster care. Surpassing this milestone brings a new challenge for the future: the rising number of families seeking post-permanency services. Even though these former state wards no longer need the regular casework and judicial oversight that foster care supervision provides, their homes still need family support and sometimes more intensive interventions to preserve family stability.

The Children and Family Research Center maintains a database on families that contact the post-guardianship office for services. This database documents the reason for the contact, services provided, and outcomes. It is the most

comprehensive set of data on post-guardianship services available. Historically this database was primarily information on Cook County cases. This has changed and future analysis should be inclusive of the entire state. However, for this report we focus on Cook County cases for this analysis. The CFRC database shows that since the inception of the program, 602 cases have ruptured in Cook County, 47% ruptured because the caretaker died, and 51% of the ruptured guardianships were dissolved. Of this 51% that were dissolved, sixty-one percent were returned to state guardianship, thirty-one percent were returned to their biological parent(s), and the remaining had a new private guardian assigned. The fact that almost half of the ruptures in Cook County were because of the guardian's death emphasizes the importance of successor guardianships being established at the time of placement with a subsidized guardian, and the need to emphasize the importance of this plan, particularly when placing children with older guardians.

YOUTH VOICES

In my life, I want to be known as…

In my life, I want to be known as the one that never gave up on life, on people, and especially, on myself. No matter how much some one said I would fail, I kept going with what I had to do. No matter how much people have disappointed me, I have stayed optimistic about the future, while learning from the past. I didn't give up on them like they gave up on me – and see that I am a better person because of it. I will not let pain and anger mold my face. I will not let the Bads of this world tire my heart. I will be true to myself and honest with myself. I will believe in the Better and strive for it. In my life I only ask to be known, and never to be forgotten again.

—Kim

Post-Permanency Survey Results

In March 2005, the Illinois House of Representatives passed a resolution that called for a study of post-adoption services in Illinois. Researchers at the School of Social Work at the University of Illinois at Urbana-Champaign conducted a study at the request of DCFS.[16] This study looked at the post-permanency service needs of adoptive and guardianship caregivers and found that the majority of caregivers, 81% (representing 213 families) reported no unmet service needs. This study also found that those that did have service needs – 19% of families surveyed – had significant service needs, and five percent reported needing more intensive diagnostic and therapeutic services. The families with significant unmet service needs were most likely to live in Cook County. The children in these families were likely to have a mental health diagnosis, and the children were more likely to have a behavioral problem (as measured by the caregiver's completion of a standardized behavioral index). The study found that services for these families were either not available or were not intensive enough to meet their child's needs. If support for these families cannot be found, families are faced with the potential of further disruption in their lives, and the state could see an increase in ruptures from adoptions and subsidized guardianship families. CFRC researchers are currently working in collaboration with Children's Home and Aid Society of Illinois (CHASI) and Family Focus to design a model of service and research to address the needs of families after adoption and subsidized guardianship has been established. If implemented, this research could begin to address one of the greatest challenges of the new wave in child welfare – meeting the needs of families in a post-permanency world.

Length of Time in Substitute Care

A recently published study[17] shows that children who entered kinship foster care in the early 1990s in Illinois were 43% less likely than children in non-related foster care to find permanent homes with their caregivers. But by the late 1990s, this had all changed. Children who entered kinship foster care in 1997 were 57 percent more likely to be adopted or taken into private guardianship by their caregivers. Consequently, the median length of time in care for African Americans compared to whites shrank from a 5 to 1 disparity for children entering care in fiscal year 1993 down to 2 to 1 for children entering in FY 1999. Figure 4.10 shows the median number of months a child stays in foster care when entering for the first time. While the entire state has seen this median decrease since the mid-to-late 1990s, the largest decrease has been among African-American children. In 1997, African-American children typically spent three years (36 months) in foster care before exiting the system to permanence. The most recent cohort of African-

16 Fuller, T., Bruhn, C., Cohen, L., Lis, M., Rolock, N., Sheridan, K. *Supporting adoptions and guardianships in Illinois: An analysis of subsides, services, and spending* (2006, unpublished).

17 Testa, M. (2005). The changing significance of race and kinship for achieving permanence for foster children. In D. Derezotes, J. Poertner, & M. Testa (Eds.), *Race matters in child welfare: The overrepresentation of African Americans in the system* (pp. 231 – 241). Washington, DC: CWLA Press.

Box 4.4—**Warning Sign: What is the Cause of the Decreased Length of Stay for Children in Cook County?**

The large change in median length of stay in FY 2003 can be attributed to Cook County. Cook County has traditionally seen a much longer length of stay than the rest of the state – typically children stay in care twice as long in Cook as they do in the rest of the state. During 2003, however, this has changed. The biggest change in children exiting care was those that were reunified within 2 weeks in Cook County. This percentage averaged 12 to 13 percent in the six years before 2003 and then jumped to 20 percent in 2003. This raises the question, are practices in Cook County reverting to those of previous years where children are removed more readily, only to be quickly reunited? This issue will need monitored and reviewed in the upcoming year.

American children analyzed stayed in care for 26 months. By contrast, the population of white foster children had a consistent median length of stay of 15 to 17 months during the six years from 1997 to 2002 (see Indicator 4.G). The latest year shown saw this median increase to 19 months. The large change in median length of stay in FY 2003 can be attributed to Cook County (see Box 4.4), and warrants further investigation.

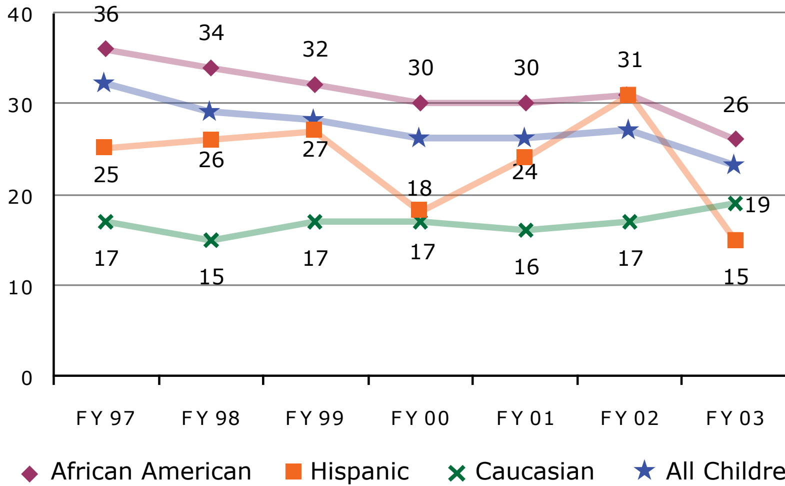
Observations on Permanence in Illinois

The Illinois Department of Children and Family Services has received national attention and praise for its work in moving children to permanent homes, particularly children who have been in foster care for many years. This report illustrates that Illinois continues to improve its achievement of moving children from foster care to permanent homes. This report also shows that this push towards permanence has been good for children – that the permanent homes found for foster youth have been long-lasting, stable homes. This success is the result of an increase in all three types of permanence – reunification, adoption, and subsidized guardianship.

With the increase in children moving to permanent homes, concern was raised that perhaps these arrangements were made in haste and that the children moved to permanent homes would end up back in state custody. This report tracks children for two, five and ten years after permanence and has found that the vast majority of children that were adopted or living with a subsidized guardian remain in these permanent homes at least until they are eighteen years old. In addition, the rate at which children are reunified and remain at home has also increased so that, despite the fact that reunifications rupture more often than either adoptions or subsidized guardianships, these ruptures are happening less frequently than in previous years.

However, the findings presented in this chapter also raise the caution that success in finding permanent, long-lasting homes for children is not a guarantee. Illinois has reached a milestone – the number of children living in state-assisted permanent homes with adoptive parents or legal guardians exceeds the number of children living in state-funded foster care. With this milestone comes a challenge for the future: the rising demand in the number of families seeking post-permanency services. The recently completed survey (June 2006) of adoptive and guardian caregivers revealed a small but vulnerable sub-population of families for whom these resources are critical. Without a clear focus on, and resources for, services to these families, children are at risk for re-entering the system. As the leader in permanence for foster youth, Illinois is in a prime position to lead the nation in this endeavor.

Figure 4.10 **The Median Number of Months a Child Stays in Care When Entering for the First Time**



CHAPTER 5

WELL-BEING

CHILDREN IN OUT-OF-HOME CARE

Children (shall) receive adequate services to meet their educational... physical and mental heath needs.[1]

The well-being of children in out-of-home care is best assured by restoring them to permanence through safe and stable family reunification or, when this is not possible, by finding alternative permanent homes with loving relatives, adoptive parents, or legal guardians. A half-century of research demonstrates that children's emotional well-being, educational success, and capacity for leading healthy and productive lives build first upon meeting basic human needs for safety, trust, and connection with loving and caring adults. When primary family relationships are disrupted it is incumbent upon the state to ensure that a child's developmental opportunities for health, education, emotional, and economic well-being are not unduly compromised by out-of-home placement.

Assuring the well-being of children in out-of-home care provokes questions that are not easily answerable: To what standards of well-being should agencies and the courts be held accountable while working towards reunification or alternative permanency plan? What are the public obligations when the goal of family permanence cannot be achieved? Should foster children be given special assistance and scholarships for which children moved into permanent living arrangements are ineligible?

Unlike safety and permanence, the role of child welfare agencies and juvenile courts in assuring child well-being is more indirect and typically shared with other institutions, such as schools, police, medical providers, and employers. A recent report on court accountability concludes that it is premature at this time to have juvenile and family courts adopt measures of well-being particularly when consensus does not exist on the measures for which the courts have direct responsibility, such as safety, appropriate removal from the home, continuity of care, and timely achievement of permanence.[2] But no matter whether accountability is direct or indirect, a state agency stands in an analogous relationship to these other institutions as does a parent or private guardian and therefore has an obligation to advocate and act on behalf of the well-being of each child while he or she remains under state custody.

Child Well-Being

As the number of children entering foster care skyrocketed during the 1980s, the ability of the Department to care for children's safety, to arrange permanent homes, and to minister to their basic needs in order to support well-being came into serious question. The BH Consent Decree, which was the result of the *B. H. v. Johnson* class action suit on behalf of 20,000 children filed in 1988 in Illinois, mandated that the Department achieve minimum standards of adequacy in meeting the safety, permanency and well-being needs of children in placement. The Children and Family Research Center (CFRC) has been the chief agency assigned to measure outcomes surrounding the BH Consent Decree and produce an annual report on findings. To date, the BH monitors have expressed satisfaction with the level of adequacy attained for safety and permanency outcomes for children in care in Illinois. However, BH monitors continue to require that the well-being of Illinois children in care be evaluated and monitored over time. In addition to safety and physical support, the BH Consent Decree requires the Department to conform to the following standards to support well-being:

- Children shall receive at least minimally adequate health care.
- Children shall receive mental health care adequate to address their serious mental health needs.

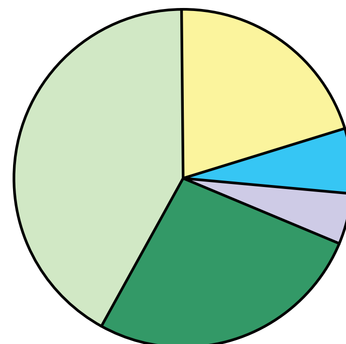
1 U.S. Department of Health and Human Services. (2003). Child and Family Services Reviews Onsite Review, Instrument and Instructions. U.S. Social Security Act, Sec. 475. [42 U.S.C. 675].

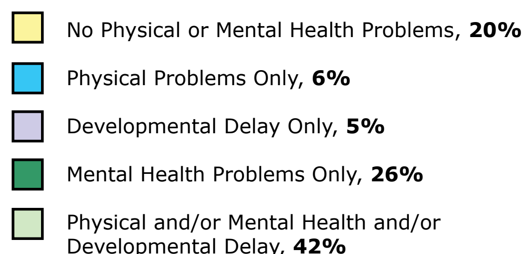
2 American Bar Association (Center on Children and the Law), National Center for State Courts, & National Council of Juvenile and Family Court Judges. (2004). *Building a better court: Measuring and improving court performance and judicial workload in child abuse and neglect cases*. Los Altos, CA: The David and Lucile Packard Foundation.

CHILD WELL-BEING AT A GLANCE [a]

The vast majority of children in foster care in Illinois have a reported physical or mental health issue identified. As Figure 5.1 shows, 20% report no mental or physical health problem, 42% reported two or more issues and the remaining 37% have one identified issue, typically a mental health issue. Each of these subjects is summarized below.

Figure 5.1 **Physical and Mental Health Status Reported for Illinois Foster Children**





MENTAL HEATH

56 percent of Illinois children ages 6 to 18 and 27 percent of children ages 1 ½ to 5 had serious behavior problems, as identified by their caregiver or a child's self report. This compares to 7 percent of the general population of children in the United States. Males were more likely to be identified as having a behavioral problem than females (51% and 43% respectively).

Children in traditional foster care placements are twice as likely as children in kinship care placements to be reported as having serious behavior problems (57% and 27% respectively), while children in kinship care are more likely than children in traditional foster care to self-report having clinical level depression (4% and 1% respectively).

Foster children in Illinois and the nation have similar rates of mental health symptoms.

- ***Trauma:*** Children reported similar rates of clinical or near-clinical trauma symptoms; between 9 and 23% in Illinois and between 9 and 20% nationally.[b]
- ***Depression:*** Children reported similar levels of clinical level depression; between 2 and 9% in Illinois and between 4 and 10% nationally.
- ***Behavior:*** Similar rates of children have been identified by their caregivers as having behavior problems in the clinical or borderline clinical range on the Child Behavior Checklist; between 43 and 58% in Illinois and between 41 and 53% nationally.

MENTAL HEALTH SERVICES

Comparison between Illinois and national data reveals statistically significant differences in the receipt of mental health services from the following sources:

- ***Mental health center:*** A smaller proportion of foster children in Illinois receive mental health services at a community center (between 3 and 9% in Illinois and between 11 and 22% nationally).
- ***Family or medical doctor (for mental health needs):*** A smaller proportion of foster children in Illinois have visited a doctor for mental health needs in the past 12 months (between 7 and 14% in Illinois and between 14 and 23% nationally).
- ***Medical hospital inpatient unit:*** A larger proportion of foster children in Illinois receive mental health services from a hospital inpatient unit (between 3 and 8% in Illinois and between 1 and 2.4% nationally).

[a] For this chapter, when data on Illinois is referenced, this refers to the Illinois Child Well Being Survey, Round II. When the national comparison is made, this references the National Survey of Child and Adolescent Well Being (NSCAW), Long-term Foster Care sample, Wave I.

[b] Percentages shown constitute 95% confidence intervals, using weighted data.

CHILD WELL-BEING AT A GLANCE (continued)

HEALTH

66% of Illinois children were reported by their caregivers at having a serious and/or chronic health condition, and 62% of those with health conditions had more than one condition.

Similarities were observed for Illinois foster children and foster children nationally with regard to the following health indicators.

- ***The child has persistent health problems:*** The difference in persistent health problems reported for foster children in Illinois and the nation is not statistically significant (between 25 and 38% in Illinois and between 22 and 31% nationally).
- ***The child's health is fair or poor:*** Between 5 and 13% in Illinois and between 5 and 10% nationally.
- ***The child has not been to a dentist in the past 12 months:*** Between 14 and 25% in Illinois and between 15 and 26% nationally.

With regard to health services indicators, Illinois foster children differ somewhat from foster children nationally.

- ***Admitted to a hospital overnight:*** A smaller proportion of Illinois foster children have been admitted to a hospital for an overnight stay (statistically significant, between 5 and 12% in Illinois and between 10 and 15% nationally).
- ***Visited emergency room or urgent care center:*** Fewer foster children in Illinois have gone to an emergency room or urgent care facility (between 18 and 30% in Illinois and between 26 and 36% nationally).

PREGNANCY AND PARENTHOOD

Foster youth in Illinois aged 12 and 15:[c]

- 37% of females and 39% of males reported having had sexual intercourse.
- Of these, 9% of females reported having been pregnant and all have had children.
- A quarter of youth reported that their first sexual intercourse experience was non-consensual.

Foster youth in Illinois aged 16 and 17:

- 71% of females and 89% of males reported having had sexual intercourse.
- Of these, 18% of females reported having been pregnant and all have had children; 14% of males reported having fathered a child.

EDUCATION

Caregivers indicate that:

- 43% of Illinois children are not in the grade level that would be expected given their chronological age, a situation referred to as the child being over-age-in-grade.
- 28% of children are receiving grades below "C" in at least one class.
- 36% of Illinois children were receiving special education services.

[c] Percentages shown represent point estimates within a 95% confidence interval based on weighted survey data. The sample size and incidence rate on these indicators for the national data (which is for youth ages 12-15 only) is too small to allow comparison.

YOUTH VOICES

Enclosed *a poem by Rebekah*

I am in hiding
From you and from so many who'd rather not see me
I am hurting, aching
From your indifference and from so many who've confused my heart
What am I to do?
I have tried to fix our problems
I am a reactionary person, one who strives to fix all the problems in site
If I can't fix them, I have to at least find a way to reconcile them in my head
This brings me to the biggest problem of all
The fact that you see no problem at all
Perhaps I am to wishful, I want everything to be wonderful
But not really, I just want to feel loved
I know along with love, there comes ups and downs
Twists and turns of all kinds
But I'd rather feel than not feel
I'd rather cry and rejoice, I'd rather live
I'd rather overcome and settle into it all than to just stand still
But you won't let me, you make things worse when I try to improve them
When I try to fix a problem you tell me that it doesn't exist
I do not want to fight you, so I just comply
And so, I do not live, I exist.
I am the Lava inside a volcano
You cannot see me; you can only see the dark mountain like figure
One day I will explode, one day you will understand
One day I will find a solution, I will find happiness
I will feel loved
One day you will see me

- Children shall be free from unreasonable and unnecessary intrusions by DCFS upon their emotional and psychological well-being.
- Children shall receive at least minimally adequate training and services to enable them to secure physical safety, freedom from emotional harm, and minimally adequate food, clothing, shelter, health, and mental health care.

Most children who enter foster care have already been exposed to adverse conditions in the home and surrounding community that severely compromise their chances for healthy emotional and social growth and educational progress. Traumatic incidents early in life, such as abuse and neglect, insinuate themselves in the development of the child and, if ignored, can lead to reduced self-esteem, truancy, aggressiveness, delinquency, and school drop-out in later life.[3] To avoid losing critical time, the Department has instituted a number of initiatives in the past four years that are designed to assess, provide for, and track the well-being needs of children in its care. The Department has devoted clinical resources to a comprehensive "integrated assessment" of each child within three weeks of first entering DCFS custody. The Department is currently implementing new methods to geographically identify and match children's mental health (and other) needs to local providers. In addition, the Department is channeling dollars to provide treatment to reduce the negative consequences associated with childhood trauma from abuse and neglect. The Department has also instituted Child and Youth Investment Teams (CAYIT) to bring multiple perspectives and voices to the process of identifying mental health issues and services needs.

Most recently, the Department has implemented its "lifetime" approach to assuring child well-being, which is designed to invest in the lives of children in its custody as if the Department was going to be responsible for each child until he or she becomes a young adult. Even if a child's stay in out-of-home care eventually results in family reunification, adoption or private guardianship, the Department reasons that, while a child remains under its guardianship, he or she cannot afford to miss critical developmental opportunities for social and emotional growth and educational progress - transitions which, if neglected, are difficult to make-up in later years. DCFS independent living programs have been redesigned to provide a seamless continuum of services to youth transitioning to young adulthood.

Child Well-Being Outcomes: Illinois and National Comparison

The CFRC's assessment of well-being presented in this chapter is constructed from data derived from two sources – the Illinois Child Well-Being Survey and national survey data from the National Survey of Child and Adolescent

3 Testa, M. & Furstenberg, F. (2002). The social ecology of child endangerment. In M. Rosenheim, M.F. Zimring, D.S. Tanenhaus, & B. Dohrn (Eds.), *A century of juvenile justice*. (pp. 237-263). Chicago: University of Chicago Press.

Well-Being (NSCAW). NSCAW is nationally representative longitudinal data drawn from first-hand reports from children and families or other caregivers, and caseworkers.[4] For a sample of foster children in Illinois, CFRC was able to build upon the very extensive instruments developed for NSCAW and has established a basis for comparison of Illinois foster children to foster children nationally on a number of child well-being indicators.

These comparisons were made with the Long-term Foster Care sample component of the NSCAW – this sample was drawn from children who had been in foster care for approximately one year at the time of initial sampling. For Illinois children, CFRC collected data for two samples of children in foster care (n=600) randomly selected from across the state. Data were collected, in some cases, using the same standardized assessments used in the NSCAW study. For both NSCAW and the CFRC study, interviews were conducted with children over the age of six, with caregivers (including foster parents, group home supervisors, and residential care staff), and with caseworkers. In addition, the CFRC study included record abstractions of case files for health data and record abstractions of school district educational records. The findings presented below on mental health, physical health, pregnancy and parenting and educational attainment are organized such that the findings for Illinois children from the CFRC study are shown first, and then the well-being of Illinois foster children are compared to foster children of the same ages in the national NSCAW sample.

Mental Health: Children in Illinois

For the Illinois Child Well-Being Study, data about children's mental health were collected by using standardized instruments to evaluate behavior, depression and trauma symptoms.

Behavior: Caregivers were asked to complete the Achenbach Child Behavior Checklist (CBCL), a widely used instrument to assess children's behavioral problems.[5] When the CBCL is administered to the general population (all children regardless of their involvement with child welfare) about 17% fall within the combined clinical/borderline range. This, however, is much higher for the foster care population. 51.4% of males and 43.2% of females are identified as having a behavioral problem, with the largest percentage occurring among males between the ages of 6 and 11 (57.8%). As depicted in Figure 5.2, children living in kinship care are least likely to report a clinical or clinical/borderline score for behavior problems (27.2%). Children living in non-kinship placements are reported by their caregivers as having similar rates of behavior problems, ranging from 53% in specialized foster care to a high of 61.6% in group homes and institutions.

Depression: To measure depression, the Children's Depression Inventory (CDI)[6] was used in both the Illinois and NSCAW studies. The CDI measures the severity of depressive symptoms across five subscales (negative mood, interpersonal problems, ineffectiveness, anhedonia,[7] and negative self-esteem) and produces a standardized total score. A series of feeling and attitude items are presented to children who then select one of three responses that best describe how they were feeling during the past 2 weeks. Responses indicate whether there is an absence of each symptom, a mild symptom or a definite symptom.

Findings specific to Illinois children show that girls are 4.1 times more likely than boys to score in the clinical range for depression. Girls age 13-17 were the most likely to report clinical range depression (7%) followed by 5% of

4 The NSCAW cohort includes 6,231 children, ages birth to 15 (at the time of sampling), who had contact with the child welfare system within a 15-month period that began in October 1999. These children were selected from two groups: 5,504 were interviewed from those entering the system between October 1999 through December 2000. A separate sample of 727 was selected from children who had been in out-of-home placement for about 12 months at the time of sampling. Children were selected from 92 primary sampling units in 97 counties located in 36 states nationwide. See http://www.acf.hhs.gov/programs/core/ongoing_research/afc/wellbeing_reports.html.

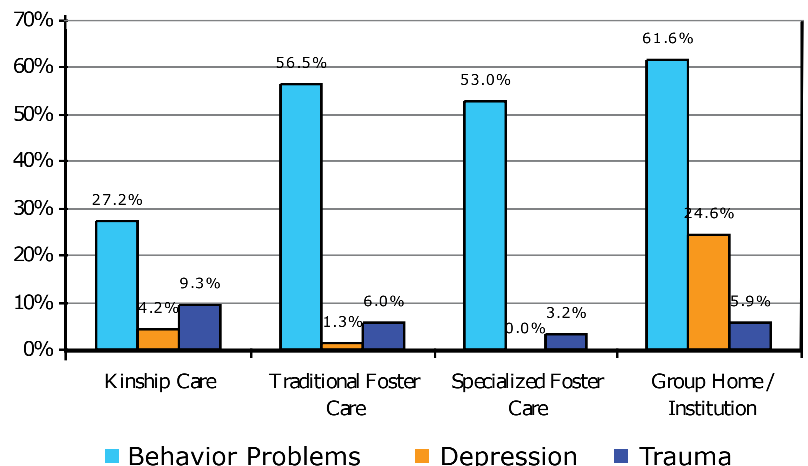
5 Child Behavior Checklist, Copyright (2006). T. M. Achenbach. Burlington, VT: University of Vermont.

6 Children's Depression Inventory, Copyright © 1982 by Maria Kovacs, Ph.D., © 1991, 1992, Maria Kovacs, Ph.D. under exclusive license to Multi-Health Systems Inc. All rights reserved. In the USA, P.O. Box 950, North Tonawanda, NY 14120-0950, 1-800-268-6011.

7 'Anhedonia' is commonly defined as the inability to gain pleasure from normally pleasurable experiences.

Figure 5.2 **Children with a clinical or clinical/borderline score for behavior problems, depression, and trauma by placement type**

Figure 5.2 **Children With a Clinical or Clinical/Borderline Score for Behavior Problems, Depression, and Trauma by Placement Type**



younger girls (7-12 years old). By comparison, 2% of boys age 13-17 scored in the clinical range and no boys age 7-12 report clinical range depression. In addition, the living care type analysis shows that children living in group homes and institutional care report significantly higher rates of depression than any other care type (24.6%) (Figure 5.2).

Trauma: For this study, the Posttraumatic Stress Clinical Sub-Scale (PTS) of the Trauma Symptoms Checklist for Children was administered.[8] PTS questions center around intrusive thoughts, sensations and memories of painful past events, as well as nightmares, fears, and cognitive avoidance of painful feelings. Questions are intended to capture the child's current experience of previous traumatizing events.[9] In Illinois, children in kinship care have the highest rates of trauma symptoms (9%) among all placement types, followed by traditional foster care and group homes or institutional care (both at 6%), and 3% of children in specialized foster care.

8 Trauma Symptom Checklist for Children by John Briere, Ph.D., Copyright 1989, 1995 by PAR, Inc. 16204 North Florida Avenue, Lutz, Florida 33549

9 These include natural disasters, such as earthquakes, witnessing domestic violence, experiencing physical or sexual abuse from parents, other adults or peers, divorce, and hospitalization of a parent.

Rates of identification of mental health needs by the formal service system and rates of service delivery are addressed in detail in the Illinois Child Well-Being Study Round II Final Report (forthcoming, 2007).

Mental Health: Illinois and National Comparison

As previously mentioned, children involved with the foster care system are much more likely to be identified as having serious behavior problems than children in the at-large population, and this finding holds for both the Illinois sample and the national sample of children. Approximately half of the children in foster care are identified as having serious behavior problems (between 43 and 58% of Illinois children and between 41 and 53% nationally). Also shown in Figure 5.3, Illinois foster children profile similarly to foster children in care throughout the nation on levels of trauma and depression; however, self-reported clinical levels of trauma and depression are lower in incidence than caregiver-reported behavior problems. Between 9 and 23% of Illinois foster children reported clinical or sub-clinical trauma symptoms,[10] compared to between 9 and 20% nationally, and between 2 and 9% of Illinois children reported clinical

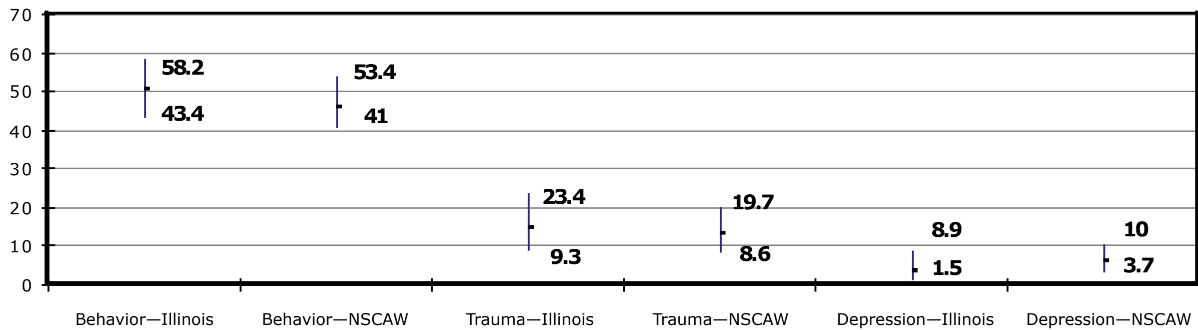
10 The clinical range contains T score values that equal or exceed the scores of 94% of the children in the national standardization sample. Children scoring in the clinical range have significant trauma symptomatology. The sub-clinical range contains T score values that are just below the clinical range cut-off. Scores in the sub-clinical range suggest that the child is experiencing difficulty and may have clinically significant symptomatology. Nationally, only children up to 15 years old were surveyed; therefore, our analysis is limited to that group of children for comparisons.

Box 5.1—**Understanding Survey Data**

Most of the data in this chapter are estimates based upon analysis of weighted survey data. This type of analysis produces two statistics: point estimates and confidence intervals. These two statistics allow us to take data that are collected on a subset of foster children and generalize the findings to all foster children. When the sample size is large, we are able to say with more confidence that the findings can be generalized to the larger foster care population; however, when the sample size is small, it is more difficult to generalize the findings. The 95 percent confidence intervals presented provide the best overall estimate of the foster care population at large. Large confidence intervals can indicate substantial variation within the group or sub-group and/or a lower number of cases. Smaller confidence intervals indicate a more homogenous group and/or a larger number of respondents and therefore more confidence in generalizability.

These distinctions are important to accurately understand the numbers as presented. In this chapter we present data that compare Illinois foster children to the nation's foster care population. In our presentation we state that, for instance, between 7% and 19% of children in Illinois experienced an outcome, and that the point estimate is 11%. We could also state that for the same outcome, the responses from the nation's children were between 5% and 15%, with a point estimate at 8%. When we look at the 95% confidence intervals, we see that the two populations overlap significantly. This tells us is that Illinois foster children profile much like the foster children in the nation on this outcome and the difference between the 11% and the 8% point estimates are insignificant.

Figure 5.3 **Comparison of Illinois Foster Children With the Nation on Reported Behavior Trauma and Depression in the Clinical or Sub-Clinical Levels**



YOUTH VOICES

You funny girl…You're an unfortunate person…You so ghetto…I bet you are one of them smart girls…

*Out of all my names—titles, labels, identities—*foster child *hurt the most. It was my biggest secret….my biggest shame. It meant that I was unwanted. I was a* foster child. *I was money for someone, their power bill, or a portion of their mortgage. But me, myself, was NOTHING, nothing but an outcast of an already oppressed group of people. No other stereotype brought as much pain to me as this name, this identity….*foster child.

I mean, I could talk about sexism with my feminist rights teacher and I could talk about racism with my racial equality preacher, but "foster-care-ism" *was something everyone participated in. I had no one to talk to about it, so I kept it my* Secret of Secrets. *My friends didn't know, however the teachers and the preachers* did *know and they knew that this also meant that I was destined for destruction. No matter how many A's I received or scriptures I memorized, I was a drug baby, the daughter of sin. And this sin was unforgivable, I mean it must have been, because I was constantly reminded of my parent's flaws, but now…they are dead. So who will repent for their sins, and release me from these labels? Who will tell the pastors that the apple can fall far from the tree and that a 'bad' tree can bear good fruit? Who will tell my teachers that* nurture *can impact way more than* nature *and that the statistics don't necessary mean that I am more likely to fail in life? My life shouldn't be a gamble. My potential shouldn't be minimized.*

I am a former foster child *now. I now carry both my biological name as well as the last name of my adopted family. Even after the adoption, I still experienced life as a* foster child. *My mom still received checks because of me. There were still foster siblings being placed and removed from my home. I still had a* Secret *to keep. This situation is as uncomfortable as gays living in a homophobic world or blacks living in a racist world. I was a* foster youth *in a 'normal' world. I couldn't tell my secrets because if I did, I would have to defend myself even more because, by saying "I am a foster youth," I am somehow saying that I am on drugs, I am a thief, I will become pregnant as a teen, I will be a juvenile delinquent. As a foster youth, according to the statistics, I was not to be trusted, I was not to be defended.*

During high school, I didn't want to change the world, I only wanted to survive it. And to survive it more comfortably, I had to deny the truth of myself. I had too many other stereotypes to fight: PoorBlackFemaleInnerCityYouth. Claiming the title foster child was unnecessary if I didn't have to. Unfortunately, keeping this secret only made me dishonest with parts of myself. I could openly talk and discuss only parts of my true identity. So I never had a positive conversation about myself as a former foster youth and the identities tied to it. These parts of me were never confronted until I became a part of Project FYSH program at the University of Illinois where I had open discussions with other youths similar to me, but could still hold onto my own uniqueness. A weight was finally lifted off my shoulder. I could finally introduce myself without fear of stereotype, and instead receive understanding from the listener. I never knew I could feel this way about myself. All I would have to say from this point on was "Hi, my name is KIM" and nothing else and nothing more.

—Kim

Box 5.2—**Warning Sign: Fewer Illinois Foster Children Receive Mental Health Services From Community Providers**

Figure 5.4 provides a summary comparison of the percentage of children in Illinois and nationally who ever received mental health services from three different settings.

- Fewer foster children in Illinois have ever received mental health services from a mental health or community mental health center.
- More foster children in Illinois have ever received hospital medical inpatient unit services.
- Fewer foster children in Illinois have ever seen a medical doctor for mental health services.

From the data available, we cannot surmise the reasons for these differences. We do not know, for instance, whether community mental health facilities are less available in Illinois or perhaps if mental health conditions in Illinois are more likely to be treated only when they have reached a critical level. The dynamics behind these differences in mental health service setting usage merit further examination.

There is no statistically significant difference in the receipt mental health services from a Residential Treatment Center or Group Home (between 2 and 12% of foster children in Illinois and between 7 and 21% of foster children nationally) or through day treatment services (between 2 and 12% of foster children in Illinois and between 7 and 21% of foster children nationally) for children in Illinois or the nation. This further substantiates the finding that community mental health facilities are less likely to be used by families caring for Illinois foster children than foster families nationally; however, further analysis is required to validate this tentative conclusion.

Figure 5.4 **Comparison of Illinois Foster Children With the Nation on Recieving Mental Health Services From Different Sources**

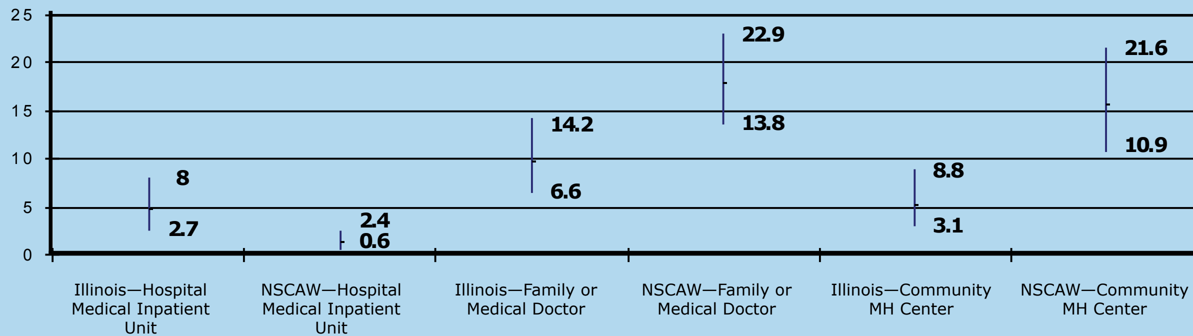


Figure 5.6 **Comparison of Illinois Foster Children With the Nation on Health Conditions and Acute Care Treatment**

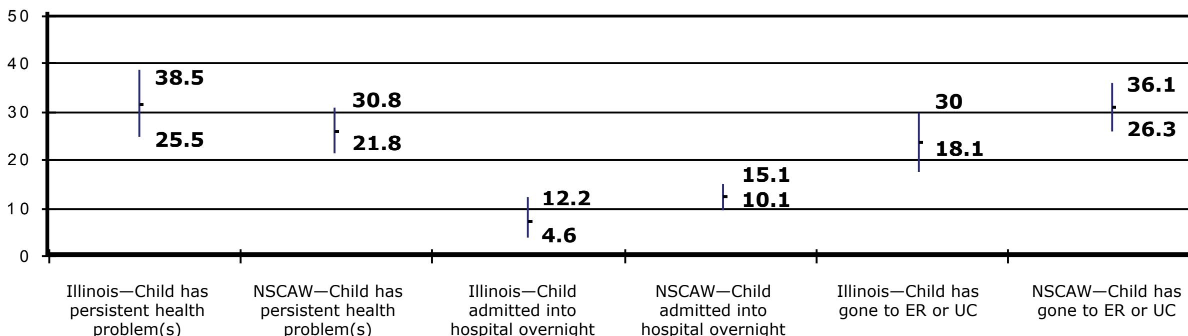
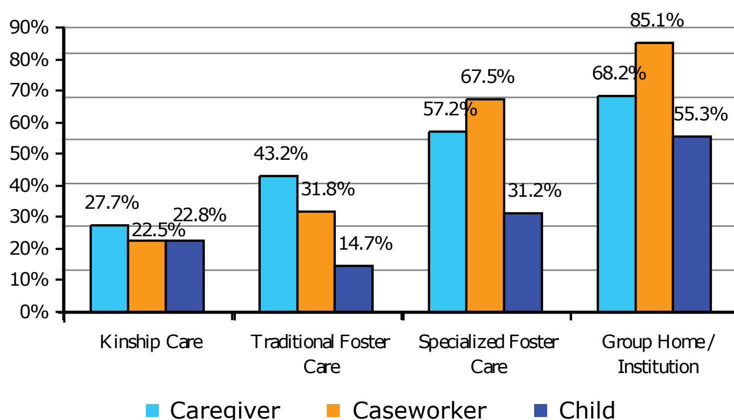


Table 5.1 Percent of Illinois Foster Children With Diagnosed Medical Conditions	
(The physical health diagnoses shown below were made by a medical doctor and abstracted from the record by the DCFS nurse and reported as ICD-09[a] diagnostic codes.)	
Musculoskeletal System	9.3
Disorders of the Eye	9.0
Respiratory Disease	8.7
Congenital Anomalies	5.6
Cerebral Palsy & Other Paralytic Syndromes	5.6
Diseases of the Skin	4.3
Complications of Pregnancy and Childbirth	2.8
Diseases of the Ear	2.6
Epilepsy & Seizure Disorders	1.8
Adverse Effects of Medical Care	1.8
All other illnesses & conditions	1.7
Diseases of the Blood	1.3
Infectious and Parasitic Diseases	1.2
Diseases of the Circulatory System	1.0

[a] International Classification of Diseases, 9th Revision.

Figure 5.5 **Serious or Chronic Physical Health Problems by Reporter and Placement Type (Does Not Include Mental Health, Developmental Delay or Routine Health Issues)**



level depression, compared to between 4 and 10% nationally. In addition, Illinois foster children differ from the national sample of foster children in their receipt of mental health services (see Box 5.2).

Physical Health

Physical Health: Illinois Children

The findings on Illinois foster children in this section are based on data collected from a medical audit of children's case records conducted by project-trained DCFS nurses and from specific health questions asked of caregivers. According to caregivers, 66.4 % of Illinois children have a serious and/or chronic health condition.[11] Of children whose case records indicated a diagnosed physical health condition, 62% had more than one diagnosis; 29% had two medical diagnoses, 15% had 3 medical diagnoses, and 18% had 4-7 diagnoses. The three most common health conditions were musculoskeletal system disorders (9%), disorders of the eye (9%), and respiratory disease (9%, predominantly asthma). A variety of other serious illnesses affect smaller percentages of children in the sample (see Table 5.1).

Figure 5.5 shows the percentage of children reported to have a serious or chronic physical or medical health condition by reporter and by placement type. Reported health conditions increase as restrictiveness of care increases. For children in kinship care, there is notable uniformity in the reporting among caregivers (27.7 percent), caseworkers (22.5 percent) and children (22.8 percent). For children in traditional foster care placements, there is greater variation among reporters with caregivers reporting the highest rates (43.2 percent) and children reporting the lowest rates (14.7). Considerably higher rates were reported for children living in specialized foster care homes, group homes, and residential facilities, and rates reported by caseworkers were higher than those reported by caregivers.

Physical Health: Illinois and National Comparison

When Illinois foster children are compared to foster children nationally on physical health issues they profile similarly. The differences in the two groups are not statistically significant. The point estimates suggest some differences but comparison of the confidence intervals suggest that, to the best of our ability to discern given the limitations of this data, the incidences are similar (see Figure 5.6, see p. 5-8). We can conclude that foster children are more likely to have a persistent health problem and more likely to have been admitted to a hospital overnight than they are to have visited an emergency room or urgent care facility. In addition, similar percentages of children exhibit fair or poor health (between 5 and 13% in Illinois and between 5 and 10% nationally). Similar

11 Acute conditions, such as colds, flu viruses, and temporary rashes, are not included in this percentage.

percentages of children have not been to a dentist in the past year (between 14 and 25% in Illinois and between 15 and 26% nationally).

Dental Care

Ensuring adequate dental care for foster children is a problem in Illinois as well as the nation. Nineteen percent children in Illinois and in the nation had not been to see a dentist for a check-up and cleaning in the past 12 months. The provision and tracking of dental care needs to be a routine service delivered to all foster children.

Pregnancy and Parenting

Several questions were asked of Illinois children ages 12 and older at the time of the interview regarding their sexual experiences, pregnancy, and parenting. Questions addressed whether the youth had ever had sexual intercourse, age at first intercourse, whether first intercourse was forced or consensual, and pregnancy and parenting history. All questions were included in both the Illinois study and the national study; a comprehensive comparison will be forthcoming in the Child Well-being Study, Round II, Final Report.

In Illinois, half of youth between the ages of 12 and 17 stated they had experienced sexual intercourse. Older children were much more likely to indicate that they had experienced sexual intercourse. Seventeen percent of children 12 to 13 years old responded positively to the question, whereas almost 76% of children 16 to 17 did so. Youth were asked about the age at which they had first had sexual intercourse. These results are presented in Figure 5.7.

Figure 5.7 **Age at Which Youth First Had Sexual Intercourse**

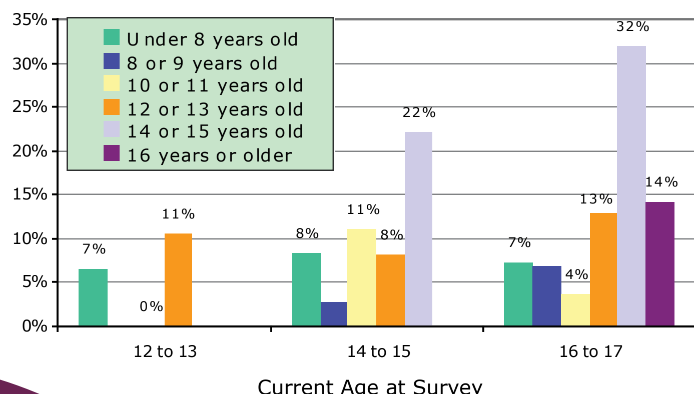


Figure 5.7 appears noteworthy in that it suggests that an unexpectedly high percentage of younger children are engaging in sexual intercourse; given the nature of the population, however, one must assume that some of the children responding to the question were referring to experiences of having been sexually abused. The extent to which this is the case is addressed in Figure 5.8.

Figure 5.8 **Status of First Sexual Intercourse Experience: Forced or Consensual**

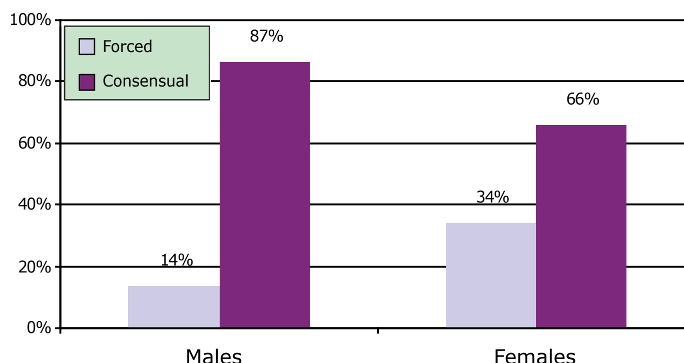


Figure 5.8 reflects figures pertaining to all youth surveyed who indicated that they had experienced sexual intercourse and whether the first sexual intercourse experience was forced or consensual. These data indicate that nearly a quarter of youth responding positively to this question perceive their first experience of sexual intercourse to have been non-consensual. This table also demonstrates that, while females among the population of children in out-of-home care are more likely to indicate that their first experiences of sexual intercourse were non-consensual, a significant proportion of males also indicate that this was the case for them.

Of youth in the Illinois study, 9% of females in the 12 to 15 years age range and 18% of females in the 16 to 17 years age range indicated that they had been pregnant. No males in the 12 to 15 years age range and 14% of males in the 16 to 17 years age range indicated that they had gotten someone pregnant. All of the youth who reported having been pregnant or having gotten someone pregnant indicated that they had children. Each youth who indicated that he or she had become a parent reported having only one child. The fact that every youth who reported having been pregnant or who reported having gotten someone pregnant also reported having a child suggests the need for some consideration. First, the probability is that not every youth who had become

pregnant or had gotten someone pregnant reported the experience. Those young women who had become parents may have felt more obligated to report the experience given that it was likely to have been known by caregivers and caseworkers. However, these data do not indicate whether those young men and women who became parents did so by choice or due to a lack of resources to terminate unwanted pregnancies. This topic suggests a need for further research in this area.

Pregnancy and Parenting: Illinois and National Comparison

Comparisons of Illinois data with national data consider only youth 12 to 15 years of age. When considering only youth between 12 and 15 years of age, Illinois closely parallels the nation with regard to overall percentage of youth in care who indicate that they have had sexual intercourse. Overall, 38% of youth 12 to 15 in foster care in Illinois and 37% of youth in the same age range in foster care nationally indicated that they have had sexual intercourse. Somewhat fewer females nationally, however, reported having had sexual intercourse (25%), whereas more males nationally reported having done so (49%). In Illinois, females (37%) and males (39%) report having had sexual intercourse at approximately equal rates. Reporting varies by age as well, with children 12 to 13 in Illinois reporting somewhat lower rates of having experienced sexual intercourse than children nationally (17.1% in Illinois, 22.4% nationally) Children in the 14 to 15 years age range in Illinois reported having experienced sexual intercourse at the same rates as children in this age range nationally (52.3% in Illinois and 52.7% nationally).

The comparison between Illinois data and NSCAW data show that rates of pregnancy and parenthood differ between Illinois and the nation such that youth between the ages of 12 and 15 nationally are more likely to report pregnancy and parenting than in Illinois. Nationally, 32% of females in this age range reported having been pregnant (compared to 9% in Illinois). Similarly, 20% of males in this age group nationally

YOUTH VOICES

Forgiveness

On what terms?
Will I forgive her for being set in her ways
Will I forgive her for whipping me?
Hopefully, she'll forgive me for hitting her back.
Hopefully, she'll forgive me for hiding her watch.
Maybe I'll forgive him for trying to rape me.
Maybe I'll forgive her for telling me to be silent about it.

That was over six years ago.
I have forgiven them both.
Hopefully, they have forgiven me.

Coming to terms with so much.
That's hard.

—Montriece

Figure 5.9 **Children's Responses to Questions on School Engagement**

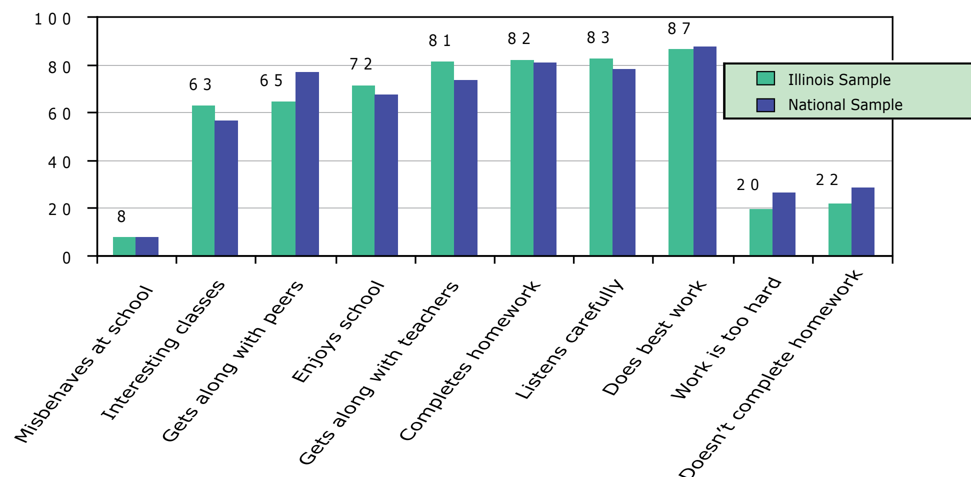


Table 5.2: Caregiver Perceptions of Children's Educational Experiences
(percentages, unless otherwise indicated)

Construct	Homes of relative	Traditional foster care	Specialized foster care	Group or residential care	All repondents
Grade level*					
Not in grade level for age	38.1	40.0	50.0	59.8	43.0
Grades					
Grades of recent report card all 'C' or higher	68.5	76.1	68.2	82.0	72.0
Special education*+					
Receiving special education	18.6	25.7	61.6	84.9	36.4
Attendance					
Average number of school days missed in the past month	1.30	.91	.72	.38	.95
Discipline*					
In-school suspensions or detentions	.61	.90	2.2	.42	1.1
Out-of-school suspensions	.40	.20	1.0	.22	.48
Has been expelled from school	10.5	6.1	11.4	---	8.7

* differences are statistically significant at the .01 level

+ Special education was defined as follows:
"An Individualized Education Plan, or IEP, identifies problems a child with a disability might be having that interfere with his or her education and explains what services the school system will provide to help a child. An Individualized Education Plan is written with administrators, educators, and specialists from the school district and is not part of DCFS or your child welfare agency. Does (child) have an Individualized Education Plan (IEP)? That is, has (child) been classified as needing special education?

reported having gotten someone pregnant, whereas no males in Illinois in this age range reported having done so. About half of females who had become pregnant nationally reported having children, whereas close to 90% of males who had gotten someone pregnant nationally reported having children. In Illinois, all youth who reported having been pregnant or having gotten someone pregnant reported having children. Notably, the confidence intervals in this data are very wide, indicating that these figures are very rough estimates. The reason for the breadth of the confidence intervals is that the number of youth responding to each question was very small. Only children over the age of 12 were asked these questions, fewer than half indicated that they had experienced sexual intercourse, and fewer still indicated that they had been or gotten someone pregnant. Obtaining a bigger sample or repeating the survey would increase confidence in the reported findings.

Education

Education: Illinois Children

A number of separate indicators of educational risk were measured for children in the Illinois Well-being Study. These indicators are among those identified by Sharon Freagon, Ph.D. and associates at the Center for Child Welfare and Education at Northern Illinois University as determinants of school and early childhood success.[12] Reporting on these indicators for this report is based on interviews with caregivers. Caregivers of a random, stratified sample of children were contacted by telephone to be interviewed. The foster parent of record was interviewed in cases of children in kinship foster care, foster care, and specialized foster care, and a case manager was interviewed in cases of children in group and residential care. Approximately 54% of caregivers completed the survey. The responses are based on the understandings of caregivers of the educational status of

12 http://www.cedu.niu.edu/ccwe/Variables.doc, retrieved October 15, 2006.

children in their care; hence, if a caregiver indicated that, for example, a child had received an in-school suspension or detention, that response would be based on the caregiver's understanding of those terms, not on a definition that was provided. The indicators presented here include progression through grades as expected based on chronological age, grades on report cards, special education service receipt, days of missed school, and school discipline.

Caregivers indicate that a total of 43% of children are not in the grade level that would be expected given their chronological age, a situation referred to as the child being over-age-in-grade. This situation can be the result of a number of circumstances, including late entry into school and failure to advance due to school transfers, runaway, grade retention, and other reasons. Caregivers were asked whether or not the child in their care had repeated or been "held back" for one or more grades, and in 19.4% of cases, caregivers indicated that the child had been. It is not known the extent to which the difference between the 43% of children over-age-in-grade and the 19% reported as having been retained represents children starting school later than expected. In some cases, caregivers may not have complete and accurate information about the educational histories of the children in their care. Being over-age-in-grade as reported by caregivers is significantly related to age, gender (females are more likely to be over-age-in-grade), and placement type. Children in home of relative care and children in traditional foster care are reported to be over-age-in-grade at approximately the same rates (38.1% and 40.0%, respectively). Fifty percent of children in specialized foster care are reported to be over-age-in-grade, as are 59.8% of children in group and residential care.

According to caregivers, 28% of children are receiving grades below "C" in at least one class. Grades as reported by caregivers are not significantly related to any demographic or placement characteristics. Analysis of the first round of Well-being Study data had suggested that, in cases where report cards were available from school records and letter grades were assigned, 61.7% children were receiving at least one grade below 'C' in their classes. However, these data represent primarily older children for whom letter grades are assigned; caregiver reports may appear more favorable because they are also answering these questions for younger children for whom progress reports are received and on which children's performances are rated as "satisfactory."

Consideration of special education services as an indicator of educational status leads to questions about whether receipt of special education services is an outcome to be sought after or one to be avoided. In some cases, children with disabilities clearly need accommodations in order to take the best advantage possible of their educational opportunities. However, special education is not without costs, including costs to the child and the family. An optimal process for identifying children in need of special education services would result in neither over-identification nor under-identification of children based on their demographic and placement characteristics. A total of 35.5% of children were found in this study to be receiving special education services based on caregiver reports. However, children with certain characteristics were clearly identified as being more likely to receive special education services. Specifically, older children (45.7% of children 14 years and older vs. 36.0% of children 6 to 13), children who have been in care longer (44.7% of children in care 3 years or longer vs. 25.8% of children in care less than 3 years), children in more intensive placement settings (from a low of 18.6% in home of relative care to 84.9% in group and residential care), and males (41.8% vs. 31.5% for females) are more likely to be identified as receiving special education services. However, the extent to which this represents over-identification or the extent to which children not so represented are under-identified is not known. Moreover, the extent to which identification of and advocacy for children needing additional support but for whom special education services are not warranted is carried out is unknown. Additional research in this area would be an important contribution to improving the well-being of children in out-of-home care.

Attendance figures as reported by caregivers were quite favorable. Children overall were reported as missing an average of .95 days of school in the last month. None of the characteristics examined had a significant association with school attendance. However, as was noted in the first round of the Well-being Study, children in more intensive placement settings appear to have better attendance records to some degree.

Caregivers were asked how many times since the beginning of the school year the children in their care had been assigned detentions or in-school suspensions and out-of-school suspensions. They were also asked whether or not the children had been expelled from school at any time in the past two years. Findings indicated that, based on caregiver reports, the average number of in-school suspensions for all children was one and that one in two children had been assigned an out-of-school suspension. A surprising number

of caregivers, 8.7%, indicated that the children in their care had been expelled from school. This finding represents the caregivers' perspective and may reflect a misunderstanding of the formal usage of the term "expulsion." All forms of caregiver-reported discipline were associated with placement type. Children in specialized foster care were reported to be at much greater risk of experiencing behavior problems in school, whereas children in group and residential care are identified as experiencing relatively few behavior problems. The latter could be due to the fact that many children in group and residential settings attend therapeutic programs and that discipline within these programs takes different forms. Relative caregivers were also more likely to indicate that the children in their care had been expelled from school. Determining whether this observation is valid based on data obtained from educational records and, if so, exploring factors driving this dynamic are important next steps.

The data suggest that, based on caregivers' perceptions, placement is an important factor associated with many of the outcomes examined, as suggested in Table 5.2. Placement was not statistically associated with caregiver reports of attendance, although a pattern is evident in the data, nor with caregiver reports of grades. However, placement is associated with caregiver reports of the likelihood of being over-age-in-grade, receiving special education services, and disciplinary actions. Overall, the message is that, according to caregivers, group and residential care appear to result in high rates of attendance and to protect children from expulsion from school but that children in more intensive placement settings in general struggle significantly with educational challenges. These findings call attention to the importance of early identification of educational struggles children are engaged in, evaluation to determine what children's needs are and what the most appropriate sources of intervention may be, and action to put supportive resources in place in order to prevent the escalation of problems to the extent indicated here.

In addition to data gathered from caregivers, questions concerning education were asked of children. These questions comprise the School Engagement Survey derived from the Rochester Assessment Package for Schools (RAPS).[13]

13 Wellborn, J. G., & Connell, J. P., (1987). *Manual for the Rochester Assessment Package for Schools*. Rochester, NY: University of Rochester.

These data were compared to national findings based on the National Survey of Child and Adolescent Well-being (NSCAW) as analyzed by the authors. The education data compiled during the course of the Illinois study and the national study are remarkable in their similarity in profiling school engagement issues for foster children in Illinois and the nation. As illustrated in Figure 5.9, with regard to educational engagement, Illinois manifests the outcomes of the nation at large, with no significant differences among the two samples. Educational engagement has been demonstrated to have a significant association with school achievement regardless of gender, race, or socioeconomic status.[14] Measurement of school engagement is rapidly becoming standard practice in high school settings. Overall, students report high levels of engagement; however, despite the fact that a majority of students report themselves as engaged, a sizeable minority appear to struggle with regard to interest, involvement, and relationships with people at school.

Observations on Child Well-Being in Illinois

A half-century of research demonstrates that children's emotional well-being, educational success, and capacity for leading healthy and productive lives build upon first meeting their basic human needs for safety, trust, and secure connection with loving and caring adults. When primary family relationships are disrupted, the state is responsible for ensuring that a child's developmental opportunities for health, education, emotional, and economic well-being are not unduly compromised by out-of-home placement.

The next tasks for the Department are to accurately measure, track and assess children's needs, the receipt of services, and the change in children's physical and emotional status over time. In establishing a statewide Integrated Assessment system, the Department has laid the groundwork to use the data generated to this end. Such tracking should pay special attention to children in kinship care to assess whether their levels of need are in fact lower than children in more restrictive settings or whether service needs are being under-diagnosed and/or under-treated. Use of such tracking may also be targeted to reduce the reliance upon highly restrictive placements, such as residential care and group homes, by meeting emotional and social needs early-on in kinship and traditional foster care placements.

14 Finn, J. (1993). *School engagement and students at risk*. Washington, DC: U.S. Department of Education, Office of Educational Research and Improvement, National Center for Education Statistics.

Regarding the persistent finding that about 20 percent of children are not receiving routine dental services, it seems that foster families are having limited success navigating local dental care options on their own. DCFS might consider collaborating with the DHS to find ways to develop providers state-wide that are willing and able to provide these services under the Medicaid payment schedule.

The Illinois Department of Children and Family Services has been instrumental in making use of advanced technologies to improve rates at which children taken into care are placed in close proximity to schools at which they are already in attendance. Making a priority of maintaining connections with schools is responsive to federal priorities as well as to the voices of children and reduces unnecessary school transfers that can negatively impact educational progress. Important next steps in improving understanding of educational progress and outcomes for children in care include continued attention to the connection between trauma, cognitive functioning, and educational performance and on methods for providing foster children emotional safety and support within effective learning environments. Additional important avenues for future investigation include extent of, reasons for, and response to over-representation of children in foster care in special education.

YOUTH VOICES

End Note

If I could teach the world,
I would and I will—
Let my actions influence others
Allow my voice to echo, never measuring
my potential by worldly standards
But rather by something True,
that comes from within…

—Kim

APPENDIX A

OUTCOME DATA BROKEN DOWN BY REGION, GENDER, AGE AND RACE OVER SEVEN YEARS[1]

Please note that all of the tables and figures in this report present data in such a way that positive changes or improvements over time are characterized by increasing numbers and trend lines. The State Fiscal Year is used throughout this data. All indicators are available on-line on our website at: http://cfrcwww.social.uiuc.edu/

1 This data was generated by the Children and Family Research Center from the December 31, 2005 data extract of the Illinois Department of Children and Family Services Integrated Database. Due to missing data on some variables, the sum of demographic breakouts may not always add up to the total for that indicator. For instance, data on geographic region is not always available for each child; therefore, the total number of children in Central, Cook, Northern and Southern regions will sometimes be less than the total for the state.

Prevalence of Child Abuse and/or Neglect

Indicator 1.A.	Of all children under age 18, what number and rate per 1,000 did not have an indicated report of child abuse and/or neglect?						
	1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
	Illinois						
Children Under 18	3,214,383	3,245,451	3,276,819	3,308,490	3,340,467	3,372,754	3,405,352
No Indicated Reports	3,184,403	3,216,564	3,251,080	3,284,009	3,315,648	3,347,969	3,380,005
Rate	990.67	991.1	992.15	992.6	992.57	992.65	992.56

	N	rate	N	rate	N	rate	N	rate	N	rate	N	rate	N	rate
Illinois	3,184,403	990.67	3,216,564	991.1	3,251,080	992.15	3,284,009	992.6	3,315,648	992.57	3,347,969	992.65	3,380,005	992.56
Central	541,084	988.33	539,880	988.12	539,458	989.34	538,637	989.83	537,410	989.57	535,475	987.99	534,217	987.66
Cook	1,375,782	992.91	1,388,924	993.64	1,402,152	994.34	1,414,958	994.66	1,427,50	994.74	1,440,798	995.21	1,453,734	995.38
Northern	975,387	994.41	997,708	994.80	1,020,906	995.56	1,043,865	995.57	1,067,226	995.48	1,091,226	995.49	1,115,606	995.36
Southern	295,815	988.75	294,892	988.44	294,360	989.43	293,860	990.53	292,964	990.29	292,077	990.07	290,978	989.13
African-American	590,266	980.28	596,298	980.92	603,753	983.78	610,329	985.08	616,432	985.52	622,947	986.5	628,885	986.48
Hispanic	521,043	994.72	549,687	995.25	579,811	995.62	611,579	995.98	645,379	996.78	680,597	996.93	717,866	997.26
White	2,149,941	993.28	2,154,548	993.63	2,159,845	992.15	2,164,093	994.46	2,166,974	992.57	2,170,457	993.83	2,173,911	992.56

Safety From Maltreatment Recurrence at 12 Months

Indicator 1.B. Of all children with a substantiated report, what percentage did not have another substantiated report within 12 months?

	1998	1999	2000	2001	2002	2003	2004
			Illinois				
Children with Substantiated Report	32,368	29,980	28,887	25,739	24,481	24,819	24,785
Children without Substantiated Recurrence within 12 months	27,362	25,604	24,661	22,353	21,643	22,037	22,035
Percent	84.5%	85.4%	85.4%	86.8%	88.4%	88.8%	88.9%

	1998		1999		2000		2001		2002		2003		2004	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	27,362	84.5%	25,604	85.4%	24,661	85.4%	22,353	86.8%	21,643	88.4%	22,037	88.8%	22,035	88.9%
Central	5,405	81.6%	5,322	83.1%	5,468	84.2%	4,925	84.8%	4,772	86.2%	4,793	84.6%	5,618	86.3%
Cook	10,216	87.7%	8,765	89.1%	7,739	86.9%	7,094	88.8%	6,913	91.1%	6,928	91.8%	6,329	91.3%
Northern	4,791	83.3%	4,677	85.4%	4,516	86.6%	4,023	88.6%	4,171	89.9%	4,385	90.4%	4,468	90.3%
Southern	2,840	81.7%	2,681	79.9%	2,792	80.9%	2,630	83.9%	2,331	83.1%	2,452	85.3%	2,501	85.7%
Female	14,286	85.1%	13,216	85.8%	12,929	86.0%	11,506	87.3%	11,278	89.0%	11,396	89.4%	11,197	89.1%
Male	12,991	83.9%	12,314	85.0%	11,658	84.6%	10,768	86.3%	10,267	87.7%	10,529	88.0%	10,662	88.6%
Under 3	7,302	85.2%	6,836	86.3%	6,566	86.0%	6,020	86.7%	5,934	88.2%	6,032	88.7%	6,113	88.7%
3 to 5	5,392	83.8%	4,928	83.7%	4,639	83.3%	4,106	84.3%	4,078	86.3%	4,150	87.4%	4,249	87.1%
6 to 8	5,058	82.0%	4,853	83.8%	4,504	83.5%	3,974	86.0%	3,731	87.2%	3,805	87.5%	3,736	88.0%
9 to 11	4,060	84.0%	3,864	84.7%	3,762	85.4%	3,553	87.2%	3,414	89.0%	3,396	88.6%	3,310	89.4%
12 to 14	3,277	86.1%	3,109	87.2%	3,031	86.7%	2,767	88.5%	2,729	89.7%	2,829	90.1%	2,940	90.9%
15 to 17	2,216	89.0%	1,984	89.3%	3,031	86.7%	1,902	92.1%	1,732	93.6%	1,805	93.6%	1,672	92.2%
African-American	11,523	86.4%	10,302	86.8%	9,888	85.3%	8,700	87.4%	8,307	89.9%	8,145	89.9%	7,647	89.7%
Hispanic	2,511	87.0%	2,501	90.5%	2,379	90.7%	2,305	90.3%	2,254	91.2%	1,891	90.7%	1,961	93.6%
Other	819	88.2%	693	88.4%	744	88.3%	736	89.0%	677	93.9%	572	93.2%	643	93.6%
White	12,509	82.2%	12,108	83.2%	11,650	84.3%	10,612	85.5%	10,405	86.4%	11,429	87.5%	11,784	87.4%

Safety From 12-Month Maltreatment Recurrence Among Intact Family Cases

Indicator 1.C.	Of all children served at home in an intact family case, what percentage did not experience a substantiated report within a 12-month period?						
	1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
			Illinois				
Number of Children in Intact Families	20,734	19,367	21,527	23,431	20,994	19,894	19,835
Children without Substantiated Recurrence	17,927	16,890	19,039	21,080	18,968	17,815	17,759
Percent	86.5%	87.2%	88.4%	90.0%	90.3%	89.5%	89.5%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	17,927	86.5%	16,890	87.2%	19,039	88.4%	21,080	90.0%	18,968	90.3%	17,815	89.5%	17,759	89.5%
Central	5,705	85.5%	5,923	86.5%	6,460	88.0%	6,616	87.5%	6,024	88.5%	5,385	86.5%	5,853	87.7%
Cook	7,053	88.3%	5,963	90.7%	7,207	90.5%	8.423	92.6%	7,946	93.3%	7,818	93.2%	7,235	92.9%
Northern	2,443	86.0%	2,305	85.9%	2,554	87.7%	2,800	89.6%	2,319	89.8%	2,434	89.9%	2,515	88.3%
Southern	2,335	83.5%	2,373	82.1%	2,215	84.0%	2,799	88.0%	2,284	86.0%	1,916	83.6%	1,968	84.8%
Female	9,042	86.6%	8,289	87.4%	9,447	88.6%	10,394	90.3%	9,480	90.5%	8,911	89.5%	8,727	89.7%
Male	8,868	86.3%	8,591	87.0%	9,584	88.3%	10,673	89.7%	9,479	90.2%	8,893	89.6%	9,009	89.4%
Under 3	4,042	83.0%	3,731	83.8%	4,176	84.8%	4,503	86.4%	4,183	86.6%	3,956	85.1%	3,909	85.7%
3 to 5	3,584	84.4%	3,158	84.1%	3,515	86.9%	3,836	88.5%	3,433	88.0%	3,165	88.1%	3,159	86.5%
6 to 8	3,294	85.1%	3,153	86.5%	3,576	87.5%	3,925	90.1%	3,337	90.6%	3,109	89.4%	2,941	88.9%
9 to 11	2,737	87.4%	2,712	88.7%	3,019	89.2%	3,409	90.7%	3,128	90.6%	2,891	90.6%	2,861	91.1%
12 to 14	2,260	89.6%	2,144	89.6%	2,426	91.0%	2,769	91.4%	2,531	93.2%	2,495	91.9%	2,553	92.3%
15 to 17	2,010	95.9%	1,992	96.4%	2,327	96.2%	2,638	96.5%	2,365	97.6%	2,199	96.8%	2,336	97.0%
African-American	8,398	88.3%	7,501	89.5%	8,897	90.1%	9,434	91.6%	8,437	92.5%	7,790	92.3%	7,588	91.4%
Hispanic	1,249	87.2%	1,210	89.1%	1,501	90.1%	1,917	91.9%	1,890	91.9%	2,017	93.6%	1,534	93.0%
Other	378	85.5%	428	85.1%	573	89.5%	618	89.2%	573	88.4%	383	88.7%	476	90.7%
White	7,902	84.5%	7,751	85.0%	8,068	86.3%	9,111	88.0%	8,068	88.0%	7,625	86.0%	8,161	87.2%

Safety From Maltreatment Recurrence in Substitute Care

Indicator 1.D.	Of all children ever served in substitute care during the year, what percentage did not have a substantiated report during placement? (note: sexual abuse excluded from reports of abuse while in care)						
	1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
	Illinois						
Children Living in Substitute Care*	53,621	44,006	36,795	32,364	29,066	26,308	24,981
Children without Substantiated Reports	52,939	43,428	36,312	31,975	28,687	25,979	24,645
Percent	98.7%	98.7%	98.7%	98.8%	98.7%	98.7%	98.7%

	1999 N	1999 %	2000 N	2000 %	2001 N	2001 %	2002 N	2002 %	2003 N	2003 %	2004 N	2004 %	2005 N	2005 %
Illinois	52,939	98.7%	43,428	98.7%	36,312	98.7%	31,975	98.8%	28,687	98.7%	25,979	98.7%	24,645	98.7%
Central	6,242	97.8%	6,011	98.1%	5,647	98.4%	5,206	98.4%	4,976	98.4%	4,868	97.8%	4,931	97.6%
Cook	37,466	98.9%	29,451	99.0%	23,397	98.9%	19,949	99.1%	17,155	98.9%	14,696	99.1%	13,203	99.1%
Northern	4,486	98.6%	4,044	98.1%	3,645	98.0%	3,379	97.9%	3,120	98.1%	2,974	98.5%	3,088	98.7%
Southern	2,369	98.5%	2,102	97.6%	2,066	98.5%	2,039	98.5%	2,063	98.3%	2,159	98.6%	2,278	98.4%
Female	25,862	98.6%	21,119	98.6%	17,393	98.6%	15,159	98.6%	13,583	98.8%	12,248	98.8%	11,595	98.7%
Male	27,031	98.8%	22,271	98.7%	18,896	98.7%	16,797	99.0%	15,089	98.6%	13,719	98.7%	13,033	98.6%
Under 3 at removal	21,617	98.8%	17,319	98.9%	13,882	98.9%	11,936	98.7%	10,543	98.7%	9,421	98.6%	9,083	98.5%
3 to 5	10,533	98.3%	8,430	98.3%	6,812	98.3%	5,900	98.5%	5,223	98.6%	4,599	98.4%	4,312	98.2%
6 to 8	8,399	98.6%	7,037	98.3%	5,969	98.3%	5,307	98.9%	4,709	98.5%	4,230	98.6%	3,890	98.8%
9 to 11	6,345	98.9%	5,430	98.7%	4,852	98.9%	4,388	99.0%	4,002	98.7%	3,585	99.0%	3,245	98.8%
12 to 14	4,529	99.3%	3,951	99.2%	3,580	98.9%	3,293	99.1%	3,048	98.9%	2,933	99.1%	2,795	99.1%
15 to 17	1,505	99.3%	1,252	99.4%	1,213	99.3%	1,148	99.5%	1,160	99.6%	1,209	99.8%	1,320	99.5%
African-American	40,027	98.8%	32,131	98.9%	25,981	98.8%	22,131	98.9%	19,275	98.9%	16,876	98.9%	15,547	99.0%
Hispanic	2,606	99.0%	2,176	98.8%	1,877	98.9%	1,745	98.8%	1,599	98.5%	1,399	98.8%	1,412	98.8%
Other	869	99.2%	781	98.7%	745	97.8%	710	98.1%	676	97.3%	557	98.6%	541	98.5%
White	9,437	98.3%	8,340	98.0%	7,709	98.5%	7,389	98.5%	7,137	98.4%	7,147	98.3%	7,235	98.0%

*Note: Only includes children living in substitute care placements that lasted 7 days or more.

Stability in Intact Family Homes

Indicator 2.A.	Of all children served in intact family cases, what percentage did not experience a substitute care placement within a 12-month period?						
	1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
				Illinois			
Children in Intact Families	20,734	19,367	21,527	23,431	20,994	19,894	19,835
No Substitute Care Placement	19,379	18,069	20,262	22,114	19,870	18,839	18,725
Percent	93%	93%	94%	94%	95%	95%	94%

	1998		1999		2000		2001		2002		2003		2004	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	19,379	93%	18,069	93%	20,262	94%	22,114	94%	19,870	95%	18,839	95%	18,725	94%
Central	6,331	95%	6,437	94%	6,929	94%	7,126	94%	6,463	95%	5,836	94%	6,293	94%
Cook	7,316	92%	6,091	93%	7,501	94%	8,585	94%	8,095	95%	8,049	96%	7,483	96%
Northern	2,639	93%	2,500	93%	2,689	92%	2,966	95%	2,426	94%	2,553	94%	2,611	92%
Southern	2,676	96%	2,699	93%	2,504	95%	2,989	94%	2,480	93%	2,127	93%	2,156	93%
Female	9,769	94%	8,847	93%	10,050	94%	10,903	95%	9,916	95%	9,450	95%	9,198	95%
Male	9,769	94%	9,212	93%	10,203	94%	11,198	94%	9,943	95%	9,377	94%	9,502	94%
Under 3	4,417	91%	4,025	90%	4,526	92%	4,783	92%	4,443	92%	4,272	92%	4,177	92%
3 to 5	3,975	94%	3,493	93%	3,802	94%	4,091	94%	3,687	95%	3,404	95%	3,425	94%
6 to 8	3,597	93%	3,408	93%	3,888	95%	4,130	95%	3,506	95%	3,309	95%	3,139	95%
9 to 11	2,948	94%	2,882	94%	3,198	95%	3,568	95%	3,275	95%	3,051	96%	2,984	95%
12 to 14	2,382	94%	2,253	94%	2,490	93%	2,856	94%	2,587	95%	2,577	95%	2,639	95%
15 to 17	2,060	98%	2,008	97%	2,358	98%	2,686	98%	2,372	98%	2,226	98%	2,361	98%
African-American	8,737	92%	7,752	92%	9,238	94%	9,701	94%	8,642	95%	8,008	95%	7,785	94%
Hispanic	1,345	94%	1,290	95%	1,603	96%	1,992	95%	1,955	95%	2,098	97%	1,604	97%
Other	414	94%	469	93%	595	93%	644	93%	591	91%	406	94%	490	93%
White	8,883	95%	8,558	94%	8,826	94%	9,777	94%	8,682	95%	8,327	94%	8,846	95%

Stability in Substitute Care

Indicator 2.B.	Of all children entering substitute care and staying for at least one year, what percentage had no more than two placements within a year of removal?													
	1998		**1999**		**2000**		**2001**		**2002**		**2003**		**2004**	
Illinois														
Entering and staying one year	6,641		6,011		4,847		4,686		4,513		4,175		4,035	
No more than two placements	4,776		4,389		3,554		3,465		3,363		3,198		3,129	
Percent	72%		73%		73%		74%		75%		77%		78%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	4,776	72%	4,389	73%	3,554	73%	3,465	74%	3,363	75%	3,198	77%	3,129	78%
Central	835	71%	902	72%	930	73%	858	77%	839	81%	943	79%	922	78%
Cook	2,897	72%	2,430	74%	1,619	73%	1,622	72%	1,587	71%	1,238	72%	1,079	74%
Northern	595	73%	585	73%	562	76%	483	75%	514	77%	481	81%	553	80%
Southern	249	68%	293	73%	278	73%	325	73%	294	74%	357	80%	409	82%
Female	2,351	71%	2,177	73%	1,768	73%	1,714	75%	1,657	74%	1,552	77%	1,454	77%
Male	4,776	72%	2,212	73%	1,785	74%	1,750	72%	1,704	75%	1,646	77%	1,674	78%
Under 3 at removal	2,184	80%	2,014	81%	1,655	83%	1,546	83%	1,521	84%	1,463	85%	1,402	85%
3 to 5	730	68%	694	71%	541	74%	529	72%	522	74%	460	74%	471	77%
6 to 8	668	69%	586	68%	445	69%	441	73%	423	73%	399	76%	376	77%
9 to 11	515	68%	448	67%	374	67%	382	67%	364	69%	354	73%	330	75%
12 to 14	432	61%	385	62%	336	58%	353	61%	337	60%	319	62%	333	66%
15 to 17	247	60%	262	69%	203	61%	214	62%	196	61%	203	65%	217	64%
African-American	3,239	73%	2,797	74%	2,210	74%	2,071	74%	1,895	74%	1,733	76%	1,571	74%
Hispanic	308	68%	259	70%	153	70%	188	68%	210	67%	148	65%	162	82%
Other	103	76%	123	75%	104	75%	119	73%	96	68%	98	75%	53	78%
White	1,126	69%	1,210	71%	1,087	72%	1,087	75%	1,162	77%	1,219	80%	1,343	81%

Youth Who Do Not Run Away From Substitute Care

Indicator 2.C.	Of all children entering care at the age of 12 or older, what percentage did not runaway from a foster care placement during the year?						
	1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
			Illinois				
Entered Substitute Care at 12 or older	1,568	1,394	1,229	1,254	1,216	1,141	1,163
Did Not Run Away During the Year	1,206	1,069	918	975	925	870	906
Percent	77%	77%	75%	78%	76%	76%	78%

	1998		1999		2000		2001		2002		2003		2004	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	1,206	77%	1,069	77%	918	75%	975	78%	925	76%	870	76%	906	78%
Central	310	78%	330	81%	290	78%	259	79%	231	78%	249	79%	242	81%
Cook	458	74%	360	73%	260	70%	314	74%	309	69%	241	65%	234	68%
Northern	212	78%	172	73%	177	73%	168	79%	176	81%	151	79%	155	76%
Southern	132	80%	122	82%	115	80%	134	81%	115	81%	116	84%	146	85%
Female	607	73%	546	75%	464	70%	493	76%	485	76%	428	74%	497	78%
Male	599	81%	523	79%	454	80%	481	80%	440	77%	442	78%	409	77%
12 to 14*	772	83%	673	83%	614	82%	635	84%	606	82%	570	84%	574	83%
15 or older*	434	68%	396	68%	304	63%	340	69%	319	66%	300	65%	332	71%
African-American	592	77%	475	72%	421	71%	460	75%	438	73%	412	72%	441	73%
Hispanic	77	71%	71	81%	41	75%	47	72%	52	74%	35	73%	30	65%
Other	24	80%	29	88%	20	69%	32	84%	30	75%	17	74%	5	45%
White	513	78%	494	81%	436	79%	436	81%	405	80%	406	82%	430	86%

* Age at case opening.

Least Restrictive Setting

Indicator 3.A	Of all the children in out-of-home care at the end of the fiscal year who were under the age of 12 at the start of the placement, what percent were not placed in a group home or institution?						
	1999	2000	2001	2002	2003	2004	2005
				Illinois			
Children Under 12	29,018	22,204	18,251	15,295	13,393	12,413	12,014
Not Placed in Institution or Group Home	28,199	21,508	17,644	14,827	13,001	12,086	11,737
Percent	97%	97%	97%	97%	97%	97%	98%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	28,199	97%	21,508	97%	17,644	97%	14,827	97%	13,001	97%	12,086	97%	11,737	98%
Central	3,121	98%	2,853	98%	2,629	98%	2,363	99%	2,378	99%	2,487	99%	2,580	99%
Cook	20,663	97%	14,921	97%	11,650	96%	9,320	96%	7,725	96%	6,625	97%	6,017	97%
Northern	2,360	98%	2,037	98%	1,768	98%	1,599	97%	1,388	98%	1,432	98%	1,535	99%
Southern	1,083	96%	953	96%	955	97%	991	98%	997	98%	1,076	99%	1,168	98%
Female	13,808	98%	10,428	98%	8,524	98%	7,149	98%	6,259	98%	5,650	98%	5,485	99%
Male	14,356	96%	11,061	96%	9,109	96%	7,668	96%	6,736	96%	6,427	97%	6,237	97%
Under 3 at removal	10,488	99%	7,861	99%	6,552	99%	5,634	99%	5,201	99%	4,986	99%	5,057	99%
3 to 5	6,758	99%	4,895	99%	3,877	99%	3,268	99%	2,717	99%	2,574	99%	2,452	99%
6 to 8	6,198	97%	4,785	97%	3,811	96%	3,077	97%	2,598	97%	2,361	97%	2,215	97%
9 to 11	4,755	91%	3,967	90%	3,404	90%	2,848	91%	2,485	91%	2,165	92%	2,013	93%
African-American	22,043	98%	16,294	97%	12,862	97%	10,305	97%	8,704	97%	7,665	97%	7,118	97%
Hispanic	1,423	96%	1,101	95%	959	95%	858	96%	768	97%	724	98%	708	98%
Other	503	98%	426	98%	415	98%	393	97%	350	98%	311	98%	309	98%
White	4,230	96%	3,687	96%	3,408	96%	3,271	97%	3,179	97%	3,386	98%	3,602	98%

Placing Children With Relatives — First Placements

Indicator 3.B.1	Of all children entering substitute care, what percentage is placed with kin in their first placement?						
	1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
				Illinois			
Entering Substitute Care	7,426	5,969	5,827	5,636	5,297	5,039	5,294
Placed With Kin	2,747	2,061	2,081	2,161	1,951	2,125	2,334
Percent	37%	35%	36%	38%	37%	42%	44%

Placed With Kin	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	2,747	37%	2,061	35%	2,081	36%	2,161	38%	1,951	37%	2,125	42%	2,334	44%
Central	531	31%	541	32%	484	33%	496	36%	599	39%	621	41%	727	48%
Cook	1,619	44%	978	40%	995	40%	1,080	44%	734	37%	687	42%	779	43%
Northern	356	35%	323	35%	332	38%	313	37%	339	45%	379	46%	417	46%
Southern	158	24%	150	26%	193	29%	219	34%	224	35%	352	47%	349	44%
Female	1,442	39%	1,059	35%	1,063	38%	1,082	39%	974	38%	1,003	42%	1,173	45%
Male	1,305	35%	1,001	34%	1,017	34%	1,076	38%	977	35%	1,120	42%	1,156	43%
Under 3 at removal	1,045	35%	794	34%	766	35%	818	38%	796	39%	802	42%	950	47%
3 to 5	521	44%	348	38%	356	39%	397	46%	326	41%	377	49%	411	51%
6 to 8	426	41%	327	41%	318	42%	329	46%	284	42%	294	46%	323	49%
9 to 11	356	41%	267	38%	286	39%	273	39%	233	36%	262	45%	270	45%
12 to 14	248	30%	209	28%	230	30%	209	28%	193	28%	254	37%	227	34%
15 to 17	151	26%	116	24%	125	25%	134	28%	119	26%	136	29%	153	29%
African-American	1,784	41%	1,282	37%	1,234	38%	1,254	42%	1,029	36%	1,033	41%	1,126	42%
Hispanic	168	38%	108	37%	105	32%	113	30%	89	31%	90	39%	124	41%
Other	50	25%	49	28%	63	29%	55	29%	58	34%	37	42%	58	43%
White	745	31%	622	30%	679	34%	739	36%	775	38%	965	44%	1,026	47%

Placing Children With Relatives

Indicator 3.B.2	Of all children in substitute care at the end of the year, what percentage is living with kin?						
	1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
Illinois							
In Substitute Care	38,107	30,681	26,352	22,881	20,143	18,466	17,612
Living with Kin	17,960	12,563	10,170	8,537	7,278	6,833	6,734
Percent	47%	41%	39%	37%	36%	37%	38%

	1999 N	1999 %	2000 N	2000 %	2001 N	2001 %	2002 N	2002 %	2003 N	2003 %	2004 N	2004 %	2005 N	2005 %
Illinois	17,960	47%	12,563	41%	10,170	39%	8,537	37%	7,278	36%	6,833	37%	6,734	38%
Central	1,338	30%	1,100	26%	1,084	28%	1,049	30%	1,076	31%	1,194	34%	1,313	37%
Cook	14,293	53%	9,601	46%	7,432	43%	5,930	41%	4,677	38%	3,968	38%	3,633	38%
Northern	1,195	37%	1,012	35%	875	33%	843	35%	792	37%	844	39%	921	41%
Southern	462	29%	419	28%	429	29%	433	30%	471	32%	586	38%	646	40%
Female	9,178	50%	6,409	44%	5,199	42%	4,330	40%	3,698	39%	3,395	40%	3,298	41%
Male	8,769	45%	6,145	38%	4,963	36%	4,196	35%	3,575	33%	3,432	34%	3,428	36%
Under 3 at removal	7,083	46%	4,796	40%	3,749	38%	3,148	37%	2,806	37%	2,652	37%	2,715	40%
3 to 5	3,768	49%	2,483	41%	1,927	38%	1,589	36%	1,328	35%	1,291	38%	1,257	39%
6 to 8	3,062	48%	2,186	42%	1,780	39%	1,516	39%	1,261	37%	1,132	37%	1,062	38%
9 to 11	2,318	49%	1,751	43%	1,485	41%	1,255	40%	1,031	38%	893	37%	841	38%
12 to 14	1,386	44%	1,062	39%	957	38%	793	36%	632	32%	621	33%	600	33%
15 to 17	338	41%	282	38%	271	37%	236	34%	220	35%	244	37%	259	36%
African-American	15,038	52%	10,294	45%	8,058	43%	6,489	41%	5,317	39%	4,663	39%	4,317	39%
Hispanic	778	41%	521	34%	437	32%	389	31%	336	30%	336	32%	356	36%
Other	253	40%	165	30%	170	31%	171	33%	145	31%	130	33%	132	33%
White	1,891	29%	1,583	27%	1,505	27%	1,488	29%	1,480	30%	1,704	34%	1,929	38%

In-State Placements

Indicator 3.C. Of all children placed in a group home or institution as of June 30th, what percentage is placed in Illinois?

	1999	2000	2001	2002	2003	2004	2005
Illinois							
Placed in a Group Home or Institution	3,617	3,368	3,036	2,759	2,396	2,112	2,031
Placed in Illinois	3,475	3,291	2,999	2,738	2,386	2,103	2,011
Percent	96.1%	97.7%	98.8%	99.2%	99.6%	99.6%	99.0%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	3,475	96.1%	3,291	97.7%	2,999	98.8%	2,738	99.2%	2,386	99.6%	2,103	99.6%	2,011	99.0%
Central	523	99.8%	531	99.6%	420	99.5%	329	100.0%	285	100.0%	276	100.0%	270	99.6%
Cook	2,241	96.2%	2,076	97.9%	1,978	99.1%	1,876	99.5%	1,596	99.6%	1,351	99.5%	1,260	98.9%
Northern	300	96.5%	296	97.4%	278	98.9%	240	100.0%	233	99.6%	233	99.6%	233	98.7%
Southern	220	92.4%	192	93.7%	169	96.6%	153	98.1%	150	100.0%	140	99.3%	146	99.3%
Female	1,106	96.6%	1,014	97.6%	906	97.8%	838	98.5%	708	99.2%	638	99.4%	622	98.9%
Male	2,368	95.8%	2,277	97.8%	2,091	99.2%	1,898	99.6%	1,677	99.8%	1,464	99.7%	1,388	99.1%
Under 3 at time of placement	88	100.0%	57	100.0%	57	100.0%	44	95.7%	50	100.0%	44	97.8%	33	100.0%
3 to 5	52	100.0%	38	100.0%	40	100.0%	31	100.0%	28	100.0%	24	100.0%	22	100.0%
6 to 8	180	99.4%	164	99.4%	141	99.3%	99	99.0%	72	98.6%	60	98.4%	60	98.4%
9 to 11	483	97.0%	425	97.5%	362	98.4%	288	99.0%	239	99.2%	196	99.5%	160	99.4%
12 to 14	1,110	97.1%	1,020	98.1%	892	99.4%	819	99.4%	700	99.9%	578	99.7%	516	98.9%
15 to 17	1,562	94.4%	1,587	97.2%	1,507	98.4%	1,457	99.3%	1,297	99.5%	1,201	99.7%	1,220	99.0%
African-American	2,315	96.0%	2,175	97.8%	2,033	99.2%	1,848	99.4%	1,642	99.6%	1,412	99.6%	1,353	98.8%
Hispanic	184	94.8%	180	96.8%	160	96.4%	159	97.5%	131	100.0%	105	98.1%	107	100.0%
Other	41	91.1%	46	95.8%	43	97.7%	46	100.0%	43	100.0%	32	100.0%	31	100.0%
White	935	96.8%	890	97.8%	763	98.3%	685	99.1%	570	99.5%	554	99.6%	520	99.2%

Keeping Children Close to Home

Indicator 3.D. Definition	Of all children entering substitute care, what percentage is placed within five miles of their home of origin?						
	1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
Traditional Foster Care							
Children Entering Foster Care	3,064	2,495	2,489	2,411	2,397	2,193	2,056
Placed within Five Miles	782	616	584	514	441	497	436
Percent	26%	25%	23%	21%	18%	23%	21%
Kinship Care							
Children Entering Kinship Care	2,910	2,278	2,253	2,274	2,069	2,127	2,504
Placed within Five Miles	1,270	825	960	837	737	878	1,012
Percent	44%	36%	43%	37%	36%	41%	40%

Preserving Sibling Bonds

Indicator 3.E. Definition	Of all children living in foster care at the end of the year, what percentage is placed with all of their siblings? (Children with no siblings in foster care are excluded from the analysis.)						
	1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
Traditional Foster Care				***2-3 Siblings***			
Children with 2-3 Siblings	4,413	4,020	3,986	3,525	3,393	3,150	2,903
Placed with All Siblings	2,004	1,819	1,877	1,729	1,743	1,717	1,646
Percent	45%	45%	47%	49%	51%	55%	57%
Kinship Care				***2-3 Siblings***			
Children with 2-3 Siblings	7,327	5,270	4,451	3,730	3,261	3,132	3,204
Placed with All Siblings	4,764	3,276	2,743	2,374	2,056	2,031	2,199
Percent	65%	62%	62%	64%	63%	65%	69%
Traditional Foster Care				***4 or more Siblings***			
Children with Four or More Siblings	3,919	2,917	2,646	2,093	1,856	1,728	1,640
Placed with All Siblings	359	274	222	245	247	252	226
Percent	9%	9%	8%	12%	13%	15%	14%
Kinship Care				***4 or more Siblings***			
Children with Four or More Siblings	7,086	4,188	2,902	2,353	1,888	1,764	1,673
Placed with All Siblings	2,348	1,354	950	754	525	515	525
Percent	33%	32%	33%	32%	28%	29%	31%

Permanence at 12 Months: Reunification

Indicator 4.A.	Of all children who entered substitute care during the year and stayed for longer than 7 days, what percentage was reunified with their parents within 12 months from the date of entry into foster care?					
	1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
			Illinois				
Entering Substitute Care	8,197	7,426	5,969	5,827	5,636	5,297	5,039
In a Permanent Home at 12 Months	1,518	1,450	1,216	1,258	1,184	1,141	1,028
12 Month Permanency Percent	19%	20%	20%	22%	21%	22%	20%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	1,518	19%	1,450	20%	1,216	20%	1,258	22%	1,184	21%	1,141	22%	1,028	20%
Central	511	31%	517	30%	503	30%	487	33%	429	31%	447	29%	407	27%
Cook	452	10%	352	10%	219	9%	234	9%	109	9%	238	12%	128	8%
Northern	292	27%	254	25%	257	27%	268	31%	238	28%	194	26%	175	21%
Southern	220	37%	267	40%	192	33%	231	35%	251	39%	219	34%	279	38%
Female	768	19%	725	20%	639	21%	612	22%	566	20%	524	21%	502	21%
Male	750	18%	725	19%	577	19%	646	21%	618	22%	616	22%	526	20%
Under 3 at removal	421	13%	440	15%	370	16%	360	17%	378	18%	368	18%	311	16%
3 to 5	256	19%	247	21%	220	24%	210	23%	201	23%	207	26%	171	22%
6 to 8	219	19%	227	22%	193	24%	183	24%	163	23%	159	24%	165	26%
9 to 11	238	25%	220	26%	157	22%	190	26%	162	23%	148	23%	143	24%
12 to 14	224	24%	179	22%	174	23%	177	23%	161	22%	156	23%	164	24%
15 to 17	160	25%	137	24%	102	21%	138	28%	119	25%	103	22%	74	16%
African-American	654	13%	565	13%	493	14%	462	14%	419	14%	430	15%	337	13%
Hispanic	105	19%	88	20%	70	24%	60	18%	73	19%	73	26%	29	12%
Other	59	31%	43	21%	39	22%	54	25%	66	35%	49	29%	25	28%
White	700	31%	754	32%	614	30%	682	34%	626	30%	589	29%	637	29%

Permanence at 24 Months: Reunification + Adoption

Indicator 4.B.	Of all children who entered substitute care during the year and stayed for longer than 7 days, what percentage attained permanency (through reunification or adoption) within 24 months from the date of entry into foster care?						
	1997	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
			Illinois				
Entering Substitute Care	9,915	8,197	7,426	5,969	5,827	5,636	5,297
In a Permanent Home at 24 Months	3,047	2,852	2,645	2,186	2,197	2,137	1,989
24 Month Permanency Percent	31%	35%	36%	37%	38%	38%	38%

	1997 N	1997 %	1998 N	1998 %	1999 N	1999 %	2000 N	2000 %	2001 N	2001 %	2002 N	2002 %	2003 N	2003 %
Illinois	3,047	31%	2,852	35%	2,645	36%	2,186	37%	2,197	38%	2,137	38%	1,989	38%
Central	855	49%	811	50%	875	51%	860	51%	797	54%	707	51%	749	49%
Cook	1,126	20%	1,086	24%	854	23%	562	23%	534	21%	523	21%	473	24%
Northern	538	44%	482	45%	407	40%	402	43%	426	49%	413	48%	331	44%
Southern	361	48%	340	57%	378	57%	268	46%	316	48%	349	54%	317	49%
Female	1,533	32%	1,438	35%	1,317	36%	1,117	37%	1,047	37%	1,047	38%	940	37%
Male	1,510	30%	1,412	34%	1,327	36%	1,069	36%	1,150	38%	1,090	38%	1,048	38%
Under 3 at removal	1,119	29%	1,094	34%	1,040	35%	836	36%	800	37%	819	38%	780	38%
3 to 5	558	33%	461	35%	450	38%	367	40%	355	39%	353	41%	337	42%
6 to 8	417	30%	399	34%	367	36%	314	39%	309	41%	277	39%	261	39%
9 to 11	334	31%	352	37%	332	39%	240	34%	294	40%	281	41%	236	37%
12 to 14	348	31%	340	36%	269	33%	282	38%	268	35%	256	35%	243	36%
15 to 17	271	34%	206	32%	187	32%	147	31%	171	35%	151	31%	132	29%
African-American	1,517	24%	1,454	28%	1,204	27%	1,008	29%	957	29%	900	30%	855	30%
Hispanic	194	33%	183	32%	144	33%	117	40%	108	32%	131	35%	114	40%
Other	77	32%	85	45%	101	50%	86	49%	86	40%	88	46%	72	42%
White	1,259	46%	1,130	49%	1,196	50%	975	47%	1,046	52%	1,018	49%	948	47%

Permanence at 36 Months: Reunification + Adoption + Guardianship							
Indicator 4.C.	Of all children who entered substitute care during the year and stayed for longer than 7 days, what percentage attained permanency (through reunification, adoption or subsidized guardianship) within 36 months from the date of entry into foster care?						
	1996	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
Illinois							
Entering Substitute Care	10,968	9,915	8,197	7,426	5,969	5,827	5,636
In a Permanent Home at 36 Months	4,535	4,789	4,236	3,996	3,301	3,278	3,172
36 Month Permanency Percent	41%	48%	52%	54%	55%	56%	56%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	4,535	41%	4,789	48%	4,236	52%	3,996	54%	3,301	55%	3,278	56%	3,172	56%
Central	1,149	63%	1,123	64%	1,071	65%	1,181	69%	1,162	69%	1,028	69%	970	70%
Cook	2,040	31%	2,224	39%	1,890	42%	1,571	43%	1,079	44%	1,063	43%	1,029	42%
Northern	665	55%	745	60%	665	62%	614	61%	583	62%	580	67%	569	67%
Southern	452	60%	479	64%	416	70%	438	65%	348	60%	433	65%	424	66%
Female	2,269	42%	2,391	49%	2,114	52%	2,009	54%	1,689	56%	1,594	57%	1,571	57%
Male	2,264	41%	2,388	47%	2,119	52%	1,986	53%	1,611	54%	1,684	56%	1,600	56%
Under 3 at removal	1,818	43%	1,979	52%	1,785	56%	1,714	58%	1,417	61%	1,295	60%	1,323	62%
3 to 5	831	44%	881	52%	692	52%	697	59%	533	58%	553	60%	514	59%
6 to 8	589	41%	698	50%	617	53%	556	54%	452	57%	448	59%	410	57%
9 to 11	507	42%	493	46%	489	52%	467	54%	352	50%	426	58%	392	57%
12 to 14	484	39%	451	40%	430	46%	359	44%	376	50%	372	49%	353	48%
15 to 17	305	33%	286	35%	223	35%	203	35%	171	36%	184	37%	180	38%
African-American	2,441	34%	2,690	42%	2,374	46%	2,077	47%	1,704	49%	1,609	49%	1,476	49%
Hispanic	277	39%	304	52%	262	46%	222	50%	164	57%	162	49%	184	49%
Other	109	49%	115	48%	120	63%	130	64%	113	64%	143	67%	122	64%
White	1,708	58%	1,680	62%	1,480	65%	1,567	66%	1,320	64%	1,364	68%	1,390	67%

Stability of Permanence at Two Years

Indicator 4.D.	Of all children who attained permanence during the year (excluding placements of less than 8 days), what percent remain with their families after two years?						
	1997	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
				Illinois			
Attained Permanence	6,748	10,414	13,430	11,302	8,396	7,427	6,423
Stable Placements (two years)	5,843	9,522	12,558	10,552	7,769	6,817	5,852
Percent	87%	91%	94%	93%	93%	92%	91%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	5,843	87%	9,522	91%	12,558	94%	10,552	93%	7,769	93%	6,817	92%	5,852	91%
Central	1,117	79%	1,274	81%	1,432	87%	1,458	87%	1,353	86%	1,384	87%	1,185	85%
Cook	3,124	92%	6,268	95%	8,796	96%	7,118	96%	4,691	96%	3,830	95%	3,046	95%
Northern	707	80%	926	85%	1,070	88%	988	89%	888	89%	837	88%	796	89%
Southern	468	79%	540	87%	647	89%	521	84%	466	83%	466	83%	483	83%
Female	2,943	88%	4,827	91%	6,331	94%	5,336	94%	3,802	93%	3,310	93%	2,801	91%
Male	2,899	86%	4,690	91%	6,225	93%	5,207	93%	3,966	92%	3,507	91%	3,049	91%
Under 3 at permanence	678	80%	948	85%	1,081	87%	980	87%	871	90%	967	89%	875	89%
3 to 5	1,405	88%	2,356	93%	3,056	96%	2,567	95%	1,791	93%	1,482	94%	1,354	93%
6 to 8	1,291	90%	2,279	94%	3,042	95%	2,518	95%	1,651	94%	1,296	93%	1,128	93%
9 to 11	975	92%	1,857	94%	2,579	95%	2,162	95%	1,549	94%	1,319	93%	1,060	93%
12 to 14	777	85%	1,264	89%	1,749	91%	1,491	92%	1,170	92%	1,046	90%	875	89%
15 to 17	717	80%	818	87%	1,051	89%	834	90%	737	88%	707	88%	560	86%
African-American	3,668	89%	6,918	94%	9,451	95%	7,874	95%	5,490	94%	4,525	94%	3,720	93%
Hispanic	337	92%	536	95%	615	95%	540	96%	393	96%	404	95%	348	92%
Other	105	89%	138	86%	167	89%	162	85%	172	87%	189	91%	166	90%
White	1,733	81%	1,930	84%	2,325	87%	1,976	88%	1,714	87%	1,699	87%	1,618	86%

Stability of Permanence at Five Years														
Indicator 4.E.	Of all children who attained permanence during the year (excluding placements of less than 8 days), what percent remain with their families after five years?													
	1994		**1995**		**1996**		**1997**		**1998**		**1999**		**2000**	
Illinois														
Attained Permanence	4,494		5,773		6,077		6,748		10,414		13,430		11,302	
Stable Placements (five years)	3,414		4,557		4,885		5,524		9,045		11,964		10,045	
Percent	76%		79%		80%		82%		87%		89%		89%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	3,414	76%	4,557	79%	4,885	80%	5,524	82%	9,045	87%	11,964	89%	10,045	89%
Central	1,003	72%	1,072	71%	1,043	72%	1,025	73%	1,179	75%	1,337	81%	1,376	82%
Cook	1,105	79%	1,884	84%	2,288	88%	2,981	88%	6,021	92%	8,426	92%	6,829	92%
Northern	541	74%	640	77%	659	74%	667	75%	871	80%	1,010	83%	918	82%
Southern	371	72%	450	74%	448	72%	432	73%	492	79%	601	82%	476	77%
Female	1,692	76%	2,283	80%	2,476	82%	2,775	83%	4,600	87%	6,048	90%	5,075	89%
Male	1,721	76%	2,270	78%	2,407	79%	2,748	81%	4,440	86%	5,914	89%	4,961	89%
Under 3 at permanence	619	72%	747	75%	659	74%	631	74%	906	81%	1,038	84%	932	83%
3 to 5	865	81%	1,015	82%	1,189	84%	1,340	84%	2,273	89%	2,944	92%	2,481	92%
6 to 8	638	81%	905	84%	1,034	84%	1,236	87%	2,177	90%	2,911	91%	2,408	91%
9 to 11	473	81%	738	86%	742	82%	914	86%	1,751	89%	2,414	89%	2,043	89%
12 to 14	394	64%	543	69%	619	76%	699	77%	1,137	80%	1,619	85%	1,366	84%
15 to 17	425	73%	608	75%	641	79%	704	78%	801	85%	1,038	88%	815	88%
African-American	1,648	76%	2,498	81%	2,938	84%	3,489	85%	6,584	89%	9,026	91%	7,515	91%
Hispanic	218	83%	234	83%	275	84%	321	87%	514	91%	585	90%	521	93%
Other	54	73%	73	74%	76	75%	87	74%	125	78%	150	80%	156	82%
White	1,494	75%	1,752	76%	1,596	74%	1,627	76%	1,822	79%	2,203	83%	1,853	82%

Stability of Permanence at Ten Years

Indicator 4.F.	Of all children who attained permanence during the year (excluding placements of less than 8 days), what percent remain with their families after ten years?					
	1990	**1991**	**1992**	**1993**	**1994**	**1995**
			Illinois			
Attained Permanence	4,768	4,727	4,664	5,016	4,494	5,773
Stable Placements (ten years)	3,159	3,052	3,169	3,477	3,187	4,300
Percent	66%	65%	68%	69%	71%	74%

	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	3,159	66%	3,052	65%	3,169	68%	3,477	69%	3,187	71%	4,300	74%
Central	743	62%	783	62%	866	66%	960	65%	925	67%	987	65%
Cook	1,128	65%	918	59%	864	63%	1,091	69%	1,040	74%	1,794	80%
Northern	476	68%	480	64%	542	69%	574	68%	508	70%	604	73%
Southern	372	63%	378	67%	397	69%	344	67%	336	65%	423	69%
Female	1,601	68%	1,550	66%	1,666	70%	1,774	71%	1,589	72%	2,164	76%
Male	1,558	65%	1,499	63%	1,503	66%	1,703	68%	1,597	70%	2,133	73%
Under 3 at permanence	645	61%	591	59%	655	67%	652	68%	578	67%	710	71%
3 to 5	681	69%	684	69%	685	71%	776	70%	803	75%	954	77%
6 to 8	595	70%	576	69%	497	71%	668	75%	581	74%	832	77%
9 to 11	386	61%	427	64%	457	65%	490	69%	421	72%	674	79%
12 to 14	368	61%	348	58%	422	63%	409	62%	380	62%	521	66%
15 to 17	483	75%	426	68%	453	71%	482	70%	424	73%	608	75%
African-American	1,385	64%	1,336	60%	1,396	63%	1,639	67%	1,515	70%	2,344	76%
Hispanic	204	73%	153	68%	215	78%	208	78%	208	79%	228	81%
Other	54	64%	60	71%	44	63%	64	76%	52	70%	72	73%
White	1,516	67%	1,503	69%	1,514	71%	1,566	71%	1,412	71%	1,656	72%

Time Spent in Foster Care

Indicator 4.G. Definition	Of all children entering foster care for the first time, what is the median number of months a child stays in care?						
	1997	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
Illinois	32	29	28	26	26	27	23
Central	16	14	17	17	18	17	21
Cook	37	36	34	32	34	34	27
Northern	18	18	21	23	18	19	23
Southern	14	5	9	14	12	11	14
Female	32	29	28	25	25	26	22
Male	32	29	28	27	26	27	23
Under 3 at removal	33	31	30	28	27	28	26
3 to 5	32	29	27	23	24	27	21
6 to 8	32	30	30	25	24	24	17
9 to 11	31	27	25	27	24	24	19
12 to 14	33	26	26	23	24	27	14
15 to 17	17	13	12	13	12	14	16
African-American	36	34	32	30	30	31	26
Hispanic	25	26	27	18	24	31	15
Other	29	19	20	19	20	17	21
White	17	15	17	17	16	17	19