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The Well-Being of Illinois Children in Substantiated Investigations:
Baseline Results from the Illinois Survey of Child and Adolescent Well-Being

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Executive Summary

Considerable research shows that abuse and neglect can cause substantial harm to children's well-being and development, both immediately and as they mature. In addition to the effects of abuse and neglect, maltreated children tend to come from unstable, high risk environments and their caregivers are often affected by poverty, unemployment, domestic violence, mental health, substance abuse, and other problems. Children involved with child welfare services are at elevated risk of chronic health problems, emotional and behavioral difficulties, and learning and educational deficits even when compared to other children with a similar social and economic background.

The Illinois Study of Child and Adolescent Well-Being (ISCAW)

Unlike the outcomes of safety and permanence, information on child and family well-being is not readily available in most child welfare administrative data systems. Realizing the need for rigorous information about the well-being of children involved with the child welfare system, the federal government made a major investment in the National Survey of Child and Adolescent Well-Being (NSCAW), a nationally representative longitudinal study of children who come into contact with the child welfare system. NSCAW was the first national study that examined child and family well-being outcomes in detail and sought to relate those outcomes to experiences with the child welfare system and to family characteristics, community environment, and other factors.

NSCAW represented a major advancement in the available information on well-being, but the complex sampling design employed in the data collection prevented state-level data analysis. In an effort to capitalize on the ongoing NSCAW data collection, the State of Illinois Department of Children and Family Services (DCFS, the Department) partnered with the University of Illinois Children and Family Research Center (CFRC) and the Research Triangle Institute (RTI) to conceptualize and implement the Illinois Study of Child and Adolescent Well-Being (ISCAW). ISCAW is a statewide probability study that builds on the data collection of the second cohort of the National Survey of Child and Adolescent Well-Being (NSCAW 2); it includes 818 cases randomly sampled to be representative of the entire population of Illinois children involved in substantiated investigations. ISCAW measures multiple domains of well-being of children who are placed in substitute care and those who remain at home following

substantiation, with or without continuing DCFS services. ISCAW includes interviews with caseworkers, caregivers, teachers, and children themselves. Because of ISCAW random sampling procedures, the sample percentages are good estimates of the percentages in the entire population of children in substantiated investigations in Illinois.

Based on analysis of ISCAW data, this report provides a comprehensive look at the well-being of children involved with the Illinois Department of Children and Family Services. The report utilizes data from the baseline data collection of ISCAW, which occurred approximately 4-5 months following the target child's investigation. The chapters describe children's well-being outcomes related to cognitive and language development (Chapter 2); education (Chapter 3); physical health (Chapter 4); and social, emotional, and behavioral functioning (Chapter 5). A final chapter describes the family and environmental risk factors present in the lives of Illinois children involved in substantiated maltreatment investigations (Chapter 6). The purpose of this report is to provide a rich description of the well-being of Illinois children in substantiated investigations at a time shortly after their investigation. Comparisons are shown, when possible, between maltreated children in Illinois and their non-maltreated peers (normative sample) to highlight the areas in which these children may need more intensive intervention to achieve healthy levels of functioning and development. In addition, the shared methodologies of ISCAW and NSCAW 2 allow comparisons between maltreated children in Illinois and those in the nation; these comparisons to the national sample are also described when appropriate.

Detailed results are provided in the chapters and the appendix tables. For each well-being outcome, the following comparisons are made: child setting (traditional foster care, kinship foster care, remaining at home with services, remaining at home without services); region (Cook, Northern, Central, Southern); population density (rural, non-rural); sex (male, female); race-ethnicity (African-American, White, Hispanic, Other); and child age (under 3, 3-5, 6-8, 9-11, 12-17). Readers are encouraged to refer to the appendix tables for more information about the measures used, the children included in each analysis, and significant differences among groups. The remainder of this executive summary highlights significant findings.

Characteristics of the ISCAW sample

- Four to five months after the close of their substantiated investigations, 82% of the children in the sample were living at home: 36% of families were receiving ongoing services from the Department (intact family cases) and 46% did not have an open case following the investigation. Of the 18% of children living in substitute care, 13% were living with kinship foster parents and 5% with traditional (i.e., non-kin) foster parents.
- 28% of the children were living in Cook Region, 29% in the Northern Region, 31% in the Central Region, and 12% in the Southern region.
- 35% of the children were living in a rural area of Illinois, defined as an area with an average of less than 110 people per square mile.
- Girls and boys were about evenly represented (51% and 49%, respectively).
- 42% of the children in the sample were African-American, 34% were White, 20% were Hispanic, and 4% were of an "other" racial category.
- The largest age group in the sample was children under three years (32%), followed by children 3 to 5 years (25%), 6 to 8 years (15%), 9 to 11 years (14%), and 12 to 17 years (14%).
- Neglect was the most frequently occurring type of substantiated maltreatment (26%).

Summary of Major Findings on Child Development

Development in young children:

- 64% of infants and toddlers (ages 0 to 2 years) involved in substantiated investigations scored as high risk for *developmental delay* on a neurodevelopmental screening tool.
- Most young children (ages 0 to 4 years) scored within the normal range on a measure of *cognitive development* (Illinois mean = 91.7; normative mean = 100, SD = 15).
- However, 17% of Illinois children involved in substantiated investigations had "very low" *cognitive development* scores (defined as two or more standard deviations below the normative mean), indicating significant delays in cognitive development. This percentage was similar to the 18.7% of children with very low scores in the national sample of maltreated children.

- Young children (ages 0 to 6 years) in substantiated investigations in Illinois scored slightly below the normal range on a measure of preschool *language development* (Illinois mean = 84; normative mean = 100, SD = 15).
- 28% of these children had "very low" scores on *language development*, which is higher than the 18.7% of maltreated children in the national sample with very low scores.
- A broad measure of *developmental need*, similar to that used in the Individuals with Disabilities Education Improvement Act of 2004 (IDEA, 2004), was created that combined caregiver reports of medical or mental conditions associated with a high probability of developmental delay plus very low scores on measures of cognitive, language, and adaptive functioning. Based on this measure, 31% of Illinois children in substantiated investigations showed evidenced of *developmental need*.

Development of School-Aged Children

- Children four and older scored within the normal range on a measure of *cognitive development* (Illinois mean = 93; normative mean = 100, SD = 15). Subscales measuring verbal and non-verbal intelligence both fell within the normal range as well (91.6 and 95.9, respectively).
- 70% of the children in the sample were reported by their caregivers to have adequate to high *adaptive living skills*, 18% had moderately low adaptive living skills, and 12% had very low adaptive living skills (more than two standard deviations below the normative mean). The percentage in Illinois with very low adaptive living skills was similar to that in the national comparison sample of maltreated children (11.1%).

Developmental Testing and Services

- According to caregivers, 28% of children had been tested for developmental problems. Traditional foster parents were more likely to report that their foster child had been tested (43%) than kinship foster parents (27%), or biological parents of children living at home following an investigation (27-28%).
- According to caregivers, 5% of children (ages 0 to 3) had an Individual Family Service Plan (IFSP). Traditional foster parents were significantly more likely to report that their children had an IFSP (17%) than kinship foster parents (7%), biological

parents of children in substantiated investigations that were receiving intact family services (6%) or biological parents who were not receiving intact family services (2%).

- According to caregivers, 30% of children (ages 5 to 17) had an Individualized Education Plan (IEP). Traditional foster parents were significantly more likely to report that their children had an IEP (62%) than kinship foster parents (37%), biological parents of children in substantiated investigations that were receiving intact family services (25%) or biological parents who were not receiving intact family services (30%).

Summary of Major Findings on Education

- Overall, 74% of children (ages 0 to 5) in substantiated maltreatment investigations were enrolled in early childhood care and education programs or kindergarten.
- Enrollment in early childhood education varied by child age: 5 year olds were more likely to be enrolled (94%) than 4 year olds (74%) or 3 year olds (58%).
- According to teachers, about half of the children were below *grade level proficiency* in each academic domain: 46% in math, 43% in science, and 56% in language. Some were performing at grade level: 37% in math, 43% in science, and 23% in language; and some above grade level in math (18%), science (13%) and language (21%).
- According to caregivers, about 13% of the sample had *repeated a grade* at some point in their educational careers, significantly lower than the 26% in the national sample.
- Children in Illinois scored within the normal range on tests of *academic achievement*: 97.8 on Letter-Word Identification subscale, 92.9 on Passage Comprehension, and 92.5 on Applied Problems.

Summary of Major Findings on Child Health

- 95% of caregivers reported that their child was in good, very good, or excellent *overall health*.
- According to caregivers, 40% of children in substantiated investigation have a *special health care need* (SHCN), defined as an ongoing or long-term need for remediation of a chronic or repeated health condition. Boys were more likely (48%) to have a SHCN than girls (31%), and older children were more likely to have a SHCN than younger children: < 3 years (30%), 3-5 years (34%), 6-8 years (57%), 9-11 years (45%), and 12-17 years (46%).
- 6% of children were *underweight* (below the 5th percentile on the Body Mass Index chart).
- 21% of children were *obese* (above the 95th percentile on the Body Mass Index chart). This is higher than children in the general population (17%) but lower than maltreated children nationally (29%).

Health Services:

- According to caregivers, 99% of children in substantiated investigations in Illinois had health insurance, which is higher than the 90% of children in the national study.
- According to caregivers, 88% of children in substantiated investigations in Illinois had received a well-child visit in the past year, similar to the percentage in the national study. Young children were more likely to have received a well-child visit than older children.
- 98% of children in substantiated investigations in Illinois have a medical home, which is slightly higher than the percentage in the national study.
- 98% of children in substantiated investigations in Illinois are up-to-date on their immunizations, which is not significantly different from the percentage in the national study.
- 70% of children in substantiated investigations in Illinois had received a dental check-up in the past year; 77% had ever received one. These percentages were not significantly different than those in the national study.

- 35% of children in substantiated investigations in Illinois had visited an emergency room in the past year. This was not significantly different from the percentage in the national comparison of substantiated investigations, but is substantially higher than the rate among children in general.

Summary of Major Findings on Social, Emotional, and Behavioral Well-Being

- Over a third of the children in substantiated investigations (37%) scored in the clinical or borderline clinical range on at least one version of a standardized checklist of *emotional and behavioral problems*.
- Caregiver-reported emotional and behavior problems were much higher for children in traditional foster care (61%) compared to children in kinship foster care (26%) and children in intact family cases (25%).
- On a self-report measure of *depressive symptoms*, 9% of children in substantiated investigations in Illinois had scores in the clinically significant range, which is similar to children in the national maltreatment sample (11%) and the general child population (7%).
- On a self-report measure of *trauma symptoms*, 8% of children in substantiated investigations in Illinois had scores in the clinically significant range, which is similar to children in the national maltreatment sample (11.6%) and the general child population.
- Younger children (11% in children 7 to 8 years and 14% in children 9 to 11 years) were significantly more likely to report trauma symptoms in the clinical range than older children (2% in children 12 to 17).
- Significantly fewer children in substitute care reported clinically significant trauma symptoms (3%) compared to children who remained at home following their substantiated investigation (7-9%).
- Caregivers reported that 70% of children had average to above average *social skills*, similar to the 66% reported in the national sample of maltreated children.
- 53% of the youth age 11 and older reported committing a *delinquent act* in the past six months. This included minor acts like being unruly in public or at school,

skipping school, and shoplifting, as well as serious acts such as concealing a weapon and stealing.

- 8% of the youth reported that they had been *arrested* in the previous six months.
- Youth 11 to 17 years were asked about their *substance use*; 41% had used alcohol, 15% had used marijuana, and 21% had used "hard drugs" which included cocaine, heroin, methamphetamines, and ecstasy.
- On a screening test for *substance abuse*, 15% of the youth had a score indicating a substance use disorder, which was not significantly different than the national comparison sample (19%).
- Of the youth age 11 to 17, 16% of the females report having *consensual sex* and 4% report having *forced sex*; 24% of the males report having consensual sex and 8% report having forced sex.

Mental Health Services

- 15% of the *children in substitute care* had received a specialty outpatient mental health service (i.e., one from a mental health professional) since being placed into substitute care (interview occurred 4-5 months following the investigation). This percentage was significant smaller than that in the national comparison sample (25%).
- This percentage increased to 40% when outpatient mental health services were examined among children with clinically significant emotional or behavioral problems (as measured by the CBCL). This percentage was also much smaller than that in the national comparison sample (55%).
- 13% of the *children in intact family cases* had received a specialty outpatient mental health service (i.e., one from a mental health professional) since their investigation. This was not significantly different than that in the national comparison sample (18%).
- This percentage increased to 20% when outpatient mental health services were examined among children in intact family cases with clinically significant emotional or behavioral problems (as measured by the CBCL). This percentage was about half of that in the national comparison sample (39%).

- 10% of the *children whose cases were closed following investigation* had received a specialty outpatient mental health service since their investigation. This was significantly lower than that in the national comparison sample (16%).
- Child age was strongly associated with the receipt of specialty outpatient mental health services; school age children were much more likely to receive services than those five years or younger.
- The most frequently received *specialty* outpatient mental health service (in all groups of children) was treatment by a mental health professional in private practice (e.g., psychologist, social worker).
- Among all types of mental health services, the most commonly received were from non-mental health specialists such as guidance counselors or school social workers.
- Inpatient mental health service receipt was very rare in the Illinois sample (less than 3% for all groups).
- Overall, 8% of the children in the sample were currently taking psychotropic medication to address an emotional or behavioral problem, which is not significantly different than the percentage in the national comparison sample (12%). Children 9 years and older were much more likely to be taking psychotropic mediation than those 5 years and younger.

Summary of Major Findings on Risk in Children's Environments

- Caseworkers reported an average of two "caregiver risk factors" for parents of children involved in substantiated investigations, such as alcohol abuse, substance abuse, domestic violence, mental health problems, history of arrest or jail, intellectual impairment, and high stress related to poverty and unemployment.
- Parents of children in substitute care were significantly more likely to have several problems (3 or more) than parents of children that remained at home following the investigation.
- *Domestic violence* was the most frequently caseworker-reported caregiver risk factor among the families involved in substantiated investigations in Illinois; it was reported by caseworkers in 28% of all families.

- A majority of parents of children in substantiated investigations (58%) reported living at or below the federal *poverty* line.
- Parents of children who remained at home following the investigation were much more likely to live in poverty (64%) than either kinship foster parents (32%) or traditional foster parents (23%).
- Traditional foster parents also reported much lower levels of other risk factors (*mental health or physical health issues*, *low social support*) compared to both kinship foster parents and biological parents of children in substantiated investigations.
- Kinship foster parents reported below average social support (25%) and poor physical health (18%) at levels similar to biological parents of children in substantiated investigations (25% and 17%, respectively).
- 66% of children in substantiated investigations reported *witnessing* one or more acts of *severe violence* in the past year.
- 6% of children in substantiated investigations reported *experiencing* one or more acts of *severe violence* in the past year.
- Children living in substitute care were much more likely to report *experiencing severe violence* in the past year (34%) than children living at home following a substantiated investigation (2-4%).

Chapter 1: Introduction

This report provides a comprehensive look at the well-being of children involved in substantiated maltreatment investigations with the Illinois Department of Children and Family Services (DCFS, the Department). It reports results from analysis of the Illinois Survey of Child and Adolescent Well-Being (ISCAW), a statewide probability study of this population that examines child well-being and development in multiple life domains and the services children receive subsequent to a substantiated investigation. The report utilizes data from the baseline data collection of the ISCAW, which occurred 4-5 months after the close of the children's maltreatment investigations.

Research showing substantial harm resulting from abuse and neglect lends weight to the importance of evaluating the well-being of child maltreatment victims. The damage from maltreatment not only affects children immediately but also has an enduring impact over time, and its effect can grow when it leads to deficits that hinder children as they mature. The evidence for damage is even clearer in recent years with research that shows specific effects of child maltreatment on brain development.[1] Abused and neglected children often have a disrupted capacity to attach to others, making forming and maintaining relationships with caregivers difficult.[2] In addition to the effects of abuse and neglect, maltreated children tend to come from unstable, high-risk environments, and their caregivers are often affected by poverty, unemployment, domestic violence, mental health, substance abuse, and other social problems.[3] As a result of the threats to their well-being, children involved with child welfare services are at elevated risk of chronic health problems, emotional and behavioral difficulties, and learning and

[1] Twardosz, S., & Lutzker, J.R. (2010). Child maltreatment and the developing brain: review of neuroscience perspectives. *Aggression and Violent Behavior*, *15*, 59–68.

[2] Aber, J.L., & Allen, J.P. (1987). The effects of maltreatment on young children's socioemotional development: An attachment theory perspective. *Developmental Psychology*, *23*, 406–414.

[3] Edleson, J.L. (1999). The overlap between child maltreatment and woman battering. *Violence Against Women*, *5*, 134–154. Merritt, D. (2009). Child abuse potential: Correlates with child maltreatment rates and structural measures of neighborhoods. *Children and Youth Services Review, 31*, 927-934. Walsh, C., MacMillan, H.E., & Jamieson, E. (2003). The relationship between parental substance abuse and child maltreatment: Findings from the Ontario Health Study. *Child Abuse & Neglect, 27*, 1409-1425. Debellis, M.D., Broussard, E.R., Herring, D.J., Wexler, S., Moritz, G., & Benitez, J.G. (2001). Psychiatric co-morbidity in caregivers and children involved in maltreatment: A pilot research study with policy implications. *Child Abuse & Neglect, 25,* 923-944.

educational deficits, even when compared to other children with a similar social and economic background.[4]

The Illinois Survey of Child and Adolescent Well-Being

ISCAW is a component of the second cohort of the National Survey of Child and Adolescent Well-Being (NSCAW 2), a longitudinal probability study of well-being and service delivery for children who become involved with child welfare services. Data collection for ISCAW was carried out by the research firm RTI International as part of the NSCAW 2 field operation. ISCAW includes 818 cases sampled to be representative of the entire population of Illinois children involved in substantiated maltreatment reports. To provide accurate statewide estimates, the study used two-stage random sampling: DCFS field offices within the state were randomly sampled and then children were randomly sampled within these geographic units. ISCAW is the most extensive data collection effort conducted to date on the well-being of maltreated children in Illinois. It measures multiple domains of well-being of children who are placed in substitute care as well as children who remain at home following a substantiated investigation, with or without continuing DCFS services.

ISCAW includes interviews with caseworkers, caregivers, teachers, and child victims. The caregiver interviews provide information about caregivers' perceptions of children's well-being and development; about caregivers' problems, resources, and opinions about child welfare; about the characteristics of family, home, and neighborhood; and about services children have received. Several standardized measures of child well-being and functioning are embedded within the caregiver interview. The child interview includes age-dependent questions about their well-being and standardized measures of development and functioning. Caregiver and child interviews are completed using an audio computer-assisted self-interview (ACASI) technique that enhances families' privacy while also increasing consistency in the interview method.[5] Caseworkers complete measures about the investigation and the child welfare response and provide their perceptions of the child and family's problems and resources. Teachers complete measures of children's academic progress and behavior in school.

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[4] Gilbert, R., Widom, C.S., Browne, K., Fergusson, D., Webb, E., & Jannson, S. (2009). Burden and consequences of child maltreatment in high income countries. *Lancet*, *373,* 68 -81.

[5] NSCAW Research Group. (2002). Methodological lessons from the National Survey of Child and Adolescent Well-Being: The first three years of the USA's first national probability study of children and families investigated for abuse and neglect. *Children and Youth Services Review, 24*, 513-541.

Because of the random sampling procedures utilized in ISCAW, the percentages reported in the following chapters and appendices can be viewed as good estimates of the percentages in the entire population of children in substantiated investigations in Illinois. The standard errors (SE) indicate how much the estimates could vary due to the element of chance involved in sampling. The mathematics of sampling tells us that there is a 95% probability that the true percentage lies within two standard errors of the percentages reported here.

ISCAW represents a significant departure in several ways from previous studies of child well-being conducted by the Children and Family Research Center, such as the Illinois Child Well-Being (ILCWB) Study.[6] The ILCWB studied children in out-of-home care, while ISCAW studies all children involved in a substantiated report, a large majority of whom remained in their home following the investigation. Because the baseline ISCAW interview took place 4-5 months following the investigation, a portion of the cases included in the sample were closed following investigation and no longer continued to be involved with the Department. However, those children who remain at home following an investigation represent a high risk group, with the possibility of future DCFS investigation and removal. Information about children that remain home following substantiated maltreatment will be a valuable tool in DCFS' efforts to develop and improve services at the "front end" of DCFS involvement – efforts meant to protect children and prevent placement in substitute care.

It is also important to note that prior child well-being studies in Illinois were point-in-time (or cross-sectional) studies, whereas ISCAW is a longitudinal cohort study. ILCWB sampled from the population of children in substitute care who had been in a placement at least three months, regardless of their length of time in care. In Round 2 of ILCWB, for example, half the sample had been in care more than three years. A point-in-time study like ILCWB has the advantage of profiling all children in substitute care in a given year, but it biases estimates of outcomes because children who have been in substitute care longer are overrepresented.[7] In contrast, ISCAW samples a cohort of children involved in substantiated investigations, all of whom begin contact with DCFS at about the same time. ISCAW is representative of all Illinois children who are involved in substantiated investigations and its subsample of children in

[6] Hartnett, M.A., Bruhn, C., Helton, J., Fuller, T., & Steiner, L. (2009). *Illinois child well-being study: Year two final report*. Urbana, IL: Children and Family Research Center.
[7] Wulczyn, F. (1996). A statistical and methodological framework for analyzing the foster care experiences of children. *Social Service Review, 70*, 318-329.

substitute care at baseline is representative of all children who enter substitute care during or shortly after a substantiated investigation.

Table 1 in the Appendix presents data on characteristics of the children in the baseline ISCAW sample. Eighty-two percent of the children were living at home and were not removed following their substantiated investigation. Of the children that were removed from home and placed into substitute care, 5% were in traditional foster care and 13% were in kinship foster care. No children in the ISCAW sample were living in residential treatment facilities or group homes at the time of the baseline data collection. The percentages of the sample from Cook County, the Northern Region and the Central Region were about the same (28% to 31%), with a smaller percentage in the Southern region (12%). The sample was about two-thirds non-rural and one-third rural, defined as living in an area with an average of less than 110 people per square mile. Girls and boys were about evenly represented. African-American children were a plurality (42%), but there were substantial percentages of White children (34%) and Hispanic children (20%). A majority of children (57%) were 5 years or younger, while 15% were ages 6 to 8, 14% were ages 9 to 11, and 14% were ages 12 to 17. Neglect was the most commonly identified type of substantiated maltreatment (26%), with percentages of other types of maltreatment such as exposure to domestic violence, physical abuse, sexual abuse, and exposure to drugs ranging from 10% to 18%.

Data Analysis in the Report

The chapters that follow present findings related to different domains of well-being. In each chapter, we first present statewide estimates of the percentage of children with a particular outcome or the average score on a continuous measure of well-being. National norms exist for many of the outcome variables, allowing us to compare the well-being of Illinois children in substantiated investigations to the well-being of children in the general population. We know, however, that well-being outcomes for maltreated children often suffer when compared to children in the general population. Part of the original inspiration for the Illinois Study of Child and Adolescent Well-Being came from the desire to be able to compare the well-being of Illinois children involved with the child welfare system to a similar group of maltreated children at the national level using the same outcomes measured with the same instruments. Therefore, the current report also presents comparisons between Illinois children in substantiated investigations (ISCAW) and maltreated children included in the national study of which ISCAW is a part

(NSCAW 2). Percentages for the national sample were pulled directly from the NSCAW 2 baseline child well-being report.[8] Thus, NSCAW 2 results include data from Illinois children, since they were a part of the national study. In addition, the ISCAW and NSCAW 2 samples differed in an important way: ISCAW includes only children in substantiated investigations of maltreatment whereas most other states in NSCAW 2 include both substantiated and unsubstantiated cases of maltreatment.[9] Although the national sample of maltreated children in NSCAW 2 is not completely analogous to that in ISCAW, it does provide a more closely matched comparison group than children in the general population.

Additional analyses were conducted to explore how different groups of children in substantiated investigations compared on well-being variables. One comparison was among children in different "placement" settings at the time of the data collection: a) children in DCFS custody living in traditional (i.e., non-kinship) foster care; b) children in DCFS custody living in kinship foster care; c) children who remained in their home following the investigation with an open service case (known as intact family cases in Illinois); and d) children who remained in their home who received no post-investigation services from DCFS (i.e., closed cases). For some comparisons, sample sizes were not sufficient to compare all four groups, and in these instances certain groups were collapsed or omitted to permit an adequate statistical analysis. For instance, children who remained at home (including both those receiving and not receiving services) may be compared to children in out-of-home care (including both traditional and kinship care).

Other analyses compared results for the Cook, Northern, Central and Southern regions, and for rural areas (defined as area with an average of less than 110 people per square mile) and non-rural areas of Illinois. Additional comparisons were made using child characteristics: sex, race-ethnicity, and age. Results from all these comparisons are presented in tables in the Appendix, and statistically significant differences from these comparisons are reported in the chapters that follow.

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[8] Casanueva, C., Ringeisen, H., Wilson, E., Smith, K., & Dolan, M. (2011). *NSCAW II baseline report: Child well-being.* OPRE Report #2011-27b. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Available from http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/reports/nscaw2_child/nscaw2_childpdf

[9] The Illinois Department of Children and Family Services would not allow children in unsubstantiated investigations to be included in either NSCAW 2 or ISCAW.

Organization of the Report

The succeeding chapters present results related to different domains of child well-being. Chapter 2 examines child development, including cognitive, language, and social-emotional development in infants and young children as well as school-aged children. This chapter also examines the developmental testing and services that these children receive to identify and remediate developmental delays. Chapter 3 addresses children's educational and academic achievement. Chapter 4 looks at children's health and health care. Chapter 5 examines children's social, emotional, and behavioral well-being, as well as their receipt of mental health services. Chapter 6 focuses on family and neighborhood risks to children's well-being. The Appendix includes tables showing the results for most well-being and service measures broken down by child setting (traditional foster care, kinship care, child remaining in the home with DCFS services, child remaining in the home without DCFS services), region, population density (rural vs. non-rural), child sex, child race-ethnicity and child age.

Chapter 2: Child Development

The opportunity to grow and develop in step with one's peers unperturbed by harm from the environment is central to children's well-being. The relevance of this for child welfare has become clearer with research that details the many ways in which child maltreatment can sidetrack children's cognitive, social, and emotional development at every age from infancy to adolescence.[10] ISCAW includes a number of measures of cognitive, intellectual, language, and social-emotional development. This chapter examines the developmental status of children involved with the Illinois child welfare system as well as rates of developmental testing and services received at the time of the baseline data collection, approximately 4-5 months following the conclusion of the investigation.

Developmental Status of Young Children

The Bayley Infant Neurodevelopmental Screener (BINS) is a screening tool designed to detect potential developmental delays or neurological impairments in children ages 3 to 24 months old, and is intended to identify children needing additional diagnostic testing. Overall, 64% of children in the ISCAW sample scored in a range that indicates high risk on the BINS (Appendix Table 2). This rate is substantially higher than the percentage of children who score in the high risk range in the general population (14%), and is somewhat higher than the percentage reported in the national (NSCAW 2) baseline sample (50.8%).[11] There were no significant differences in developmental risk by child race, sex, region, population density, or placement setting.

The Battelle Developmental Inventory (BDI) is a measure of a range of cognitive skills such as attention, memory, and perception for use with children age zero to four years old.[12] The mean BDI score for Illinois children in substantiated investigations was 91.7, which is within the "normal" range, defined as one standard deviation (15) above or below the normative mean of 100 (Appendix Table 3). However, the percentage of Illinois children with "very low" BDI

[10] Bolger, K.E., Patterson, C.J., & Kupersmidt, J.B. (1998). Peer relationships and self-esteem among children who have been maltreated. *Child Development, 69,* 1171-1197. Culp, R.E., Watkins, R.V., Lawrence, H., Letts, D., Kelly, D.J., & Rice, M.L. (1991). Maltreated children's language and speech development: Abused, neglected, and abused and neglected. *First Language, 11,* 377-389. Mackner, L.M., Starr, R.H. Jr., & Black, M.M. (1997). The cumulative effect of neglect and failure to thrive on cognitive functioning. *Child Abuse & Neglect*, *21*, 691-700.
[11] Casanueva, C., Ringeisen, H., Wilson, E., Smith, K., & Dolan, M. (2011). *NSCAW II baseline report: Child well-being.* OPRE Report #2011-27b. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.
[12] Newborg, J. (2005). *Battelle Developmental Inventory—Second Edition*. Itasca, IL: Riverside.

scores (defined as scores two or more standard deviations below the normative mean) was 17%, which was very similar to the percentage with very low scores in the NSCAW 2 sample (18.7%). Although small numbers prevent exact estimation, there was a significant difference in the percentage of children with very low BDI scores by child setting, with the highest percentages among children in traditional foster care (27%) and children remaining at home without services (29%), compared to children in kinship foster care (3%) and children remaining at home with services (11%). There were no significant differences in children with very low scores by child age, race, sex, region, or population density.

The Preschool Language Scale-3 (PLS-3) is a measure of the development of children's ability to comprehend language and to express themselves using language.[13] In the ISCAW sample, the average PLS-3 Total score was 84, which is slightly more than one standard deviation below the normative mean (100 is the normative mean, with a standard deviation of 15; Appendix Table 4). Mean PLS-3 Total score in the national sample of maltreated children (NSCAW 2) was very similar (86.3). However, 28% of children in the sample had "very low" scores on the PLS-3 Total (two or more standard deviations below the mean), which is larger than the percentage in the national maltreatment sample (18.7%), and more than 13 times higher than that of the general population. There were no differences in language development in any of the subgroup analyses.

In addition to looking at individual domains of development in young children, we utilized a method developed in the larger NSCAW study that looked across domains to see what proportion of young children age zero to four years showed evidence of "developmental need" in one or more developmental area. The definition of developmental need created in the NSCAW was based on that used in Part C of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA 2004), which defined developmental need among young children as "(i) experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in 1 or more of the areas of cognitive development, physical development, communication development, social or emotional development, and adaptive development; or (ii) a diagnosed physical or mental condition which has a high probability of resulting in a

[13] Zimmerman, I. L., Steiner, V. G., & Pond, R. E. (1992). *PLS-3: Preschool Language Scale-3.* San Antonio, TX: The Psychological Corporation.

developmental delay."[14] Based on this definition and using assessments available in NSCAW 2, the authors created a measure of developmental need among young children defined by the caregivers' reports of diagnosed mental or medical conditions that have a high probability of resulting in developmental delay (e.g., Down syndrome) and/or being two standard deviations below the mean in at least one developmental area or 1.5 standard deviations below the mean in two areas. Areas included cognitive development based on the BDI or K-BIT, language development based on the PLS-3, and adaptive development based on the Vineland Daily Living Skills.[15] In Illinois, 31% of the children zero to four years showed evidence of developmental need as defined in this way. This is similar to the 32.2% of young children (ages 0 to 5) with developmental need in the national maltreatment study (NSCAW 2).

Developmental Status of School-Age Children

Other ISCAW child development measures are relevant for school-age children. Cognitive development was measured with the Kaufman Brief Intelligence Test (K-BIT), which consists of a Vocabulary subtest that assesses children's expressive vocabulary and word definitions (verbal intelligence) and a Matrices subtest that measures children's ability to understand conceptual relationships and analogies (non-verbal intelligence), as well as a Composite score that combines the two.[16] The mean K-BIT Composite score for children in substantiated investigation in Illinois was 93, which is within the normal range of 100 plus or minus 15, and slightly better than that of the national sample of maltreated children (Appendix Table 5). Mean scores of Illinois children in substantiated investigation on the Vocabulary and Matrices subtests were also within the normal range (91.6 and 95.9, respectively). Seven percent of Illinois children in substantiated investigations had extremely low scores (more than two standard deviations below the mean) on the K-BIT Composite scale, which is three times the rate in the general child population, but less than the 13.2% in the national study of maltreated

[14] Shackelford, J. (2006). *State and jurisdictional eligibility definitions for infants and toddlers with disabilities under IDEA (NECTAC Notes No. 21).* Chapel Hill, NC: The University of North Carolina, FPG Child Development Institute, National Early Childhood Technical Assistance Center.
[15] Ringeisen, H., Casanueva, C., Smith, K., & Dolan, M. (2011). *NSCAW II baseline report: Children's services.* OPRE Report #2011-27f. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. According to Casanueva's personal communication (2/11/12), the BINS was omitted from calculation of the developmental need variables because it is a screening measure that did not have a normative standard deviation.
[16] Kaufman, A., & Kaufman, N. (1990). *Kaufman Brief Intelligence Test (K-BIT)*. Circle Pines, MN: American Guidance Service.

children. There were no differences in this measure by child age, race, sex, region, placement setting, or population density.

The Vineland Adaptive Living Skills scale measures skills that children ages one to ten need in everyday life, such as dressing themselves, performing household tasks and using a telephone (Appendix Table 6). Scored in reference to the skills that are expected at different ages, the Vineland is a fairly sensitive measure of developmental delay. About 70% of children in the Illinois study had adequate to high daily living skills, which is slightly smaller than the general population, and 12% had very low daily living skills (two or more standard deviations below the mean), which is six times higher than the general child population, but similar to the national sample of maltreated children (11.1%). Boys were significantly more likely (17%) to have very low daily living skills than girl (7%), and very young children 0-2 years were less likely to have very low adaptive living skills than all other age groups.

We also employed a conservative method to measure developmental need for children age five and older based on whether children showed evidence of developmental problems on either the K-BIT or the Vineland.[17] Because our methodology used very low scores as a cut-off, only children with serious impairment were identified. Using this methodology, 19% of the sample of children and youth age five and older showed evidence of developmental need.

Developmental Testing and Services

Children need to have developmental problems identified in order to receive appropriate services to lessen their effects and facilitate learning.[18] Several ISCAW variables from the caregiver interview capture identification, assessment, and service delivery for children's developmental problems.[19]

Developmental testing. One important question concerns the extent to which children in the ISCAW sample population are tested for developmental problems. Caregivers were asked if

[17] In this report, developmental need for children five and older was based on children scoring 2 standard deviations below the mean on the Kaufman Brief Intelligence Test and/or having low daily living skills on the Vineland Adaptive Behavior Scale.

[18] National Research Council. (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: The National Academies Press.

[19] One limitation of ISCAW's measurement of developmental testing and services is that the information on service delivery comes from caregivers, and caregivers (especially foster parents) may not have a clear idea of whether and how their children are being assessed, or if service provision occurs. Thus, the percentages provided here may be underestimates.

the child had ever been tested for learning problems, special needs, or developmental disabilities by an education or health professional. Overall, caregivers reported 28% of children had been tested (Appendix Table 7). Traditional foster parents were significantly more likely to report that the child had been tested (43%) than kinship foster parents (27%), or biological parents of children living at home following the investigation (27-28%). Caregivers reported that boys were significantly more likely to be tested than girls; and White children were more likely to be tested than either African-American or Hispanic children. There was no significant difference between Illinois and the national samples on the percentages of children tested for developmental problems.

Developmental services. Caregivers were asked whether their child had either an Individualized Family Service Plan (IFSP) or an Individualized Education Plan (IEP), depending on the child's age (Appendix Table 8). For children zero to three with a developmental delay, an IFSP is a written plan that outlines the specific early intervention services the child needs and how they will be delivered. Caregivers in the ISCAW sample reported that 5% of children age zero to three in substantiated investigations in Illinois had an IFSP, which is the same as the percentage in the national comparison of substantiated investigations (5%). Traditional foster parents were significantly more likely to report that their children had an IFSP (17%) than kinship foster parents (7%), biological parents of children in substantiated investigations that were receiving intact family services (6%) or biological parents who were not receiving intact family services (2%). Also, caregivers in the Southern region were more likely to report that their child had an IFSP (11%) than those in other regions of the state (4-5%). Clearly, not all young children require an IFSP, only those with demonstrated developmental delay. The analysis was therefore repeated to include only those children who had a developmental need, which was defined in an earlier section. When the analysis was limited to these children, who probably should have an IFSP based on the results of the standardized tests of development, caregivers reported that 14% had IFSPs.

Caregivers of school-age children were asked whether their children received an Individualized Education Plan (IEP), which specifies the services that children with special needs receive to assist them in making educational progress. Altogether, caregivers reported that 30% of school-age children in the ISCAW sample had an IEP, which was not different from the national sample. Traditional foster parents were significantly more likely to report that their

children had an IEP (62%) than kinship foster parents (37%) or biological parents receiving intact family services (25%) or not receiving services (30%).

Another question asked caregivers whether their child was receiving services "such as physical therapy, occupational therapy, speech or language therapy, or orientation and mobility training, on a regular basis." Overall, Illinois caregivers reported that 12% of children received one or more of these services, identical to the 12% in the national comparison (Appendix Table 8). Children in traditional foster care were significantly more likely to receive such services (29%) than children in kinship care (7%), those at home with services (13%) or without services (11%). There were no differences in therapeutic services by child age, sex, race, or region.

Summary of Major Findings on Child Development

Development in young children:

- 64% of infants and toddlers (ages 0 to 2 years) involved in substantiated investigations scored as high risk for developmental delay on a neurodevelopmental screening tool.
- Most young children (ages 0 to 4 years) scored within the normal range on a measure of cognitive development (Illinois mean = 91.7; normative mean = 100, SD = 15).
- However, 17% of Illinois children involved in substantiated investigations had "very low" cognitive development scores (defined as two or more standard deviations below the normative mean), indicating significant delays in cognitive development. This percentage was similar to the 18.7% of children with very low scores in the national sample of maltreated children.
- Young children (ages 0 to 6 years) in substantiated investigations in Illinois scored slightly below the normal range on a measure of preschool language development (Illinois mean = 84; normative mean = 100, SD = 15).
- 28% of these children had "very low" scores on language development, which is higher than the 18.7% of maltreated children in the national sample with very low scores.
- A broad measure of developmental need, similar to that used in the Individuals with Disabilities Education Improvement Act of 2004 (IDEA, 2004), was created that combined caregiver reports of medical or mental conditions associated with a high

probability in developmental delay plus very low scores on measures of cognitive, language, and adaptive functioning. Based on this measure, 31% of Illinois children in substantiated investigations showed evidenced of developmental need.

Development of School-Aged Children

- Children four and older scored within the normal range on a measure of cognitive development (Illinois mean = 93; normative mean = 100, SD = 15). Subscales measuring verbal and non-verbal intelligence both fell within the normal range as well (91.6 and 95.9, respectively).
- 70% of the children in the sample were reported by their caregivers to have adequate to high adaptive living skills, 18% had moderately low adaptive living skills, and 12% had very low adaptive living skills (more than two standard deviations below the normative mean). The percentage in Illinois with very low adaptive living skills was similar to that in the national comparison sample (11.1%).

Developmental Testing and Services

- According to caregivers, 28% of children had been tested for developmental problems. Traditional foster parents were more likely to report that their foster child had been tested (43%) than kinship foster parents (27%), or biological parents of children living at home following an investigation (27-28%).
- According to caregivers, 5% of children (ages 0 to 3) had an Individual Family Service Plan (IFSP). Traditional foster parents were significantly more likely to report that their children had an IFSP (17%) than kinship foster parents (7%), biological parents of children in substantiated investigations that were receiving intact family services (6%) or biological parents who were not receiving intact family services (2%).
- According to caregivers, 30% of children (ages 5 to 17) had an Individualized Education Plan (IEP). Traditional foster parents were significantly more likely to report that their children had an IEP (62%) than kinship foster parents (37%), biological parents of children in substantiated investigations that were receiving intact family services (25%) or biological parents who were not receiving intact family services (30%).

Chapter 3: Education

Given the many challenges to their development and well-being, it is not surprising that children who have been maltreated often have learning problems and struggle with school achievement. Poor grades, repeating a grade, and involvement with special education services are more common for maltreated children than for other children.[20] Previous research on Illinois children in substitute care has shown that the majority function satisfactorily in school, but a disproportionate percentage has educational difficulties.[21] This chapter reports on the educational status of *all* Illinois children in substantiated investigations, not just those in substitute care.

Early Childhood Education

Education prior to entering elementary school has increasingly been considered an important part of children's educational experience, and considerable research shows improved educational outcomes for at-risk children who are enrolled in early childhood education programs.[22] Yet a recent study shows that most 3 to 5 year olds entering foster care in Illinois are not enrolled in early educational programs *prior to DCFS intervention*.[23] DCFS has a policy (Procedure 314.70) of providing early childhood education to all children in custody aged 3 to 5, and encouraging parents of children served in their home to enroll their children of that age as well.[24]

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[20] Jonson-Reid, M., Drake, B., Kim, J., Porterfield, S., & Han, L. (2004). A prospective analysis of the relationship between reported child maltreatment and special education eligibility among poor children. *Child Maltreatment, 9*, 382−394. Kendall-Tackett, K. A., & Eckenrode, J. (1996). The effects of neglect on academic achievement and disciplinary problems: A developmental perspective. *Child Abuse & Neglect*, *20*, 161−169.

[21] Shumow, L., & Baron-Jeffrey, A. (2008). Educational well-being. In N. Rolock & M. Testa (Eds.), *Conditions of children in or at risk of foster care in Illinois: 2010 Monitoring report of the B.H. Consent Decree*. Urbana, IL: Children and Family Research Center. Smithgall, C., Gladden, R., Howard, E., Goerge, R., & Courtney, M. (2004). *Educational experiences of children in out-of-home care.* Chicago: Chapin Hall Center for Children.

[22] Barnett, W.S. (January, 2006). *Benefits of preschool for all*. National Institute for Early Education Research. New Brunswick, NJ: Rutgers University. Available at *http://nieer.org/resources/files/Benefits.pdf* Campbell, F.A., Ramey, C.T., Pungello, E., Sparling, J., & Miller-Johnson, S. (2002). Early childhood education: Young adult outcomes from the Abecedarian project. *Applied Developmental Science,* 6, 42-57. Reynolds, A.J., Temple, J.A., Robertson, D.L., & Mann, E.A. (2002). *Age 21 cost-benefit analysis of the Title I Chicago Child-Parent Centers.* (Discussion Paper no. 1245-02). Madison, WI: Institute for Research on Poverty. Schweinhart, L.J., Barnes, H.V., Weikart, D., Barnett, W.S., & Epstein, A. (1993). *Significant benefits: The High/Scope Perry Preschool study through age 27. Monographs of the High/Scope Educational Research Foundation No. 10.* Ypsilanti, MI: High/Scope Educational Research Foundation.

[23] Smithgall, C., Jarpe-Ratner, E., Walker, L. (2010). *Looking back, moving forward: Using integrated assessments to examine the educational experiences of children entering foster care.* Chicago: Chapin Hall at the University of Chicago.

[24] See http://dcfswebresource.dcfs.illinois.gov/procedures/procedures_314/homepage.phtml?page=6#P591_80384

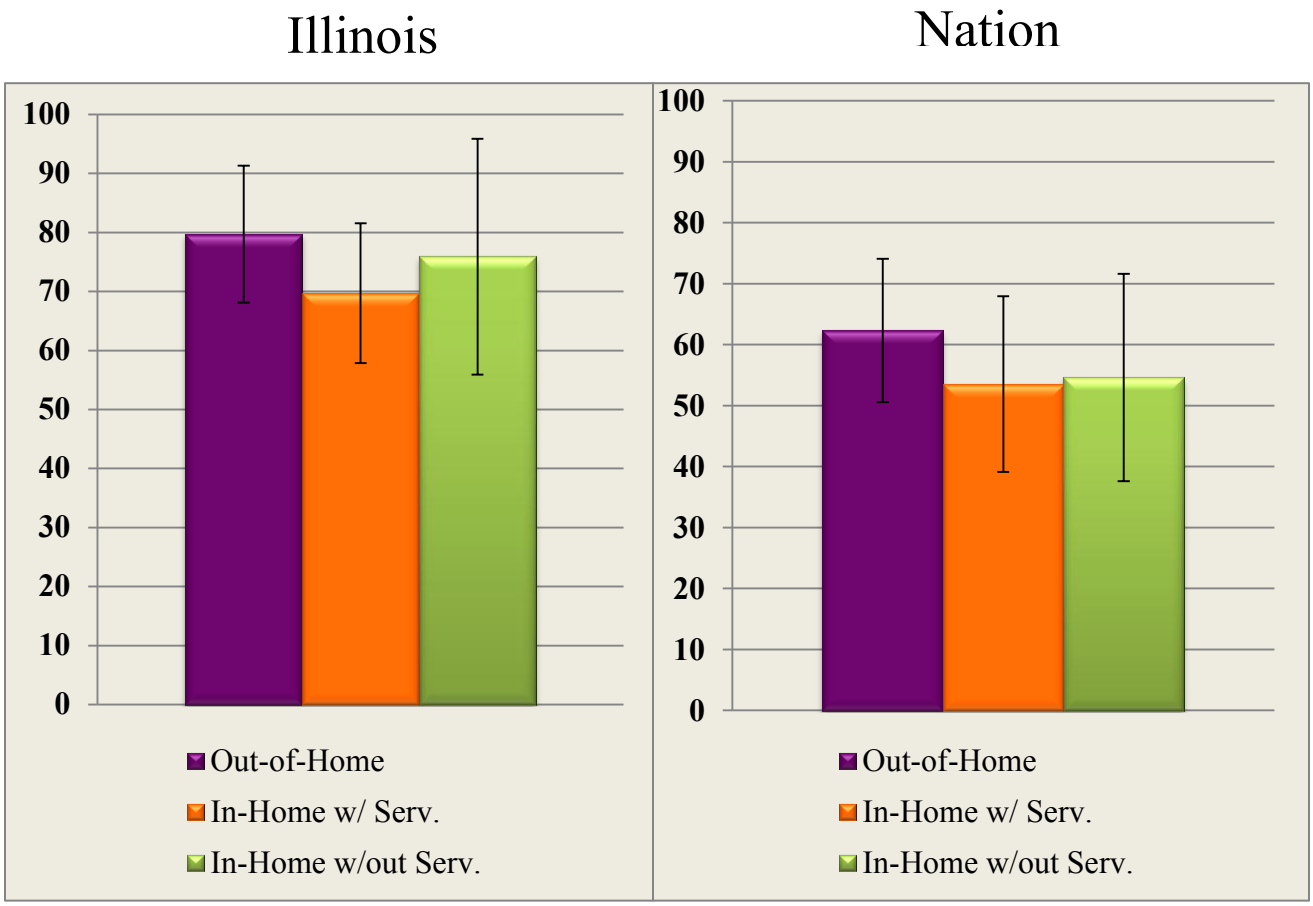
Caregivers in ISCAW reported information about children's enrollment in early childhood education and from their responses we calculated the percentage of children age 3 to 5 enrolled in early childhood education (see Appendix Table 9).[25] Some of the five year olds in the sample were already in kindergarten; we interpreted early childhood education to include this group as well. Because we were not able to identify children in accredited child care, one of the categories covered by DCFS Procedure 314.70, and because some referrals to early childhood programs may have been in process, the percentages of children enrolled in early childhood education may be underestimates. Results of the analysis indicated that 74% of the children in substantiated investigations in Illinois received early childhood education. Results varied, but not significantly so, by placement setting: 80% of children living in out-of-home care, 70% of children receiving intact family services, and 76% of children who remained at home without services. There were significant differences in enrollment in early childhood education by child age: 5 year olds were more likely to be enrolled (94%) than 4 year olds (74%) or 3 year olds (58%). There were no differences in enrollment by sex, race, or region.

Because of DCFS' policy on early childhood education, which distinguishes it from a number of other states, results were compared to NSCAW for children in substantiated cases (see *Figure* 3.1). Outside of Illinois, significantly smaller percentages of 3 to 5 year olds were enrolled in an education program: 55% of children living in-home without services, 54% of children living in-home with services, and 62% of children living in out-of-home cases.[26] Thus, the Illinois policy seems to be having its intended effect.

[25] Cross, T.P., & Helton, J. (2010). *Enrollment in early childhood education programs for young children involved with child welfare*. Urbana, IL: Children and Family Research Center.

[26] Because the samples are relatively small for the 3-5 year old age group, the margins of error (represented by the black line superimposed on the bars in Figure 3.1) are fairly large and readers should interpret these percentages with caution.

Figure 3.1 Children 3-5 Years Enrolled in Early Childhood Education or Kindergarten

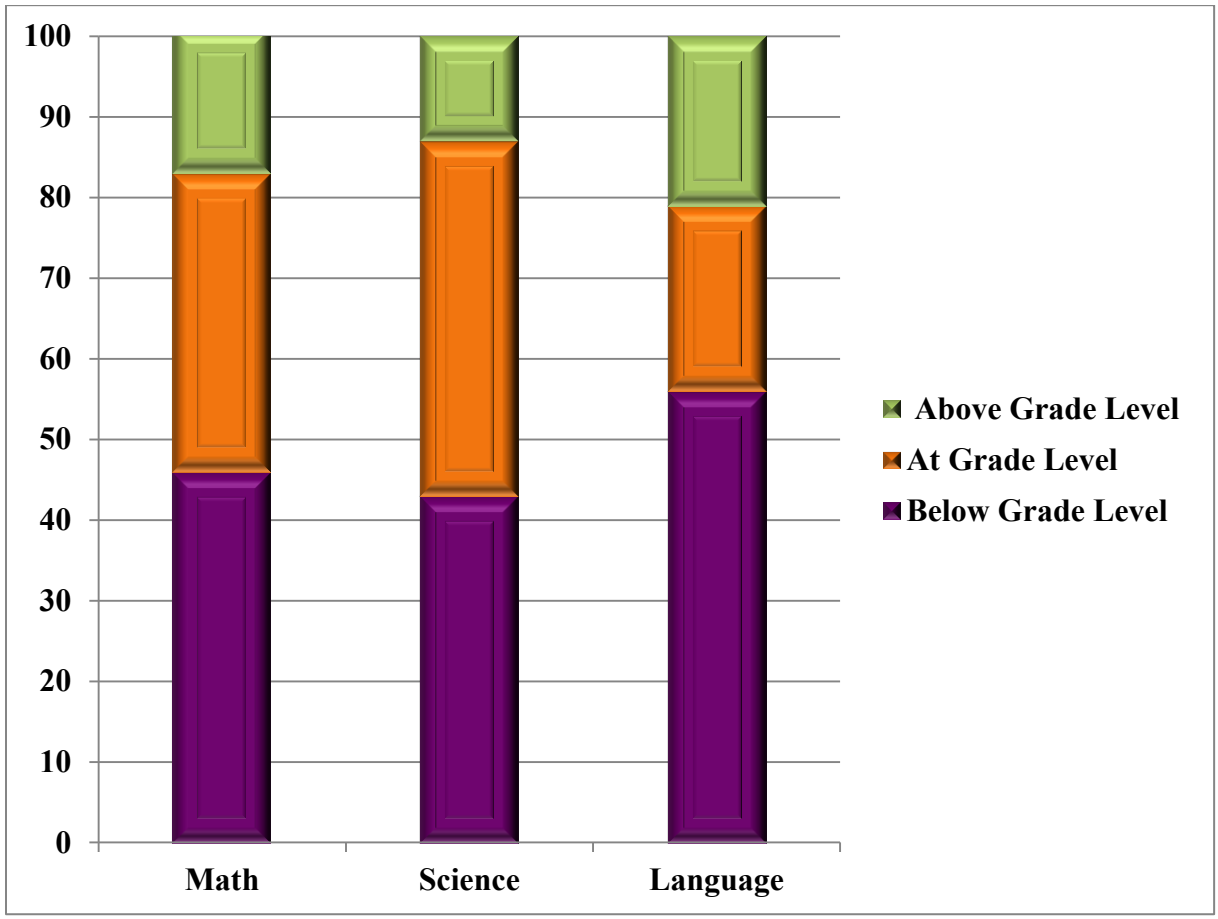


Education of School-Aged Children

Other ISCAW data concerned the education of school-aged children. Because many children in the sample were too young to be in school and because limits on resources for the research restricted the number of teachers who could be surveyed, data on this measure were available for a subsample of 94 children.

Grade-level proficiency. Teachers were asked whether students had achieved grade-level proficiency in math, science and language (Appendix Table 10). According to teachers, about half of the children in the sample were below grade-level proficiency in each academic domain: 46% in math, 43% in science, and 56% in language (see *Figure* 3.2). Some were performing at grade level: 37% in math, 43% in science, and 23% in language; and some above grade level in math (18%), science (13%) and language (21%). There were no significant differences in grade- level proficiency by child age, race, sex, region, or placement setting.

Figure 3.2 Grade-Level Proficiency in Math, Science, and Language



Grade repetition. Caregivers reported that 13% of children and youth age 6 to 17 years old had repeated a grade at some point in their school career, although data were only available for a relatively small subsample of 72 cases (Appendix Table 11). This percentage is about the same as the rate of 12% found in a national report on all children,[27] and half of that reported for maltreated children in the NSCAW 2 (26%). Not surprisingly given their longer tenure in school, children age 10 to 17 were more likely to have repeated a grade (24%) than those ages 5 to 9 (6%). None of the other subgroup analyses revealed significant differences.

Academic achievement. Academic achievement was measured by the Woodcock Johnson III Tests of Cognitive Abilities (Appendix Table 12). Three subscales were administered: Letter-Word Identification (ages 5-17), which measures basic reading skills involving naming letters and reading words aloud from a list; Passage Comprehension (ages 5-

[27] National Center for Education Statistics. (2010). *Status and trends in the education of racial and ethnic groups*. Washington, DC: NCES. http://nces.ed.gov/pubs2010/2010015/tables/table_17a.asp

11), which measures reading comprehension; and Applied Problems (ages 5-17), which measures math reasoning requiring the child to solve oral word problems. Each subscale has a normative mean of 100 and standard deviation of 15. The mean scores for Illinois children in substantiated maltreatment investigations on all three subscales were within the normal range: 97.8 on Letter-Word Identification subscale, 92.9 on Passage Comprehension, and 92.5 on Applied Problems. Scores on these subscales in the national sample of maltreated children were slightly lower: 92.4, 87.9, and 87.1, respectively.

Separate analyses not included in Appendix Table 12 examined how many youth scored in the very low range on at least one of the three subscales. On this measure, 10% of Illinois children in substantiated investigations had scores more than 2 standard deviations below the mean, indicating significant learning problems; this was 5 times the percentage in the national sample.

Summary of Major Findings on Education

- Overall, 74% of children ages 0-5 were enrolled in early childhood care and education programs or kindergarten at the baseline data collection.
- Enrollment in early childhood education varied by child age: 5 year olds were more likely to be enrolled (94%) than 4 year olds (74%) or 3 year olds (58%).
- According to teachers, about half of the children were below grade-level proficiency in each academic domain: 46% in math, 43% in science, and 56% in language. Some were performing at grade level: 37% in math, 43% in science, and 23% in language; and some above grade level in math (18%), science (13%) and language (21%).
- According to caregivers, about 13% of the sample had repeated a grade at some point in their educational careers, significantly lower than the 26% in the national sample.
- Children in Illinois scored within the normal range on tests of academic achievement: 97.8 on Letter-Word Identification subscale, 92.9 on Passage Comprehension, and 92.5 on Applied Problems.

Chapter 4: Physical Health

Monitoring physical health is a priority for tracking any child's well-being, and is particularly important given the increased risk that maltreated children have for experiencing health problems.[28] A disproportionate percentage of children involved with child welfare services have chronic health conditions.[29] Children can be injured or otherwise physically harmed because of abuse or neglect (e.g., head trauma or fractures caused by physical abuse; malnutrition caused by neglect).[30] Neglect can also interfere with the delivery of health care (e.g., children not going to the doctor because of a parent's medical neglect).[31] In addition, children who have pre-existing health conditions may be at greater risk for maltreatment,[32] probably because of the greater demands of caring for them. This chapter reports results on physical health and health care for Illinois children in substantiated investigations.

Overall Health

As part of the baseline interviews, caregivers were asked to provide an overall assessment of their children's health. The overwhelming majority (95%) reported that children were in good, very good or excellent health (Appendix Table 13). This result did not vary significantly by child race, region, age, sex, or placement setting.

Physical Disability and Special Health Care Need

Caregivers also answered a number of specific questions regarding children's physical disability and special health care need. A physical disability is a physical impairment that interferes with daily functioning, while a special health care need (SHCN) is an ongoing or long-term need for remediation of a chronic or repeated health condition. SHCNs include physical disabilities but also other disabilities like mental retardation or learning disabilities and chronic

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[28] Kortenkamp, K., & Ehrle, J. (2002). *The well-being of children involved with the child welfare system: A national overview.* Series B, No. B-43. Washington, DC: The Urban Institute. Palaszynski, K.M., & Nemeroff, C.B. (2009). Medical consequences of child abuse and neglect. *Psychiatric Annals, 39,* 1004-1009.

[29] Ringeisen, H., Casanueva, C., Urato, M., & Cross, T.P. (2008). Special health care needs among children in child welfare. *Pediatrics*, *122*, 232-241.

[30] Block, R.W., & Krebs, N.F. (2005). Failure to thrive as a manifestation of child neglect. *Pediatrics*, *116*, 1234-1237. Makaroff, K.L., & Putnam, F.W. (2003). Outcomes of infants and children with inflicted traumatic brain injury. *Developmental and Medical Child Neurology, 45*, 497–502

[31] Dubowitz, H., Giardino, A., & Gustavson, E. (2000). Child neglect: Guidance for pediatricians. *Pediatric Review, 21***,** 111–116.

[32] Jaudes, P.K., & Mackey-Bilaver, L. (2008). Do chronic conditions increase young children's risk of being maltreated? *Child Abuse & Neglect*, *32*, 671–681.

medical conditions like asthma. An estimated 13% to 19% of American children have SHCNs[33] but a previous NSCAW study found that 35% of children who had been involved with child welfare investigations had a SHCN.[34]

Overall, caregivers reported that 40% of children involved with DCFS had a SHCN, and 2% of children ages 5 to 17 had a physical disability (Appendix Table 13). The SHCNs reported included asthma (16%), mental retardation (7%), repeated ear infections (7%), language impairment, learning disability and vision problems (each 4%). Certain segments of the ISCAW sample were at higher risk of a SHCN. A greater proportion of boys (48%) had SHCNs than girls (31%), probably because several of the health conditions such as learning disabilities have a higher incidence among boys. Children under the age of 5 were significantly less likely to have a SHCN than older children, probably because several of these conditions (e.g., language impairments, learning disabilities) are usually evident only at later developmental stages.

Unhealthy Weight

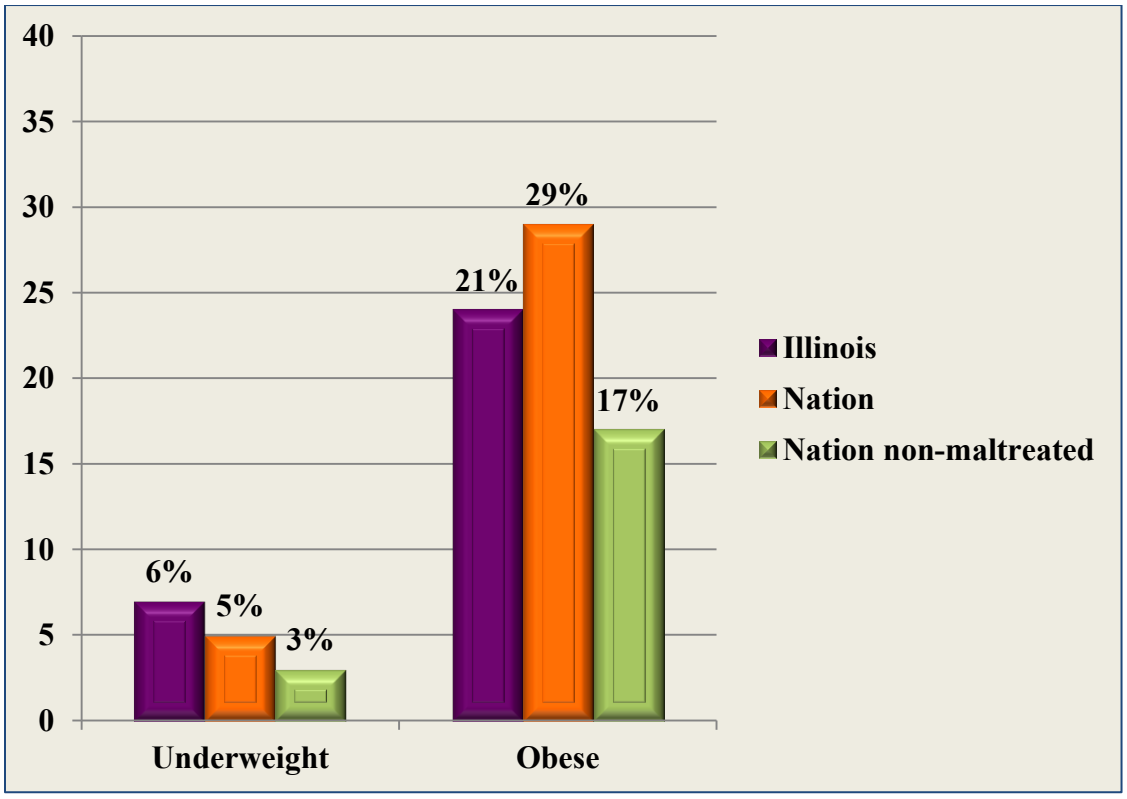
Obesity is a major risk for American children: a recent study shows that 31% of American children met criteria for overweight or obesity.[35] Children involved with DCFS may be at special risk for obesity both because neglectful caregivers may be less likely to provide good nutrition and because disadvantaged families have less money for and less access to healthier foods. At the other extreme, but of equal concern, are dangerously underweight children. ISCAW includes measures of child height and weight, which can be used to calculate body mass index (BMI). In the following analysis, which was adapted a research brief on unhealthy child weight conducted by the Children and Family Research Center,[36] children's BMIs were compared to growth charts developed by the Centers for Disease Control to identify which children are underweight, at a healthy weight, and obese (see *Figure* 4.1). Results for Illinois children in substantiated investigations were compared to results from NSCAW data on children in substantiated investigations across the country and to national data for children in the general

[33] Bethell, C.D., Read, D., Blumberg, S.J., & Newacheck, P.W. (2008). What is the prevalence of children with special health care needs? Toward an understanding of variations in findings and methods across three national surveys. *Maternal Child Health Journal, 12,* 1–14.
[34] Ringeisen, H., Casanueva, C., Urato, M., & Cross, T.P. (2008). Special health care needs among children in child welfare. *Pediatrics*, *122*, 232-241.
[35] Ogden, C.L., Carroll, M.D., Curtin, L.R., Lamb, M.M., & Flegal, K.M. (2010). Prevalence of high body mass index in US Children and Adolescents, 2007-2008. *Journal of the American Medical Association*, *303*, 242-249.
[36] Helton, J. (2011). *Are children being served by Illinois DCFS at risk for unhealthy weight?* Urbana, IL: Children and Family Research Center.

population. Because caregiver reports were used to calculate BMI in ISCAW and NSCAW, results should be considered estimates.

Overall, 6% of children in substantiated investigations in Illinois were underweight, which is slightly larger than the 5% of maltreated children nationally and the 3% of children in the general population (Appendix Table 14). At the other end of the continuum, 21% of maltreated Illinois children were obese. This is higher than among American children in general, 17% of whom are obese,[37] but lower than maltreated children nationally (29%). Seventy three percent of children with a substantiated investigation in Illinois had a body mass index in the healthy range.

Figure 4.1 Body Mass Index for Children 2 Years and Older**



**National estimates from 2007 and 2008 survey by the CDC

Health Services

ISCAW includes a number of variables measuring children's health services including children's coverage by health insurance (Appendix Table 15). According to the caregiver interview, 99% of children in substantiated investigations have health insurance. Of these

[37] Ogden et al., ibid.

children: 86% were covered by Medicaid, 11% by employer-based insurance, and 2% by other insurance plans. Illinois children in substantiated investigations were significantly more likely to have health insurance than in the national (NSCAW) comparison of substantiated investigations (90%).

Another question concerns whether children are receiving the well-child care needed to help insure good health and development (Appendix Table 15). Caregivers were asked whether the child received a well-child care visit during the previous 12 months, defined as a "general check-up when he or she was not sick or injured." For substitute caregivers, the time period covered was the time during which the child was in their care. Overall, 88% of Illinois children in substantiated investigations had received a well-child visit, which was not significantly different from the national comparison of children in substantiated investigations. Young children (ages 5 and younger) were more significantly more likely (93-94%) to have received a well-child visit than older children (74% among 9 to 11 year olds and 80% among 12 to 17 year olds). Although not a statistically significant difference ($p<.10$), children in traditional foster care (99%) and kinship foster care (93%) were more likely to have received a well-child visit than children who remained at home without services (84%) following the investigation.

Caregivers reported whether or not children had a medical home—a place such as a pediatrician's office or a clinic in which they regularly received health care (Appendix Table 15). A medical home promotes continuity and coordination of care and pulls together all medical record information.[38] The American Academy of Pediatrics recommends a medical home for every child, and it is especially important for children with special health care needs. According to caregivers, 98% of children had a medical facility they usually went to when the child was sick or the caregiver needed advice about the child's health; for 96% of children this was a doctor's office, clinic, health center, or health maintenance organization. This Illinois percentage was slightly higher than that in the national comparison, in which caregivers reported a medical home for children in 95% of cases, and the difference, though small, was statistically significant.

Caregivers were also asked whether the child was up-to-date with his or her immunizations. Almost all (98%) of caregivers reported that children were up-to-date, with a

[38] Sia, C., Tonniges, T.F., Osterhus, E., & Taba, S. (2004). History of the medical home concept. *Pediatrics, 113*, 1473-1478.

slightly but significantly higher percentage for girls (99%) than boys (97%). The Illinois-national comparison showed no significant difference (Appendix Table 13).

Caregivers were also asked if the child had received a dental check-up in the last 12 months (or, for foster caregivers, during the child's stay in substitute care) and if he or she had ever received one. In the time period specified, 70% of children had received a dental check-up and 77% had ever received one, which was not significantly different from the national comparison (Appendix Table 15). National data show that, overall, caregivers report 78.4% of children in the general population had dental check-ups during a one-year period,[39] so caregivers of Illinois children in substantiated investigations are reporting annual dental care for their children at only a slightly lower rate. The subgroup analyses revealed no significant differences between groups on dental check-ups.

One important variable for tracking medical care is the extent to which children visit emergency departments (EDs) in hospitals.[40] This variable can signal difficulties with management of medical conditions, leading to acute situations requiring emergency care, and also inappropriate use of EDs for non-urgent care, which lacks the continuity of care of a medical home. In the Illinois sample, caregivers reported that 35% of children had visited an emergency room or urgent care center in the previous 12 months (or for substitute caregivers, during the time child was in care; Appendix Table 16). This was not significantly different from the percentage in the national comparison of substantiated investigations, but is substantially higher than the rate among children in general, which in 2008 was about 21%.[41] Less than 1% of caregivers, however, reported that the emergency department was the place the child goes most often for health care.

Finally, caregivers were asked whether the child ever needed health services that the child was unable to get. Overall caregivers answered yes on this question in 5% of cases. Traditional foster caregivers were significantly more likely to answer yes on this question (12%), as were caregivers of youth age 12 to 17 (12% vs. 7% or less for every other age category; 1% for children under 3).

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[39] Centers for Disease Control and Prevention. (2011). Dental care. In *Child health 2011*. Atlanta, GA: CDC. Retrieved from http://mchb.hrsa.gov/chusa11/hsfu/downloads/pdf/c1161.pdf

[40] Schneiderman**,** J.U., Hurlburt, M.S., Leslie, L.K., Zhang, J., Horwitz, S. M. (2012). Child, caregiver, and family characteristics associated with emergency department use by children who remain at home after a child protective services investigation. *Child Abuse & Neglect*, *36*, 4-11.

[41] National Center for Health Statistics. (2011). *Health, United States, 2010: With special feature on death and dying*. Hyattsville, MD: NCHS.

Summary of Major Findings on Child Health

- 95% of caregivers reported that their child was in good, very good, or excellent health
- According to caregivers, 40% of children in substantiated investigation have a special health care need (SHCN), defined as an ongoing or long-term need for remediation of a chronic or repeated health condition. Boys were more likely (48%) to have a SHCN than girls (31%), and older children were more likely to have a SHCN than younger children: < 3 years (30%), 3-5 years (34%), 6-8 years (57%), 9-11 years (45%), 12-17 years (46%).
- 6% of children were underweight (below the 5th percentile on the Body Mass Index chart).
- 21% of children were obese (above the 95th percentile on the Body Mass Index chart). This is higher than children in the general population (17%) but lower than maltreated children nationally (29%).

Health Services:

- According to caregivers, 99% of children in substantiated investigations in Illinois had health insurance, which is higher than the 90% of children in the national study.
- According to caregivers, 88% of children in substantiated investigations in Illinois had received a well-child visit in the past year, similar to the percentage in the national study. Young children were more likely to have received a well-child visit than older children.
- 98% of children in substantiated investigations in Illinois have a medical home, which is slightly higher than the percentage in the national study.
- 98% of children in substantiated investigations in Illinois are up-to-date on their immunizations, which is not significantly different from the percentage in the national study.
- 70% of children in substantiated investigations in Illinois had received a dental check-up in the past year; 77% had ever received one. These percentages were not significantly different than those in the national study.
- 35% of children in substantiated investigations in Illinois had visited an emergency room in the past year. This was not significantly different from the percentage in the

national comparison of substantiated investigations, but is substantially higher than the rate among children in general.

Chapter 5: Social, Emotional, and Behavioral Well-Being

Maltreatment can impair emotional and social development, contributing to both immediate and long-term emotional and behavioral problems.[42] Abused and neglected children are more likely to experience conduct problems, depression, delinquent behavior, substance abuse, and youth sexual activity. Environmental stressors like parental alcoholism that can accompany child maltreatment also take a toll on children's mental health. Youth with mental health problems also sometimes become involved with child welfare services because parents act abusively in a desperate attempt to deal with their children's behaviors, or because families without resources to provide care for their emotionally disturbed children have turned to child welfare agencies for help, occasionally surrendering custody to qualify youths for mental health services.[43] This chapter examines the social, emotional and behavioral well-being of Illinois children involved in substantiated maltreatment investigations, and concludes with an examination of mental health service receipt.

Emotional and Behavioral Problems

Three standardized problem checklists, parallel in content, were used to assess child emotional and behavioral problems: the Child Behavior Checklist (CBCL, completed by caregivers), the Teacher Report Form (TRF) and the Youth Self-Report (YSR, completed by youth age 11 or older). Emotional and behavioral problems are prevalent among children involved with DCFS (Appendix Table 17). On the CBCL, 29% scored in the clinical or borderline clinical range. On the TRF, 34% scored in the clinical or borderline clinical range. On the YSR, 27% scored in the clinical or borderline clinical range. Altogether, 37% of youth were in the clinical or borderline range on at least one of these three measures.[44]

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[42] Cicchetti, D., & Lynch, M. (1995). Failures in the expectable environment and their impact on individual development: The case of child maltreatment. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology: Risk, disorder, and adaptation* (pp. 32-71). New York: Wiley. Shonk, S.M., & Cicchetti, D. (2001). Maltreatment, competency deficits, and risk for academic and behavioral maladjustment. *Developmental Psychology, 37,* 3-17. Kendall-Tackett, K.A., Williams, L.M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin, 113,* 164-180.

[43] U.S. Government Accounting Office. (2003). *Child welfare and juvenile justice: Federal agencies could play a stronger role in helping states reduce the number of children placed solely to obtain mental health services. (03-397)*. Washington, DC: Government Accounting Office.

[44] Comparisons to results from the NSCAW 2 report are not available, because they reported percentages in the clinical range only.

The sample size was substantially larger for the caregiver-completed CBCL (N=401) than for the teacher-completed TRF (N=96) and the youth self-reported YSR (N=85), so it is not surprising that there are more statistically significant differences for the CBCL. There were significant and large differences in emotional and behavior problems by placement setting: 61% of children in traditional foster care were in the clinical or borderline clinical range compared to 26% of children in kinship foster care, 25% of children in intact family cases, and 31% of children not receiving services. A significantly lower percentage of children in the Southern region (15%) scored in the clinical or borderline clinical range compared to all other regions (28% to 36%). Emotional and behavioral problems were highly related to child age: 18% of children age 1.5 to 4 years scored in the clinical/borderline clinical range compared to 38% of children 5-7 years, 36% of children 8-10 years, 31% of children 11-13 years, and 43% of youth 14-17 years. Only one comparison was marginally significantly different on the Teacher Report Form: teachers rated almost two thirds of children in out-of-home care (63%) as having clinical or borderline clinical levels of emotional and behavioral problems, compared to about one-quarter (28%) of children in-home.

Depression and Trauma Symptoms

Two additional measures completed by youth captured specific types of problems: depression and trauma symptoms (Appendix Table 18). The Children's Depression Inventory (CDI), completed by youths age 7 to 17, captures children's self-reported symptoms of depression. On the CDI, 9% of children scored in the clinically significant range for depression, which is similar to the rate for children in the general child population (7%)[45] as well as the national comparison of maltreated children (11%). Also used was an adaptation of the Trauma Symptom Checklist for Children (TSCC), which measures symptoms like nightmares and intrusive thoughts which are lasting remnants of past traumas children have experienced. On the TSCC, completed by youth age 8 to 17, 8% of youth scored in the clinical or borderline range, which is very similar to the normative rate, and slightly lower than the percentage in the national comparison sample (11.6%). Significantly fewer children who had been removed from the home (3%) experienced trauma symptoms compared to children who remained at home (9%). Fewer

[45] Kovacs, M. (2003). *Children's Depression Inventory (CDI): Technical manual update*. North Tonawanda, NY, USA: Multi-Health Systems Inc.

older youth (ages 12 to 17) experienced trauma symptoms (2%) compared to younger (14% for ages 9 to 11, and 11% for ages 7 to 8).

Social Competence

Children who have been maltreated often struggle more in relationships with peers and adults because they have poorer social skills, such as the ability to share, inhibit aggressive behaviors, and understand others' feelings.[46] ISCAW used a caregiver version of the Social Skills Rating System to gather information about children's social competence (i.e., cooperation, assertion, responsibility, and self-control in social relationships) for youth in third to twelfth grade (Appendix Table 19). Caregivers rated 62% of children as having "average" social skills, 30% of children as having "fewer" social skills, and 8% of children as having more social skills than other children; these percentages are very similar to those reported for maltreated children in the national study (56%, 34%, and 10%, respectively). The only difference in the subgroup analyses was for population density: children in rural areas were less likely than children in non-rural areas to be rated by their caregivers as below average in social skills.

Youth Risk Behaviors

Delinquent and other high risk behaviors among youth age 11 and older were measured through a self-report delinquency scale about behavior in the last six months (Appendix Table 20). Of 83 adolescents completing the measure, 53% committed a delinquent act in the past 6 months. This includes minor acts like being unruly in public, skipping school, and shoplifting, as well as serious delinquent acts like participating in gang fights, concealing a weapon, and stealing (see *Figure* 5.1). Eight percent of the youth reported that they had been arrested in the previous six months (Appendix Table 20).

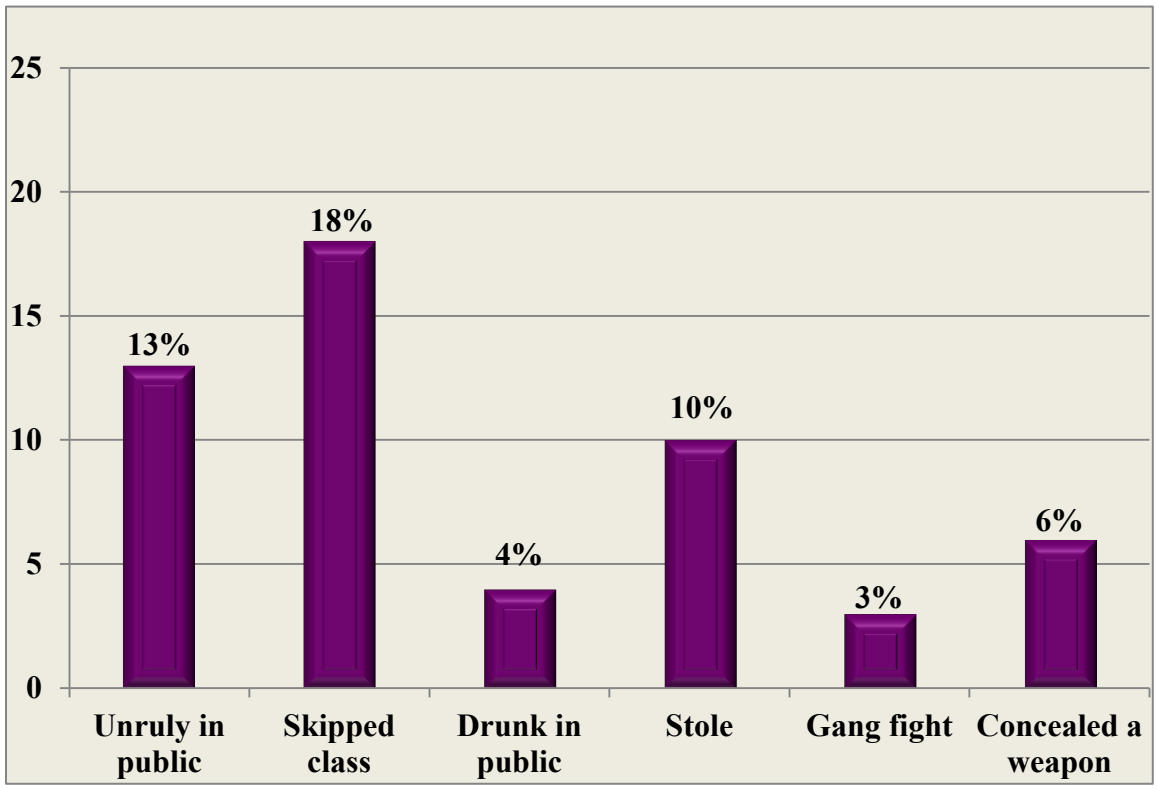
The youth also completed questions about substance use (Appendix Table 21). Response rates indicated 41% of youths reported having used alcohol, 10% cigarettes, 15% marijuana and 21% hard drugs (including cocaine, heroin, glue, ecstasy, and methamphetamines). Youth in Cook County were significantly less likely than youth in non-Cook regions of the state to report using alcohol (22% versus 51%), marijuana (3% versus 20%), and hard drugs (8% versus 27%). Children in rural areas were significantly less likely than those in non-rural areas to reporting using cigarettes (0% versus 14%) and marijuana (2% versus 20%). Children in out-of-home care

[46] Dodge, K.A., Pettit, G.S., & Bates, J.E. (1994). Effects of physical maltreatment on the development of peer relations. *Development and Psychopathology, 6*, 43–55.

were much more likely than those that remained at home following the investigation to report using cigarettes (18% versus 1%) and marijuana (40% versus 8%). Finally, children 14 to 17 years were much more likely than those 11 to 13 years to report using cigarettes (20% versus 3%) and marijuana (27% versus 7%). In addition, 23% of all youth reported riding in a car while the driver was intoxicated. On a separate substance use disorder screening test in ISCAW, 15% of youth had a score indicating a substance use disorder, which was not significantly different than the percentage in the national sample of maltreated children (19%).

Adolescents were also asked about sexual behaviors (Appendix Table 22). Among females, 16% reported ever having consensual sex and 4% reported having been forced to have sex, percentages which are significantly lower than the national comparison sample (28% and 11%, respectively). Among males, 24% reported ever having consensual sex and 8% reported having forced sex, the former is lower than the national comparison (30.5%) and the latter is higher (5.6%). Of the entire group who had had consensual sex, 48% reported having more than one partner. No youth in the ISCAW sample reported ever being pregnant or getting another person pregnant.

Figure 5.1 Youth Participating in Delinquent Behaviors (Percent)



Mental Health Services

ISCAW provides ample data on children's mental health services. Because previous reports have shown a disparity on receipt of mental health services between children in substitute care in Illinois and the rest of the country,[47] Illinois-national comparisons are more extensive in this section.

The caregiver interview asked a series of questions about a range of specific mental health services that the child might have received. If the child was placed in substitute care, foster parents were asked about services since the time of placement. Because the interview took place 4-5 months after a maltreatment investigation, "since the time of placement" generally refers here to a short period covering the first few months of a child's placement in substitute care. It should be pointed out that at the time of the baseline data collection, no children in the

[47] Bruhn, C., Helton, J., Cross, T.P., Shumow, L., & Testa, M. (2008). Well-being. In N. Rolock & M. Testa (Eds.), *Conditions of children in or at risk of foster care in Illinois 2007: An assessment of their safety, stability, continuity, permanence, and well-being*. Urbana, IL: Children and Family Research Center. Cross, T.P., & Bruhn, C. (2009). Well-being. In N. Rolock & M. Testa (Eds.), *Conditions of children in or at risk of foster care in Illinois 2008: An assessment of their safety, stability, continuity, permanence, and well-being*. Urbana, IL: Children and Family Research Center. Cross, T.P., & Bruhn, C. (2010). Delivery of mental health services for a state's population of children in foster care: A comparison of Illinois and national data. *Illinois Child Welfare, 5*, 87-107.

ISCAW sample were placed in a congregate care setting. If the child remained in his or her home following an investigation, the caregivers were asked about service receipt in the previous 12 months. This includes time before, during and after the investigation so it is not possible to tie service delivery specifically to a period of DCFS involvement for children who remained in the home following the substantiated investigation.

Questions were adapted from the Child and Adolescent Services Assessment (CASA),[48] which asks caregivers whether the child received a range of specific mental health services. Questions concerned both *specialty* and *non-special*ty mental health services. Specialty mental health services are those services provided by or overseen by mental health professionals like psychologists, psychiatrists or social workers. Specialty *outpatient* mental health services included outpatient drug or alcohol clinic, mental health or community mental health center, private professional help, in-home counseling, day treatment facility, or therapeutic foster care. Specialty *inpatient* mental health services included psychiatric hospital, inpatient detoxification unit, hospital medical inpatient unit, or the emergency room. By aggregating data on individual services, we were also able to determine whether children received *any* specialty outpatient mental health services or *any* specialty inpatient mental health service. Non-specialty mental health services were mental health services provided by other helping professionals who are not categorized as mental health specialists, such as guidance counselors and other school professionals and family doctors.

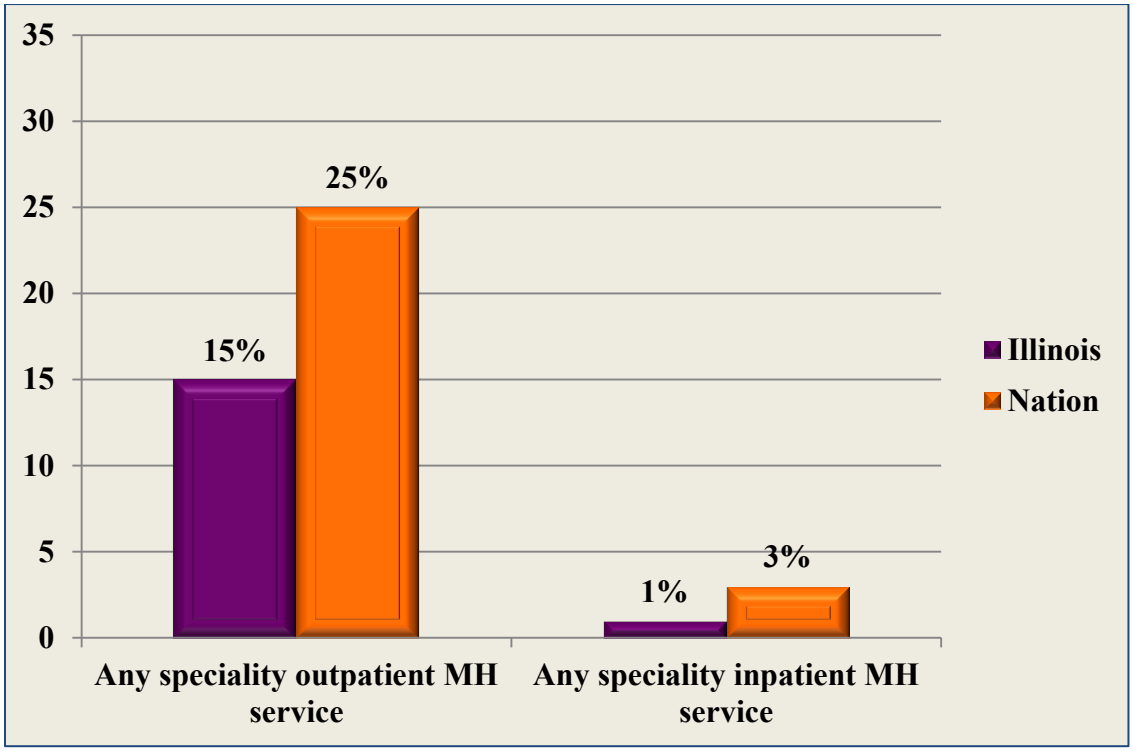
The analysis looks separately at mental health services for children in three groups: a) children in substitute care following the investigation; b) children who remained in the home following an investigation with an open child welfare case (i.e., intact family cases); and c) children who remained in the home whose cases were closed following the substantiated investigation.

Mental health service receipt among children in substitute care. Children in substitute care comprised 18% of baseline ISCAW sample. Because baseline data collection occurred at 4 to 5 months following the completion of a substantiated investigation, this analysis examines mental health service delivery for children recently placed into substitute care. The percentage of children in substitute care who received *at least one* specialty outpatient mental

[48] Ascher, B.H., Farmer, E.M., Burns, B.J., & Angold, A. (1996). The Child and Adolescent Services Assessment (CASA): Description and psychometrics. *Journal of Emotional and Behavioral Disorders, 4*, 12-20.

health service was 14.6% in Illinois and 25.2% nationally, a statistically significant difference (see *Figure* 5.2 and Appendix Table 23). The percentages receiving specialty inpatient services were low both in Illinois (1.3%) and nationally (3.3%), and this difference was not statistically significant.

Figure 5.2 Specialty Mental Health Service Receipt Among Children in Substitute Care



Receipt of specific types of mental health services among children in substitute care in Illinois and the nation were compared (Appendix Table 23). In addition to specialty mental health services, comparisons were made for non-specialty mental health services from guidance counselors, school social workers, and school psychologists; and from family doctors or other medical doctors. The most frequent specialty outpatient mental health service for Illinois children in substitute care was treatment from a private mental health practitioner: 9.5% of children received this service. This percentage was significantly less than that among children in substitute care in the national sample (18.8%). The percentages of Illinois children in substitute care that received mental health center services, in-home counseling or crisis services, and day treatment were all below 8%, not significantly different from the percentages for the national comparison.

The analysis of specific inpatient services reveals that the only inpatient services Illinois children in substitute care received was emergency room visits (1.3%), and this percentage was significantly higher than that reported in the national sample (.2%). Overall, the most commonly received "mental health" service among Illinois children in substitute care was seeing a school guidance counselor, school psychologist or school social worker (13.2%), and this was not significantly different from the percentage in the national comparison (9.2%). Only 2.7% saw a family doctor or medical doctor for mental health services, which was comparable to the percentage in the national sample (5.1%).

The preceding analysis does not address the extent to which *children that need services* are receiving them. To examine this issue more closely, service receipt among a subgroup of children with clinically significant emotional and behavioral problems at baseline is explored. For this analysis, a subgroup of children was identified who scored in the clinical range (Total Problem Score ≥63) on the Child Behavior Checklist (CBCL) completed by caregivers. The CBCL is a frequently used, valid, and reliable method of assessing child emotional and behavioral problems; research shows that it matches well with a psychiatric assessment by professionals[49] and is frequently used in research on mental health services in child welfare.[50] The clinical range corresponds to the most troubled 10% of children and is a common threshold for determining serious mental health need.

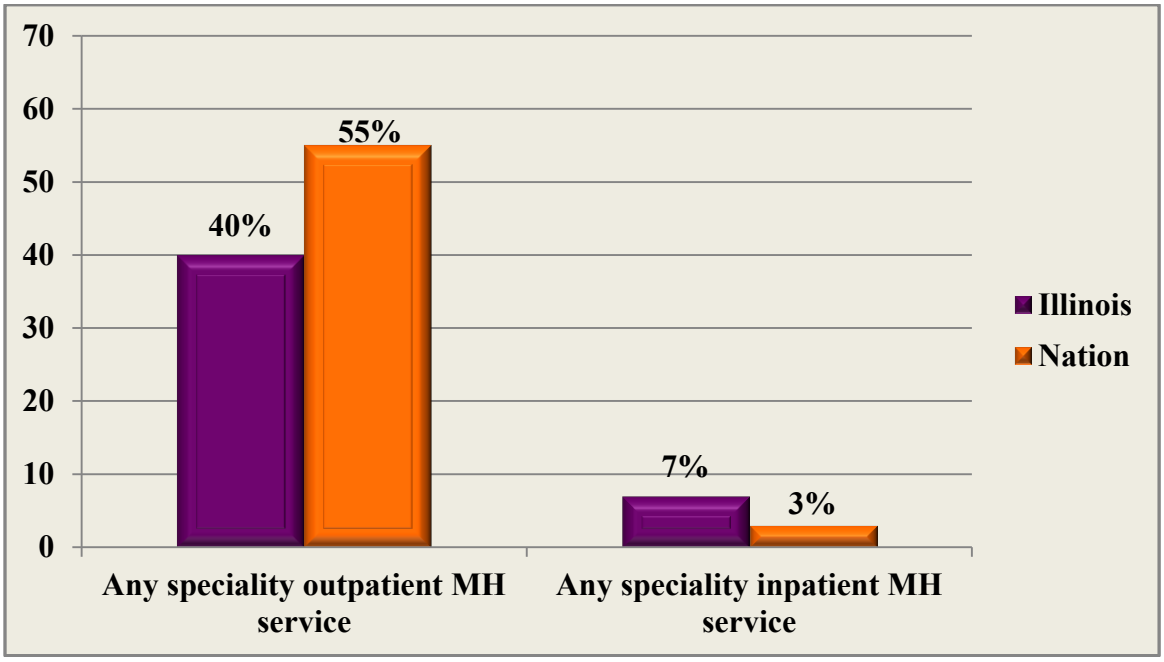
In the ISCAW sample, the number of children in substitute care with mental health need as measured by the CBCL was small – 26 children – so results for this small group should be interpreted cautiously. Of this group, 39.6% received specialty outpatient mental health services, compared to 54.8% in the national comparison (see *Figure* 5.3 and Appendix Table 23). Though this difference was not statistically significant because of the small sample, it does raise questions about the extent to which children in substitute care in Illinois with significant behavioral or emotional needs are received needed services. The percentage of children in

[49] Edelbrock, C., & Costello, A.J. (1988). Convergence between statistically derived behavior problem syndromes and child psychiatric diagnoses. *Journal of Abnormal Child Psychology, 16,* 219–231. Gould, M.S., Bird, H., & Jaramillo, B.S. (1993). Correspondence between statistically derived behavior problem syndromes and child psychiatric diagnoses in a community sample. *Journal of Abnormal Child Psychology*, 21*, 287*–313.

[50] Burns, B.J., Phillips, S.D., Wagner, H.R., Barth, R.P., Kolko, D.J., Campbell, Y., & Landsverk, J. (2004). Mental health need and mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43,* 960–970. Garland, A.F., Landsverk, J., Hough, R.L., & Ellis-MacLeod, F. (1996). Type of maltreatment as a predictor of mental health service use for children in foster care. *Child Abuse & Neglect, 20*, 675-588.

substitute care with clinically significant behavioral problems that received specialty inpatient services was slightly higher in Illinois (6.5%) than the rest of the country (3%), a difference that was not statistically significant (likely due to small sample size).

Figure 5.3 Specialty Mental Health Service Receipt Among Children in Substitute Care with Clinically Significant Behavioral Problems



When types of specialty outpatient mental health services are examined, children with clinically significant behavioral problems were about equally likely to receive treatment from a private mental health practitioner (27.6%), at a mental health center (24.8%), or through in-home counseling or crisis services (26.8%), and slightly less likely to receive day treatment (17.7%). When types of specialty inpatient mental health services are examined, the only service received was treatment in a hospital emergency room (6%).

Over a quarter (26.4%) of these children received mental health services from a guidance counselor, school social worker, or school psychologist; and 13.2% received mental health services from a family doctor.

Mental health service receipt among children in intact family cases. Slightly over 13% of children in intact families received any specialty outpatient mental health services (Appendix Table 24). This was slightly less than the percentage in the analogous national sample (17.6%), but the difference was not statistically significant. The most commonly received specialty outpatient service was treatment from a private practitioner (7.5%) followed by mental

health center services (4.9%) and in-home counseling or crisis services (4.2%). The percentages of children receiving these services in the national comparison were slightly higher, but not significantly so.

Receipt of specialty inpatient services among children in intact family services was rare in both the Illinois sample (2.5%) and the national comparison sample (2.8%). Of the specialty inpatient services, 1.9% of children in intact family cases received inpatient psychiatric services and 1.1% received treatment in a hospital emergency room, percentages that were not significantly different from the national sample of children receiving services in their homes.

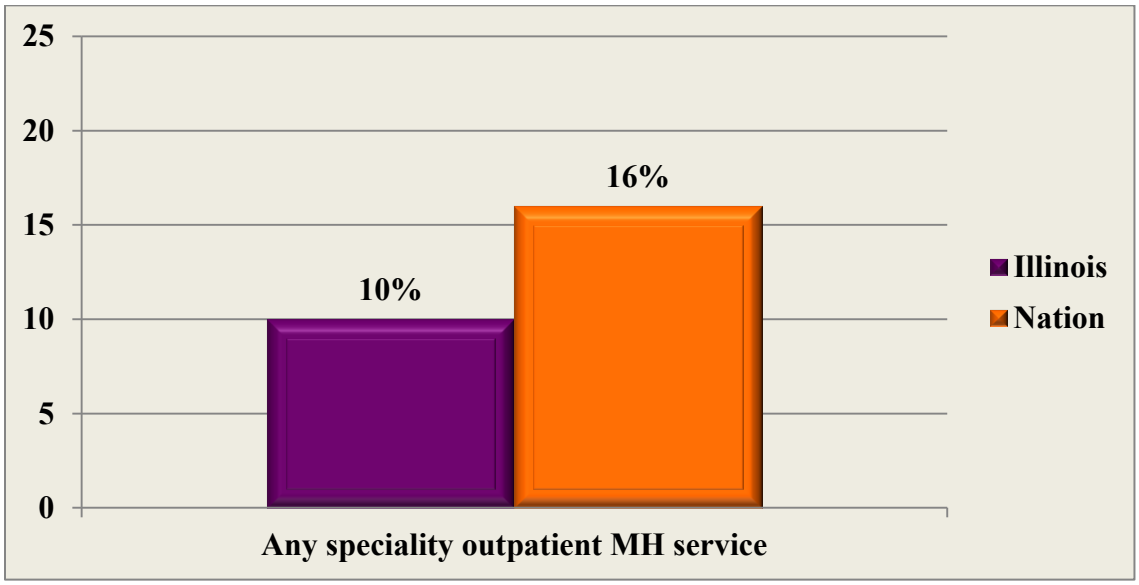
Overall, the most commonly received service for children in intact family cases in Illinois was the non-specialty services of seeing a guidance counselor, school social worker, or school psychologist—14% received these services, comparable to the percentage in the national sample (10.1%). Only a small percentage (3.1%) received mental health care from a family doctor or other medical doctor – this was somewhat less than the national comparison (6.2%) but the difference was not statistically significant.

When the subset of children (n=30) in intact family cases with a clinically significant behavioral or emotional problem (as defined by CBCL scores) is examined, 20.4% received a specialty outpatient mental health service compared to 38.6% in the national sample; this difference was not statistically significant given the small size of the Illinois sample (Appendix Table 24). The percentage of this group who received a specialty inpatient mental health service was 14.7%, compared to 12% in the national comparison, again a difference that was not statistically significant. About a third (31.3%) of these children saw a guidance counselor or other school professional, which was comparable to that in the national sample (27%). Illinois children were significantly less likely to see a family doctor or other medical doctor for mental health care (6.5%) than children in the national sample (16.1%).

Mental health service receipt among children in closed cases. In ISCAW, almost half of the children in the sample (45%) remained in their homes without an open service case at the time of the baseline data collection, 4-5 months following the substantiated investigation. The percentage of children in cases closed after investigation who received specialty outpatient services was 9.7% which was significantly lower than that (15.9%) in the national comparison (see *Figure* 5.4 and Appendix Table 25). Again, the most frequent specialty outpatient service was help from a private practitioner, which was provided to 7% of children in closed cases in

Illinois and 12.3% of children in closed cases nationally (not a statistically significant difference). Illinois children in closed cases were significantly less likely to receive in-home counseling or crisis services (1.6%) than were children in closed cases nationally (6.7%). The percentage of Illinois children in closed cases involved in day treatment was small, 1.8%, but significantly greater than in the national comparison of closed cases, which had no cases with day treatment. Less than 2% of children in closed cases received specialty inpatient mental health services, and the national percentage was similar (3.4%).

Figure 5.4 Specialty Outpatient Mental Health Service Receipt Among Children in Cases Closed After Investigation



The most commonly provided service in this group was the non-specialty service of seeing a guidance counselor, school social worker, or school psychologist—18.8% received this service, which is higher than the national comparison (13.3%), but not significantly so. Only a small percentage of Illinois children in cases closed after investigation (3.2%) received mental health care from a family doctor or other medical doctor—this was significantly lower than the national comparison (7.4%). The number of children with clinically significant behavioral or emotional needs (as defined by CBCL scores) was too small (n=14) to produce reliable estimates of mental health service use among this group.

Mental health service receipt by child characteristics. Differences in the receipt of specialty outpatient mental health services by child gender, race, age, and locality (region and rural/urban) were also examined for Illinois children in substitute care, intact family cases, and

closed cases (Appendix Table 26). Differences in the receipt of specialty inpatient services could not be computed due to the very small numbers of children who received inpatient services. In these analyses, the race-ethnicity variable was limited to three groups – White, African-American, and Hispanic – because only a small number of children and youth (n=27) had "other" ethnicities and there were very large standard errors for this group. Only those differences that were statistically significant are described in this section.

Among the children in substitute care, those in non-rural areas received a specialty outpatient mental health service more frequently (19%) than children in rural areas (5%). A significantly higher percentage of older children (ages 14-17) in substitute care (58%) received a specialty outpatient service compared to younger children ages 6 to 11 (31%), children ages 3 to 5 (12%), and children less than 3 years old (4%).

For children in intact family cases, a significantly greater proportion in the Central and Northern regions (18% and 24%, respectively) received a specialty outpatient service compared to Cook (7%) and Southern (3%) regions. A significantly greater proportion of children in rural settings received an outpatient service (22%) compared to children in non-rural settings (9%). A significantly higher percentage of school-aged children received a specialty outpatient service compared to preschool-aged and younger (27% vs 5%). Significantly smaller percentages of African-American (7%) and Hispanic (9%) children received a specialty outpatient service compared to White children (26%).

For children in closed cases, only child age was associated with receiving a specialty outpatient service in the past year. Youth age 12 to 17 received a specialty outpatient mental health service in 19% of cases, but 0% of children under the age of 6 received one.

Medication for emotional and behavioral problems. Caregivers were asked if children were currently taking medication for emotional or behavioral problems (Appendix Table 27). Overall, this was true for 8% of the population of children in substantiated investigations. Children in intact family cases were less likely to be taking psychiatric medication (4%) than children in every other placement setting (traditional foster care=12%; kinship foster care=11%; closed after investigation=10%). Children in the "other" racial-ethnic group were significantly more likely to be taking medication than any other group, but this could be a function of the very small number of children in this group (27) causing an unreliable estimate. Children and youth age 9 and older were more likely to take medication than younger children. Children in Illinois

(8%) were less likely to receive psychiatric medication than children in the national sample (12%), although this difference was not statistically significant.

Summary of Major Findings on Social, Emotional, and Behavioral Well-Being

- Over a third of the children in substantiated investigations (37%) scored in the clinical or borderline clinical range on at least one version of a standardized checklist of emotional and behavioral problems.
- Caregiver-reported emotional and behavior problems were much higher for children in traditional foster care (61%) compared to children in kinship foster care (26%) and children in intact family cases (25%).
- On a self-report measure of depressive symptoms, 9% of children in substantiated investigations in Illinois had scores in the clinically significant range, which is similar to children in the national maltreatment sample (11%) and the general child population (7%).
- On a self-report measure of trauma symptoms, 8% of children in substantiated investigations in Illinois had scores in the clinically significant range, which is similar to children in the national maltreatment sample (11.6%) and the general child population.
- Younger children (11% in children 7 to 8 years and 14% in children 9 to 11 years) were significantly more likely to report trauma symptoms in the clinical range than older children (2% in children 12 to 17).
- Significantly fewer children in substitute care reported clinically significant trauma symptoms (3%) compared to children who remained at home following their substantiated investigation (7-9%).
- Caregivers reported that 70% of children had average to above average social skills, similar to the 66% reported in the national sample of maltreated children.
- 53% of the youth age 11 and older reported committing a delinquent act in the past six months. This included minor acts like being unruly in public or at school, skipping school, and shoplifting, as well as serious acts such as concealing a weapon and stealing.
- 8% of the youth reported that they had been arrested in the previous six months.

- Youth 11 to 17 years were asked about their substance use; 41% had used alcohol, 15% had used marijuana, and 21% had used "hard drugs" which included cocaine, heroin, methamphetamines, and ecstasy.
- On a screening test for substance abuse, 15% of the youth had a score indicating a substance use disorder, which was not significantly different than the national comparison sample (19%).
- Of the youth age 11 to 17, 16% of the females report having consensual sex and 4% report having forced sex; 24% of the males report having consensual sex and 8% report having forced sex.

Mental Health Services

- 15% of the children in substitute care had received a specialty outpatient mental health service (i.e., one from a mental health professional) since being placed into substitute care (interview occurred 4-5 months following the investigation). This percentage was significant smaller than that in the national comparison sample (25%).
- This percentage increased to 40% when outpatient mental health services were examined among children with clinically significant emotional or behavioral problems (as measured by the CBCL). This percentage was also much smaller than that in the national comparison sample (55%).
- 13% of the children in intact family cases had received a specialty outpatient mental health service (i.e., one from a mental health professional) since their investigation. This was not significantly different than that in the national comparison sample (18%).
- This percentage increased to 20% when outpatient mental health services were examined among children in intact family cases with clinically significant emotional or behavioral problems (as measured by the CBCL). This percentage was about half of that in the national comparison sample (39%).
- 10% of the children in substantiated investigations whose cases were closed following investigation had received a specialty outpatient mental health service (i.e., one from a mental health professional) since their investigation. This was significantly lower than that in the national comparison sample (16%).

- Child age was strongly associated with the receipt of specialty outpatient mental health services; school age children were much more likely to receive services than those five years or younger.
- The most frequently received *specialty* outpatient mental health service (in all groups of children) was treatment by a mental health professional in private practice (psychologist, social worker) .
- Overall, the most commonly received mental health services were from non-mental health specialists such as guidance counselors or school social workers.
- Inpatient mental health service receipt was very rare in the Illinois sample (less than 3% for all groups).
- Overall, 8% of the children in the sample were currently taking psychotropic medication to address an emotional or behavioral problem, which is not significantly different than the percentage in the national comparison sample (12%). Children 9 years and older were much more likely to be taking psychotropic mediation than those 5 years and younger.

Chapter 6: Risk in Children's Environment

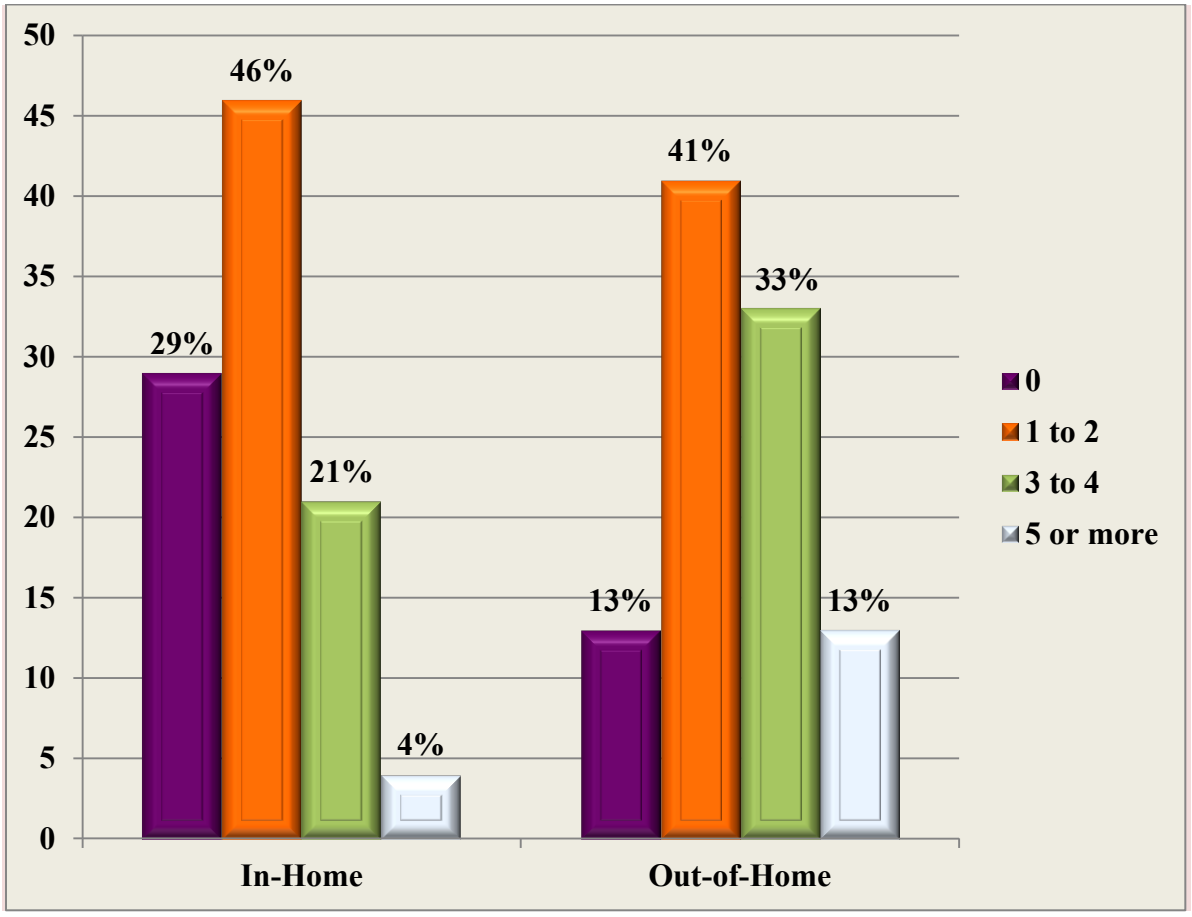
A central element of children's well-being is the capacity of their caregivers to provide safety, security, and opportunities for healthy development. If families experience major problems like poverty, substance abuse, or parental mental health problems, children may not receive the care they need and may be at increased risk of continued maltreatment with additional risk to their health and development. ISCAW gathered substantial data on problems in the family and neighborhood environments that could affect children's well-being.

Caseworker-Reported Risk Factors

The caseworker interview included questions about the presence of several caregiver risk factors such as alcohol abuse, substance abuse, mental health problems, history of arrests or jail time, intellectual impairment, physical impairment, low social support, and high stress related to situations such as unemployment and poverty. For children in out-of-home care, these questions pertained to the caregivers from whom they had been removed. For children who remained in their homes, the questions pertained to their primary caregivers with whom they continued to live. For all families in the ISCAW sample, the overall average number of caregiver risk factors reported by the caseworkers was 1.7.

Figure 6.1 shows the total number of caseworker-identified risk factors experienced by children who remained in their homes following a substantiated investigation (in-home) and children who were removed from their homes (out-of-home). Only 13% of children in out-of-home care did not have a caregiver risk factor, while 29% of children in-home did not have a caregiver risk factor. Almost half (46%) of children in out-of-home care had experienced 3 or more risk factors, a significantly higher percentage than the 25% of children in-home.

Figure 6.1 Number of Caseworker-Reported Family Risks



Percentages for the top five specific caregiver risk factors are shown in Appendix Table 28. Domestic violence was the most frequently reported family risk, reported by caseworkers in 28% of all cases. Caseworkers reported smaller proportions of cases with caregiver mental health problems (18%), history of arrest (16%) and substance abuse (15%). There were significant differences in the presence of caretaker problems by child setting: in general, children who were receiving services – either in the home or in substitute care – were more likely to have parents with risk factors (a history of arrest, mental health problems, substance use problems, alcohol use problems) than children who remained at home without services.

Very few differences in the caregiver risk factors were found among different groups of children. Children in rural areas experienced most risk factors at about the same rate as children in non-rural areas, with the exception of domestic violence, which was significantly more common among children in rural (35%) than non-rural (24%) areas. Caregiver substance abuse was more common among parents of girls (20%) compared to boys (11%); and among caregivers

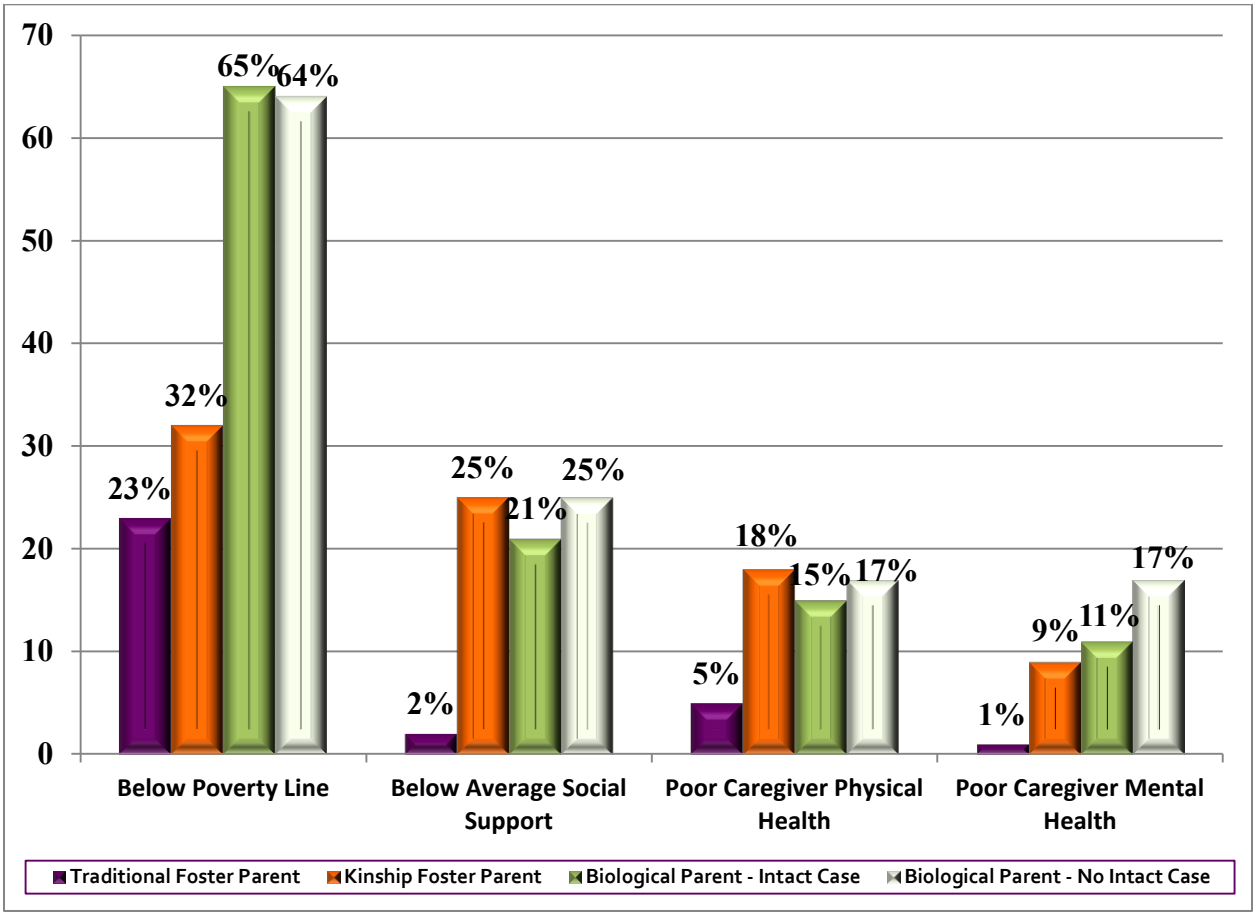
of children under 3 (26%) compared to all other age groups (5% to 14%). No significant differences in caregiver risk factors were found among children living in difference regions of the state or children of different race-ethnicities.

Caregiver-Reported Risk Factors

The caregiver interview contained questions about problems or risks in several different areas, such as physical health, mental health, financial hardship, and social support (Appendix Table 29). These questions were answered by biological parents when the children remained in the home and by foster parents when the child had been removed from the home. Overall, 58% of the caregivers reported that they live below the federal poverty line, the minimum level of income deemed necessary to achieve an adequate standard of living. Although a significant percentage of traditional foster parents (23%) and kinship foster parents (32%) were living in poverty, biological families of children in substantiated investigations were much more likely (64-65%) to be living below the federal poverty threshold (*Figure* 6.2).

Traditional foster parents reported risk factors such as low social support, poor physical and mental health at much lower rates than kinship foster parents and biological parents (*Figure* 6.2). For instance, only 2% of traditional foster parents reported that they experience low social support, compared to 25% of kinship foster care and 25% of biological parents in cases closed after investigation. Kinship foster parents were also more likely to report being in poor physical health (25%) when compared to traditional foster parents (5%), although the difference was not statistically significant. Parents in substantiated investigations who were not receiving intact family services were the most likely to report mental health problems – 17% – a rate significantly higher than the other groups (*Figure* 6.2).

Figure 6.2 Caregiver-Reported Risk Factors



Children's Exposure to Violence

Another indicator of environmental risk is children's exposure to violence. Children and youth age 7 to 17 years completed the Violence Exposure Scale for Children (VEX-R), a 23-item measure of witnessing or being the victim of different violent actions in the home, ranging in severity from spanking to stabbing or shooting (Appendix Table 30). Of the 135 youth who completed the measure, 66% reported *witnessing* one or more items on the severe violence subscale, such as a gun or knife being pointed (witnessed by 8%), stabbing (8%), shooting (3%), someone getting arrested (51%), adult stealing in the home (27%), and dealing drugs (12%). There were no significant differences in witnessing severe violence between sub-groups, with the exception that fewer children who remained in home without services witnessed severe violence compared to all other children.

Only 6% of the 135 youth who responded reported that they had *experienced* severe violence, such as an adult (not necessarily their caretaker) pointing a knife or gun at them. Sub-

group analysis revealed that this percentage was significantly different among children in out-of-home care (34%) versus children who remained at home following the investigation, either with (2%) or without (4%) services.

Summary of Major Findings on Risk in Children's Environments

- Caseworkers reported an average of two "caregiver risk factors" for parents of children involved in substantiated investigations, such as alcohol abuse, substance abuse, domestic violence, mental health problems, history of arrest or jail, intellectual impairment, and high stress related to poverty and unemployment.
- Parents of children in substitute care were significantly more likely to have several problems (3 or more) than parents of children that remained at home following the investigation.
- Domestic violence was the most frequently caseworker-reported caregiver risk factor among the families involved in substantiated investigations in Illinois; it was reported by caseworkers in 28% of all families.
- A majority of parents of children in substantiated investigations (58%) reported living at or below the federal poverty line.
- Parents of children who remained at home following the investigation were much more likely to live in poverty (64%) than either kinship foster parents (32%) or traditional foster parents (23%).
- Traditional foster parents also reported much lower levels of other risk factors (mental health or physical health issues, low social support) compared to both kinship foster parents and biological parents of children in substantiated investigations.
- Kinship foster parents reported below average social support (25%) and poor physical health (18%) at levels similar to biological parents of children in substantiated investigations (25% and 17%, respectively).
- 66% of children in substantiated investigations reported witnessing one or more acts of severe violence in the past year.
- 6% of children in substantiated investigations reported experiencing one or more acts of severe violence in the past year.

- Children living in substitute care were much more likely to report experiencing severe violence in the past year (34%) than children living at home following a substantiated investigation (2-4%).

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APPENDIX

The Well-Being of Illinois Children in Substantiated Investigations: Baseline Results from the Illinois Survey of Child and Adolescent Well-Being

Table 1: Characteristics of the ISCAW Sample

	N	Percent/(SE)
Total	**818**	
Child Setting		
Traditional Foster Care	**145**	**5% (.1)**
Kinship Care	**182**	**13% (1.6)**
In-Home w/Services	**360**	**36% (3.1)**
In-Home w/out Services	**131**	**46% (4.4)**
Region		
Cook	**417**	**28% (1.6)**
Central	**197**	**31% (1.9)**
Northern	**130**	**29% (3.3)**
Southern	**74**	**12% (2.5)**
Population Density		
Non-Rural	**632**	**65% (15.6)**
Rural	**186**	**35% (15.6)**
Sex		
Male	**416**	**49% (1.9)**
Female	**402**	**51% (1.9)**
Race/Ethnicity		
African-American	**442**	**42% (5.3)**
White	**192**	**34% (6.1)**
Hispanic	**155**	**20% (3.1)**
Other	**27**	**4% (0.1)**
Child Age		
Under 3	**497**	**32% (2.7)**
3 to 5	**125**	**25% (1.4)**
6 to 8	**69**	**15% (3.2)**
9 to 11	**64**	**14% (1.8)**
12 to 17	**63**	**14% (1.1)**

Note: The standard errors (SE) indicate how much the estimates could vary because of chance involved in sampling. The mathematics of sampling tells us that there is a 95% likelihood that the true percentage lies within two standard errors of the percentages reported here.

Table 2: Infant Development

	N	BINS average score Mean/SE	High Risk for Developmental Delay Percent/SE
Total	**258**	**6.0 (.2)**	**64% (5.5)**
Child Setting			[a]
Traditional Foster Care	**17**	**7.1 (.9)**	**59% (15.2)**
Kinship Care	**50**	**7.4 (.5)**	**48% (15.5)**
In-Home w/Services	**174**	**5.9 (.3)**	**58% (4.6)**
In-Home w/out Services	**17**	**5.5 (.8)**	**83% (7.7)**
Region			
Cook	**163**	**5.3 (.1)**	**66% (4.3)**
Central	**49**	**5.8 (.8)**	**71% (14.9)**
Northern	**29**	**6.8 (.2)**	**57% (12.6)**
Southern	**17**	**7.0 (.8)**	**55% (11.9)**
Population Density			
Non-Rural	**217**	**6.0 (.2)**	**61% (3.6)**
Rural	**41**	**6.0 (.7)**	**70% (12.0)**
Sex			
Male	**129**	**5.6 (.3)**	**64% (7.5)**
Female	**129**	**6.4 (.3)**	**65% (5.0)**
Race/Ethnicity			
African-American	**140**	**5.8 (.5)**	**69% (8.9)**
White	**55**	**6.3 (.3)**	**65% (17.2)**
Hispanic	**59**	**6.0 (.5)**	**55% (12.3)**
Other	**3**	**N/A**	**N/A**

Note: Children age 0 to 2. From the Bayley Infant Neurodevelopment Screener (BINS) in the Child Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result. ([a]p< .10).

Table 3: Cognitive Development of Young Children Birth to 47 Months Old

	N	High Risk for Cognitive Delay Percent/SE	Total Cognitive Developmental Quotient Mean/SE	Attention & Memory Domain Mean/SE	Reasoning & Academic Domain[1] Mean/SE	Perception & Concepts Domain Mean/SE
Total	**288**	**17% (4.0)**	**91.7 (.9)**	**9.3 (.2)**	**7.6 (.6)**	**7.4 (.3)**
Child Setting		**				
Traditional Foster Care	**19**	**27% (9.5)**	**96.9 (4.9)**	**10.4 (1.1)**	**6.9 (1.6)**	**7.5 (1.1)**
Kinship Care	**48**	**3% (1.0)**	**94.8 (4.6)**	**9.1 (.7)**	**9.4 (1.3)**	**8.3 (1.0)**
In-Home w/Services	**192**	**11% (1.7)**	**93.6 (1.7)**	**9.6 (.5)**	**8.1 (.5)**	**8.1 (.3)**
In-Home w/out Services	**29**	**29% (8.9)**	**87.8 (3.6)**	**8.9 (.5)**	**6.8 (1.2)**	**6.3 (.8)**
Region						
Cook	**172**	**17% (4.1)**	**92.0 (1.2)**	**9.3 (.2)**	**7.4 (.6)**	**7.7 (.5)**
Central	**49**	**9% (8.1)**	**92.2 (2.3)**	**9.4 (.2)**	**9.8 (1.0)**	**7.7 (.4)**
Northern	**39**	**17% (6.8)**	**93.1 (.6)**	**9.5 (.4)**	**7.9 (.7)**	**7.5 (.2)**
Southern	**28**	**32% (17.9)**	**87.4 (4.5)**	**8.7 (.6)**	**6.0 (1.9)**	**6.5 (1.1)**
Population Density						
Non-Rural	**239**	**18% (5.1)**	**91.8 (1.2)**	**9.4 (.2)**	**7.5 (.8)**	**7.3 (.3)**
Rural	**49**	**16% (4.7)**	**91.3 (1.1)**	**9.0 (.2)**	**7.9 (.5)**	**7.7 (.3)**
Sex		[a]				
Male	**150**	**24% (6.7)**	**88.9 (2.5)**	**8.7 (.6)**	**7.3 (.7)**	**7.0 (.6)**
Female	**138**	**9% (2.8)**	**94.8 (2.2)**	**10.0 (.5)**	**8.1 (.8)**	**7.9 (.4)**
Race/Ethnicity						
African-American	**163**	**13% (5.0)**	**93.3 (1.8)**	**9.5 (.5)**	**8.6 (1.0)**	**7.9 (.3)**
White	**71**	**25% (4.6)**	**88.8 (1.7)**	**9.0 (.4)**	**7.0 (.6)**	**6.6 (.4)**
Hispanic	**50**	**15% (16.9)**	**92.4 (7.6)**	**9.3 (1.4)**	**7.2 (2.7)**	**7.7 (1.4)**
Other	**3**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Child Age (months)		[a]		*[2]		*[3]
0-5	**79**	**10% (7.8)**	**100.2 (4.8)**	**9.8 (.7)**	**N/A**	**10.3 (1.1)**
6-11	**92**	**4% (2.9)**	**104.4 (1.9)**	**11.7 (.5)**	**N/A**	**9.5 (.4)**
12-17	**46**	**14% (10.8)**	**89.0 (3.2)**	**8.9 (.7)**	**N/A**	**7.8 (.6)**
18-23	**24**	**9% (3.6)**	**93.1 (2.8)**	**9.6 (.6)**	**N/A**	**7.9 (.4)**
24-35	**23**	**21% (7.7)**	**86.6 (1.4)**	**8.7 (.4)**	**8.0 (.6)**	**6.2 (.7)**
36-47	**24**	**43% (17.0)**	**77.9 (5.6)**	**7.1 (1.2)**	**7.2 (1.0)**	**3.9 (1.2)**

Note: Children age 0 to 4. From the Battelle Development Inventory in the Child Interview. All analyses used weighted data. The sample sizes presented are unweighted. Cell results are omitted when cell n falls below 15. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result ([a] p<.10, *p<.05, **p<.01).

[1] Children 24 to 47 months were interviewed

[2] 6-11 > 24-47

[3] 36-47 < 0-23

Table 4: Language Development in Young Children

	N	PLS-3 Total Mean/SE	PLS-3 Auditory Mean/SE	PLS-3 Expressive Mean/SE
Total	**337**	**84.0 (2.0)**	**88.1 (1.5)**	**82.5 (2.2)**
Child Setting				
Out of Home	**76**	**84.9 (4.5)**	**86.9 (4.5)**	**82.8 (5.3)**
In-Home w/Services	**213**	**85.3 (2.1)**	**88.0 (1.5)**	**84.8 (2.9)**
In-Home w/out Services	**48**	**82.2 (2.2)**	**88.5 (2.2)**	**79.9 (2.4)**
Region				
Cook	**193**	**81.9 (3.8)**	**87.7 (1.9)**	**78.8 (4.8)**
Central	**56**	**82.9 (2.6)**	**87.7 (.56)**	**80.3 (3.3)**
Northern	**47**	**87.4 (5.6)**	**89.8 (4.8)**	**87.4 (4.6)**
Southern	**41**	**83.9 (.7)**	**86.9 (3.3)**	**84.0 (4.6)**
Population Density				
Non-Rural	**61**	**84.8 (2.3)**	**89.7 (1.6)**	**82.5 (2.7)**
Rural	**276**	**82.1 (2.4)**	**84.6 (1.1)**	**82.5 (3.0)**
Sex				
Male	**177**	**82.4 (2.9)**	**86.5 (2.8)**	**80.7 (2.6)**
Female	**160**	**85.8 (1.3)**	**90.1 (1.1)**	**84.7 (2.4)**
Race/Ethnicity				
African-American	**186**	**82.0 (2.2)**	**86.9 (1.2)**	**80.1 (3.1)**
White	**88**	**86.4 (4.5)**	**88.8 (4.2)**	**87.0 (3.3)**
Hispanic	**57**	**82.7 (3.3)**	**86.7 (3.8)**	**79.7 (2.0)**
Other	**8**	**N/A**	**N/A**	**N/A**
Child Age				
Under 3	**265**	**84.5 (2.5)**	**88.0 (2.1)**	**84.5 (2.5)**
3 to 5	**72**	**83.3 (2.0)**	**88.3 (1.4)**	**80.0 (2.6)**
6 to 8	**0**	**N/A**	**N/A**	**N/A**
9 to 11	**0**	**N/A**	**N/A**	**N/A**
12 to 17	**0**	**N/A**	**N/A**	**N/A**

Note: From the Preschool Language Test-3 (PLS-3; children age 0 to 5) in the Child Interview. "N/A" indicates that the measure is not applicable to a group. All analyses used weighted data. The sample sizes presented are unweighted. Cell results are omitted when cell n falls below 15. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result.

Table 5: Cognitive Development of School-Aged Children

	N	K-BIT Composite Mean/SE	K-BIT Vocabulary Mean/SE	K-BIT Matrices Mean/SE
Total	**199**	**93.0 (1.2)**	**91.6 (1.3)**	**95.9 (1.1)**
Child Setting				
Out of Home	**33**	**90.5 (2.9)**	**84.1 (3.4)**	**98.9 (2.4)**
In-Home w/Services	**89**	**90.8 (1.6)**	**89.6 (2.0)**	**94.4 (1.3)**
In-Home w/out Services	**77**	**94.2 (1.9)**	**93.7 (1.7)**	**95.8 (1.9)**
Region				
Cook	**79**	**93.4 (1.0)**	**89.4 (.61)**	**98.8 (1.5)**
Central	**52**	**92.0 (2.9)**	**90.9 (2.8)**	**95.1 (2.1)**
Northern	**45**	**94.4 (2.0)**	**95.1 (2.2)**	**94.7 (2.3)**
Southern	**23**	**91.3 (2.6)**	**88.4 (.6)**	**95.1 (4.5)**
Population Density				
Non-Rural	**143**	**92.7 (1.2)**	**90.2 (1.0)**	**96.5 (1.3)**
Rural	**56**	**93.6 (2.5)**	**94.1 (2.5)**	**94.9 (1.9)**
Sex				*
Male	**100**	**89.5 (1.4)**	**89.6 (2.0)**	**91.8 (1.0)**
Female	**99**	**96.0 (1.7)**	**93.3 (1.6)**	**99.5 (1.6)**
Race/Ethnicity				
African-American	**89**	**93.3 (1.4)**	**89.5 (1.2)**	**98.4 (1.8)**
White	**62**	**94.7 (1.4)**	**97.0 (2.0)**	**93.5 (1.8)**
Hispanic	**37**	**88.3 (2.4)**	**84.8 (1.8)**	**94.2 (3.1)**
Other	**11**	**N/A**	**N/A**	**N/A**
Child Age				
Under 3	**0**	**N/A**	**N/A**	**N/A**
3 to 5	**45**	**90.1 (3.3)**	**94.1 (2.8)**	**89.0 (4.8)**
6 to 8	**47**	**95.0 (2.6)**	**94.4 (3.0)**	**96.6 (1.9)**
9 to 11	**48**	**96.4 (2.6)**	**90.8 (4.2)**	**102.6(1.9)**
12 to 17	**59**	**90.8 (3.3)**	**87.8 (2.5)**	**95.7 (3.9)**

Note: From the Kaufman Brief Intelligence Test (K-BIT; children age 4 and older) in the Child Interview. "N/A" indicates that the measure is not applicable to a group. All analyses used weighted data. The sample sizes presented are unweighted. Cell results are omitted when cell n falls below 15. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result (* $p<.05$).

Table 6: Adaptive Living Skills

	N	Very Low Percent/SE	Moderate Low Percent/SE	Adequate to High Percent/SE
Total	**765**	**12% (1.4)**	**18% (1.7)**	**70% (1.2)**
Child Setting				
Traditional Foster Care	**140**	**22% (9.8)**	**21% (9.8)**	**57% (5.9)**
Kinship Care	**177**	**17% (7.7)**	**19% (4.0)**	**64% (9.3)**
In-Home w/Services	**340**	**10% (1.7)**	**17% (3.1)**	**73% (3.2)**
In-Home w/out Services	**108**	**12% (2.1)**	**19% (1.8)**	**69% (3.0)**
Region				
Cook	**389**	**15% (.4)**	**16% (1.5)**	**69% (2.0)**
Central	**183**	**7% (3.3)**	**18% (4.8)**	**75% (2.0)**
Northern	**122**	**13% (3.0)**	**19% (3.0)**	**67% (2.7)**
Southern	**71**	**11% (4.4)**	**22% (1.2)**	**67% (3.3)**
Population Density		**ª**		
Non-Rural	**588**	**15% (1.2)**	**17% (1.0)**	**69% (1.7)**
Rural	**177**	**7% (2.4)**	**21% (3.8)**	**72% (2.4)**
Sex		******		
Male	**389**	**17% (2.0)**	**25% (3.5)**	**59% (2.4)**
Female	**376**	**7% (1.9)**	**12% (2.1)**	**81% (2.6)**
Race/Ethnicity		**ª**		
African-American	**420**	**9% (3.3)**	**12% (2.8)**	**78% (2.3)**
White	**180**	**16% (4.3)**	**25% (3.6)**	**59% (4.7)**
Hispanic	**142**	**12% (5.8)**	**21% (2.4)**	**67% (6.4)**
Other	**21**	**1% (1.3)**	**0% (0)**	**99% (1.3)**
Child Age		*		
0 to 2	**496**	**4% (1.4)**	**22% (3.2)**	**74% (2.3)**
3 to 5	**125**	**20% (2.7)**	**21% (3.8)**	**59% (2.9)**
6 to 8	**69**	**17% (4.8)**	**10% (3.8)**	**73% (7.6)**
9 to 11	**64**	**10% (3.1)**	**18% (4.5)**	**72% (7.0)**
12 to 17	**11**	**N/A**	**N/A**	**N/A**

Note: From the Vineland Adaptive Behavior Scale in the Caregiver Interview. All analyses used weighted data. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by an asterisk alongside the variable name (ªp< .10, * p<.05, **p < .01).

Table 7: Child Tested for Developmental Disability or Learning Problem

	N	Child Tested for Developmental Disability Percent/SE	Told by Professional Child has Disability Percent/SE
Total	**818**	**28% (2.1)**	**21% (1.6)**
Child Setting		*	
Traditional Foster Care	**145**	**43% (6.4)**	**28% (5.5)**
Kinship Care	**182**	**27% (4.1)**	**24% (5.3)**
In-Home w/Services	**360**	**27% (1.4)**	**17% (2.1)**
In-Home w/out Services	**131**	**28% (4.1)**	**22% (4.3)**
Region			
Cook	**417**	**23% (1.9)**	**19% (2.5)**
Central	**197**	**24% (5.0)**	**21% (6.5)**
Northern	**130**	**36% (4.5)**	**21% (5.7)**
Southern	**74**	**31% (2.8)**	**22% (.8)**
Population Density			
Non-Rural	**632**	**29% (2.2)**	**22% (2.0)**
Rural	**186**	**27% (4.6)**	**19% (1.4)**
Sex		*	*
Male	**416**	**32% (1.9)**	**27% (2.6)**
Female	**402**	**24% (3.0)**	**14% (3.3)**
Race/Ethnicity		**	
African-American	**442**	**23% (2.8)**	**19% (3.1)**
White	**192**	**38% (5.8)**	**24% (7.3)**
Hispanic	**155**	**16% (3.0)**	**13% (4.5)**
Other	**27**	**59% (13.4)**	**52% (8.0)**
Child Age			**
Under 3	**497**	**19% (4.7)**	**7% (1.3)**
3 to 5	**125**	**28% (6.3)**	**18% (3.5)**
6 to 8	**69**	**43% (8.2)**	**30% (6.4)**
9 to 11	**64**	**30% (2.3)**	**30% (2.6)**
12 to 17	**63**	**32% (6.6)**	**38% (4.1)**

Note: From various measures in the Caregiver Interview. Cells include percentages and standard errors. All analyses used weighted data. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result ($^a p < .10$, $^* p < .05$, $^{**} p < .01$).

Table 8: Early Intervention, Special Education, and Therapeutic Services

	N	Child Ever had an IFSP Percent/SE	Child Ever had an IEP Percent/SE	Physical, Occupational, or Speech Therapy on a Regular Basis Percent/SE
Total	**818**	**5% (1.4)**	**30% (3.2)**	**12% (1.0)**
Child Setting		**	[a]	*
Traditional Foster Care	**145**	**17% (2.0)**	**62% (13.2)**	**29% (7.5)**
Kinship Care	**182**	**7% (4.6)**	**37% (7.8)**	**7% (4.3)**
In-Home w/Services	**360**	**6% (1.1)**	**25% (6.5)**	**13% (2.8)**
In-Home w/out Services	**131**	**2% (2.0)**	**30% (4.3)**	**11% (3.4)**
Region		*		
Cook	**417**	**5% (.3)**	**24% (1.4)**	**13% (1.7)**
Central	**197**	**5% (4.5)**	**33% (4.5)**	**9% (2.6)**
Northern	**130**	**4% (1.7)**	**31% (9.5)**	**13% (2.0)**
Southern	**74**	**11% (1.8)**	**31% (3.1)**	**15% (3.6)**
Population Density				
Non-Rural	**632**	**6% (1.3)**	**29% (4.1)**	**13% (.9)**
Rural	**186**	**4% (1.9)**	**32% (5.1)**	**9% (2.2)**
Sex		[a]		
Male	**416**	**7% (2.5)**	**40% (3.3)**	**15% (2.7)**
Female	**402**	**3% (.5)**	**23% (6.9)**	**8% (3.4)**
Race/Ethnicity				
African-American	**442**	**8% (4.0)**	**27% (6.8)**	**12% (2.7)**
White	**192**	**3% (1.3)**	**35% (8.3)**	**13% (3.7)**
Hispanic	**155**	**4% (3.2)**	**16% (5.1)**	**9% (2.9)**
Other	**27**	**0% (0)**	**N/A**	**15% (13.9)**
Child Age			[a]	
Under 3	**497**	**5% (2.1)**	**N/A**	**12% (2.0)**
3 to 5	**125**	**6% (2.1)[1]**	**12% (9.7)[2]**	**8% (1.8)**
6 to 8	**69**	**N/A**	**28% (6.8)**	**19% (5.9)**
9 to 11	**64**	**N/A**	**33% (7.2)**	**16% (3.0)**
12 to 17	**63**	**N/A**	**38% (5.6)**	**9% (2.9)**

Note: From various measures in the Caregiver Interview. Cells include percentages and standard errors. All analyses used weighted data. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result ([a] p<.10, *p<.05, ** p<.01).

[1] Children ages 3 to 4

[2] Children age 5

Table 9: Enrollment in Early Childhood Care and Education

	N	Percent/SE
Total	**125**	**74% (6.7)**
Child Setting		
Out-of-Home Care	**39**	**80% (7.8)**
In-Home w/Services	**53**	**70% (6.0)**
In-Home w/out Services	**33**	**76% (10.3)**
Region		
Cook	**50**	**67% (3.4)**
Central	**35**	**61% (14.8)**
Northern	**19**	**85% (12.5)**
Southern	**21**	**90% (14.2)**
Population Density		
Non-Rural	**88**	**71% (8.0)**
Rural	**37**	**78% (11.8)**
Sex		
Male	**69**	**69% (9.3)**
Female	**56**	**79% (6.4)**
Race/Ethnicity		[a]
African-American	**65**	**76% (7.7)**
White	**34**	**77% (6.3)**
Hispanic	**22**	**58% (10.8)**
Other	**4**	**N/A**
Child Age		*
3	**50**	**58% (10.6)**
4	**46**	**74% (9.5)**
5	**29**	**94% (5.9)**

Note: Children age 3 to 5. From various measures on the Caregiver Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result ([a] $p<.10$, *$p < .05$).

Table 10: Grade-Level Proficiency by Subject

		Math Percent/SE			Science Percent/SE			Language Percent/SE		
	N	Below	Average	Above	Below	Average	Above	Below	Average	Above
Total	94	46%	37%	18%	43%	43%	13%	56%	23%	21%
		(4.9)	(5.2)	(3.6)	(4.6)	(6.7)	(5.9)	(5.0)	(5.1)	(3.3)
Setting										
Out-of-Home	20	49%	37%	14%	65%	23%	12%	64%	14%	22%
		(7.6)	(12.8)	(9.0)	(14.3)	(14.1)	(9.2)	(14.5)	(9.2)	(11.1)
In-Home w/Services	39	39%	50%	11%	45%	44%	11%	50%	34%	16%
		(10.6)	(11.8)	(6.0)	(6.5)	(6.5)	(7.0)	(7.7)	(5.4)	(5.4)
In-Home w/out Services	35	48%	29%	23%	41%	44%	15%	59%	19%	22%
		(8.2)	(5.8)	(5.8)	(9.4)	(11.2)	(7.9)	(10.9)	(8.9)	(6.2)
Region										
Cook	37	42%	54%	4%	51%	42%	7%	68%	21%	11%
		(8.6)	(12.9)	(4.3)	(2.2)	(11.4)	(9.2)	(2.4)	(2.9)	(.6)
Central	27	45%	38%	17%	46%	37%	17%	61%	21%	18%
		(6.4)	(5.9)	(3.6)	(6.5)	(5.9)	(3.6)	(7.5)	(12.1)	(5.4)
Northern	20	49%	24%	27%	37%	46%	17%	45%	21%	34%
		(10.9)	(7.4)	(4.0)	(10.2)	(17.4)	(15.5)	(9.1)	(4.1)	(5.5)
Southern	10	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Population Density										
Non-Rural	66	45%	38%	17%	44%	39%	17%	57%	21%	22%
		(5.6)	(7.7)	(4.3)	(5.6)	(5.5)	(7.9)	(7.4)	(5.6)	(4.9)
Rural	29	47%	34%	19%	43%	50%	7%	55%	27%	18%
		(5.9)	(5.7)	(6.1)	(6.6)	(9.9)	(3.4)	(6.0)	(8.0)	(5.7)
Sex										
Male	49	44%	49%	7%	53%	39%	8%	62%	25%	13%
		(8.8)	(10.0)	(5.2)	(4.7)	(9.3)	(5.9)	(8.6)	(9.2)	(4.3)
Female	46	47%	25%	28%	34%	48%	18%	51%	22%	27%
		(8.8)	(6.9)	(5.4)	(9.0)	(9.4)	(7.3)	(9.1)	(8.2)	(5.5)
Race										
African-American	40	44%	38%	18%	32%	53%	15%	50%	31%	19%
		(8.5)	(13.4)	(9.1)	(7.0)	(9.1)	(9.6)	(10.7)	(9.3)	(6.7)
White	25	45%	35%	20%	48%	42%	10%	55%	20%	25%
		(8.6)	(5.7)	(7.0)	(12.4)	(17.9)	(7.6)	(4.8)	(2.6)	(3.4)
Hispanic	27	43%	38%	19%	46%	35%	19%	65%	16%	19%
		(15.6)	(7.5)	(7.0)	(16.0)	(8.4)	(10.2)	(8.6)	(7.0)	(10.2)
Other	3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Child Age										
5 to 10	55	48%	37%	15%	42%	47%	11%	54%	25%	21%
		(5.2)	(5.2)	(6.1)	(6.7)	(9.7)	(5.7)	(5.0)	(5.8)	(3.1)
11 to 17	40	41%	36%	23%	45%	38%	17%	59%	21%	20%
		(10.4)	(9.5)	(9.2)	(8.8)	(7.1)	(9.0)	(8.3)	(9.0)	(8.5)

Note: School-age children and youth. From selected questions in the Teacher Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result.

Table 11: Grade Repetition

	N	Percent/SE
Total	**72**	**13% (4.3)**
Child Setting		
Out-of-Home	**15**	**13% (9.1)**
In-Home w/Services	**28**	**10% (3.3)**
In-Home w/out Services	**29**	**14% (7.2)**
Region		
Cook	**28**	**19% (4.9)**
Central	**21**	**6% (5.5)**
Northern	**17**	**19% (8.9)**
Southern	**6**	**N/A**
Population Density		
Non-Rural	**50**	**13% (2.8)**
Rural	**22**	**13% (8.7)**
Sex		
Male	**32**	**18% (3.7)**
Female	**40**	**9% (5.7)**
Race/Ethnicity		
African-American	**27**	**6% (1.5)**
White	**23**	**15% (7.6)**
Hispanic	**21**	**19% (7.3)**
Other	**1**	**N/A**
Child Age		**
5 to 9	**45**	**6% (3.6)**
10 to 17	**27**	**24% (6.9)**

Note: School-age children and youth. From selected questions in the Caregiver Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result (** p< .01).

Table 12: Academic Achievement

	N	WJ Letter Identification Mean/SE	WJ Passage Comprehension Mean/SE	WJ Applied Problems Mean/SE
Total	**171**	**97.8 (1.3)**	**92.9 (1.4)**	**92.5 (1.5)**
Child Setting				
Out-of-Home	**32**	**93.2 (3.8)**	**86.5 (5.8)**	**89.0 (3.1)**
In-Home w/ Services	**77**	**99.2 (2.0)**	**91.6 (1.1)**	**91.4 (1.9)**
In-Home w/out Services	**66**	**97.8 (2.4)**	**95.4 (2.7)**	**93.8 (2.1)**
Region		*		*
Cook	**68**	**95.3 (.9)**	**87.6 (.9)**	**87.6 (.8)**
Central	**45**	**97.4 (2.6)**	**90.3 (3.3)**	**92.7 (1.7)**
Northern	**40**	**101.4 (1.4)**	**98.1 (1.5)**	**95.4 (3.5)**
Southern	**18**	**93.0 (5.0)**	**91.6 (1.8)**	**95.2 (2.2)**
Population Density				
Non-Rural	**122**	**100.8 (1.7)**	**90.9 (2.0)**	**90.4 (1.7)**
Rural	**49**	**95.9 (1.5)**	**96.0 (2.1)**	**96.1 (1.7)**
Sex				
Male	**87**	**94.4 (2.4)**	**90.3 (2.0)**	**89.4 (2.1)**
Female	**84**	**100.5 (1.1)**	**95.0 (1.2)**	**95.1 (2.1)**
Race/Ethnicity				
African-American	**77**	**94.7 (2.4)**	**90.8 (1.1)**	**89.2 (1.6)**
White	**53**	**101.8 (1.3)**	**97.1 (1.7)**	**95.3 (2.9)**
Hispanic	**32**	**97.0 (2.5)**	**84.2 (5.0)**	**93.9 (2.9)**
Other	**9**	**N/A**	**N/A**	**N/A**
Child Age				*
5-7	**46**	**97.8 (3.2)**	**96.3 (2.3)**	**89.7 (3.4)**
8-10	**45**	**100.3 (2.0)**	**92.0 (2.3)**	**98.5 (2.3)**
11-13	**49**	**96.1 (2.6)**	**86.2 (5.9)**	**90.8 (2.0)**
14-17	**31**	**96.2 (2.2)**	**N/A**	**90.2 (1.0)**

Note: From the Woodcock-Johnson III Tests of Achievement in the Child Interview. All analyses used weighted data. The sample sizes presented are unweighted. Cell results are omitted when cell n falls below 15. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result (*$p < .05$).

Table 13: General Child Health

	N	Percent in Good Health[1] Percent/SE	Up-to-date with Immunizations Percent/SE	Caregiver Reports Special Healthcare Need[2] Percent/SE	Physical Disability[3] Percent/SE
Total	**818**	**95% (1.3)**	**98% (.5)**	**40% (1.7)**	**2% (1.2)**
Child Setting					
Traditional Foster Care	**145**	**95% (1.8)**	**97% (1.5)**	**49% (5.4)**	**2% (1.6)**
Kinship Care	**182**	**95% (3.5)**	**98% (1.8)**	**35% (3.9)**	**3% (2.7)**
In-Home w/Services	**359**	**95% (1.5)**	**96% (1.0)**	**40% (2.4)**	**1% (.5)**
In-Home w/out Services	**130**	**95% (1.7)**	**99% (.8)**	**42% (4.1)**	**2% (1.0)**
Region				[a]	
Cook	**417**	**92% (1.6)**	**95% (.5)**	**36% (4.3)**	**3% (2.7)**
Central	**197**	**95% (2.4)**	**99% (.6)**	**37% (2.4)**	**2% (1.9)**
Northern	**130**	**98% (1.3)**	**99% (.4)**	**48% (4.2)**	**0% (0)**
Southern	**74**	**95% (1.8)**	**97% (3.8)**	**33% (.7)**	**9% (4.4)**
Population Density					
Non-Rural	**632**	**94% (1.2)**	**97% (.5)**	**38% (2.8)**	**4% (1.5)**
Rural	**186**	**96% (2.0)**	**99% (1.0)**	**42% (2.6)**	**0% (0)**
Sex			*	*	
Male	**416**	**94% (1.5)**	**97% (.8)**	**48% (3.0)**	**2% (1.4)**
Female	**402**	**96% (1.3)**	**99% (.3)**	**31% (4.7)**	**3% (1.8)**
Race/Ethnicity					
African-American	**442**	**93% (2.4)**	**97% (1.0)**	**40% (3.4)**	**4% (2.3)**
White	**192**	**98% (1.3)**	**100% (.2)**	**44% (3.8)**	**0% (0)**
Hispanic	**155**	**94% (3.0)**	**96% (2.0)**	**30% (5.1)**	**3% (2.6)**
Other	**27**	**95% (1.2)**	**100% (0)**	**51% (15.9)**	**N/A**
Child Age				**	
Under 3	**497**	**97% (1.9)**	**95% (1.5)**	**30% (3.3)**	**N/A**
3 to 5	**125**	**95% (3.0)**	**97% (1.9)**	**34% (4.8)**	**0% (0)**
6 to 8	**69**	**96% (3.3)**	**100% (0)**	**57% (4.6)**	**4% (2.9)**
9 to 11	**64**	**93% (3.0)**	**100% (0)**	**45% (6.6)**	**3% (2.6)**
12 to 17	**63**	**92% (3.4)**	**100% (0)**	**46% (4.9)**	**1% (1.2)**

Note: From various measures in the Caregiver Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result ([a]p< .10 *p < .05, **p < .01).

[1] "Good health" was defined as caregiver ratings of "good, very good, or excellent" health.

[2] "Special Health Care need" was defined here using 2 overall sections of the caregiver reported child health and health services interview: chronic health and disability. For the first section, caregivers were asked about specific health problems, such as asthma, diabetes, etc., as well as specific questions about conditions that are expected to last at least one year (life-threatening allergic reaction, reduced effort, vision and hearing problems). The second section (disability) asks caregiver if a professional has ever told them that their child has a learning problem or special need. Some children have both chronic health conditions and disabilities, but were counted only once for special health care needs.

[3] A physical disability is defined as a condition that substantially limits one or more basic physical activities, such as walking, climbing stairs, reaching, lifting, or carrying. This was measured for children 5-17 years of age and included cystic fibrosis, cerebral palsy, muscular dystrophy, blindness, deafness, traumatic brain injury, and orthopedic impairment.

Table 14: Body Mass Index (BMI) of Children 2 Years of Age and Older

	N	Underweight[1] Percent/SE	Healthy Weight Percent/SE	Obese Percent/SE
Total	**338**	**6% (2.0)**	**73% (3.5)**	**21% (4.4)**
Child Setting				
Traditional Foster Care	**37**	**1% (.8)**	**70% (10.4)**	**29% (9.8)**
Kinship Care	**66**	**12% (3.8)**	**67% (5.1)**	**20% (6.4)**
In-Home w/Services	**131**	**5% (3.0)**	**71% (4.4)**	**24% (4.2)**
In-Home w/out Services	**104**	**5% (1.9)**	**76% (5.9)**	**19% (6.6)**
Region				
Cook	**130**	**7% (6.3)**	**63% (2.9)**	**30% (3.3)**
Central	**99**	**7% (3.0)**	**76% (9.3)**	**17% (11.5)**
Northern	**70**	**3% (3.1)**	**75% (2.6)**	**21% (4.6)**
Southern	**39**	**7% (.1)**	**79% (1.0)**	**13% (1.0)**
Population Density				
Non-Rural	**233**	**7% (2.7)**	**71% (2.5)**	**22% (3.6)**
Rural	**105**	**4% (2.0)**	**76% (8.4)**	**20% (10.1)**
Sex				
Male	**176**	**8% (3.3)**	**72% (4.9)**	**20% (5.3)**
Female	**762**	**4% (1.6)**	**74% (3.7)**	**22% (4.1)**
Race/Ethnicity				
African-American	**149**	**7% (3.2)**	**66% (6.5)**	**27% (6.0)**
White	**103**	**2% (1.2)**	**80% (3.1)**	**18% (3.8)**
Hispanic	**70**	**12% (5.2)**	**73% (6.0)**	**15% (2.4)**
Other	**16**	**1% (.8)**	**72% (17.7)**	**27% (17.0)**
Child Age				
2 to 5	**158**	**6% (2.4)**	**73% (4.3)**	**21% (5.1)**
6 to 11	**120**	**7% (3.1)**	**74% (4.8)**	**19% (5.3)**
12 to 17	**60**	**4% (3.0)**	**72% (6.4)**	**24% (7.7)**

Note: From the Child Health Questionnaire in the Caregiver Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result (* p<.10).

[1] Following Center for Disease Control methods, Body Mass Index (BMI) was calculated by age and gender of child with this equation: [weight/(height^2)] x 703. "Underweight" was lowest 5th percentile of BMI and "obese" was above the 95th percentile.

Table 15: Well-Child Medical and Dental Care

	N	Child has Insurance Coverage Percent/SE	Well-Child Visits in Previous 12 Months Percent/SE	Child has a Medical Home[1] Percent/SE	Dental Check-Up: Ever Percent/SE	Dental Check-Up: Since DCFS Contact Percent/SE
Total	**818**	**99% (0.4)**	**88% (2.2)**	**98% (.5)**	**77% (3.9)**	**70% (3.2)**
Child Setting			[a]			
Traditional Foster Care	**145**	**100% (0.5)**	**99% (.6)**	**99% (.4)**	**72% (10.0)**	**72% (9.8)**
Kinship Care	**182**	**97% (1.4)**	**93% (3.9)**	**97% (1.8)**	**65% (7.3)**	**58% (6.6)**
In-Home w/Services	**359**	**99% (0.8)**	**90% (1.7)**	**98% (.8)**	**79% (3.7)**	**71% (2.9)**
In-Home w/out Services	**130**	**99% (0.1)**	**84% (3.6)**	**98% (.9)**		
Region						
Cook	**417**	**96% (1.3)**	**89% (2.2)**	**98% (.7)**	**81% (2.2)**	**73% (1.5)**
Central	**197**	**99% (0.5)**	**82% (6.4)**	**99% (.6)**	**76% (7.1)**	**69% (3.3)**
Northern	**130**	**100% (0.3)**	**91% (1.7)**	**97% (1.2)**	**76% (9.6)**	**71% (10.3)**
Southern	**74**	**100% (0)**	**96% (.8)**	**99% (1.4)**	**71% (12.3)**	**61% (5.5)**
Population Density						
Non-Rural	**632**	**98% (0.7)**	**88% (2.2)**	**98% (.6)**	**78% (2.8)**	**69% (2.3)**
Rural	**186**	**100% (0.2)**	**87% (6.0)**	**98% (1.0)**	**75% (7.1)**	**71% (6.0)**
Sex				*		
Male	**416**	**98% (0.5)**	**86% (1.7)**	**96% (.9)**	**71% (5.5)**	**63% (4.3)**
Female	**402**	**99% (0.8)**	**90% (3.1)**	**99% (.5)**	**82% (3.6)**	**76% (3.2)**
Race/Ethnicity						
African-American	**442**	**99% (0.8)**	**91% (1.1)**	**97% (1.2)**	**79% (5.2)**	**67% (3.1)**
White	**192**	**99% (0.8)**	**84% (4.9)**	**98% (1.4)**	**74% (8.0)**	**72% (7.3)**
Hispanic	**155**	**98% (1.3)**	**89% (4.4)**	**99% (.8)**	**80% (10.1)**	**70% (9.2)**
Other	**27**	**100% (0.5)**	**89% (11.1)**	**100% (0)**	**70% (15.3)**	**69% (15.3)**
Child Age			*			
0-2	**497**	**98% (0.2)**	**94% (1.5)**	**97% (1.7)**	**31% (13.0)**	**31% (13.0)**
3 to 5	**125**	**99% (1)**	**93% (2.1)**	**96% (2.2)**	**67% (3.8)**	**64% (2.3)**
6 to 8	**69**	**100% (0)**	**87% (4.6)**	**100% (0)**	**90% (2.8)**	**80% (4.2)**
9 to 11	**64**	**99% (0.6)**	**74% (9.2)**	**99% (1.3)**	**94% (3.4)**	**76% (4.6)**
12 to 17	**63**	**98% (1.6)**	**80% (4.9)**	**99% (1.1)**	**90% (3.2)**	**84% (3.4)**

Note: From various measures in the Caregiver Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result ([a]p< .10 *p < .05).

[1] Medical home indicates a child has a place to go when they are sick. These include clinic, doctor's office, health center, or hospital outpatient department.

Table 16: Emergency Department Visits

	Emergency dept usage	
	N	Percent/SE
Total	**811**	**35% (4.1)**
Child Setting		
Traditional Foster Care	**141**	**22% (4.5)**
Kinship Care	**181**	**31% (5.6)**
In-Home w/Services	**358**	**36% (4.8)**
In-Home w/out Services	**131**	**37% (7.1)**
Region		
Cook	**411**	**26% (4.8)**
Central	**196**	**33% (3.0)**
Northern	**130**	**47% (11.7)**
Southern	**74**	**35% (9.8)**
Population Density		
Non-Rural	**625**	**29% (3.2)**
Rural	**186**	**47% (6.9)**
Sex		
Male	**409**	**42% (3.9)**
Female	**402**	**29% (5.0)**
Race/Ethnicity		
African-American	**437**	**30% (3.2)**
White	**191**	**48% (7.7)**
Hispanic	**154**	**27% (7.7)**
Other	**27**	**27% (16.4)**
Child Age		
0-2	**494**	**39% (2.4)**
3 to 5	**123**	**39% (5.2)**
6 to 8	**69**	**36% (13.6)**
9 to 11	**64**	**18% (6.6)**
12 to 17	**61**	**35% (6.1)**

Table 17: Children in Clinical/Borderline Clinical Range for Emotional and Behavior Problems

Who Reported on Child/Youth's Problems?

	Caregiver[1]		Teacher[2]		Youth Themselves[3]	
	N	Percent/SE	N	Percent/SE	N	Percent/SE
Total	**401**	**29% (2.0)**	**96**	**34% (5.4)**	**85**	**27% (8.5)**
Child Setting		****[4]**				
Traditional Foster Care	**45**	**61% (7.1)**				
Kinship Care	**78**	**26% (8.6)**				
In-Home w/Services	**162**	**25% (3.9)**				
In-Home w/out Services	**116**	**31% (2.2)**				
Child Setting[5]				**a**		
Out-of-Home			**21**	**63% (16.8)**	**18**	**34% (15.0)**
In-Home			**70**	**28% (4.4)**	**63**	**27% (9.7)**
Region		*****				
Cook	**164**	**30% (2.9)**	**37**	**45% (6.8)**	**40**	**21% (12.0)**
Central	**111**	**28% (2.1)**	**28**	**33% (7.8)**	**25**	**32% (16.9)**
Northern	**78**	**36% (2.5)**	**22**	**24% (7.8)**	**12**	**N/A**
Southern	**48**	**15% (4.8)**	**9**	**N/A**	**8**	**N/A**
Population Density						
Non-Rural	**282**	**29% (2.6)**	**66**	**38% (6.7)**	**67**	**25% (6.4)**
Rural	**119**	**30% (3.4)**	**30**	**29% (8.9)**	**18**	**31% (25.2)**
Sex		**a**				
Male	**215**	**37% (3.1)**	**50**	**38% (9.5)**	**45**	**31% (11.7)**
Female	**186**	**22% (4.3)**	**46**	**30% (7.1)**	**40**	**24% (8.2)**
Race/Ethnicity						
African-American	**186**	**30% (5.1)**	**39**	**35% (10.2)**	**41**	**29% (7.6)**
White	**113**	**31% (4.0)**	**26**	**33% (9.7)**	**18**	**21% (14.8)**
Hispanic	**86**	**24% (3.6)**	**27**	**28% (5.8)**	**19**	**20% (5.8)**
Other	**16**	**34% (18.2)**	**4**	**N/A**	**7**	**N/A**
Child Age		*****				
1 ½ -4	**177**	**18% (1.6)**	**0**	**N/A**	**0**	**N/A**
5-7	**72**	**38% (5.2)**	**22**	**28% (9.9)**	**0**	**N/A**
8-10	**67**	**36% (5.3)**	**33**	**27% (7.9)**	**0**	**N/A**
11-13	**50**	**31% (8.4)**	**25**	**51% (12.3)**	**50**	**25% (8.6)**
14-17	**35**	**43% (5.8)**	**16**	**32% (13.8)**	**35**	**29% (9.3)**

Note: Total scale scores used. All analyses used weighted data. The sample sizes presented are unweighted. Cell results are omitted when cell n falls below 15. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result ($^a p < .10$ $^* p < .05$).

[1] Child Behavior Checklist from the Caregiver Interview, children and youth age 1½ to 17.

[2] Teacher Report Form, children and youth age 5 to 17.

[3] Youth Self-Report, youth age 11 to 17.

[4] Traditional Foster Care > all other placements

[5] Small sample sizes on the TRF and YSR required us to collapse the child settings into two categories.

Table 18: Depression and Trauma Symptoms

	N	Depressed Percent/SE	Trauma Percent/SE
Total	**140**	**9% (2.7)**	**8% (4.0)**
Child Setting			*
Out-of-Home	**27**	**13% (8.8)**	**3% (2.6)**
In-Home w/Services	**61**	**8% (3.4)**	**7% (3.7)**
In-Home w/out Services	**52**	**9% (3.8)**	**9% (4.7)**
Region			
Cook	**56**	**2% (2.1)**	**2% (2.0)**
Central	**39**	**14% (6.7)**	**8% (4.3)**
Northern	**33**	**8% (2.8)**	**17% (10.6)**
Southern	**12**	**N/A**	**N/A**
Population Density			
Non-Rural	**102**	**9% (3.4)**	**9% (4.9)**
Rural	**38**	**11% (4.0)**	**6% (5.6)**
Sex			
Male	**71**	**6% (4.5)**	**7% (5.0)**
Female	**69**	**12% (3.9)**	**9% (3.7)**
Race/Ethnicity			
African-American	**63**	**12% (4.5)**	**6% (2.9)**
White	**40**	**7% (3.2)**	**6% (5.4)**
Hispanic	**28**	**5% (4.8)**	**11% (7.7)**
Other	**9**	**N/A**	**N/A**
Child Age			*
7 to 8	**34**	**6% (4.2)**	**11% (10.8)**
9 to 11	**47**	**15% (5.0)**	**14% (5.2)**
12 to 17	**59**	**7% (3.3)**	**2% (1.3)**

Note: Children and youth age 7 to 17. From the Children's Depression Inventory and Trauma Symptom Checklist in the Child Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result (*$p < .05$).

Table 19: Social Skills

	N	Fewer Percent/SE	Average Percent/SE	Above Percent/SE
Total	**321**	**31% (4.8)**	**61% (3.9)**	**8% (2.2)**
Child Setting				
Traditional Foster Care	**30**	**63% (11.4)**	**34% (3.9)**	**3% (2.1)**
Kinship Care	**61**	**31% (8.0)**	**63% (7.9)**	**6% (4.1)**
In-Home w/Services	**129**	**35% (4.8)**	**56% (6.9)**	**9% (6.1)**
In-Home w/out Services	**101**	**27% (7.9)**	**66% (7.0)**	**7% (2.6)**
Region				
Cook	**108**	**37% (7.9)**	**57% (6.5)**	**6% (1.4)**
Central	**77**	**30% (11.2)**	**67% (1.1)**	**3% (2.1)**
Northern	**53**	**27% (8.5)**	**63% (4.9)**	**10% (5.9)**
Southern	**31**	**31% (7.6)**	**55% (9.3)**	**14% (1.7)**
Population Density				
Non-Rural	**187**	**38% (4.9)**	**57% (4.6)**	**5% (1.6)**
Rural	**82**	**19% (1.4)**	**69% (2.8)**	**12% (4.2)**
Sex				
Male	**133**	**33% (5.9)**	**60% (4.9)**	**7% (1.6)**
Female	**136**	**30% (5.7)**	**62% (5.6)**	**8% (3.8)**
Race/Ethnicity				
African-American	**121**	**32% (6.3)**	**59% (6.6)**	**9% (2.1)**
White	**76**	**27% (8.8)**	**67% (8.0)**	**6% (2.0)**
Hispanic	**59**	**40% (7.9)**	**51% (3.9)**	**9% (9.9)**
Other	**13**	**10% (9.6)**	**90% (9.6)**	**0 (0)**
Child Age				
3 to 5	**104**	**36% (5.3)**	**59% (4.1)**	**5% (2.2)**
6 to 8	**57**	**29% (3.9)**	**64% (3.9)**	**7% (4.8)**
9 to 11	**56**	**36% (12.1)**	**60% (12.7)**	**4% (2.2)**
12 to 17	**52**	**21% (5.5)**	**64% (4.7)**	**15% (9.0)**

Note: Children and youth age 3 to 17. From the Social Skills Rating System in the Caregiver Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result (**p < .01).

Table 20: Delinquent Acts within the Past 6 Months

	N	Any Delinquent Act[1] Percent/SE	Arrested Percent/SE
Total	**83**	**53% (6.5)**	**8% (4.0)**
Child Setting			
Out-of-Home	**16**	**67% (15.0)**	**8% (6.6)**
In-Home w/Serv.	**35**	**38% (11.4)**	**4% (3.1)**
In-Home w/out Serv.	**32**	**59% (5.3)**	**10% (6.7)**
Region			
Cook	**40**	**44% (4.1)**	**7% (1.1)**
Downstate	**43**	**57% (9.0)**	**8% (5.9)**
Population Density			[a]
Non-Rural	**66**	**56% (4.2)**	**10% (3.7)**
Rural	**17**	**46% (17.2)**	**2% (2.6)**
Sex			[a]
Male	**44**	**53% (6.2)**	**13% (4.4)**
Female	**39**	**53% (9.6)**	**4% (3.6)**
Race/Ethnicity			
African-American	**40**	**50% (8.9)**	**5% (3.8)**
White	**17**	**67% (6.2)**	**4% (3.7)**
Hispanic	**19**	**41% (17.4)**	**8% (6.4)**
Other	**7**	**N/A**	**N/A**
Child Age			
11 to 13	**48**	**54% (9.0)**	**3% (2.6)**
14 to 17	**35**	**53% (8.2)**	**15% (9.4)**

Note: Youth age 11 to 17. From the Modified Self Report of Delinquency Scale in the Child Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result ([a]p<.10).

[1] Delinquent acts represent such acts as being unruly in public, skipping school, shoplifting, damaging property, gang fights, concealing a weapon, stealing, etc. All acts reported in the last 6 months.

Table 21: Substance Use Ever

		Alcohol Percent/SE	Cigarettes Percent/SE	Marijuana Percent/SE	Hard Drugs[1] Percent/SE	Rode with Driver Who Was Intoxicated Percent/SE	Substance Use Disorder for Self-Report (CRAFFT)[2] Percent/SE
Total	**84**	**41% (8.3)**	**10% (5.7)**	**15% (6.2)**	**21% (8.8)**	**23% (9.0)**	**15% (7.4)**
Child Setting			**	[a]			
Out-of-Home	**16**	**59% (12.1)**	**18% (14.0)**	**40% (17.3)**	**36% (19.5)**	**34% (18.1)**	**36% (19.5)**
In-Home w/serv.	**36**	**35% (11.6)**	**1% (.3)**	**8% (4.2)**	**9% (6.2)**	**17% (5.2)**	**10% (7.9)**
In-Home w/out	**32**	**43% (10.2)**	**14% (7.3)**	**15% (7.4)**	**25% (11.6)**	**25% (13.2)**	**14% (10.2)**
Region		*		*	*		
Cook	**40**	**22% (3.1)**	**3% (2.5)**	**3% (2.5)**	**8% (.4)**	**9% (6.7)**	**6% (4.6)**
Downstate	**44**	**51% (11.5)**	**13% (8.6)**	**20% (8.6)**	**27% (12.7)**	**30% (11.9)**	**19% (10.2)**
Population Dens.			*	*	[a]	*	
Non-Rural	**66**	**47% (7.7)**	**14% (6.1)**	**20% (5.5)**	**27% (9.4)**	**29% (9.2)**	**19% (8.1)**
Rural	**18**	**28% (6.3)**	**0% (0)**	**2% (2.6)**	**6% (4.9)**	**11% (1.3)**	**8% (7.2)**
Sex							
Male	**44**	**38% (9.5)**	**9% (7.9)**	**13% (8.2)**	**15% (7.5)**	**17% (7.7)**	**15% (8.0)**
Female	**40**	**44% (11.7)**	**10% (5.3)**	**17% (7.2)**	**25% (12.4)**	**28% (11.3)**	**16% (7.7)**
Race/Ethnicity							
African-Amer.	**40**	**41% (7.9)**	**2% (2.2)**	**9% (2.6)**	**8% (4.5)**	**17% (7.0)**	**8% (4.7)**
White	**18**	**35% (10.2)**	**11% (8.9)**	**17% (13.6)**	**33% (20.0)**	**33% (13.6)**	**11% (4.6)**
Hispanic	**19**	**44% (19.4)**	**15% (12.0)**	**17% (12.3)**	**27% (18.2)**	**24% (19.1)**	**28% (18.9)**
Other	**7**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Child Age			**	*			
11 to 13	**49**	**34% (7.0)**	**3% (2.9)**	**7% (3.3)**	**19% (7.1)**	**18% (5.5)**	**15% (5.6)**
14 to 17	**35**	**53% (12.6)**	**20% (10.5)**	**27% (11.9)**	**24% (12.9)**	**32% (16.8)**	**15% (8.4)**

Note: Youth age 11 to 17. From the Youth Risk Behavior Survey in the Child Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result ([a]p < .10, *p < .05, **p<.01).

[1] Hard drugs consist of cocaine, heroin, glue, ecstasy, and methamphetamines

[2] CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) is a substance abuse screening test. A score of 2 or more is highly correlated with having a substance abuse related diagnosis and the need for substance abuse treatment. Percent reported are for youth with a score of 2 or more on the CRAFFT screener.

Table 22: Sexual Activity Ever

	N	No Percent/SE	Yes – Consensual Percent/SE	Yes – Forced Percent/SE
Total	**84**	**75% (8.2)**	**17% (5.2)**	**8% (3.2)**
Child Setting				
Out-of-Home	**16**	**73% (12.2)**	**9% (6.6)**	**18% (13.9)**
In-Home w/Services	**35**	**77% (10.2)**	**23% (10.2)**	**0% (0)**
In-Home w/out Services	**32**	**74% (12.8)**	**15% (5.5)**	**11% (9.8)**
Region				
Cook	**40**	**80% (.2)**	**20% (.2)**	**0% (0)**
Downstate	**44**	**72% (12.1)**	**20% (7.7)**	**8% (4.6)**
Population Density				
Non-Rural	**66**	**73% (7.8)**	**21% (4.0)**	**6% (4.2)**
Rural	**18**	**78% (12.4)**	**16% (9.7)**	**6% (4.8)**
Sex				
Male	**44**	**68% (7.8)**	**24% (5.7)**	**8% (4.0)**
Female	**40**	**80% (9.7)**	**16% (6.8)**	**4% (3.5)**
Race/Ethnicity				
African-American	**40**	**81% (9.3)**	**14% (5.9)**	**5% (4.3)**
White	**18**	**70% (9.9)**	**22% (8.5)**	**8% (4.6)**
Hispanic	**19**	**72% (11.1)**	**28% (11.1)**	**0% (0)**
Other	**7**	**N/A**	**N/A**	**N/A**
Child Age				
11 to 13	**49**	**58% (12.7)**	**31% (5.6)**	**11% (9.1)**
14 to 17	**35**	**85% (7.0)**	**13% (6.3)**	**3% (2.8)**

Note: Youth age 11 to 17. From selected questions in the Child Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result.

Table 23: Mental Health Service Receipt: Children In Substitute Care

		Children in Substitute Care		Children in Substitute Care with Clinically Significant Behavior Problems	
		Illinois (n=305)	Nation (n=1354)	Illinois (n=26)	Nation (n=165)
Specialty Outpatient Mental Health Services	Any specialty outpatient mental health service	**14.6* (2.3)**	**25.2 (2.6)**	**39.6 (11.5)**	**54.8 (5.9)**
	Private professional help	**9.5* (3.6)**	**18.8 (2.7**	**27.6 (14.3)**	**46.9 (6.3)**
	Mental health or community mental health center	**5.4 (1.5)**	**5.9 (1.1)**	**24.8 (6.9)**	**16.8 (4.3)**
	In-home counseling or crisis services	**6.8 (2.7)**	**7.4 (1.1)**	**26.8 (13.2)**	**13.0 (2.7)**
	Day treatment	**7.7 (7.1)**	**1.6 (.8)**	**17.7 (13.8)**	**3.0 (1.7)**
	Outpatient drug or alcohol clinic	**0 (0)**	**0 (0)**	**0 (0)**	**0 (0)**
Specialty Inpatient Mental Health Services	Any specialty inpatient mental health service	**1.3 (1.1)**	**3.3 (.9)**	**6.5 (5.6)**	**3.0 (1.2)**
	Psychiatric hospital unit	**0 (0)**	**.7 (.3)**	**0 (0)**	**1.6 (.8)**
	Hospital Medical inpatient unit	**0 (0)**	**.1 (.1)**	**0 (0)**	**0 (0)**
	Detox, drug or alcohol unit	**0 (0)**	**1.0 (1.0)**	**0 (0)**	**0 (0)**
	Hospital emergency room	**1.3* (1.1)**	**.2 (.1)**	**6.0* (4.9)**	**.4 (.4)**
Non-Specialty Mental Health Service	Guidance counselor, school psychologist, or school social worker	**13.2 (3.2)**	**9.2 (1.5)**	**26.4 (7.5)**	**32.1 (5.5)**
	Family doctor or other medical doctor	**2.7 (2.5)**	**5.1 (.8)**	**13.2 (11.5)**	**14.8 (3.1)**

Note: From various measures in the Caregiver Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result (*$p < .05$).

Table 24: Mental Health Service Receipt: Children in Intact Family Cases

		Children in Intact Family Cases		Children in Intact Family Cases with Clinically Significant Behavior Problems	
		Illinois (n=358)	Nation (n=895)	Illinois (n=30)	Nation (n=99)
Specialty Outpatient Mental Health Services	Any specialty outpatient mental health service	**13.1 (1.8)**	**17.6 (3.4)**	**20.4 (10.7)**	**38.6 (7.2)**
	Private professional help	**7.5 (1.6)**	**11.2 (2.4)**	**15.0 (9.4)**	**31.0 (6.4)**
	Mental health or community mental health center	**4.9 (1.6)**	**6.5 (1.6)**	**5.7 (4.4)**	**12.7 (3.6)**
	In-home counseling or crisis services	**4.2 (1.3)**	**7.8 (2.1)**	**7.6 (6.2)**	**21.6 (6.5)**
	Day treatment	**0 (0)**	**1.3 (.7)**	**0 (0)**	**2.4 (1.8)**
	Outpatient drug or alcohol clinic	**0 (0)**	**.2 (.2)**	**0 (0)**	**.5 (.6)**
Specialty Inpatient Mental Health Services	Any specialty inpatient mental health service	**2.5 (.6)**	**2.8 (1.4)**	**14.7 (4.8)**	**12.0 (5.7)**
	Psychiatric hospital unit	**1.9 (.2)**	**2.2 (1.2)**	**10.1 (2.9)**	**9.8 (5.2)**
	Hospital Medical inpatient unit	**.5 (.3)**	**1.3 (1.2)**	**3.7 (2.8)**	**6.1 (5.4)**
	Detox, drug or alcohol unit	**0 (0)**	**0 (0)**	**0 (0)**	**0 (0)**
	Hospital emergency room	**1.1 (.7)**	**2.6 (1.3)**	**7.8 (5.2)**	**11.9 (5.7)**
Non-Specialty Mental Health Service	Guidance counselor, school psychologist, or school social worker	**14.0 (3.7)**	**10.1 (1.9)**	**31.3 (8.2)**	**27.0 (7.6)**
	Family doctor or other medical doctor	**3.1 (1.4)**	**6.2 (1.5)**	**6.5* (.9)**	**16.1 (5.7)**

Note: From various measures in the Caregiver Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result (*$p < .05$).

Table 25: Mental Health Service Receipt: Children at Home Without Services

		Children at Home Without Services		Children at Home Without Services with Clinically Significant Behavior Problems[1]	
		Illinois (n=131)	Nation (n=433)	Illinois (n=14)	Nation (n=75)
Specialty Outpatient Mental Health Services	Any specialty outpatient mental health service	**9.7* (1.8)**	**15.9 (2.6)**	**N/A**	**N/A**
	Private professional help	**7.0 (1.9)**	**12.3 (2.7)**	**N/A**	**N/A**
	Mental health or community mental health center	**4.7 (2.4)**	**3.6 (1.6)**	**N/A**	**N/A**
	In-home counseling or crisis services	**1.6* (1.0)**	**6.7 (2.2)**	**N/A**	**N/A**
	Day treatment	**1.8* (1.7)**	**0 (0)**	**N/A**	**N/A**
	Outpatient drug or alcohol clinic	**0 (0)**	**2.4 (2.3)**	**N/A**	**N/A**
Specialty Inpatient Mental Health Services	Any specialty inpatient mental health service	**1.8 (1.7)**	**3.4 (1.3)**	**N/A**	**N/A**
	Psychiatric hospital unit	**.8 (.8)**	**2.0 (.9)**	**N/A**	**N/A**
	Hospital Medical inpatient unit	**0 (0)**	**0 (0)**	**N/A**	**N/A**
	Detox, drug or alcohol unit	**0 (0)**	**1.2 (1.2)**	**N/A**	**N/A**
	Hospital emergency room	**1.0 (.9)**	**1.7 (.9)**	**N/A**	**N/A**
Non-Specialty Mental Health Service	Guidance counselor, school psychologist, or school social worker	**18.8 (2.2)**	**13.3 (2.5)**	**N/A**	**N/A**
	Family doctor or other medical doctor	**3.2* (.5)**	**7.4 (2.1)**	**N/A**	**N/A**

Note: From various measures in the Caregiver Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result (*$p < .05$).

[1] The small sample size for Illinois children in this group prevents analysis.

Table 26: Specialty Outpatient Mental Health Service Receipt by Placement and Child Characteristics

	Percent Receiving a Specialized Outpatient Mental Health Service		
	In Substitute Care	**In Intact Family Case**	**At Home Without Services**
	Percent/SE	Percent/SE	Percent/SE
Total	**14 (2.3)**	**13 (1.8)**	**10 (1.8)**
Region		*	
Cook	**23 (2.1)**	**7 (1.3)**	**2 (2.8)**
Central	**6 (3.4)**	**18 (2.4)**	**9 (3.9)**
Northern	**15 (7.4)**	**24 (8.8)**	**15 (2.4)**
Southern	**12 (7.0)**	**3 (3.3)**	**7 (4.6)**
Population Density	*	*	
Non-Rural	**19 (2.5)**	**9 (1.8)**	**10 (1.8)**
Rural	**5 (3.6)**	**22 (4.7)**	**9 (3.8)**
Sex			
Male	**17 (4.4)**	**14 (4.4)**	**11 (3.3)**
Female	**11 (3.9)**	**12 (1.8)**	**9 (2.2)**
Race/Ethnicity		*	
African-American	**14 (3.1)**	**7 (2.7)**	**7 (4.6)**
White	**14 (5.1)**	**26 (5.9)**	**12 (5.0)**
Hispanic	**13 (10.4)**	**9 (5.1)**	**2 (2.3)**
Child Age	**	*	*
Under 3	**4 (2.9)**	**3 (2.2)**	**0 (0)**
3 to 5	**12 (5.3)**	**8 (6.2)**	**0 (0)**
6 to 11	**31 (8.9)**	**28 (11.2)**	**17 (5.2)**
12 to 17	**58 (10.7)**	**26 (6.9)**	**19 (6.8)**

Note: From various measures in the Caregiver Interview. All analyses used weighted data. The sample sizes presented are unweighted. Cell results are omitted when cell n falls below 15. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result (*p < .05, **p < .01).

Table 27: Psychotropic Medication

	N	Child Ever Taken Prescription Medication Percent/SE
Total	**818**	**8% (1.8)**
Child Setting		*
Traditional Foster Care	**145**	**12% (3.2)**
Kinship Care	**182**	**11% (3.2)**
In-Home w/Services	**360**	**4% (1.5)**
In-Home w/out Services	**131**	**10% (2.8)**
Region		
Cook	**417**	**7% (4.0)**
Central	**197**	**10% (4.5)**
Northern	**130**	**10% (3.7)**
Southern	**74**	**2% (1.8)**
Population Density		
Non-Rural	**632**	**9% (1.4)**
Rural	**186**	**7% (4.1)**
Sex		
Male	**416**	**9% (2.8)**
Female	**402**	**8% (2.7)**
Race/Ethnicity		**
African-American	**442**	**6% (1.8)**
White	**192**	**10% (4.8)**
Hispanic	**155**	**5% (.9)**
Other	**27**	**39% (15.8)**
Child Age		**
Under 3	**497**	**1% (.4)**
3 to 5	**125**	**3% (1.7)**
6 to 8	**69**	**7% (2.3)**
9 to 11	**64**	**20% (7.0)**
12 to 17	**63**	**23% (7.9)**

Note: From various measures in the Caregiver Interview. Cells include percentages and standard errors. All analyses used weighted data. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result (*p < .05, ** p<.01).

Table 28: Caseworker-Reported Caregiver Risk Factors

	N	Alcohol Abuse Percent/SE	Substance Abuse Percent/SE	Domestic Violence Percent/SE	Mental Health Problem Percent/SE	History of Arrest Percent/SE
Total	**616**	**10% (1.9)**	**15% (2.9)**	**28% (2.7)**	**18% (3.7)**	**16% (2.6)**
Child Setting		*	**		**	**
Traditional Foster Care	**93**	**12% (2.2)**	**28% (3.0)**	**22% (6.8)**	**34% (6.5)**	**43% (8.6)**
Kinship Care	**126**	**18% (3.1)**	**25% (4.9)**	**22% (5.2)**	**32% (7.4)**	**27% (3.7)**
In-Home w/Services	**283**	**15% (2.2)**	**29% (3.5)**	**26% (3.6)**	**27% (4.0)**	**20% (2.4)**
In-Home w/out Services	**105**	**3% (1.9)**	**2% (1.2)**	**31% (4.6)**	**7% (3.3)**	**10% (3.7)**
Region						
Cook	**287**	**11% (4.0)**	**26% (.1)**	**20% (3.8)**	**26% (2.2)**	**26% (.1)**
Central	**170**	**10% (2.7)**	**11% (5.8)**	**33% (6.3)**	**19% (9.0)**	**15% (7.1)**
Northern	**111**	**7% (3.7)**	**13% (4.6)**	**34% (1.9)**	**10% (5.2)**	**10% (1.2)**
Southern	**48**	**12% (4.3)**	**15% (10.8)**	**13% (12.52)**	**21% (9.1)**	**19% (1.0)**
Population Density				*		
Non-Rural	**461**	**9% (2.0)**	**16% (3.6)**	**24% (3.4)**	**17% (2.6)**	**16% (2.9)**
Rural	**33**	**10% (3.2)**	**15% (3.6)**	**35% (2.7)**	**20% (8.0)**	**17% (4.4)**
Sex			*			
Male	**314**	**9% (1.6)**	**11% (4.5)**	**27% (3.1)**	**20% (3.9)**	**17% (2.9)**
Female	**302**	**10% (3.1)**	**20% (2.3)**	**29% (4.0)**	**16% (4.4)**	**16% (3.9)**
Race/Ethnicity						[a]
African-American	**328**	**9% (3.1)**	**20% (3.2)**	**27% (4.9)**	**17% (2.9)**	**20% (3.7)**
White	**147**	**10% (3.6)**	**10% (2.1)**	**24% (3.0)**	**18% (6.0)**	**14% (2.7)**
Hispanic	**121**	**12% (3.2)**	**14% (5.4)**	**35% (4.3)**	**23% (8.0)**	**8% (3.2)**
Other	**20**	**5% (4.0)**	**26% (20.2)**	**37% (14.2)**	**1% (1.0)**	**40% (16.6)**
Child Age			*		[a]	
Under 3	**368**	**12% (2.4)**	**26% (3.5)**	**28% (3.0)**	**24% (5.3)**	**20% (2.6)**
3 to 5	**95**	**10% (2.8)**	**14% (5.5)**	**29% (7.1)**	**23% (5.1)**	**16% (5.0)**
6 to 8	**54**	**12% (6.5)**	**9% (2.1)**	**28% (6.8)**	**9% (3.5)**	**12% (4.3)**
9 to 11	**56**	**8% (4.4)**	**10% (4.1)**	**26% (4.9)**	**6% (3.3)**	**14% (7.5)**
12 to 17	**43**	**2% (1.3)**	**5% (3.7)**	**29% (13.4)**	**16% (9.7)**	**17% (8.5)**

Note: From the Risk Assessment Measure in the Investigative Caseworker Interview. All analyses used weighted data. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result ([a]p<.10 *p < .05, **p < .01).

Table 29: Caregiver-Reported Risk Factors

	N	Below Poverty Line Percent/SE	Below Average Social Support Percent/SE	Poor Caregiver Physical Health Percent/SE	Poor Caregiver Mental Health Percent/SE
Total	**745**	**58% (3.0)**	**23% (2.4)**	**16% (1.6)**	**13% (2.8)**
Child Setting		*			*
Traditional Foster Care	**129**	**23% (10.4)**	**2% (2.8)**	**5% (1.1)**	**1% (.6)**
Kinship Care	**169**	**32% (3.7)**	**25% (12.0)**	**18% (4.3)**	**9% (4.0)**
In-Home w/Services	**320**	**65% (5.3)**	**21% (1.8)**	**15% (1.6)**	**11% (1.7)**
In-Home w/out Services	**127**	**64% (5.4)**	**25% (4.4)**	**17% (2.8)**	**17% (4.5)**
Region					
Cook	**363**	**61 (3.4)**	**28% (6.6)**	**11% (.20)**	**13% (2.3)**
Central	**187**	**61 (3.3)**	**27% (.7)**	**18% (3.1)**	**10% (4.7)**
Northern	**122**	**53 (9.5)**	**20% (5.0)**	**17% (1.3)**	**18% (6.8)**
Southern	**73**	**56 (6.7)**	**11% (3.5)**	**19% (9.7)**	**12% (8.5)**
Population Density					
Non-Rural	**563**	**54 (1.7)**	**19% (6.1)**	**15% (1.4)**	**12% (1.6)**
Rural	**182**	**66 (2.5)**	**28% (2.5)**	**18% (2.6)**	**16% (6.2)**
Race/Ethnicity			*		
African-American	**395**	**65 (2.1)**	**21% (4.7)**	**14% (2.5)**	**11% (3.3)**
White	**182**	**49 (9.9)**	**17% (2.8)**	**19% (2.6)**	**16% (5.3)**
Hispanic	**142**	**59 (5.8)**	**32% (4.0)**	**15% (2.1)**	**13% (3.2)**
Other	**24**	**65 (13.2)**	**48% (10.6)**	**12% (11.0)**	**14% (8.9)**
Child Age					
Under 3	**440**	**54 (5.9)**	**18% (4.4)**	**10% (1.8)**	**12% (4.1)**
3 to 5	**115**	**68 (4.1)**	**29% (7.4)**	**18% (5.8)**	**16% (5.1)**
6 to 8	**66**	**67 (3.9)**	**15% (4.3)**	**20% (6.1)**	**12% (5.4)**
9 to 11	**62**	**45 (7.9)**	**21% (8.0)**	**18% (6.6)**	**11% (5.0)**
12 to 17	**61**	**56 (7.9)**	**33% (5.3)**	**18% (5.4)**	**17% (5.2)**

Note: From various measures in the Caregiver Interview. Cells include percentages and standard errors. All analyses used weighted data. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result ($^{a}p<$ .10 *$p < .05$).

Table 30: Youth Who Witnessed or Experienced Severe Violence

	N	Witnessed Percent/SE	Experienced Percent/SE
Total	**135**	**66% (4.1)**	**6% (2.3)**
Child Setting		*	**
Out-of-Home	**25**	**84% (9.8)**	**34% (10.1)**
In-Home w/Services	**58**	**75% (6.8)**	**2% (1.9)**
In-Home w/out Services	**52**	**55% (6.4)**	**4% (2.6)**
Region			
Cook	**59**	**59% (9.7)**	**3% (2.9)**
Central	**38**	**72% (2.9)**	**7% (4.8)**
Northern	**27**	**63% (10.6)**	**4% (2.5)**
Southern	**11**	**N/A**	**N/A**
Population Density		ª	
Non-Rural	**103**	**62% (5.6)**	**8% (2.5)**
Rural	**32**	**74% (3.2)**	**2% (1.5)**
Sex			
Male	**68**	**66% (6.6)**	**9% (5.2)**
Female	**67**	**66% (4.6)**	**3% (2.3)**
Race/Ethnicity			
African-American	**57**	**69% (10.8)**	**5% (3.5)**
White	**32**	**57% (11.5)**	**2% (2.3)**
Hispanic	**37**	**68% (5.8)**	**6% (3.1)**
Other	**9**	**N/A**	**N/A**
Child Age		ª	
7 to 8	**22**	**77% (7.2)**	**0% (0)**
9 to 11	**51**	**52% (7.0)**	**5% (3.5)**
12 to 17	**62**	**74% (8.3)**	**9% (3.7)**

Note: Youth age 7 to 17. From VEX-R in the Child Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result (ªp< .10, *p<.05, **p < .01).