CHILDREN AND FAMILY RESEARCH CENTER

REPORT ON CHILD SAFETY AND PERMANENCY IN ILLINOIS FOR FISCAL YEAR 2001

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EXECUTIVE SUMMARY

This annual report on child safety, permanency and well-being for children who are the responsibility of the Illinois Department of Children and Family Services is a product of the Children and Family Research Center containing outcome information through Fiscal Year 01 (July 1, 2000 through June 30, 2001).

The Department is the state agency that responds to reports of child abuse and neglect and assures that children who come to its attention are safe and have a permanent family. To understand the Department's performance in these areas it is important to be cognizant of its legal and social context.

Public child welfare changed substantially during the decade of 1990s. Throughout the 1990s, state and federal laws underwent substantial change, with a stronger emphasis on achieving permanent homes for vulnerable children while maintaining their safety. The effect of the Adoption and Safe Families Act (ASFA) and accompanying Illinois permanency legislation in accomplishing these goals is still being assessed.

The 1990s were also a period of great change in Department policies, court decisions, and social conditions which have had a profound impact on the number of children and families for which the Department is responsible. Court decisions and Department policies regarding children placed with relatives (kinship care) have had an impact on Department responsibilities. The following data demonstrate a pattern of increasing caseloads through FY 95 with subsequent decreases in demand for services (Chapter 1).

- In FY 90, 103,421 children were reported as suspected victims of abuse and neglect. This number increased to an all-time high of 139,720 in FY 95. Between FY 95 and FY 00 these reports have decreased to 100,413 which is below the FY 90 level.

- In FY 90, investigations found 38,207 children to be victims of abuse or neglect. This number increased by 40% to 53,272 in FY 95 and has subsequently declined by 46% to 28,868 in FY 01.
- Between FY 90 and FY 95 the number of children in substitute care increased 130%. Between FY 95 and FY 01, the number of children in substitute care decreased by 44% to 27,009.

The outcome data in this report comes from the Integrated Administrative Database, which is compiled from the Department's administrative information systems. This database contains information on reports of child abuse and neglect (with the exception of records deleted according to state law), all children placed out of the home, and all families for which a case was opened. Data on children and families for which there was an open case are available for the fiscal years 1990 through 2001.

These databases were originally designed to assure a timely and consistent response to reports of abuse and neglect, keep track of children in care, assure timely and accurate payment for services, and comply with federal reporting requirements. While these databases include detailed data at the case level, they were not designed to report on child outcomes. As a result, safety indicators are restricted to findings of abuse and neglect subsequent to Department involvement. Other important dimensions of child safety cannot be determined from these data. Similarly, measures of permanence of family relations are restricted to case status indicators that rely on movement of children between placements. Child well-being indicators are nonexistent in this database. In addition, information about children who are served by other systems such as education, mental health, or juvenile justice is not included.

From a management point of view, it is important to have standards for comparison of current outcome performance. These standards, or benchmarks, are normally derived from an organization's past performance or from the performance of comparable organizations. While the results included in this report are compared, where possible, with prior years and other systems, these are not intended as comparisons against standards for at least two reasons. First, comparisons between child welfare systems are difficult because of differences in state laws. Second, it is not the role of the Center to establish performance standards for the Department.

CHILD SAFETY

Safety is measured by indicated reports of abuse or neglect for children who come to the attention of the Department.[1] While it is unacceptable to have any child who is the responsibility of the Department abused or neglected, a 100% standard of safety is difficult to guarantee. Community and family environments are ever-changing and include unpredictable risks of physical and psychological harm.

For workers charged with the responsibility for making decisions about child safety, the placement decision is one of the most difficult. Workers know they are risking child safety when deciding to remove a child from the home. Accurately predicting abuse events is nearly impossible given the changing composition of families and communities. The child who is left at home may be nurtured by familiar and important family members or may suffer unpredictable abuse or neglect. The child who is placed into substitute care may be freed from a dangerous and oppressive situation and

[1] Much of the background material that supports the selection of outcome indicators provided in the first report is not included here. The outcome indicators were selected based upon the child welfare literature in collaboration with a wide range of constituent groups in Illinois. Readers are referred to the first report for this material.

learn and grow or be troubled by the loss of family and familiar surroundings and begin a cycle of disruptive behavior and failed placements.

Key Safety Indicators

- For all children who are investigated by the Department for abuse or neglect and the reported is indicated, 10% have another indicated report within six months.

- Since FY 95 the rate of abuse and neglect of children served in family cases has declined. In FY 95, the abuse rate for children in family cases was 19 per 100 children in care for 1 year. This rate was 11 in FY 01.

- For every 100 children in out-of-home care for 1 year in FY 01, between 1.5 and 2 had an indicated report of abuse or neglect.

Children in substitute care are placed in a variety of out-of-home placements. Currently, the most frequent such placements in Illinois are home-of-relative, family foster care, specialized foster care, and institutions.

- For every 100 children placed in the home of a relative for 1 year in FY 01, between 1.5 and 1.8 had an indicated report of abuse or neglect.
- The rate of abuse and neglect of children living in non relative family foster care in FY 01, was between 1.8 and 2.3 per 100 children in care for one year.
- For every 100 children living in specialized foster care for 1 year in FY 01, between 1.3 and 2.0 had an indicated report of abuse or neglect.

- For every 100 children living in institutional care for 1 year during FY 01 between 0.9 and 1.6 had an indicated report of abuse or neglect.

When safety outcomes are examined by age, race, and Department region, some differences are found.

- Children who are identified as Hispanic experience a lower rate of recurrence within six months then do African American or White children. While 6% of Hispanic children had another indicated report within 6 months in FY00, White and African American children expereinced a six month recurrence rate of 10%.
- Children living in family cases and identified as White experience a higher rate of abuse or neglect than African American or Hispanic. The rate for White children was 13 per 100 in family cases for 1 year. This compares to 9.5 for African American children and 8 for Hispanic children.
- Children under the age of 3 who are living in family cases expereince the highest rate of abuse (22 children per 100 living in family cases for 1 year).

PERMANENCY OF FAMILY RELATIONS

Permanency refers to maintaining children at home or assuring timely movement to a safe permanent family arrangement when a placement out of the home is necessary. Results in this area indicate substantial increases in the adoption of children and the transfer of guardianship to a private person. However, large numbers of children still remain in substitute care for extended periods of time (Chapter 3).

- In FY 01 the rate at which children were maintained at home in family cases was 91 per 100 children in care for 1 year. This is an increase from 86 children per 100 in care for 1 year in FY 95.
- The percent of children returned home within 12 months of entering substitute care was 28% in FY 00. This compares to 36% in FY 91 and 21% in FY 95.
- The percent of children who reenter substitute care within 12 months of family reunification was 16% in FY 00. This compares to 22% in FY 91 and 20% in FY 95.
- The rate at which children are adopted is now 15 children per 100 in care for one year. This compares to a yearly rate of 4 per 100 from FY 91 through FY 97.
- Four out of every 100 children in substitute care for 1 year in FY 01 achieved permanency through guardianship.[2] This rate was near zero from FY 92 through FY 96.

[2] While children must be in care for at least two years before guardianship be transferred to a private person, this is an annual rate so that comparisons can be made across years.

- Ten to fifteen percent of the children entering the care of the Department from FY 91 through FY 96 remain in care. This was more than 20% in last years outcome report.

When the permanency outcomes are examined by age, race, and Department region responsible for the case, differences are found. For children served in family cases, those from Cook County regions, those who are African American and children under the age of 3 all experience higher placement rates.

- For every 100 African American children in family cases for one year in FY 01, 10 were placed out-of-home. This compares to a rate of 7 per 100 for Hispanic children and 8 for White children.
- For every 100 children under the age of 3 who were in family cases for 1 year in FY 01, 10 were placed out-of-home.

Examining differences between groups for other permanency outcomes is best done by examining exits from care for children who entered care in the same fiscal year.

- African American children exit care more frequently through adoption or guardianship while White children exit most frequently through being reunified with their families. The majority of African American children in substitute care in Illinois are placed with relatives. These children tend to achieve permanency through adoption or subsidized guardianship with relatives.

- For those African American children entering care from FY 92 through FY 96, 38% to 43% exited care through adoption or guardianship while about 25% returned home (Table 4.32). During these same years 20% of White children exited care through adoption or guardianship and 45% to 50% returned home.
- Since it takes more than two years for most adoptions or guardianship to occur, a higher percentage of African American children compared to White children remain in care for FY 99 through FY01. For African American children entering care in FY 99, 53% were still in care at the end of FY 01. This compares to 36% for White children.

CHILD WELL-BEING

A special study of Department wards diagnosed with asthma was conducted using Medicaid claims data. Major findings of this study included:

- Children for whom the initial diagnosis of asthma was at the time of Medicheck required fewer follow-up claims with no difference in the number of emergency room visits or hospitalizations.
- Children whose first diagnosis of asthma occurred in the course of hospitalization were subsequently hospitalized much more frequently. These children may represent a biologically more unstable group of children.
- Children who are African American used more acute care resources and fewer non-acute visits. They visited a physician less often than other children subsequent to the diagnosis of asthma.

Chapter 1

THE CONTEXT OF CHILD ABUSE AND NEGLECT

The Children and Family Research Center annually reports on outcomes for children who are the responsibility of the Department. However, the results of the Illinois Department of Children and Family Services' (DCFS) efforts on behalf of vulnerable children are best understood in multiple contexts. While child abuse and neglect occur within families and communities, public response is determined by legislative mandates, court decision, and the ecology of child abuse and neglect. It is the state legislature that defines child abuse and neglect and shapes our collective response. It is DCFS carrying out of state policy that is the front line response to child abuse and neglect in Illinois. It is the court system that rules on conflicts that inevitably arise from state intervention in private matters.

Previous Center reports included descriptions of legislative and legal contexts and demonstrated how the state legislature and the federal congress have a major influence on the Department. The report for FY 98, briefly summarized two 1997 legislative actions that greatly influence the context for Department operations (CFRC). The report for FY 99 focused on the provisions of the Adoption and Safer Families Act of 1997 (ASFA) (PL 105-89). The report for FY 00 focused on the federal outcome reporting requirements that were mandated by the Adoption and Safe Families Act and the first Department of Health and Human Services (DHHS) outcome report to Congress (CFRC, 2001).

Since there is no new major child welfare legislation and DHHS has just issued the second child welfare outcome report for the states, this report begins with a review of the Illinois context for child abuse and neglect. The Department of Children and Family Services responds to child abuse and neglect within a context of children, families, communities, and the larger society in the economically and socially diverse state of

Illinois. To understand safety, permanency, and well-being outcomes for children who are victims of child abuse or neglect, it is important to understand the variation within Illinois. This chapter draws upon available data to briefly describe the context for understanding child abuse and neglect.

Recent theories on the causes of child maltreatment recognize the role of ecological factors in the development of a social interaction model that recognizes multiple causes. This model emphasizes viewing child maltreatment within a context larger than the individual pathology of a parent. Rather, child maltreatment is viewed in the context of family, community, and society (Garbarino, 1977). Recent research indicates that several factors occurring at the same time can result in the abuse or neglect of a child (Wells, 1995). Factors occurring in various combinations that place children at risk include poverty, drug and alcohol abuse, parental personality characteristics, intergenerational transmission of abusive parenting, child characteristics, unemployment, high-risk neighborhoods, inadequate parenting knowledge, marital status, and stressful life events (National Research Council, 1993). Child abuse and neglect in Illinois are as diverse and complex as the multicausal social interaction model suggests. Some of the factors that have placed Illinois children at risk of abuse or neglect can be attributed to social and economic conditions, including single-parent families, concentrated inner-city poverty, and chronic unemployment.

THE LOCAL CONTEXT

Child abuse and neglect occur within a family and a community. The diversity of families and communities in Illinois is another factor that makes developing a state response that balances child safety with the permanency of family relations difficult. Geographic diversity in a state that ranges from Rockford to Cairo and Chicago to East St. Louis is one dimension. In addition, social circumstances such as poverty and female-

headed households, which are frequently associated with higher levels of child abuse and neglect, are unequally distributed across communities.

Previous Center reports have used poverty and other social indicators reported by the Child and Adolescent Local Area Network (LAN) to describe variation in social circumstances across Illinois. However, the 2000 census data reporting on poverty and other social indicators at the community level are not yet available. Consequently the FY 01 rate of indicated reports of abuse or neglect per 1,000 children age 18 or less in the population is used to describe the community context within Illinois.

Illinois is divided into 62 LANs which are geographic areas that are organized to respond to the needs of children and their families by providing community-based services. Outside of Cook County, variation in child abuse and neglect can be seen by comparing LAN 6 (East St. Louis) with a rate of 17 children per 1,000 with LAN 39 (Dupage County) where this rate was 2 children per 1,000. Similar variation exists within Cook County where 1 child per 1,000 in LAN 37A had a substantiated report of abuse or neglect compared to 13 per 1,000 of children LAN 80[3] (Office of the Research Director).

These rates of indicated reports of child abuse and neglect may not represent the true incidence of abuse and neglect. Many people believe that a large number of cases of child abuse and neglect do not come to the attention of child protective services. For example, the Child Welfare League of America shows rates of indicated reports of abuse or neglect for 1997 ranging from 2 per 1,000 children in the population to 50 per 1,000. The national median was 11 per 1,000 children for the states included in their study (CWLA, 2002). A large national study reported incidence rates of 23 children per 1,000 when using a rather stringent harm standard and 42 children per 1,000 when using an endangerment standard (Sedlak & Broadhurst, 1996).

Abuse and Neglect Reports: Investigations and Results

The Department seeks to fulfill its mandates of safety and permanency through the child protection and substitute care systems. The number of cases that a child welfare system works with impacts system design and operation. For example, an administrator of an agency in a small community with 100 children may know the individual situations of these children and families, whereas an administrator of an agency that is responsible for 50,000 children must rely on resources other than personal knowledge to achieve safety and permanency. Changes in the volume of reports over time are also important in understanding agency responses.

For DCFS, the child protection function starts with calls to the State Central Register Hotline. The number of these calls increased each year between FY 90 and FY 95 (Table 1.1). In FY 90 there were 255,887 incoming calls (701 per day). The volume of calls reached an all-time high in FY 95 with 377,467 calls (1,034 per day). Since FY 95 there has been a decline in calls reaching a low of 304,945 in FY 99. Since then call volume has been relatively stable with 306,506 incoming calls (840 per day) in FY 01.[4]

The number of calls is not the same as the number of children reported as abused or neglected. Some calls do not meet the criteria of a report. Even when a call does meet the criteria for a report there may be several reports for the same incident. For example, a teacher and a doctor may report the same child, or the report may simply identify a family. Between FY 90 and FY 95, the number of Illinois children reported as victims of child abuse and neglect increased 35% from 103,421 children to 139,720 (Table 1.1). Since FY 95 this number has decreased by 28% to 100,413 in FY 01. Since poverty and

[3] LAN data comes from http://dcfsresearchdir.social.uiuc.edu/index.html.

[4] The volume and trend information in this section is from the Office of Quality Assurance, Illinois DCFS Executive Statistical Summary, unless otherwise noted.

unemployment is highly correlated with child abuse and neglect, the current rise in unemployment might be expected to result in an increased number of children being reported for child abuse or neglect. Through FY 01 this has not occurred. It is likely that there will be some increase in these numbers in over the next year.

Table 1.1 Abuse and Neglect Reports: Investigations and Results

	FY 90	FY 95	FY 01	Change from FY 95 to FY 01
Number of calls reporting child abuse and neglect	255,887	377,467	306,506	-19%
Number of children reported as suspected victims of abuse or neglect	103,421	139,720	100,413	-28%
Number of children found to be abused or neglected	38,207	53,272	28,868	-46%
Number of indicated family reports	21,890	28,709	16,716	-42%

While it is difficult to make comparisons across states because of different reporting laws and systems, it is useful to place Illinois in a national perspective. There are 8 states that each have more than 2,000,000 children in their population and together total nearly 50% of all children in this country. The most recent statistics on child abuse and neglect reporting volume per 1,000 children in the population for these states were:

Michigan	61	
New York	54	
Florida	53	
Ohio	48	
California	46	
Illinois	35	
Texas	31	
Pennsylvania	8	(CWLA, 2002).

Not all reports identify victims of child abuse or neglect. For a report to be "indicated" investigators must find credible evidence of abuse or neglect. That is evidence that could cause a reasonable person to believe that a child had been abused or neglected. In Illinois, in FY 01 there were 28,868 children who were identified as being abused or neglected. That is 29% of those children reported were identified as being abused or neglected. This compares to a total of 53,272 children (38%) indicated in FY 95. In FY 90, 103,421 children reported resulted in 38,207 indicated cases (37%) (Table 1.1). There has been a 46% decrease in the number of children identified as abuse or neglected since FY 95.

The rate per 1,000 children in the population of substantiated or indicated abuse or neglect for the 8 states with a large child population shows substantial variation. Florida reports the highest rate at 23 per 1,000 children and Pennsylvania the lowest at 2

per 1,000. Illinois is at the median for this group of states at 11 per 1,000 children in the population.

Florida	23	
New York	19	
California	18	
Ohio	12	
Illinois	11	
Michigan	9	
Texas	7	
Pennsylvania	2	(CWLA, 2002).

Child deaths due to child abuse or neglect maybe an indicator of the severity of the child abuse or neglect problem in the state. Wang & Daro (1997) reported that at least three children die each day as a result of child abuse or neglect. The Child Welfare League of America (2002) reports that there were 2.4 maltreatment-related fatalities per 100,000 children in Illinois in 1990 and 1992, and 2.5 in 1997.

The DCFS Caseload

The increases in child abuse and neglect reporting together with the Department's policies (e.g. kinship care) resulted in increases in the Department's caseload in the early to mid 1990s. The Department's caseload has substantially decreased since FY 95. The caseload consists of families with their children at home (intact) plus those with children in placement (non-intact). The total child and family caseload has decreased 41% since FY 95 (Table 2.2). The number of intact family cases has decreased from 14,565 in FY 95 to 9,277 in FY 01, a 36% decline. The number of non-intact family cases has decreased by nearly 40%.

Table 1.2 Caseload Changes Between FY 95 and FY 01[**]

	FY 95	FY 01	% Change FY 95 to 01
Total child and family caseload	66,438	38,920	–41%
Number of intact family cases	14,565	9,277	–36%
Number of non-intact family cases	18,171	10,966	–40%
Number of children in substitute care	47,862	27,009	–44%
Number of children in kinship care	27,071	10,425	–61%

[**] References - Executive Statistical Summary of the Department (September, 2001)

Children in Placement with the Department

The decades of the 1980s and 1990s were times of nationwide growth in the number of children in substitute care. In Illinois, the period from 1985 to 1995 was a time of unprecedented growth. One key to understanding the current substitute care population in Illinois is the changes that have occurred in the Department's use of home-of-relative placements, which is the largest category of out-of-home placements for Illinois children.

Home-of-relative care in Illinois. Kinship care was a placement option long before the creation of the Department of Children and Family Services in 1964. The courts were always able to assign children to the custody and guardianship of their relatives. With the establishment of DCFS, the courts began to grant custody and guardianship to the Department, which would then determine whether the relative placement was in the child's best interest. Until 1977, the children placed in kinship care accounted for no more than 15% of all children in the Department's custody (Testa, Shok, Cohen, Woods, 1996).

Between 1986 and 1991, the number of children in kinship care rose from 3,718 to 10,477, an annual rate increase of 23%. At the same time the number of children in non-relative care only increased 6% (Testa, 1996). In June of 1994, kinship care made up 55% of the placements of children in the custody of the Department (Testa, 1997). The number of children in kinship care reached 27,071 in FY 95 (Testa, 1996). According to the Child Welfare League of America, Illinois had the highest rate of kinship care in the country. Illinois had 8.8 children per 1,000 in kinship care whereas the median for the 39 states reporting was 1.1 child per 1,000 (Petit & Curtis, 1997).

The rates per 1,000 children in the population for states similar to Illinois in 1996 were:

Illinois	9.0
New York	3.5
Florida	3.4
Michigan	1.7
Texas	0.4
Ohio	not available
California	not available
Pennsylvania	not available (CWLA, 2002).

In July of 1995 the Department implemented reforms in the home-of-relative program. First, the Department stopped taking into custody those children in relative care arrangements with no protective need. It offered these families support services to address financial and legal problems that might threaten the living arrangement. Second, the Department implemented a single foster home licensing system that eliminated the separate approval process for relatives. The Department continues to place children in unlicensed kinship care if the home passes basic safety and criminal checks. Children in these placements are supported by a level of payment that the state says is needed to maintain "a livelihood compatible with health and well-being" (Testa, 1997). Since FY 95 the number of children in home-of-relative placement has decreased by nearly 61% (Table 2.2).

THE NATIONAL PERSPECTIVE

The Multistate Foster Care Data Archive is a project of The Chapin Hall Center for Children that provides a broader context in which to understand the growth in the substitute care population. This database was built from the computerized case records that state agencies use to track children living in child welfare placements. Twelve states

now participate in this research: Alabama, Illinois, California, Iowa, Maryland, Michigan, Missouri, New Mexico, New York, Ohio, Texas, and Wisconsin. More than half of the United States' foster care population resides in these states (Wulczyn, Hislop, & Goerge, 2000).

Some of the major changes in caseloads in these states include:

- California's caseload has grown steadily since 1983 with a pronounced period of growth from 1987 to 1989.
- In Illinois, caseload growth accelerated in 1988, leveled off in 1996, and declined in 1997 and 1998.
- New York's foster care caseload grew rapidly from 1986 to 1991 and has been steadily declining since 1991.
- Between 1989 and 1995, Alabama's foster caseload declined slightly each year. After 1995, caseloads began to grow.
- Caseloads in Maryland, Missouri, Ohio, and Wisconsin have grown steadily over time.
- Between 1983 and 1987, Michigan's foster care caseload increased by nearly two-thirds.

The substitute care placements in Illinois consist of children who are placed in foster care, relative care, institutional care, and group-home care. The total number of children in substitute care at the end of FY 01 was 27,009. From FY 95 through FY 01 the substitute care population decreased by 44% (Table 1.2).

The prevalence rates, which express how many children are in out-of-home care per 1,000 children in a state's overall population, increased in the United States from 3.9 in 1962 to 6.6 in 1998.[5]

The 1995 rate for Illinois of 17.1 was the highest in the country. The 1998 rates for the eight largest states were:

Illinois	15.4
California	12.3
New York	11.4
Ohio	7.3
Florida	6.8
Michigan	6.8
Texas	2.5
Pennsylvania	not available

(CWLA, 2002).[6]

[5] This is the most recent year for which comparison data exists.

[6] As is true of all comparisons between state, there are differences in what each state includes in a given measure. For example, some states do not count children placed with relatives as being in out-of-home care.

Chapter 2

CHILD SAFETY OUTCOMES

Child safety is assessed through indicators of abuse or neglect subsequent to involvement with the Department of Children and Family Services. In spite of the difficulties with this measure, it remains useful for managing or assessing large public child welfare systems. This chapter reports on child safety for all children with an indicated report of abuse or neglect, children in "family" cases, all children in substitute care, and by child living arrangements. For purposes of comparison, results are reported by fiscal year for the last 7 years. When possible, comparisons to other states are included.

Outcome results need to be interpreted in light of other factors including characteristics of communities, families, and children. For example, children from poor neighborhoods who come to the attention of the Department for reasons of neglect present very different challenges compared to children who live in rural areas and are victims of some form of abuse. The community's role in identifying potential victims, as well as the role of the local police and court system, is important in understanding which children come to the attention of the Department. In addition, understanding child safety outcomes requires linking these results to actions of the Department and others involved in child protection such as the courts. These include the ways in which workers implement state law and Department policy, the services that are available, and the reactions of the children to these services including placement out of the home.

Safety outcomes are derived from the DCFS integrated database maintained by The Chapin Hall Center for Children at the University of Chicago. The database is

compiled from the Department's administrative information systems and is updated quarterly. The Child Abuse and Neglect Tracking System known as CANTS is linked with the child placement information systems (MARS/CYCIS) to yield safety results. Operational definitions for the safety indicators were developed with the staff of the Department and The Chapin Hall Center for Children and are included in the appendix of this report.

SUMMARY OF SAFETY RESULTS

This report begins by providing a summary of safety results for children who have come into contact with the Department through investigations of child abuse or neglect, those served in family cases, substitute care, and the major types of substitute care placements for Department wards. More complete results for each safety measure follow the summary. Due to state laws governing deletion of identifying information from CANTS, child protective service data yields reliable results for the previous 5 years. Therefore, safety results prior to FY 97 are taken from previous reports.

A new safety indicator in this report is the percentage of children with an indicated report of abuse or neglect with another indicated report within 6 months. This is an indicator that the Department of Health and Human Services developed as a response to the Adoption and Safe Families Act (see Chapter 1 of the Center's Report on Child Safety and Permanency for Fiscal Year 2000; CFRC 2001). In Illinois, this recurrence rate has remained stable and has ranged from 10.3% in FY 97 to 9.9% in FY 00 (Table 2.1). The rate for FY 01, 8.3% may not represent the true rate since six months has not elapsed since the end of FY 01 when the data for this report were generated. The current DHHS standard for this indicator is 6.1%. While DHHS is using this standard to judge child welfare systems, there are many difficulties with this standard that are discussed in the Center's Report on Child Safety and Permanency for Fiscal Year 2000 (CFRC, 2001).

Table 2.1 Summary of Child Safety Results

	FY 95	FY 96	FY 97	FY 98	FY 99	FY00	FY01
Percent of children abused or neglected within 6 months of an initial indicated report			10.3	10.9	10.1	9.9	8.3[7]
Children in family cases	18.8	14.0	12.9	13.0	12.1	11.9	11.0
Children in intact family cases	19.7	14.3	13.2	13.5	12.2	12.2	11.2
Children in non-intact family cases	13.3	11.6	10.5	9.8	11.0	9.3	9.3
Children in substitute care	3.5	2.8	2.2-2.7	1.5-1.9	1.5-1.9	1.5-2.1	1.5-2.0
Children in relative care	3.4	2.3	1.8-2.1	1.4-1.6	1.3-1.6	1.4-1.7	1.5-1.8
Children in family foster care	4.3	4.2	3.4-4.3	2.1-2.7	2.1-2.7	1.8-2.6	1.8-2.3
Children in specialized foster care	3.2	2.9	1.6-2.4	1.6-2.1	1.2-1.7	1.7-2.5	1.3-2.0
Children in institutional placements	3.3	3.3	2.4-4.0	0.9-1.8	0.9-1.4	1.2-1.9	0.9-1.6
Children in group-home placements	3.0	3.1	2.1-3.4	0.5-1.1	0.6-1.6	1.6-1.9	1.8-2.5

Note. Except for the first row the values represent number of children abused or neglected per 100 children in care for 1 full year.

[7] The percentage for FY 01 under estimates the true rate since at the time of report preparation a full six months of data after the end of FY 01 was not available.

The rate of abuse or neglect for children being served in family cases[8] demonstrates a decline from FY 95 (18.8 per 100 children in care for 1 year) through FY 01 (11.0 per 100 children in care for 1 year) (Table 2.1). Children in family cases include both children in intact family cases as in well as in non-intact family cases. Rates of abuse or neglect in these two situations show a similar decline over time. Rates of abuse or neglect for children in non-intact family cases are somewhat lower than those for children in intact family cases. For non-intact family cases, 13.3 children per 100 children in care for 1 year were abused or neglected in FY 95, declining to 9.3 for FY 00 and FY 01. This compares to an abuse or neglect rate of 19.7 per 100 children in intact family care for 1 year for FY 95, declining to 11.2 for FY 01.

Abuse or neglect of children in substitute care is much lower than that for children in family cases and shows a decrease since FY 95. The overall rate was 3.5 children per 100 in care for 1 year in FY 95 with a subsequent reduction to a range of 1.5-2.0 for FY 01. This report now includes a range for the abuse rate for children in substitute care because of retrospective reporting[9] of some types of abuse. The true rate of abuse or neglect for children in substitute care is less than the high end of the range and higher than the low end of the range. Rates for the years prior to FY 97 are equivalent to the high end of the ranges reported for the last five years.

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[8] The terms family cases, intact family cases and non-intact family cases are defined on **p 2-8.**

[9] Retrospective reporting is a problem in the database where some prior incidents of abuse or neglect are counted against the current placement. This is described in more detail later in this chapter.

A range is reported because there is no date for the abuse incident in the CANTS data system. This results in the abuse indicator overestimating the incidence of abuse or neglect for Department wards. Through special studies of random samples of children who were indicated as abused while in care, the Center has found that the error in this estimator is primarily due to retrospective reporting of sexual abuse. Some times a child who is placed in a foster home develops a relationship with the foster parent or the child's counselor or therapist and discloses an incident of abuse prior to entering care. Since foster parents and therapists are required to report these incidents, the report shows up in CANTS as occurring while the child was in care. The Center is working on developing a correction for this that will result in a more accurate indicator. Since this corrected indicator in not yet available, this report includes the original indicator with and without sexual abuse allegations. The resulting range identifies the lower and upper limits of abuse or neglect for children in substitute care.

The rate of abuse for children in care varies somewhat by type of substitute care. The majority of Department wards are placed with relatives and these placements had a recurrence rate ranging from 1.8 to 2.1 children per 100 in care for 1 year in FY 97. This range has decreased to 1.5 to 1.8 per 100 children in care for one year in FY 01. Children in family foster home placements have a higher rate of abuse or neglect with this range being 3.4 to 4.3 per 100 in care for 1 year FY 97. The current rate (FY 01) is between 1.8 and 2.3 per 100 children in care for 1 year.

Abuse or Neglect Subsequent To Department Involvement: Children with an Indicated Report of Abuse or Neglect.

A common tenet of public child welfare is that once children come to the attention of the child welfare agency due to abuse or neglect that they should be protected from further harm. The United States Department of Health and Human Services, in responding to the Adoption and Safe Families Act of 1997 that directed the development of child safety and permanency indicators developed such an indicator. The following indicator, while not identical to that developed by DHHS, is similar.

Indicator: The percentage of all children who were victims of an indicated child abuse and/or neglect during the fiscal year, with another indicated report within six months.

Table 2.2 shows recurrence rates for each of the last 5 years along with the number of children with indicated reports, the number with another indicated report and the average number of days from the first indicated report to the second. This recurrence rate has been fairly stable ranging from 10.9% in FY 98 to 9.9% in FY 00. The rate of 8.3% for FY 01 underestimates the true rate since the data used for this report were drawn before a full six months elapsed from the end of the fiscal year.

The standard for the DHHS indicator has been established as 6.1%. While this standard is lower than the rate reported here, it should be interpreted carefully. There is no federal definition of abuse or neglect. Child abuse and neglect are defined by state laws that vary widely. What is considered abuse or neglect in Illinois may not be in another state. Until unified definitions of abuse and neglect exist for all of the states, the use of a national standard to compare abuse rates between states is not appropriate. Examining changes in the indicator over time within states is a better comparison.

Abuse or Neglect Subsequent to Department Involvement: Children in Family Cases

When a worker investigates a report of abuse or neglect and finds reason to believe that a caretaker has abused or neglected a child, a report is indicated. The worker has a number of options in responding to these cases. Some reports are indicated, but no case is opened because the child is judged to be safe. Frequently in these situations the family is referred to local service providers for assistance. In some cases, reports are indicated by a worker who opens a case to provide services to the family, with all of the children remaining at home. These are called "intact family" cases. In some cases, abuse or neglect is indicated and concerns for the child's safety result in opening a child case and placing some of the children in substitute care but leaving some at home. In these situations the children remaining at home are counted as children served in non-intact family cases.

Table 2.2 Recurrence of Abuse/Neglect Within Six Months of Initial Abuse/Neglect by Fiscal Year

Note: Recurrence for Fiscal Year 2001 is incomplete since the follow up period has been less than 6 months for some children.

Fiscal Year	Number Children with One Indicated Report	Number Recurrent	Percentage Recurrent	Mean Time to First Recurrence (days)
1997	36,840	3,777	10.3	73.1
1998	32,462	3,538	10.9	71.7
1999	30,089	3,053	10.1	72.5
2000	29,037	2,888	9.9	72.3
2001	25,817	2,152	8.3	62.6

This report defines children in family cases as including both those in intact family cases and non-intact family cases. Since the Department does not have an indicator for intact or non-intact families in the information system, it is difficult to compute safety results for this group of children. Analysis requires identifying these children in the database through a process of elimination. First, families with all children in placement at the time of family case opening are eliminated. Then to find the children of these intact families, clients over the age of 18 and married teens over the age of 16 who did not have an open child case are eliminated. If no children from the family are in placement at the time of case opening, each child is an intact family child. If a child in a family case has at least one sibling in placement, that child is counted as in non-intact family care.

Indicator: Number of children with an indicated report of abuse or neglect in a family case during the fiscal year per 100 children in care for 1 year.

The rate per 100 children in care for 1 year is used because simple percentages underestimate the relative risk of abuse or neglect. When comparing simple percentages the risk to a child with an indicated report who has been involved with the Department for only 1 month is counted equally as the risk to a child with an indicated report who has been in care for 11 months. As a result, attention to developing safety indicators that take time in care into consideration has been increasing (Lowman, Kotch, Jong, & Browne, 1998). Center staff consulted with the Illinois Statistics Office of the University of Illinois at Urbana-Champaign for assistance with refining the safety indicators to account for time in care. Simpson, Imrey, Geling, and Butkus (1998) demonstrated that the simple percentages typically used in reporting safety results underrepresented the true rate of abuse and neglect and suggested a rate that accounts for time in care. This rate involves taking into consideration the average number of days during the year that the child has been in the care of the Department. The result is an abuse and neglect rate per 100 child-years rather than per 100 children. The term 100 child-years may be a little confusing. An equivalent way of stating this is as a rate per 100 children living in a given arrangement for 1 full year.

Table 2.3 Indicated Reports of Abuse or Neglect of Children Living in Family Cases

Case Type	Fiscal Year	Children Living in a Family Case*	Indicated Reports**	Rate of Abuse or Neglect (%)	Mean Duration (days)	Reports per 100 Childcare-Years
Family Cases	1995	49,459	5,007	10.1	197	18.8
	1996	52,194	4,079	7.8	205	14.0
	1997	47,094	3,240	6.9	195	12.9
	1998	37,304	2,578	6.9	194	13.0
	1999	29,401	1,852	6.3	191	12.1
	2000	27,704	1,618	5.8	180	11.9
	2001	27,216	1,499	5.5	182	11.0
Intact Family Cases	1995	43,763	4,493	10.3	190	19.7
	1996	46,941	3,652	7.8	199	14.3
	1997	42,399	2,894	6.8	188	13.2
	1998	33,298	2,302	6.9	186	13.5
	1999	26,052	1,604	6.2	184	12.2
	2000	25,064	1,451	5.8	173	12.2
	2001	25,117	1,366	5.4	177	11.2
Non-intact Family Cases	1995	5,696	514	9.0	248	13.3
	1996	5,253	427	8.1	256	11.6
	1997	4,695	346	7.4	256	10.5
	1998	4,006	276	6.9	257	9.8
	1999	3,349	248	7.4	245	11.0
	2000	2,640	167	6.3	248	9.3
	2001	2,099	133	6.3	249	9.3

* Number of children with family cases open during the fiscal year for 7 or more days.
** Number of children with at least one indicated report occuring 7 or more days after the family case opened.

Table 2.3 includes the percent of children in family cases who were victims of subsequent abuse or neglect and the rate per 100 children living in family cases for 1 year. This table includes the number of children with an indicated report for each of the last 7 fiscal years, the total number of children living in a family case sometime during the year, and the average number of days that children remained in these family cases for the two subcategories: intact and non-intact families.

The rate of abuse or neglect per 100 children in family care for 1 year has decreased from 18.8 children for FY 95 to 11.0 for FY 01. The rate of abuse or neglect for children in non-intact family cases is lower than that of children in intact family cases. For FY 95, 13.3 children per 100 in non-intact family care for 1 year were victims of abuse or neglect while the comparable rate was 19.7 for children living in intact family care. These rates have decreased to 9.3 per 100 children living in non-intact family care for 1 year in FY 01 and 11.2 for children in intact families.

Abuse or Neglect for Children Subsequent to the Department Opening a Child Case with Placement in Substitute Care

When a worker judges that safety concerns require opening a child case and a judge concurs, the child is frequently placed outside of the home. The child may be placed with a relative, a foster family, or some special placement such as a group home. Safety results for children in substitute care and by type of substitute care placement are presented here.

Indicator: Number of children with an indicated report of abuse or neglect subsequent to the Department opening a child case and placing the child in substitute care per 100 children in care for 1 year.

Because of characteristics of the administrative data systems maintained by the Department it was necessary to use three decision rules to produce meaningful rates for this indicator. The first rule establishes that the Department is responsible for a case if that case is open 7 days or longer; cases open less than 7 days were dropped from analysis. In some situations, a worker or other authority believes that a child is in danger, opens a case, and takes protective custody of the child. However, subsequent examination of the situation reverses this decision and the child returns home. This decision rule eliminates these situations. The rule may

also eliminate some very short-term cases that should be counted. However, the number of these cases is thought to be small.

The second decision rule counts an indicated report during a child placement only when it occurs 7 or more days after the start of a placement. CANTS does not record the date of an abuse or neglect incident but only the date of the report. This limits the ability to link an indicated report of abuse or neglect to other dates such as the date of case opening or the date a child placement starts. The second decision rule makes it more likely that the indicator includes those incidents that occur after a placement begins.

The third rule only counts a child placement if it lasts at least 7 days. There are a variety of reasons for short-term placements including children being treated in a hospital for normal medical procedures. This rule eliminates these short-term placements.

This report includes a range of abuse rates for children in substitute care. This is due to the retrospective reporting of some types of abuse. The high end of the range overstates the true rate of abuse or neglect while the low end understates this rate. Safety indicators prior to FY 97 are taken from the previous report and are equivalent to the high end of the range reported for the last five years.

The rate of abuse for children in substitute care for FY 97 was between 2.2 and 2.7 children per 100 in care for a year and between 1.5 and 2.0 for FY 01 (Table 2.4, Table 2.5). The high end of the range overestimates the true rate of abuse in care because some abuse that occurs prior to entering care is reported while the child is in care (Table 2.4). The Center has found that this retrospective reporting largely applies to allegations of sexual abuse. Consequently, Center staff has produced a second set of rates that do not include allegations of sexual abuse (Table 2.5). Some children in care do experience sexual abuse resulting in the true rate of abuse for children in care being between the lower and upper limits of this range.

Table 2.4 Indicated Reports of Abuse or Neglect of Children in Substitute Care by Fiscal Year

Fiscal Year	Total Children Served During FY [a]	Children With at Least One Report [b]	Percentage Children with Indicated Reports	Mean Duration (days)	Reports per 100 Childcare - Years
1997	60,258	1,399	2.3	309	2.7
1998	59,122	938	1.6	302	1.9
1999	53,671	794	1.5	292	1.9
2000	44,028	720	1.6	287	2.1
2001	36,701	573	1.6	287	2.0

[a] Number of children with child cases open during the fiscal year for 7 or more days.
[b] Number of children with at least one indicated report occurring 7 or more days after the start of placement.

Table 2.5 Indicated Reports of Abuse or Neglect of Children in Substitute Care by Fiscal Year (allegations of sexual abuse excluded)

Fiscal Year	Total Children Served During FY [a]	Children With at Least One Report [b]	Percentage Children with Indicated Reports	Mean Duration (days)	Reports per 100 Childcare - Years
1997	60,258	1,124	1.9	309	2.2
1998	59,122	745	1.3	302	1.5
1999	53,671	628	1.2	292	1.5
2000	44,028	530	1.2	287	1.5
2001	36,701	442	1.2	287	1.5

[a] Number of children with child cases open during the fiscal year for 7 or more days.
[b] Number of children with at least one indicated report occurring 7 or more days after the start of placement.

The National Context

The safety indicators developed by DHHS under the Adoption and Safe Families Act include incidence of child abuse and/or neglect in foster care. Their indicator counts the number of children who were reported in NCANDS as maltreated by a perpetrator who was a foster parent or a residential facility staff person for the nine month period of January 1 through September 30 for 1997 and 1998. They then divide that number by the population of children serviced in foster care, as reported in AFCARS, for the same time period (ACYF, 2001). There are several problems with this indicator as discussed in the previous Center outcome report (CFRC, 2001). DHHS has also developed a standard for this indicator which is currently .57%. The comparable rate for Illinois is between 1.3% and 1.6%.

Abuse or Neglect After Department Involvement and Before the Case is Closed: By Type of Placement

The largest number of children in the care of the Department is placed in the home of relatives. The rate of abuse or neglect with and without sexual abuse over the last five years ranges from 1.8 to 2.1 children per 100 in care for 1 year in FY 97 to 1.5 to 1.8 in FY 01 (Table 2.6, Table 2.7). This rate has been very stable over the last four years.

The next largest number of children in substitute care is placed in family foster care. This rate ranged (without and with sexual abuse allegations) from 3.4 children in care for one year to 4.3 in FY 97 and has since decreased to 1.8 to 2.3 for FY 01. These rates have been very similar for the last two fiscal years.

Table 2.6 Indicated Reports of Abuse or Neglect of Children in Department Custody by Living Arrangement by Fiscal Year

Fiscal Year	Living Arrangement [a]	Total in Placement [b]	Indicated Reports [c]	Rate of Abuse or Neglect (%)	Mean Duration (days)	Reports per 100 Childcare-Years
1997	**Relative Care**	35,781	604	1.7	296	2.1
	Family Foster Care	17,040	483	2.8	242	4.3
	Specialized Foster Care	8,642	149	1.7	267	2.4
	Group Home	1,717	26	1.5	164	3.4
	Institution	7,588	146	1.9	175	4.0
1998	**Relative Care**	35,384	452	1.3	287	1.6
	Family Foster Care	17,400	307	1.8	243	2.7
	Specialized Foster Care	7,997	119	1.5	256	2.1
	Group Home	1,588	8	0.5	171	1.1
	Institution	6,744	56	0.8	169	1.8
1999	**Relative Care**	31,626	369	1.2	270	1.6
	Family Foster Care	16,897	299	1.8	241	2.7
	Specialized Foster Care	6,452	78	1.2	263	1.7
	Group Home	1,379	11	0.8	183	1.6
	Institution	6,252	41	0.7	170	1.4

[a] Living arrangement is operationally defined in the appendix of this report.
[b] Number of children in Department custody ever living in a given placement type during the fiscal year.
[c] Number of children in Department custody ever living in a given placement type during the fiscal year with at least one indicated report.

Table 2.6 Indicated Reports of Abuse or Neglect of Children in Department Custody by Living Arrangement by Fiscal Year (*continued*)

Fiscal Year	Living Arrangement [a]	Total in Placement [b]	Indicated Reports [c]	Rate of Abuse or Neglect (%)	Mean Duration (days)	Reports per 100 Childcare-Years
2000	**Relative Care**	24,227	297	1.2	260	1.7
	Family Foster Care	14,931	257	1.7	239	2.6
	Specialized Foster Care	5,802	105	1.8	262	2.5
	Group Home	1,235	12	1.0	183	1.9
	Institution	5,674	54	1.0	183	1.9
2001	**Relative Care**	18,879	246	1.3	257	1.8
	Family Foster Care	13,552	199	1.5	233	2.3
	Specialized Foster Care	4,952	70	1.4	264	2.0
	Group Home	1,069	14	1.3	190	2.5
	Institution	5,479	44	0.8	179	1.6

[a] Living arrangement is operationally defined in the appendix of this report.
[b] Number of children in Department custody ever living in a given placement type during the fiscal year.
[c] Number of children in Department custody ever living in a given placement type during the fiscal year with at least one indicated report.

Table 2.7 Indicated Reports of Abuse or Neglect of Children in Department Custody by Living Arrangement by Fiscal Year (allegations of sexual abuse excluded)

Fiscal Year	Living Arrangement [a]	Total in Placement [b]	Indicated Reports [c]	Rate of Abuse or Neglect (%)	Mean Duration (days)	Reports per 100 Childcare-Years
1997	Relative Care	35,781	536	1.5	296	1.8
	Adoptive Placement	801	3	0.4	74	1.8
	Family Foster Care	17,040	382	2.2	242	3.4
	Specialized Foster Care	8,642	104	1.2	267	1.6
	Group Home	1,717	16	0.9	164	2.1
	Institution	7,588	89	1.2	175	2.4
1998	Relative Care	35,384	387	1.1	287	1.4
	Adoptive Placement	1,307	0	0.0	70	0.0
	Family Foster Care	17,400	238	1.4	243	2.1
	Specialized Foster Care	7,997	92	1.2	256	1.6
	Group Home	1,588	4	0.3	171	0.5
	Institution	6,744	28	0.4	169	0.9
1999	Relative Care	31,626	313	1.0	270	1.3
	Adoptive Placement	1,219	0	0.0	75	0.0
	Family Foster Care	16,897	234	1.4	241	2.1
	Specialized Foster Care	6,452	54	0.8	263	1.2
	Group Home	1,379	4	0.3	183	0.6
	Institution	6,252	25	0.4	170	0.9

[a] Living arrangement is operationally defined in the appendix of this report.
[b] Number of children in Department custody ever living in a given placement type during the fiscal year.
[c] Number of children in Department custody ever living in a given placement type during the fiscal year with at least one indicated report.

Table 2.7 (continued) Indicated Reports of Abuse or Neglect of Children in Department Custody by Living Arrangement by Fiscal Year (allegations of sexual abuse excluded)

Fiscal Year	Living Arrangement [a]	Total in Placement [b]	Indicated Reports [c]	Rate of Abuse or Neglect (%)	Mean Duration (days)	Reports per 100 Childcare-Years
2000	**Relative Care**	24,227	242	1.0	260	1.4
	Family Foster Care	14,931	174	1.2	239	1.8
	Specialized Foster Care	5,802	71	1.2	262	1.7
	Group Home	1,235	10	0.8	183	1.6
	Institution	5,674	34	0.6	183	1.2
2001	**Relative Care**	18,879	201	1.1	257	1.5
	Family Foster Care	13,552	157	1.2	233	1.8
	Specialized Foster Care	4,952	47	0.9	264	1.3
	Group Home	1,069	10	0.9	190	1.8
	Institution	5,479	25	0.5	179	0.9

[a] Living arrangement is operationally defined in the appendix of this report.
[b] Number of children in Department custody ever living in a given placement type during the fiscal year.
[c] Number of children in Department custody ever living in a given placement type during the fiscal year with at least one indicated report.

The low end of the abuse rate (excluding sexual abuse allegations) for children placed in specialized foster care has ranged from 1.6 per 100 children in care for one year in FY 97 to 1.3 in FY 01. Fiscal years 1997, 1998 and 2000 show similar rates of 1.6 to 1.7. These rates for fiscal years 1999 and 2001 are similar at 1.2 and 1.3 per 100 children in care for one year.

The rate of abuse or neglect for children in institutional placements without sexual abuse allegations was 2.4 per 100 children in care for 1 year in FY 97. This rate decreased to 0.9 for FY 98, FY 99 and FY 01. This rate for FY 00 was 1.2.

Children placed in group homes experienced abuse or neglect at a rate (excluding sexual abuse allegations) of 2.1 per 100 children in care for 1 year in FY 97. This rate decreased to 0.5 and 0.6 in FY 98 and FY 99. There has been an increase in this rate in the last two years to 1.6 in FY 00 and 1.8 in FY 01.

Results of Special Studies of Retrospective Reporting of Child Abuse or Neglect.

Reporting abuse rates with and without sexual abuse allegation may be confusing. The reason for the two rates is partly because of reporting of sexual abuse by children placed in care that occurred prior to entering care. Practice wisdom suggests that recurrence rates are inflated because of retrospective reporting of incidents of abuse or neglect. Center staff have confirmed that retrospective reporting of abuse occurs. It was also found that this largely occurred with allegations of sexual abuse. Center staff confirmed this retrospective reporting of sexual abuse through two special studies. The population of interest for the first study was all indicated reports during FY 99 for children placed in relative care, non-related family foster care, and specialized foster care. For the second study indicated reports occurring in FY 00 were studied. In addition to the placement types used in the first study, children in group homes and institutions were included.

During FY 99 there were over 55,000 children in relative care, non-related family foster care and specialized foster care placements. There were a total of 746 incidents of abuse or neglect identified as occurring in these placements. A stratified random sample of 305 cases of these indicated reports was drawn with the strata being the three placement types. The sample size was determined by estimating the number needed to be 95% certain that the sample mean

would be within 5% of the true mean of the population. For FY 00 there were 691 indicated reports of abuse or neglect in the placement types included in the study. The sample size for this second study was 302 cases.

Child Protective Services' reports were obtained for 301 child cases in the first study and 299 in the second. Determining responsibility for many cases of children abused or neglected in foster care is difficult. The actual circumstances of an incident of maltreatment are often ambiguous and confusing. In Illinois, a report is initiated by placing a phone call to the DCFS State Central Register (SCR), otherwise known as the Child Abuse Hotline. A report, the CANTS I, is completed by the intake worker and if the report meets certain criteria, is referred to the local DCFS Child Protective Service (CPS) office. The incident is investigated and the CANTS II is completed. The CANTS system is then updated with the CPS data.

Oftentimes, the CANTS I is not complete. As this is the initial report, names may be missing or unknown. It may later be determined that there were other children residing in the home that were not identified in the initial report. In the present study, the names of twenty-nine children who were subjects of this study were not listed on the CANTS I. Only by using the CANTS computer database was it possible to determine that they were, in fact, involved somehow in the incident. In addition, 24 children were not identified with any allegation. In these cases the allegations involved another child in the home where they resided or were present at the time of the incident.

In both studies, the majority of incidents attributed to the foster care placement did occur while the child was officially placed in a family foster home, a relative foster home, or a specialized foster home. A total of 252 (84%) incidents in the first study and 212 (73%) in the second occurred, either during the current placement, in a respite placement, or in a previous foster care placement, (Table 2.8).

In the first study, 47 (16%) incidents attributed to substitute care placements were retrospective reports of abuse that occurred prior to entry into foster care. Results of the second study found that 80 (27%) incidents were retrospective. These appear to be circumstances when the hotline is called by a foster parent, caseworker, or therapist to report an incident of child maltreatment that occurred prior to the child being placed in care.

Table 2.8 Retrospective and Non-retrospective Incidents of Abuse or Neglect

Responsibility	Placement Type								Total	
	Family Foster Home		Relative Foster Home		Specialized Foster Home		Groups Homes and Institutions[10]			
	Study 1	Study 2	Study 1	Study 2	Study 1	Study 2	Study 1	Study 2	Study 1	Study 2
Substitute Care	91 (78%)	71 (68%)	134 (90%)	92 (81%)	27 (77%)	31 (66%)		18 (67%)	252 (84%)	212 (73%)
Retrospective	25 (22%)	34 (32%)	14 (10%)	21 (19%)	8 (23%)	16 (34%)		9 (33%)	47 (16%)	80 (27%)
Total	116	105	148	113	35	47		27	299	292

[10] Group home and institutional placements not included in the first study.

There were differences in the percent of retrospective reports across placement types. For children in home of relative placements 10% of incidents in the first study and 19% in the second study were retrospective reports. Family and specialized foster care had nearly equal rates of retrospective report with percentages of 22% and 23% respectively in the first study and 32% and 34% in the second. One third of the incidents attributed to group homes and institutions in the second study were retrospective.

The two studies yielded very different rates of retrospective reporting. It is not possible to identify the reasons for this. It may be that this is due to normal variations between random samples. It may be that Center staff were more able to discern retrospective cases in the second study given their experience with the first study. In either case replications are needed. Some experts suggest that as many as ten replications of studies of this type are needed to develop a reasonable estimate of the true rate of retrospective reporting of abuse or neglect.

Practice wisdom suggests that retrospective reports are largely incidents of sexual abuse. Table 2.9 indicates that this was the case 68% of the time in the first study and 74% in the second. Retrospective reports of sexual abuse occurred less frequently in home of relative placements (57%) in the first study but similar to other placement types in the second (76%). In the first study 88% of retrospective reports in specialized foster care placements were identified as sexual abuse while the second study found this to be 62%. These percentages for family foster care were 68% in the first study and 74% in the second.

The identified perpetrator for retrospective indicated reports was most frequently birth parents (47% and 45% – Table 2.10). This was the case for 71% and 57% of the incidents in home of relative placements, 38% and 31% of the specialized foster care placements and 36% and 47% of the family foster care placements. The next most common perpetrator was unrelated parent substitute (19% and 20%). This occurred most often in family foster care (24% and 20%) and less frequently in relative care (14%) in the first study but nearly equal to that of family foster care in the second study (19%).

Table 2.9 Types of Allegations by Placement Types

Allegations	Placement Type								Total	
	Family Foster Home		Relative Foster Home		Specialized Foster Home		Group Homes and Institutions [11]			
	Study 1	Study 2	Study 1	Study 2	Study 1	Study 2	Study 1	Study 2	Study 1	Study 2
Physical Abuse	1 (4%)	0	0	1 (5%)	1 (12%)	2 (12%)		0	2 (4%)	3 (4%)
Sexual Abuse	17 (68%)	25 (74%)	8 (57%)	16 (76%)	7 (88%)	10 (63%)		8 (89%)	32 (68%)	59 (74%)
Neglect	2 (8%)	1 (3%)	1 (7%)	0	0	1 (6%)		1 (11%)	3 (6%)	3 (3%)
Substantial Risk of Harm	4 (16%)	8 (24%)	3 (21%)	4 (19%)	0	3 (19%)		0	7 (15%)	15 (19%)
None	1 (4%)	0	2 (14%)	0	0	0		0	3 (6%)	0
Total	25	34	14	21	8	16		9	47	80

[11] Group home and institutional placements not included in the first study.

Table 2.10 Perpetrator's Relationship to the Child – Retrospective Cases

Perpetrator's Relationship to the Child	Placement Type								Total	
	Family Foster Home		Relative Foster Home		Specialized Foster Home		Group Homes and Institutions [12]			
	Study 1	Study 2	Study 1	Study 2	Study 1	Study 2	Study 1	Study 2	Study 1	Study 2
Birth Parent	9 (36%)	16 (47%)	10 (71%)	12 (57%)	3 (38%)	5 (31%)		3 (33%)	22 (47%)	36 (45%)
Step Parent	5 (20%)	1 (3%)	0	0	0	1 (6%)		2 (22%)	5 (11%)	4 (5%)
Adult Relative	1 (4%)	2 (6%)	1 (7%)	0	2 (25%)	0		0	4 (8%)	2 (2%)
Sibling	3 (12%)	2 (6%)	0	1 (5%)	1 (12%)	1 (6%)		2 (22%)	4 (8%)	6 (8%)
Unrelated Parent Substitute	6 (24%)	7 (20%)	2 (14%)	4 (19%)	1 (12%)	5 (31%)		1 (11%)	9 (19%)	16 (20%)
Other Child	0		0	3 (14%)	1 (12%)	1 (6%)		0	1 (2%)	4 (5%)
Other Person	1 (4%)		1 (7%)	1 (5%)	0	0		1 (11%)	2 (4%)	2 (2%)
Babysitter	0	6 (18%)	0	0	0	3 (19%)		0	0	9 (11%)
Total	25	34	14	21	8	16		9	47	80

[12] Group home and institutional placements not included in the first study.

The perpetrator was an unrelated parent substitute in 12% of the incidents for children in specialized foster care in the first study and 31% in the second.

Retrospective reporting of child abuse or neglect does occur at a sufficient rate that the Center now adjusts recurrence rates for this problem. Since the two studies of retrospective reporting resulted in very different estimates of the occurrence of retrospective reporting, additional studies will be undertaken. These studies have demonstrated that sexual abuse is the most frequent allegation linked to retrospective reporting. Therefore until sufficient studies have been completed to produce a reliable correction factor, abuse or neglect in substitute care will be reported with and without sexual abuse allegations. This results in a range for each recurrence rate. The upper limit of this range overestimates the true incidence of recurrence since it includes all retrospective reports. The lower limit of the range is likely to under estimate the true incidence of recurrence since it eliminates all allegations of sexual abuse, both those that are retrospective and those that are not.

Additional Safety Outcomes Analysis: Gender, Race, Age, Region, and Type of Allegation

This section of the report includes additional analysis of recurrence of abuse or neglect for the previously reported safety indicators. This includes analysis by age, race, gender and region for:

- all children who are investigated by the Department for abuse or neglect and the report is indicated
- children in family cases
- children in substitute care

Six Month Recurrence of Abuse or Neglect for Children with an Indicated Report by Gender, Race, Age, and Region[13]

There are no differences in recurrence of abuse or neglect within six months for males and females. Consequently, these data are not presented here. Table 2.11 shows the six month recurrence rates of abuse or neglect by race. Since very few of the children served by the Department in family cases are identified as a race other than African American, White, or Hispanic, these are the only categories presented. Children identified as White experience a higher rate of recurrence within six months than do African American or Hispanic children. White children experienced an 11.3% recurrence rate in FY 97 and 10.5% in FY 00. For African American children these percentages were 9.6% in FY 97 and 10.1% in FY 00. Hispanic children experienced the lowest recurrence rate of 7.8% in FY 97 and 6.3% in FY 00.

Six month recurrence of abuse or neglect is generally lower for children age 12 or older (Table 2.12). In general, younger children experience higher rates of subsequent abuse or neglect following an indicated report. For example, the recurrence rate for children age 12 to 15 was 8.6% in FY 97 and 8.1% in FY 00. For children age 3 to 6 these percentages were 11.6% in FY 97 and 11.4% in FY 00.

[13] This category includes all children who were investigated by the Department for abuse or neglect and the report was indicated. This is regardless of Department action, therefore this category includes situations where no further action was taken by the Department as well as where the Department provided services in the home or placed the child into substitute care.

Table 2.11 Recurrence of Abuse/Neglect Within Six Months of Initial Abuse/Neglect by Race by Fiscal Year

Fiscal Year	Childs Race	Number of Children with One Indicated Report	Number of Children with Another Indicated Report	Percentage of Children with Another Indicated Report	Mean Time to First Recurrence
1997	**African American**	15,973	1,541	9.6	74.3
	Hispanic	3,207	251	7.8	73.4
	White	16,430	1,860	11.3	72.5
1998	**African American**	13,308	1,219	9.2	73.3
	Hispanic	2,888	282	9.8	69.0
	White	15,121	1,894	12.5	71.2
1999	**African American**	11,774	1,094	9.3	72.3
	Hispanic	2,773	179	6.5	58.0
	White	14,478	1,672	11.5	74.0
2000	**African American**	11,488	1,156	10.1	72.2
	Hispanic	2,627	165	6.3	63.5
	White	13,773	1,447	10.5	73.8
2001	**African American**	9,718	803	8.3	59.9
	Hispanic	2,542	142	5.6	57.9
	White	12,378	1,093	8.8	65.2

Note: Recurrence for Fiscal Year 2001 is incomplete since the follow up period has been less than 6 months for some children.

Recurrence of abuse or neglect within six months is higher for non-Cook regions than it is for Cook regions (Table 2.13). For the 3 non-Cook regions the recurrence rate was 11.7% in FY 97 and 10.5% in FY 00. For the Cook County regions comparable rates were 8.4% for FY 97 and 9.0 in FY 00.

Safety Outcome Analysis for Children in Family Cases: Gender, Race, Age, and Region

There are no differences in abuse or neglect rates for males and females living in family (intact and non-intact) cases. Consequently, these data are not presented here. Table 2.14 shows the rates of abuse or neglect for children in family cases by race. Since very few of the children served by the Department in family cases are identified as a race other than African American, White, or Hispanic, that these are the only categories presented. These results show that Hispanic children in family cases generally experience the lowest rate of abuse or neglect ranging from 17.2 per 100 children in care for 1 year in FY 95 to 8.0 in FY 01.

White children living in family cases experience the highest rate of abuse or neglect ranging from 18.5 per 100 children in care for 1 year in FY 95 to 12.7 in FY 01. The rate for African American children was 19.4 per 100 in care for 1 year in FY 95 and decreased to 9.5 in FY 01.

Large differences exist in abuse or neglect rates for children in family cases by age of the child (Table 2.15). Children under the age of 3 experience the highest rates of abuse or neglect, ranging from 29.3 per 100 in care for 1 year in FY 95 to 22.1 in FY 01. The rate of abuse or neglect decreases as the age of the child increases, with children from 15 through 18 years of age experiencing the lowest rate of abuse or neglect. These rates range from 8.7 per 100 children in care for 1 year in FY 95 to 5.2 in FY 00.

Table 2.12 Recurrence of Abuse/Neglect Within Six Months of Initial Abuse/Neglect by Cook/non-Cook by Fiscal Year

		Number Children with One Indicated Report	Number of Children with Another Indicated Report	Percentage of Children with Another Indicated Report	Mean Time to First Recurrence
Fiscal Year	**Cook vs. non-Cook**				
1996	**Cook County**	17,081	1,564	9.2	69.0
	Non-Cook Counties	21,913	2,792	12.7	74.1
1997	**Cook County**	16,044	1,349	8.4	72.5
	Non-Cook Counties	20,796	2,428	11.7	73.4
1998	**Cook County**	13,048	1,117	8.6	73.3
	Non-Cook Counties	19,414	2,421	12.5	71.0
1999	**Cook County**	11,231	903	8.0	69.8
	Non-Cook Counties	18,858	2,150	11.4	73.6
2000	**Cook County**	10,137	910	9.0	71.5
	Non-Cook Counties	18,900	1,978	10.5	72.7
2001	**Cook County**	9,194	718	7.8	57.0
	Non-Cook Counties	16,623	1,434	8.6	65.5

Table 2.13 Indicated Reports of Abuse or Neglect of Children Living in Family Cases by Ethnicity by Fiscal Year

Fiscal Year	Ethnicity	Family Cases				
		Children Living in a Family Case*	Indicated Reports**	Rate of Abuse or Neglect (%)	Mean Duration (days)	Reports per 100 Childcare-Years
1995	African American	26,380	2,817	10.7	201	19.4
	Hispanic	3,731	356	9.5	202	17.2
	White	18,329	1,745	9.5	188	18.5
1997	African American	24,193	1,612	6.7	200	12.2
	Hispanic	4,529	191	4.2	199	7.7
	White	17,250	1,339	7.8	189	15.0
1999	African American	13,626	767	5.6	202	10.2
	Hispanic	2,592	161	6.2	198	11.4
	White	12,411	846	6.8	179	13.9
2001	African American	11,637	563	4.8	186	9.5
	Hispanic	2,718	102	3.8	171	8.0
	White	11,969	758	6.3	182	12.7

*Number of children with family cases open during the fiscal year for 7 or more days.
**Number of children with at least one indicated report occurring 7 or more days after the family case opened.

Table 2.14 Indicated Reports of Abuse or Neglect of Children Living in Family Cases by Age by Fiscal Year

Fiscal Year	Age*	Family Cases				
		Children Living in a Family Case**	Indicated Reports***	Rate of Abuse or Neglect (%)	Mean Duration (days)	Reports per 100 Childcare-Years
1995	Up to 3 yrs	12,986	1,757	13.5	169	29.3
	3 - 6 yrs	10,669	1,287	12.1	201	21.9
	6 - 9 yrs	8,390	848	10.1	205	18.0
	9 - 12 yrs	6,506	533	8.2	204	14.7
	12 - 15 yrs	5,456	398	7.3	204	13.1
	15 - 18 yrs	3,678	179	4.9	205	8.7
1997	Up to 3 yrs	10,706	1,056	9.9	163	22.1
	3 - 6 yrs	9,862	823	8.3	199	15.3
	6 - 9 yrs	8,547	615	7.2	202	13.0
	9 - 12 yrs	6,630	380	5.7	206	10.2
	12 - 15 yrs	5,427	241	4.4	203	8.0
	15 - 18 yrs	3,880	118	3.0	211	5.3
1999	Up to 3 yrs	6,764	673	9.9	153	23.7
	3 - 6 yrs	5,544	417	7.5	191	14.4
	6 - 9 yrs	5,367	334	6.2	200	11.4
	9 - 12 yrs	4,343	215	5.0	199	9.1
	12 - 15 yrs	3,383	143	4.2	203	7.6
	15 - 18 yrs	2,437	68	2.8	210	4.9
2001	Up to 3 yrs	6,105	530	8.7	144	22.1
	3 - 6 yrs	5,194	356	6.9	179	14.0
	6 - 9 yrs	4,790	236	4.9	186	9.7
	9 - 12 yrs	4,074	171	4.2	193	8.0
	12 - 15 yrs	3,313	135	4.1	195	7.6
	15 - 18 yrs	2,378	69	2.9	206	5.2

*Number of children with family cases open during the fiscal year for 7 or more days.
**Number of children with at least one indicated report occurring 7 or more days after the family case opened.
***Age in fiscal year is defined in the appendix of this report.

Table 2.15 Recurrence of Abuse/Neglect Within Six Months of Initial Abuse/Neglect by Age by Fiscal Year

		Number Children with One Indicated Report	Number of Children with Another Indicated Report	Percentage of Children with Another Indicated Report	Mean Time to First Recurrence
Fiscal Year	**Childs Age**				
1997	**Up to 3 yrs**	10,183	1,072	10.5	73.9
	3 - 6 yrs	7,590	880	11.6	72.0
	6 - 9 yrs	6,699	744	11.1	74.0
	9 - 12 yrs	5,146	551	10.7	75.2
	12 - 15 yrs	4,307	370	8.6	70.6
	15 - 18 yrs	2,543	151	5.9	69.2
1998	**Up to 3 yrs**	8,829	1,013	11.5	71.6
	3 - 6 yrs	6,451	775	12.0	70.9
	6 - 9 yrs	6,040	748	12.4	71.4
	9 - 12 yrs	4,703	370	8.6	70.6
	12 - 15 yrs	3,737	349	9.3	75.0
	15 - 18 yrs	2,305	141	6.1	68.7
1999	**Up to 3 yrs**	8,172	880	10.8	70.5
	3 - 6 yrs	5,845	672	11.5	71.6
	6 - 9 yrs	5,745	629	10.9	72.7
	9 - 12 yrs	4,439	451	10.2	73.2
	12 - 15 yrs	3,513	292	8.3	77.5
	15 - 18 yrs	2,048	118	5.8	76.8
2000	**Up to 3 yrs**	7,847	864	11.0	68.6
	3 - 6 yrs	5,508	630	11.4	73.7
	6 - 9 yrs	5,373	598	11.1	74.2
	9 - 12 yrs	4,329	406	9.4	75.8
	12 - 15 yrs	3,449	279	8.1	74.2
	15 - 18 yrs	2,137	103	4.8	67.4
2001	**Up to 3 yrs**	7,091	670	9.4	62.6
	3 - 6 yrs	4,833	455	9.4	63.5
	6 - 9 yrs	4,561	416	9.1	60.0
	9 - 12 yrs	4,030	305	7.6	63.6
	12 - 15 yrs	3,081	234	7.6	65.6
	15 - 18 yrs	1,909	69	3.6	60.5

Note: Recurrence for Fiscal Year 2001 is incomplete since the follow up period has been less than 6 months for some children.

Rates of abuse or neglect for children in family cases by region are presented by comparing the three Cook regions to the three non-Cook regions (Table 2.16). Except for FY 95, reabuse rates were higher for the non-Cook regions, ranging from 18.5 children per 100 in care for 1 year in FY 95 to 12.8 in FY 01. For the Cook regions these rates were 19.1 in FY 95 and decreased to 8.4 in FY 01.

Safety Outcome Analysis for Children in Substitute Care: Gender, Race, Age, and Region

Due to the retrospective reporting problem that has been described above, the following results are reported excluding sexual abuse allegations. Retrospective reporting of abuse has been shown to be largely reporting of sexual abuse allegations that occurred prior to entry into substitute care. Safety results for all children in substitute care were reported as a range that both included sexual abuse allegations and excluding them. The true rate of abuse or neglect is likely to be somewhat higher than the lower end of the range and lower than the higher end of the range. Since there is a large amount of data when the safety results are reported by gender, race, age and region, a decision was made to report only the lower end of the range. While this rate underestimates the true rate of abuse, Center studies show these estimates to be closer to the true rate than the rate that includes all allegations.

There are no appreciable differences in the reabuse or neglect rates between males and females in substitute care; consequently, these rates are not presented here. There are differences in the safety indicators by race (Table 2.17). White children in substitute care experience the highest rates of abuse or neglect ranging from 4.6 per 100 children in care for 1 year in FY 97 to 3.4 in FY 01. These rates for African American children were 2.3 for FY 97 and 1.6 in FY 01. The rates for Hispanic children ranged from 2.9 in FY 97 to 1.8 in FY 01.

Table 2.16 Indicated Reports of Abuse or Neglect of Children Living in Family Cases by Cook versus Non-Cook Counties by Fiscal Year

Fiscal Year	Cook/Non-Cook	Family Cases				
		Children Living in a Family Case*	Indicated Reports**	Rate of Abuse or Neglect (%)	Mean Duration (days)	Reports per 100 Childcare-Years
1995	Cook County	25,974	2,785	10.7	205	19.1
	Non-Cook Counties	23,485	2,222	9.5	187	18.5
1996	Cook County	29,313	2,114	7.2	219	12.0
	Non-Cook Counties	22,881	1,965	8.5	186	16.8
1997	Cook County	25,806	1,533	5.9	200	10.8
	Non-Cook Counties	21,288	1,707	8.0	189	15.5
1998	Cook County	18,342	1,105	6.0	204	10.8
	Non-Cook Counties	18,962	1,473	7.8	184	15.4
1999	Cook County	12,499	685	5.5	208	9.6
	Non-Cook Counties	16,902	1,167	6.9	178	14.2
2000	Cook County	11,274	498	4.4	189	8.5
	Non-Cook Counties	16,430	1,120	6.8	174	14.3
2001	Cook County	10,948	450	4.1	180	8.4
	Non-Cook Counties	16,268	1,049	6.4	184	12.8

*Number of children with family cases open during the fiscal year for 7 or more days.
**Number of children with at least one indicated report occurring 7 or more days after the family case opened.

Table 2.17 Indicated Reports of Abuse or Neglect of Children in Substitute Care by Ethnicity by Fiscal Year

Fiscal Year	Ethnicity	Total Children Served During FY [a]	Children With at Least One Report [b]	Percentage Children with Indicated Reports	Mean Duration (days)	Reports per 100 Childcare-Years
1997	**African American**	45,858	934	2.0	318	2.3
	Hispanic	2,803	65	2.3	295	2.9
	White	10,696	373	3.5	276	4.6
1998	**African American**	45,163	608	1.3	309	1.6
	Hispanic	2,865	55	1.9	287	2.4
	White	10,189	266	2.6	274	3.5
1999	**African American**	40,532	552	1.4	299	1.7
	Hispanic	2,636	32	1.2	285	1.6
	White	9,609	200	2.1	264	2.9
2000	**African American**	32,501	429	1.3	293	1.6
	Hispanic	2,215	33	1.5	283	1.9
	White	8,496	244	2.9	266	3.9
2001	**African American**	26,210	340	1.3	294	1.6
	Hispanic	1,887	26	1.4	280	1.8
	White	7,803	190	2.4	265	3.4

Rates of abuse or neglect for children in substitute care do not show the same kinds of differences by age that they do for children in family cases (Table 2.18). Children under the age of 3 in substitute care do not experience the same level of abuse or neglect as those in family cases. The rates for children under the age of 3 in substitute care range from 3.0 per 100 in care for 1 year in FY 97 to 1.6 in FY 01. In general the rate of abuse or neglect for children in substitute care does not vary greatly across the age groups. Youth in substitute care from 15 through 18 years of age show the lowest rate of abuse or neglect with 1.6 per 100 children in care for 1 year in FY 97 and FY 01.

Rates of abuse or neglect for children in substitute care are higher for the non-Cook regions than for the Cook regions (Table 2.19). For the non-Cook regions these rates were 4.8 in FY 97 and 3.2 in FY 01. For the three Cook regions they ranged from 2.1 in FY 97 to 1.4 in FY 01.

Table 2.18 Indicated Reports of Abuse or Neglect of Children in Substitute Care by Age by Fiscal Year

Fiscal Year	Age [a]	Total Children Served During FY [b]	Children With at Least One Report [c]	Percentage Children with Indicated Reports	Mean Duration (days)	Reports per 100 Childcare-Years
1997	**Up to 3 yrs**	8,353	184	2.2	272	3.0
	3 - 6 yrs	12,127	314	2.6	320	3.0
	6 - 9 yrs	11,382	312	2.7	324	3.1
	9 - 12 yrs	9,193	254	2.8	327	3.1
	12 - 15 yrs	8,131	223	2.7	319	3.1
	15 - 18 yrs	7,965	104	1.3	297	1.6
1998	**Up to 3 yrs**	7,494	94	1.3	263	1.7
	3 - 6 yrs	11,451	199	1.7	309	2.1
	6 - 9 yrs	11,350	237	2.1	313	2.4
	9 - 12 yrs	9,594	184	1.9	315	2.2
	12 - 15 yrs	8,169	132	1.6	314	1.9
	15 - 18 yrs	7,799	89	1.1	298	1.4
1999	**Up to 3 yrs**	6,722	85	1.3	261	1.8
	3 - 6 yrs	9,673	158	1.6	293	2.0
	6 - 9 yrs	9,990	212	2.1	297	2.6
	9 - 12 yrs	8,986	161	1.8	303	2.2
	12 - 15 yrs	7,561	116	1.5	305	1.8
	15 - 18 yrs	7,275	61	0.8	295	1.0

[a] Age in fiscal year is defined in the appendix of this report.
[b] Number of children with child cases open during the fiscal year for 7 or more days.
[c] Number of children with at least one indicated report occurring 7 or more days after the start of placement.

Table 2.18 Indicated Reports of Abuse or Neglect of Children in Substitute Care by Age by Fiscal Year *(continued)*

Fiscal Year	Age [a]	Total Children Served During FY [b]	Children With at Least One Report [c]	Percentage Children with Indicated Reports	Mean Duration (days)	Reports per 100 Childcare-Years
2000	**Up to 3 yrs**	5,708	65	1.1	263	1.6
	3 - 6 yrs	7,332	129	1.8	284	2.3
	6 - 9 yrs	7,596	179	2.4	288	3.0
	9 - 12 yrs	7,139	156	2.2	295	2.7
	12 - 15 yrs	6,405	127	2.0	300	2.4
	15 - 18 yrs	6,321	62	1.0	297	1.2
2001	**Up to 3 yrs**	4,936	56	1.1	259	1.6
	3 - 6 yrs	5,756	106	1.8	286	2.4
	6 - 9 yrs	5,667	127	2.2	293	2.8
	9 - 12 yrs	5,573	119	2.1	296	2.6
	12 - 15 yrs	5,427	91	1.7	299	2.1
	15 - 18 yrs	5,625	72	1.3	299	1.6

[a] Age in fiscal year is defined in the appendix of this report.
[b] Number of children with child cases open during the fiscal year for 7 or more days.
[c] Number of children with at least one indicated report occurring 7 or more days after the start of placement.

Table 2.19 Indicated Reports of Abuse or Neglect of Children in Substitute Care by Cook versus Non-Cook Counties by Fiscal Year

Fiscal Year	Cook/Non-Cook	Total Children Served During FY [a]	Children With at Least One Report [b]	Percentage Children with Indicated Reports	Mean Duration (days)	Reports per 100 Childcare-Years
1997	**Cook County**	44,498	823	1.8	320	2.1
	Non-Cook Counties	15,760	576	3.7	279	4.8
1998	**Cook County**	43,863	582	1.3	311	1.6
	Non-Cook Counties	15,259	356	2.3	274	3.1
1999	**Cook County**	39,175	470	1.2	300	1.5
	Non-Cook Counties	14,496	324	2.2	268	3.0
2000	**Cook County**	30,609	343	1.1	297	1.4
	Non-Cook Counties	13,419	377	2.8	266	3.9
2001	**Cook County**	24,208	285	1.2	298	1.4
	Non-Cook Counties	12,493	288	2.3	265	3.2

[a] Number of children with child cases open during the fiscal year for 7 or more days.
[b] Number of children with at least one indicated report occurring 7 or more days after the start of placement.

Chapter 3

PERMANENCY OF FAMILY RELATIONS OUTCOMES

As a child welfare outcome, permanency means that children who are the responsibility of DCFS are raised in safe and permanent family homes. Permanency of family relations has four positive outcomes: 1) a child being maintained at home, 2) a child returned home from substitute care, 3) a child being adopted, or 4) a child being placed with someone who subsequently becomes the legal guardian. The failure of these outcomes is an additional set of permanency indicators. This chapter also presents these permanency outcomes by age, race, gender, and region.

Except where indicated, the following outcomes data were derived from the DCFS Integrated Database that contains data from the Department's administrative information systems. To show changes in permanency results over time, the data are presented by fiscal year from 1991 through 2001. The data used to produce the results reported here are from Department sources updated as of September 30, 2001.

It is important to understand that the Department databases used in this report were not created for reporting on outcomes but to keep track of children in substitute care and to assure timely and accurate payment for services. Consequently, much work is required to construct operational definitions from the data rather than using the preferable process of defining the terms, selecting the measures, and then collecting data. Operational definitions for the permanency indicators are included in the Appendix of this report. These definitions were developed collaboratively with personnel from the Department of Children and Family Services and the Chapin Hall Center for Children.

One way to judge performance on outcomes indicators is to examine trends over time. When possible, outcomes data are reported for fiscal years from FY 91 through FY 01. Another way to compare performance is by examining results from similar systems. Where available, data from other systems are used as a basis of comparison.

SUMMARY OF PERMANENCY OUTCOMES

This report begins by providing a summary of overall permanency outcomes. More complete results for children maintained at home, reunified with their family, adopted or with guardianship transferred to a private person follow the summary. Table 3.1 summarizes the permanency outcomes for selected years from 1991 through 2001. Two-year intervals are reported so that trends might be more easily identified. While the data must be interpreted carefully, they do provide an overview of the permanency performance of the Department.

Children remain in family cases at rates between 86 and 91 per 100 children in care for 1 year. This rate decreased between FY 91 (91 per 100 children in care for 1 year) and FY 95 (86) and subsequently increased to 91 children per 100 in care for 1 year in FY 01. The current rate is nearly identical to that of the 1991 fiscal year.

The rate at which children remain in family cases is different for those children in intact family cases than those in non-intact cases[14]: Children remain in intact family cases at a higher rate. This rate was 91 per 100 children in care in FY 91, 86 in FY 95, and 92 in FY 01. For children in non-intact family cases, these rates were 89 per 100 children in care for 1 year in FY 91, 81 in FY 95, and 83 in FY 01. These results must be examined in the context of the rate at which children in intact families are identified as having an indicated report of abuse or neglect (Chapter 2). It is sometimes difficult to balance keeping families together and maintaining child safety.

The percent of children returning home within 12 months is beginning to return to the rates of the early 1990s. Return home rates were as high as 36% at that time and dropped to as low as 21% in FY 95. However, since then this rate has increased to 28% in FY 00. The percentage of these reunifications that fail and the child reenters substitute care within 12 months declined from 22% in FY 91 and FY 93 to 16% in the last three years.

[14] The terms family cases, intact family cases and non-intact family cases are defined in chapter 2.

Table 3.1 Permanency Outcome Rates for Illinois Children

	FY 91	FY 93	FY 95	FY 97	FY 99	FY 01
Rate at which children remain in family cases [a]	90.9	89.0	85.5	89.2	89.2	91.0
Rate at which children remain in intact family cases [a]	91.3	89.8	86.3	90.3	90.8	92.0
Rate at which children remain in non-intact cases [a]	88.6	85.6	81.4	82.8	81.0	83.3
Percent of children entering substitute care in the fiscal year who are returned home within 12 months (reunification)	36.3	27.0	21.2	23.7	27.4	28.5[b]
Percent of children who reenter substitute care within 12 months	22.4	22.3	19.8	16.5	15.5	15.6[b]
Rate at which children are adopted [a]	3.5	3.6	3.4	4.3	17.0	15.0
Percent of children in adoption assistance cases who are displaced	3.5	2.9	2.9	2.1	1.4	1.1[b]
Rate at which guardianship is transferred to a private person	.08	.02	.02	.38	4.80	3.98

[a] This is the rate per 100 child-years.
[b] A full twelve months have not elapsed since June 30, 2001. Therefore this is the percentage for FY 00.

Adoption rates have increased since the early 1990s. In FY 91 only 3.5 children per 100 in care for 1 year were adopted. The current rate is 15 children per 100 in care for 1 year. Similarly, the guardianship transfer rate was .08 per 100 children in care for 1 year in FY 91. The current rate is 3.98 per 100 children in care for one year.

Adoption displacement is assessed as the percent of children who are transferred out of adoption assistance cases. These are children who move from adoption assistance to substitute care or have an adoption assistance case closed before the child reaches age18. Since nearly all children adopted through the Department receive adoption assistance this is a good approximation of adoption displacements. This rate has steadily declined from 3.5% in FY 91 to 1.1% in FY 00.

Children Maintained At Home

Children are maintained at home in at least two situations. In the first situation, a family case is opened without concurrently opening cases for any of the children in the family. Within the Department these are referred to as "intact" family cases. These cases are usually opened as a result of an abuse or neglect investigation about which the worker judges the risk to the children to be low and believes that the children can be maintained safely at home if the family receives services.

In the second situation, the worker may have concerns about one or more of the children in a family, opens a case for that child and places some of the children in substitute care.[15] The children remaining at home are said to be in non-intact family cases. The rate at which children move from these situations to substitute care is one indication of the success or failure of efforts to maintain a child safely at home.

> **Indicators:** Percent and rate (per 100 child-years) of children who are placed from family cases.

[15] A child case is not opened unless a court makes DCFS responsible for the child.

Family Cases

Table 3.2 gives the placement rate per 100 children living in family cases for 1 year. This rate increased from 9 children per 100 in care for 1 year in FY 91 to a high of 14 in FY 95. This rate has since declined to 9 children per 100 in care for 1 year in FY 01.

Family cases include both children in intact and non-intact family cases. Table 3.2 indicates that most children in family cases are in intact family situations. Consequently, the placement rate for these children is similar to the overall rate. In FY 91, 9 children in intact family cases per 100 in care for 1 year were placed into substitute care. This rate increased to 14 for FY 95 and has decreased to 8 in FY 01.

The movement of children from non-intact family cases is higher than the rate for children in intact family cases. This rate was 11 children per 100 in care for 1 year in FY 91 and has increased to 19 in FY 95. The rate for the most recent year was 17. The higher rate for children in non-intact family cases may reflect a higher risk for children in these cases. For example, these cases include situations where a child is born into a family with one or more siblings already in the custody of the Department. It is reasonable that some of these are high-risk situations result in subsequent removal of the child.

Table 3.2 Substitute Care Placement From Family Cases: Intact and Non-intact by Fiscal Year

Fiscal Year	Case	Children Leaving Home to Substitute Care	Children at Home with Open Family Cases	Mean Duration in Care (days)	Placement Rate (percent)	Placement Rate per 100 Child-Years
1991	Family [a]	2,818	50,939	221	5.5	9.1
	Intact [b]	2,256	44,240	214	5.1	8.7
	Non-intact [c]	562	6,699	268	8.4	11.4
1992	Family [a]	3,522	49,982	219	7.0	11.8
	Intact [b]	2,804	42,642	212	6.6	11.3
	Non-intact [c]	718	7,340	261	9.8	13.7
1993	Family [a]	3,113	45,834	226	6.8	11.0
	Intact [b]	2,347	38,618	218	6.1	10.2
	Non-intact [c]	766	7,216	269	10.6	14.4
1994	Family [a]	3,867	47,405	216	8.2	13.8
	Intact [b]	2,911	39,859	207	7.3	12.9
	Non-intact [c]	956	7,546	261	12.7	17.7
1995	Family [a]	4,813	57,668	210	8.3	14.5
	Intact [b]	3,784	50,101	201	7.6	13.7
	Non-intact [c]	1,029	7,567	267	13.6	18.6
1996	Family [a]	3,740	59,399	217	6.3	10.6
	Intact [b]	2,895	52,695	209	5.5	9.6
	Non-intact [c]	845	6,704	282	12.6	16.3
1997	Family [a]	3,216	52,298	208	6.1	10.8
	Intact [b]	2,455	46,569	199	5.3	9.7
	Non-intact [c]	761	5,729	283	13.3	17.2
1998	Family [a]	2,399	41,158	206	5.8	10.3
	Intact [b]	1,825	36,383	196	5.0	9.3
	Non-intact [c]	574	4,775	279	12.0	15.7
1999	Family [a]	1,915	32,231	202	5.9	10.8
	Intact [b]	1,380	28,416	193	4.9	9.2
	Non-intact [c]	535	3,815	270	14.0	19.0
2000	Family [a]	1,474	29,821	189	4.9	9.6
	Intact [b]	1,107	26,908	180	4.1	8.3
	Non-intact [c]	367	2,913	269	12.6	17.1
2001	Family [a]	1,326	28,894	187	4.6	9.0
	Intact [b]	1,058	26,720	180	4.0	8.0
	Non-intact [c]	268	2,174	270	12.3	16.7

[a] Family case is the first family case on record for the child.

[b] Intact family case includes the first intact family case on record for the child.

[c] Non-intact family case includes the first non-intact family case on record for the child. Non-intact cases are those cases with at least one child in placement and at least one child living at home without an out-of-home placement.

CHILDREN RETURNED TO HOME OF ORIGIN

When the safety of children requires that they be placed out of the home, one of the permanency goals is to return the child to his/her home of origin as soon as possible. The element of time is important for several reasons. Research in child development indicates that the longer children are away from their parents, the more likely that the bond between the children and the parents will be undermined (Bowlby, 1969). Family systems theory suggests that the longer the child is away from the family, the more the family will adjust to the child being gone and the more difficult it will be for the child to regain his/her place in the family (Bermann, 1973; Minuchin, 1974). The child's sense of time is another consideration. One year for a 3-year old child is one-third of his/her life while 1 year for a person aged 20 is only 5%. Further, the permanency literature has consistently demonstrated that the longer a child stays in substitute care, the lower the probability of return home.

Indicator: Percent of children in substitute care who are returned home from substitute care within 6, 12, 18, and 24 months.

Reunification is reported by examining the experience of children who entered their first substitute care placement in a given year. Table 3.3 presents the number of children who had their first substitute care placement during a given fiscal year and the number and percent of these children who returned home during six different time periods. The first time period is 7 days or less. This situation primarily occurs when a child is taken into protective custody by a worker or police officer who believes the child is in imminent danger. The child is returned home when it is determined that he/she is not in danger or when the order of protective custody expires. The next time period begins at 7 days and continues through 6 months, followed by three 6-month time periods. The last time period is 24 months or longer. It should be noted that across years this is not an equal time period.

Table 3.3 Children Returning Home From Substitute Care by Time and Fiscal Year

	Children Entering Substitute Care [b]	Children Returned Home From Substitute Care													
		7 Days or Less		7 Days - 6 Months		6-12 Months		12-18 Months		18-24 Months		More Than 24 Months		Not Returned	
Fiscal Year [a]	N	N	%	N	%	N	%	N	%	N	%	N	%	N	%
1991	9,003	1497	16.6	1280	14.2	496	5.5	366	4.1	256	2.8	853	9.5	4255	47.3
1992	11,206	1333	11.9	1233	11.0	670	6.0	381	3.4	255	2.3	1136	10.1	6198	55.3
1993	10,265	1315	12.8	1034	10.1	417	4.1	294	2.9	265	2.6	1119	10.9	5821	56.7
1994	12,713	1213	9.5	1040	8.2	560	4.4	426	3.4	325	2.6	1532	12.1	7617	59.9
1995	13,848	1177	8.5	1137	8.2	625	4.5	446	3.2	428	3.1	1641	11.9	8394	60.6
1996	10,050	837	8.3	918	9.1	452	4.5	350	3.5	323	3.2	1078	10.7	6092	60.6
1997	9,134	837	9.2	869	9.5	458	5.0	427	4.7	284	3.1	853	9.3	5406	59.2
1998	7,613	791	10.4	737	9.7	417	5.5	357	4.7	271	3.6	454	6.0	4586	60.2
1999	6,889	807	11.7	660	9.6	423	6.1	316	4.6	240	3.5	268	3.9	4175	60.6
2000	5,458	605	11.1	564	10.3	386	7.1	245	4.5	115	2.1	11	0.2	3532	64.7
2001	5,381	642	11.9	564	10.5	184	3.4	17	0.3	0	0	0	0	3974	73.9

Note: A child may be returned home with his/her case closed or open.

[a] Fiscal year is the fiscal year the child first entered substitute care.
[b] Number of children whose first ever substitute care placement in his/her first case were active during the given fiscal year. Unduplicated across children.

The permanency indicators defined by HHS include examining reunification in 12-month time periods. The percentage of children reunified within 12 months dropped from 36% in FY 91 to a low of 21% in FY 95. Since then it has increased to 28% in FY 00. When the 7 day or less time period is removed, the reunification rates were 20% in FY 91, 13% in FY 95 and 17% in FY 00.

The percent of children reunified between 12 and 24 months has increased slightly. For the time period from FY 92 through FY 95, 6% of those entering care in those years were reunified in the 12 to 24 month time frame. This rate increased to 8% for FY 97 through FY 99.

Reports from the Multi-state Foster Care Data Archive (MFCDA) are useful, when making comparisons across states. The Chapin Hall Center for Children maintains this compilation of administrative data from 12 states (Alabama, California, Illinois, Iowa, Maryland, Michigan, Missouri, New Mexico, New York, Ohio, Texas, and Wisconsin). Taken together these states account for a large proportion of the foster care population in the country.

The most recent report from the MFCDA includes data on exits from foster care spells for children who had their first entry into foster care from 1988–93. They report that almost 14% of these children were still in their first out-of-home spell at the end of 1997. Of the 86% who exited care, 56% were reunified and 14% were adopted (Wulczyn, Brunner, & Goerge, 2000).

This report compares reunification rates between states and indicates that reunification varies significantly across states. For children who first entered care between 1988 and 1995, the Illinois reunification rate of 46.5% was similar to the four large states available in this report.

New York	50.6%	
Illinois	46.5%	
Michigan	45.0%	
Ohio[16]	31.2%	(Wulczyn, Hislop, & Goerge, 2000).

Children Re-entering Substitute Care

Indicator: Percent of children living at home who were previously in substitute care and then reenter substitute care.

When a caseworker returns a child to his/her parents there is a risk of abuse or neglect and/or a subsequent placement of the child into substitute care. The number of children at home who were previously in substitute care and the number and percent who reentered substitute care are shown in Table 3.4.

Reentry within 12 months is often used as the time frame to judge the performance of a child welfare system. This is also the time frame used by the Department of Health and Human Services. The percent of children who reentered substitute care within 12 months was highest in FY 91 (22%). Since then, this percentage has declined to 16% for the years FY 97 through FY 00. Table 3.4 also shows that children are most vulnerable to reentry in the first 6 months after being returned home. The highest reentry percentages occur during this time.

The MFCDA data can be used as a rough basis of comparison. Time frames and cohorts of children differ between the MFCA study and this report. The MFCA data show reentry rates of 25% of children who entered care between 1990 and 1998. Illinois had the lowest reentry rate among five large states indicated in the report.

[16] Ohio is a recent addition to this report and only includes data on first entries for 1990–1995.

Table 3.4 Reentry to Substitute Care by Time Until Reentry & Fiscal Year

	Children Returned Home [b]	Children Reentering Substitute Care											
		Less than 6 Months		6-12 Months		12-18 Months		18-24 Months		More Than 24 Months		Have Not Reentered Care	
	N	N	%	N	%	N	%	N	%	N	%	N	%
Fiscal Year [a]													
1991	3,683	577	15.6	252	6.8	164	4.5	84	2.3	386	10.5	2220	60.3
1992	3,817	515	13.5	262	6.9	147	3.9	117	3.1	322	8.4	2454	64.3
1993	4,078	649	15.9	261	6.4	167	4.1	113	2.8	289	7.1	2599	63.7
1994	3,553	522	14.7	207	5.8	133	3.7	70	2.0	201	5.7	2420	68.1
1995	4,347	609	14.0	252	5.8	8	2.5	97	2.2	206	4.7	3075	70.7
1996	4,070	491	12.0	224	5.5	133	3.3	62	1.5	194	4.8	2966	72.9
1997	4,379	497	11.3	228	5.2	104	2.4	72	1.6	166	3.8	3312	75.6
1998	4,319	473	10.9	207	4.8	87	2.0	61	1.4	130	3.0	3361	77.8
1999	4,235	455	10.7	202	4.8	93	2.2	55	1.3	40	0.9	3390	80.0
2000	3,479	396	11.3	151	4.3	94	2.7	38	1.1	6	0.2	2794	80.3
2001	3,011	322	10.7	117	3.9	10	0.3	0	0	0	0	2562	85.1

[a] Fiscal year child is returned home.
[b] Number of children living at home during the fiscal year and had previously lived in substitute care.
[c] Percentages are cumulative over time.

Ohio	24%
New York	23%
Michigan	20%
California	18%
Illinois	17% (Wulczyn, Hislop, & Goerge, 2000).

ADOPTION

Another way for children to achieve a permanent family is through adoption. The failure of an adoption is referred to here as displacement.

Indicator: Percent and rate (per 100 child-years) of children in substitute care who are adopted.

Table 3.5 shows adoption rates by fiscal year. In this table an adoption is counted for a particular fiscal year based upon the date that the case was closed for reason of adoption service. The database does not include the date that the adoption is legally consummated. For a variety of reasons a delay can occur between the time the adoption is finalized and the case is closed. Thus, the number of adoptions reported here is different than DCFS figures for any particular fiscal year but converge over a period of several years.

The number of adoptions steadily increased from 777 in FY 91 to 7,306 in FY 99. As a rate per 100 children in substitute care for 1 year, this increase is more dramatic. This rate changed little from 1991 through 1995. In 1995, 3 children per 100 in care for one year were adopted. This increased to 18 per 100 children in FY 00.

Table 3.5 Adoption From Substitute Care by Fiscal Year

Fiscal Year	Children Adopted	Children in Substitute Care [a]	Mean Duration in Care(days)	Children Adopted (percentage)	Adoption Rate per 100 Childcare Years
1991	777	30,140	270	2.6	3.5
1992	802	36,029	273	2.2	3.0
1993	1,124	40,767	284	2.8	3.6
1994	1,291	47,795	286	2.7	3.4
1995	1,537	56,321	292	2.7	3.4
1996	2,121	59,356	304	3.6	4.3
1997	2,207	60,408	309	3.7	4.3
1998	4,935	59,204	302	8.3	10.1
1999	7,306	53,753	292	13.6	17.0
2000	6,275	44,113	288	14.2	18.1
2001	4,344	36,890	286	11.8	15.0

[a] Number of children with one or more substitute care placements during the fiscal year. Cases open less than 7 days and adoption assistance cases are not included in this count.

The MFCDA report (Wulczyn, Brunner, Goerge, 2000) provides some comparative adoption data. For the those children who first entered care between 1988 and 1995, the percentage of children adopted through December 1998 was:

Illinois	20.2%
Michigan	18.4%
New York	16.4%
Ohio	11.2% (Wulczyn, Hislop, & Goerge, 2000).

Adoption Displacement

For this report the failure of an adoption is called adoption displacement. As more children achieve permanency through adoptions, there is increased concern about the stability of these adoptions. Conceptually the development of an indicator for children who have been adopted and returned to care is not difficult. However, accessing the data to provide the information is difficult. Adoption is usually accompanied with a change in the child's name so that it is difficult to know that a particular child coming into DCFS care with one name is in fact the same child who was previously in care under a different name.

The Center has developed an adoption displacement indicator. Most of the families who adopt children through the Department receive adoption assistance. When a child is adopted and the family receives adoption assistance the Department's data systems indicate that the child's case is closed and a new adoption assistance case is opened. Since adoption assistance is normally provided until the child reaches age 18, a child in an adoption assistance case who moves to substitute care or has a case closed prior to age 18 is likely to represent a child reentering care. A few cases do close before age 18 due to the death of the child, these cases are excluded from this indicator. There

maybe other reasons that an adoption assistance case is closed before age 18, but these are thought to be small in number.

Indicator: Percent of children in open adoption assistance cases who are placed in substitute care or have their adoption assistance case closed prior to age 18.

Table 3.6 shows the number of children with displaced adoptions as defined above. While the number of children counted as displaced from an adoption assistance case has increased, the percent of adoption displacements has decreased as the number of adoption assistance cases has grown. Adoption displacement rates declined from 4% in FY 91 to 1% in FY 01.

Transfer of Guardianship

Some of the children who do not return home achieve a permanent family by having someone other than the Department becomes their legal guardian. In some cases this is an extended family member; in other cases, it is an unrelated person who has a strong interest in the child.

Indicator: Percent of children and rate (per 100 child-years) in substitute care with guardianship transferred to a private person.

Table 3.7 presents the rate of transfer of guardianship. Children have been able to have guardianship transferred to a private person for many years. However, it was a little-used option until recently. In 1996, the Department instituted the subsidized guardianship program, which maintains financial assistance to families who assume legal guardianship of a child. This has greatly increased the number of children achieving permanency through this option.

Table 3.6 Adoption Displacements

Fiscal Year	Active Adoption Assistance Cases	Adoption Assistance Case Closings Under 18	Adoption Assistance Case Starting Out-of-Home Placement	Total Displaced	Percent Displaced
1991	5,507	79	112	191	3.47
1992	5,951	95	116	211	3.55
1993	6,594	70	122	192	2.91
1994	7,468	80	138	218	2.92
1995	8,735	90	159	249	2.85
1996	10,300	91	147	238	2.31
1997	11,918	73	173	246	2.06
1998	16,323	147	156	303	1.86
1999	22,967	166	153	319	1.39
2000	28,528	190	136	326	1.14
2001	32,072	290	135	425	1.33

Table 3.7 Rate at Which Guardianship Is Transferred to a Private Person

Fiscal Year	Children Transferred to Guardianship	Children in Substitute Care [a]	Mean Duration in Care(days)	Children Transferred to Guardianship (percentage)	Guardianship Transfer Rate per 100 Childcare Years
11991	18	30,140	270	0.06	0.08
11992	12	36,029	273	0.03	0.04
11993	5	40,767	284	0.01	0.02
11994	15	47,795	286	0.03	0.04
11995	9	56,321	292	0.02	0.02
11996	17	59,356	304	0.03	0.03
11997	196	60,408	309	0.32	0.38
11998	1,284	59,204	302	2.17	2.62
11999	2,061	53,753	292	3.83	4.80
22000	1,640	44,113	288	3.72	4.72
22001	1,151	36,890	286	3.12	3.98

Note: The operational definition of guardianship is included in the appendix.

[a] Number of children in one or more substitute care placement during the fiscal year. Cases open less than 7 days or adoption assistance cases are not included in this count.

From FY 91 through FY 96, less than 20 children per year achieved permanence through guardianship. In FY 97, 196 children achieved permanency through guardianship and this increased to 2,061 in FY 99. In FY 01, 1,151 children achieved permanency through guardianship. These increases can be seen even more dramatically through the rate per 100 child-years. From FY 91 through FY 96 this rate ranged from .02 to .08 per 100 children in care for 1 year. In FY 97 this rate increased to .38 and in FY 00 it was 4.72. This rate has decreased slightly to 3.98 for FY 01.

PERMANENCY OUTCOMES BY AGE, RACE, GENDER, AND REGION

This section contains additional permanency outcomes results. Selected outcomes are presented by age, race, and gender of the child. Results are also reported by Department region. The purpose of this analysis is to begin to identify differences between children and regions in achieving permanency outcomes. This type of analysis can also assist the Department in targeting its efforts to enhance performance. While data in the administrative database allow identification of differences in outcomes, they do not provide data that explains these differences. Explanatory analysis is beyond the scope of this report.

Movement of Children From Family Cases: Gender, Race, Age, and Region

No gender differences in children placed from family cases were found. Consequently these data are not reported here. There are how ever differences between racial/ethnic groups in children placed into substitute care from family cases (Table 3.8). African American children consistently have a higher placement rate than Hispanic or White children. In FY 91, 11 African American children per 100 in family cases for 1 year were placed into substitute care. This rate increased to 18 per 100 children in care for 1 year in FY 95 and subsequently decreased to 10 per 100 in care for 1 year in the FY 01. The rate at which White children were placed from family cases increased from 7 per 100 children in care for 1 year in FY 91 to 10 in FY 95. Since then the rate has decreased to between 8 per 100 children in care for 1 year in the last several fiscal years. The placement rate for Hispanic children increased between FY 91 and FY 95 from 7 per 100 to 12. This rate was 7 per 100 children in care for one year in FY 01.

The ratio of the African American and Hispanic placement rate per 100 children in care for one year to the rate for White children provides another way to examine disproportionate placement rates by race (Table 3.8). For example, in FY 01, 1.4 times as many African American children were placed into substitute care from family cases as compared to White children. This ratio was 0.9 for Hispanic children. These proportions are similar across years. Typically the placement rate for African American children is 1.4 to 2.0 times that of White children. The ratio for Hispanic children ranges from 0.6 to 1.3.

Rates of placement for children in family cases by age are shown in Table 3.9. To make the table easier to read, only the odd-numbered years are presented. Children under the age of 3 consistently have the highest placement rate. This rate increased from 13 per 100 children in care for 1 year in FY 91 to 18 per 100 in FY 95. Since then this placement rate has declined to 10 in FY 01.

Table 3.8 Substitute Care Placement From Family Cases by Ethnicity

Fiscal Year	Ethnicity	Children Leaving Home to Substitute Care	Children at Home with Open Family Cases [a]	Mean Duration in Care (days)	Placement Rate (percent)	Placement Rate per 100 Child-Years	Ratio of Placement Rate per 100 Childcare-Years to White Placement Rate
1991	**African American**	1,922	27,978	229	6.9	11.0	1.6
	Hispanic	134	3,436	216	3.9	6.6	1.0
	White	725	18,615	210	3.9	6.8	1.0
1993	**African American**	2,210	24,509	243	9.0	13.6	1.8
	Hispanic	141	3,039	243	4.6	7.0	0.9
	White	723	17,434	200	4.1	7.6	1.0
1995	**African American**	3,447	32,273	220	10.7	17.7	1.8
	Hispanic	272	4,084	211	6.7	11.5	1.2
	White	1,027	20,146	194	5.1	9.6	1.0
1997	**African American**	2,140	27,690	218	7.7	12.9	1.5
	Hispanic	155	4,775	206	3.2	5.8	0.7
	White	850	18,586	195	4.6	8.6	1.0
1999	**African American**	1,180	15,416	219	7.7	12.8	1.5
	Hispanic	117	2,724	204	4.3	7.7	0.9
	White	566	13,262	183	4.3	8.5	1.0
2001	**African American**	692	12,496	194	5.5	10.4	1.4
	Hispanic	91	2,799	172	3.3	6.9	0.9
	White	485	12,665	184	3.8	7.6	1.0

[a] Family case is the first family case on record for the child.

Table 3.9 Substitute Care Placement From Family Cases by Age and Fiscal Year

		Children Leaving Home to Substitute Care	Children at Home with Open Family Cases [a]	Mean Duration in Care (days)	Placement Rate (percentage)	Placement Rate per 100 Child-Years
Fiscal Year	**Age in Fiscal Year**					
1991	**Up to 3 yrs**	934	12,701	207	7.4	13.0
	3 - 6 yrs	462	8,034	211	5.8	10.0
	6 - 9 yrs	355	6,332	210	5.6	9.8
	9 - 12 yrs	244	5,017	208	4.9	8.5
	12 - 15 yrs	239	3,791	205	6.3	11.2
	15 - 18 yrs	117	2,374	207	4.9	8.7
1993	**Up to 3 yrs**	924	11,183	211	8.3	14.3
	3 - 6 yrs	494	7,295	209	6.8	11.8
	6 - 9 yrs	274	5,488	209	5.0	8.7
	9 - 12 yrs	236	4,619	210	5.1	8.9
	12 - 15 yrs	230	3,506	204	6.6	11.8
	15 - 18 yrs	128	2,159	207	5.9	10.5
1995	**Up to 3 yrs**	1,388	14,417	200	9.6	17.6
	3 - 6 yrs	741	9,873	195	7.5	14.1
	6 - 9 yrs	481	7,537	195	6.4	12.0
	9 - 12 yrs	379	6,003	197	6.3	11.7
	12 - 15 yrs	345	4,932	194	7.0	13.2
	15 - 18 yrs	156	2,957	191	5.3	10.1

[a] Family case includes the first family case on record for the child.

Table 3.9 (*continued*) Substitute Care Placement From Family Cases by Age and Fiscal Year

		Children Leaving Home to Substitute Care	Children at Home with Open Family Cases [a]	Mean Duration in Care (days)	Placement Rate (percentage)	Placement Rate per 100 Child-Years
Fiscal Year	**Age in Fiscal Year**					
1997	**Up to 3 yrs**	798	12,174	198	6.6	12.1
	3 - 6 yrs	441	9,453	196	4.7	8.7
	6 - 9 yrs	302	7,757	196	3.9	7.2
	9 - 12 yrs	245	6,048	197	4.1	7.5
	12 - 15 yrs	237	5,018	195	4.7	8.9
	15 - 18 yrs	85	3,121	202	2.7	4.9
1999	**Up to 3 yrs**	486	7,639	191	6.4	12.1
	3 - 6 yrs	218	5,819	195	3.7	7.0
	6 - 9 yrs	169	4,919	191	3.4	6.6
	9 - 12 yrs	126	3,945	189	3.2	6.2
	12 - 15 yrs	110	3,246	192	3.4	6.5
	15 - 18 yrs	47	1,988	201	2.4	4.3
2001	**Up to 3 yrs**	339	7,318	178	4.6	9.5
	3 - 6 yrs	166	5,397	181	3.1	6.2
	6 - 9 yrs	127	4,844	183	2.6	5.2
	9 - 12 yrs	106	3,927	183	2.7	5.4
	12 - 15 yrs	100	3,241	187	3.1	6.0
	15 - 18 yrs	39	2,081	191	1.9	3.6

[a] Family case includes the first family case on record for the child.

Placement rates generally decrease as the age of the child increases except for those children between the ages of 12 and 15. In FY 91 the placement rate for youth in this age group was 11 per 100 children in care for one year. This rate increased to 13 in FY 95. In FY 01 this rate was 6 per 100 children in care for one year.

For most years placement rates for children in family cases are higher for Cook County regions than for non-Cook regions (Table 3.10). For Cook County regions the placement rate went from 11 per 100 children in care for 1 year in FY 91 to 18 in FY 95. Since then it has decreased to 10 per 100 in the most recent fiscal year. Comparable placement rates for non-Cook regions were 7 in FY 91 to 10 in FY 95 and were 8 per 100 in FY 01. The one year where placement rates were nearly identical for Cook County and the rest of the state was FY 00, with rates of 9.5 for Cook and 9.6 for non-Cook regions.

Children Exiting From Care: Gender, Race, Age, and Region

Analysis of the permanency outcomes of return home, adoption, and guardianship by gender, race, age and region results in a large number of tables that are difficult to combine into an overall picture of Department performance. In an attempt to portray these findings in a more readable format, this report combines the permanency outcomes to show exits from the child welfare system for groups of children who entered Department care by fiscal year (entry cohorts). Table 3.11 provides the number of children who entered Department care for each fiscal year since FY 91 and the number who returned home, were adopted, and had guardianship transferred to a private person. In addition this table shows the number of children who exited care by the age of majority while in Department care, ran away, died, and the number still in care. While this table provides a more complete picture of the ways that children leave the care of the Department, it may not be easy to interpret. To aid interpretation, Table 3.12 presents the same information with percentages.

Table 3.10 Substitute Care Placement From Family Cases by Cook/Non-Cook County Regions

Fiscal Year	Cook/Non-Cook	Children Leaving Home to Substitute Care	Children at Home with Open Family Cases [a]	Mean Duration in Care (days)	Placement Rate (percentage)	Placement Rate per 100 Child-Years
1991	**Cook County**	1,862	27,797	228	6.7	10.7
	Non-Cook Counties	956	23,142	212	4.1	7.1
1992	**Cook County**	2,384	24,981	237	9.5	14.7
	Non-Cook Counties	1,138	25,001	201	4.6	8.3
1993	**Cook County**	1,973	21,866	256	9.0	12.9
	Non-Cook Counties	1,140	23,968	200	4.8	8.7
1994	**Cook County**	2,543	22,823	230	11.1	17.7
	Non-Cook Counties	1,324	24,582	203	5.4	9.7
1995	**Cook County**	3,455	31,360	223	11.0	18.0
	Non-Cook Counties	1,358	26,308	193	5.2	9.7
1996	**Cook County**	2,622	33,962	235	7.7	12.0
	Non-Cook Counties	1,118	25,437	194	4.4	8.3
1997	**Cook County**	2,078	28,989	217	7.2	12.0
	Non-Cook Counties	1,138	23,309	197	4.9	9.1
1998	**Cook County**	1,476	20,506	221	7.2	11.9
	Non-Cook Counties	923	20,652	191	4.5	8.5
1999	**Cook County**	1,072	13,896	224	7.7	12.6
	Non-Cook Counties	843	18,335	185	4.6	9.1
2000	**Cook County**	639	12,180	202	5.2	9.5
	Non-Cook Counties	835	17,641	179	4.7	9.6
2001	**Cook County**	572	11,601	187	4.9	9.7
	Non-Cook Counties	754	17,293	187	4.4	8.5

[a] Family case is the first family case on record for the child.

Table 3.11 Number of Children Entering by Fiscal Year and Exiting Substitute Care (as of Sept. 30, 2001) by Exit Type

Fiscal Year	Children Entering Substitute Care [a]	Exit Type							
		At home	Adopted	Guard-ianship	Aged out	Runaway, case closed	Child Deceased	Closed in substitute care	Still in care
1991	9,003	3,504	2,167	348	1,329	10	47	693	905
1992	11,206	3,726	3,198	566	1,542	18	44	856	1,256
1993	10,265	3,345	3,134	616	1,259	13	48	686	1,164
1994	12,713	3,976	3,991	950	1,201	10	50	866	1,669
1995	13,848	4,347	4,304	988	1,103	11	53	851	2,191
1996	10,050	3,194	3,155	681	531	6	48	579	1,856
1997	9,134	3,091	2,561	485	364	3	39	421	2,170
1998	7,613	2,497	1,705	274	183	5	24	329	2,596
1999	6,889	2,196	888	106	103	1	22	292	3,281
2000	5,458	1,612	191	4	46	1	17	204	3,383
2001	5,381	1,223	51	0	14	0	9	141	3,943

[a] Number of children whose first ever substitute care placement in his/her first case was active during the fiscal year. Unduplicated across children.

Table 3.12 Number of Children Entering by Fiscal Year and Percentage Exiting Substitute Care (as of Sept. 30, 2001) by Exit Type

Fiscal Year	Children Entering Substitute Care [a]	Exit Type					
		At home	Adopted	Guard-ianship	Aged out	Closed in substitute care	Still in care
1991	9,003	38%	24%	3%	14%	7%	10%
1992	11,206	33%	28%	5%	13%	7%	11%
1993	10,265	32%	30%	6%	12%	6%	11%
1994	12,713	31%	31%	7%	9%	6%	13%
1995	13,848	31%	31%	7%	7%	6%	15%
1996	10,050	31%	31%	6%	5%	5%	18%
1997	9,134	33%	28%	5%	3%	4%	23%
1998	7,613	32%	22%	3%	2%	4%	34%
1999	6,889	31%	12%	1%	1%	4%	47%
2000	5,458	29%	3%			3%	61%
2001	5,381	22%				2%	73%

Note: Blank cells represent less than.5%

[a] Number of children whose first ever substitute care placement in his/her first case was active during the fiscal year. Unduplicated across children.

Exit percentages show that while many children return home, the upper limit for this rate maybe about 33% of those entering care in a given year. For those children entering care in most of the decade of the 1990s about one-third have returned home. The one exception is 1991 where the return home percentage reached 38%.

The percentage of children adopted from a given entry cohort is now equaling the percent returned home for some years. Between 28% and 31% of children entering care in the FY 92 through FY 97 cohorts have been adopted. When the adoption percentage is combined with that of guardianship, between 32% and 38% of children entering care from FY 92 through FY 94 achieved permanency through these options. As of this report, the guardianship transfer rates were highest for the FY 94 and FY 95.

Youth are aging out of care at rates of 12% – 14% for FY 91 through FY 93. For children who entered care in the first half of the 1990s, 10% - 15% are still in care. This is a substantial decrease since the last report. One year ago these percentages ranged from 21% - 27%.

The MFCDA Archive provides some comparison data. These data show that for those children who first entered care between 1988 and 1995, the comparisons of reunifications, adoption and children still in care through December 1998[17] are:

	Reunification	Adoption	Still in Care
New York	51%	16%	10%
Michigan	46%	18%	5%
Illinois	46%	20%	26%
Ohio[18]	37%	11%	5% (Wulczyn, Hislop, & Goerge, 2000).

[17] Children also exited care by reaching the age of maturity (2–5%), running away (2–9%), and other (13–28%). The other category is not explained in the MFCDA report.

[18] Ohio data based upon entries from 1990–1995.

Since it is easier to interpret changes between categories and across years with percentages, the tables present exits by race, age and region include only percentages. No tables are included for exits by gender since no appreciable gender differences were noted. Table 3.13 shows the percent of each entry cohort exiting care by race and demonstrates some of the complexity of the relationship between race and exiting Department care. For ease of presentation and the percentages were negligible, children who ran away and had their cases closed or died while in care are excluded from this table.

The pattern that emerges is that African American children exit care most frequently through adoption or guardianship while White children exit most frequently through reunification with their families. The majority of African American children in substitute care in Illinois are placed with relatives. These children tend to achieve permanency through adoption of subsidized guardianship with relatives. For those African American children entering care from FY 91 through FY 95, 34% to 43% exited care through adoption and guardianship while 24% to 29% returned home. During these same years 14% to 25% of White children exited care through adoption or guardianship and 45% to 56% returned home.

Hispanic children tend to exit care in a pattern more like White than African American children. Hispanic children tend to return home more frequently than exit through adoption or guardianship. For example for those Hispanic children entering care in FY 96, 39% returned home and 28% exited through adoption or guardianship. This rate of adoption or guardianship is similar to that of White children (25%) and much lower than that of African American children (43%). While the return home rate for Hispanic children (39%) is higher than that of African American children (24%) it is somewhat lower than the rate for White children (46%).

Table 3.13 Number of Children Entering by Fiscal Year and Percentage Exiting Substitute Care (as of Sept. 30, 2001) by Exit Type by Ethnicity

			Exit Type					
		Children Entering Substitute Care [a]	At Home	Adopted	Guard-ianship	Aged Out	Closed in Substitute Care	Still in Care
Fiscal Year	Ethnicity							
1991	African American	5,714	29%	29%	5%	14%	7%	13%
	Hispanic	467	57%	12%		10%	8%	8%
	White	2,671	56%	14%		16%	8%	3%
1992	African American	7,678	25%	32%	6%	12%	6%	13%
	Hispanic	575	43%	22%	1%	10%	12%	8%
	White	2,786	51%	18%		16%	8%	4%
1993	African American	6,969	24%	35%	7%	11%	6%	13%
	Hispanic	524	45%	22%	1%	10%	8%	10%
	White	2,628	50%	19%	2%	15%	5%	5%
1994	African American	8,831	25%	34%	9%	8%	6%	15%
	Hispanic	635	41%	27%	3%	9%	9%	6%
	White	3,014	46%	22%	2%	12%	8%	6%
1995	African American	9,579	25%	34%	8%	6%	5%	18%
	Hispanic	758	40%	27%	3%	8%	9%	10%
	White	3,267	45%	22%	3%	11%	6%	9%
1996	African American	6,561	24%	35%	8%	4%	4%	21%
	Hispanic	676	39%	27%	1%	4%	7%	17%
	White	2,618	46%	22%	3%	7%	7%	11%
1997	African American	5,906	26%	32%	6%	2%	3%	26%
	Hispanic	613	47%	18%	1%	5%	6%	20%
	White	2,371	46%	19%	3%	6%	6%	16%
1998	African American	4,783	26%	25%	3%	1%	3%	39%
	Hispanic	606	41%	14%	3%	2%	6%	30%
	White	2,032	44%	18%	3%	4%	6%	22%
1999	African American	4,148	25%	13%	1%	1%	3%	53%
	Hispanic	448	39%	7%		1%	7%	44%
	White	2,101	41%	13%	1%	2%	4%	36%
2000	African American	3,135	22%	3%			3%	69%
	Hispanic	327	40%	1%			7%	48%
	White	1,821	38%	3%		1%	3%	51%
2001	African American	2,995	17%	1%			2%	78%
	Hispanic	353	26%				4%	68%
	White	1,815	30%				2%	66%

[a] Number of children whose first substitute care placement in his/her first case was active in the given fiscal year. Unduplicated across children.

Not surprisingly, there are differences in percent of children exiting care by age (Table 3.14). For each entry cohort except the most recent, children who entered care under the age of 3 had the highest rates of exiting through adoption. For children entering care under age 3 in FY 95, 50% exited by adoption. For each entry cohort this age group also has been the largest number of children coming into care.

The youngest and the oldest children had relatively lower percentages returning home. For example, 28% of children entering care in FY 93 who were under the age of 3, returned home. The percentage returning home for children who entered at 15 to 18 years of age was also 28%. The reunification rates for children 3-15 years of age are higher than for other age groups. For example, for those children 3-15 years of age who entered care in FY 93 between 35% and 38% returned home.

Children who left care by reaching the age of majority were older when they entered care. For those children who entered care at 15 to 18 years of age in FY 91, 55% exited by aging out. This increased to 62% for children in this age group entering care in FY 93.

The largest percentage of children still in substitute care tends to be those who entered care from 6 to 12 years of age. For example, for those children who entered care in these age groups in FY 93, 21% and 23% are still in care. For those in these age groups who entered care in FY 95, 20% and 33% are still in care.

The three non-Cook County Department regions consistently have higher percentages of children returning home (Table 3.15). For those children entering care from these regions in FY 91, 54% returned home. Cook County regions had a reunification rate of 28%. This difference is fairly consistent over time, with 43% of children entering care in non-Cook regions in FY 98 returning home and 25% for Cook County regions.

Table 3.14 Number of Children Entering and Percentage Exiting From Substitute Care by Exit Type and Age in Fiscal Year

		Children Entering Substitute Care [a]	Exit Type					
Fiscal Year	Age in Fiscal Year		At Home	Adopted	Guard-ianship	Aged Out	Closed in Substitute Care	Still in Care
1991	Up to 3 yrs	3,436	35%	43%	5%		7%	8%
	3 - 6 yrs	1,524	44%	27%	7%		5%	15%
	6 - 9 yrs	1,207	44%	15%	5%	4%	7%	22%
	9 - 12 yrs	993	41%	5%		31%	9%	11%
	12 - 15 yrs	1,034	38%			50%	9%	
	15 - 18 yrs	779	34%			55%	9%	
1993	Up to 3 yrs	4,150	28%	49%	5%		6%	9%
	3 - 6 yrs	1,869	35%	34%	10%		5%	13%
	6 - 9 yrs	1,255	36%	23%	11%		7%	21%
	9 - 12 yrs	1,001	38%	10%	3%	16%	6%	23%
	12 - 15 yrs	1,159	35%	1%		50%	9%	3%
	15 - 18 yrs	795	28%			62%	7%	
1995	Up to 3 yrs	5,456	25%	50%	6%		5%	11%
	3 - 6 yrs	2,682	35%	34%	10%		4%	15%
	6 - 9 yrs	1,781	36%	24%	12%		5%	20%
	9 - 12 yrs	1,424	36%	12%	10%	2%	5%	33%
	12 - 15 yrs	1,480	37%	2%		31%	8%	19%
	15 - 18 yrs	967	27%			61%	8%	1%

Note: Blank cells include values less than .8%.

[a] Number of children whose first substitute care placement in his/her first case was active in the given fiscal year. Unduplicated across children.

Table 3.14 Number of Children Entering and Percentage Exiting From Substitute Care by Exit Type and Age in Fiscal Year (*continued)*

Fiscal Year	Age in Fiscal Year	Children Entering Substitute Care [a]	Exit Type					
			At Home	Adopted	Guard-ianship	Aged Out	Closed in Substitute Care	Still in Care
1997	**Up to 3 yrs**	3,856	26%	45%	4%		3%	19%
	3 - 6 yrs	1,596	39%	24%	7%		4%	23%
	6 - 9 yrs	1,244	41%	19%	8%		3%	26%
	9 - 12 yrs	906	40%	13%	7%		5%	32%
	12 - 15 yrs	929	36%	4%	3%	11%	6%	36%
	15 - 18 yrs	578	34%			42%	9%	12%
1999	**Up to 3 yrs**	3,052	24%	20%			3%	50%
	3 - 6 yrs	1,129	37%	10%	2%		3%	45%
	6 - 9 yrs	901	38%	5%	2%		2%	50%
	9 - 12 yrs	716	39%	6%	2%		5%	46%
	12 - 15 yrs	655	36%	2%	2%	1%	6%	49%
	15 - 18 yrs	411	36%			22%	9%	29%
2001	**Up to 3 yrs**	2,279	17%				1%	80%
	3 - 6 yrs	842	26%				2%	70%
	6 - 9 yrs	660	27%	1%			2%	68%
	9 - 12 yrs	633	27%				2%	69%
	12 - 15 yrs	582	23%	2%			4%	69%
	15 - 18 yrs	365	30%	1%		3%	7%	58%

[a] Number of children whose first substitute care placement in his/her first case was active in the given fiscal year. Unduplicated across children.

Table 3.15 Number of Children Entering by Fiscal Year and Percentage Exiting Substitute Care (as of Sept. 30, 2001) by Exit Type by Cook versus Non-Cook Regions

		Children Entering Substitute Care [a]	Exit Type					
Fiscal Year	County		At home	Adopted	Guard-ianship	Aged out	Closed in substitute care	Still in care
1991	Cook	5,390	28%	29%	5%	15%	6%	13%
	Non-Cook	3,613	54%	16%	1%	13%	8%	4%
1992	Cook	7,268	24%	33%	6%	13%	7%	14%
	Non-Cook	3,938	50%	18%	2%	13%	8%	6%
1993	Cook	6,379	22%	35%	8%	11%	6%	14%
	Non-Cook	3,886	49%	21%	2%	12%	6%	6%
1994	Cook	8,186	22%	35%	9%	8%	6%	16%
	Non-Cook	4,527	46%	23%	4%	10%	7%	7%
1995	Cook	9,346	23%	34%	8%	7%	5%	19%
	Non-Cook	4,502	46%	24%	3%	8%	6%	9%
1996	Cook	6,442	24%	36%	8%	4%	5%	21%
	Non-Cook	3,608	45%	23%	4%	6%	6%	13%
1997	Cook	5,665	26%	32%	6%	3%	3%	27%
	Non-Cook	3,469	46%	20%	4%	5%	6%	17%
1998	Cook	4,523	25%	24%	3%	1%	3%	41%
	Non-Cook	3,090	43%	19%	3%	3%	5%	23%
1999	Cook	3,814	25%	12%	2%		3%	55%
	Non-Cook	3,075	40%	13%		2%	5%	37%
2000	Cook	2,469	18%	3%			3%	73%
	Non-Cook	2,989	38%	3%		1%	4%	52%
2001	Cook	2,487	15%	1%			2%	79%
	Non-Cook	2,894	28%				2%	67%

[a] Number of children whose first substitute care placement in his/her first case was active in the given fiscal year. Unduplicated across children.
NOTE: Blank cells represent less than 0.5%.

The Cook County regions have a higher percentage of children exiting care through adoption and guardianship than the non-Cook regions. For those children entering care in Cook County in FY 91, 34% achieved permanency through adoption and guardianship. This percentages for the non-Cook regions were 17%. These results are similar to the racial differences identified for children exiting care. Since most of the African American children entering care are from Cook county and most White children entering care are from the rest of the state, the higher return rate for non-Cook regions and higher adoption rate for Cook county are expected.

Children Returned to Substitute Care: Gender, Race, Age, and Region

Since gender differences in children reentering substitute care were not found, these data are not reported here. Some differences do exist between racial groups (Table 3.16), but no consistent pattern emerges over time. A larger percentage of African American children eventually returned to care in the early 1990s.

For example, for those children returned home in FY 91, 48% of African American children returned to substitute care by September 30, 2001, compared to 29% of Hispanic and 34% of White children. For those children returned home since FY 95, nearly equal percentages of African American and White children returned to substitute care, with a slightly lower percentage of Hispanic children returning to care. For example, for those children returned home in FY 98, 22% of African American children returned to substitute care, 25% of White children reentered the system and 13% of Hispanic children returned to care.

Table 3.16 Reentry to Substitute Care by Time to Reentry, Fiscal Year, and Ethnicity

		Children Return Home [b]	Children Reentering Substitute Care [c]											
			6 Months or less		6-12 Months		12-18 Months		18-24 Months		More Than 24 Months		Have Not Reentered Care	
		N	N	%	N	%	N	%	N	%	N	%	N	%
Fiscal Year [a]	Ethnicity													
1991	African American	1,800	318	17	157	8	94	5	57	3	224	12	950	52
	Hispanic	259	24	9	7	2	11	4	1		31	11	184	71
	White	1,544	224	13	77	4	57	3	25	1	127	8	1034	66
1992	African American	1,884	253	12	175	9	111	5	81	4	197	10	1067	56
	Hispanic	229	26	10	18	7	6	2	7	3	107	3	165	72
	White	1,638	229	13	64	3	30	1	26	1	113	6	1176	71
1993	African American	2,000	317	15	169	8	101	5	78	3	164	8	1171	58
	Hispanic	259	30	11	15	5	4	1	2		16	6	192	74
	White	1,729	283	15	73	4	58	3	31	1	107	6	1177	68
1994	African American	1,734	279	15	118	6	93	5	35	2	92	5	1117	64
	Hispanic	225	17	6	8	3	2		10	4	15	6	173	76
	White	1,516	217	13	78	5	36	2	25	1	89	5	1071	70
1995	African American	2,191	274	12	151	6	49	2	53	2	123	5	1541	70
	Hispanic	262	16	6	13	4	7	2	5	1	7	2	214	81
	White	1,807	311	16	85	4	47	2	27	1	76	4	1261	69

[a] Fiscal year is the fiscal year the child was returned home from substitute care.

[b] Number of children who were living at home during the fiscal year and had previously in substitute care.

[c] From the time returned home.

Table 3.16 Reentry to Substitute Care by Time to Reentry, Fiscal Year, and Ethnicity *(continued)*

			Children Reentering Substitute Care [c]											
		Children Return Home [b]	6 Months or Less		6-12 Months		12-18 Months		18-24 Months		More Than 24 Months		Have Not Reentered Care	
		N	N	%	N	%	N	%	N	%	N	%	N	%
Fiscal Year [a]	Ethnicity													
1996	African American	2,143	222	9	120	5	71	3	34	1	117	5	1579	73
	Hispanic	257	31	12	7	2	2		5	1	6	2	206	80
	White	1,573	227	14	90	5	56	3	21	1	69	4	1110	70
1997	African American	2,408	232	9	134	5	73	3	40	1	83	3	1846	76
	Hispanic	319	15	4	8	2	3		8	2	14	4	271	84
	White	1,549	239	15	83	5	28	1	23	1	58	3	1118	72
1998	African American	2,523	268	9	115	4	58	2	39	1	73	2	1970	78
	Hispanic	354	17	4	7	1	1		7	1	11	3	311	87
	White	1,322	172	12	76	5	26	1	13		39	2	996	75
1999	African American	2,416	219	8	109	4	55	2	33	1	22		1978	81
	Hispanic	337	17	4	11	3	5	1	2		2		300	89
	White	1,362	207	14	75	5	31	2	20	1	15	1	1014	74
2000	African American	2,088	209	9	96	4	55	2	17		2		1709	81
	Hispanic	265	15	5	4	1	5	1	4	1	0	0	237	89
	White	1,023	154	14	48	4	30	2	17	1	4		770	75
2001	African American	1,595	153	9	57	3	1		0	0	0	0	1384	86
	Hispanic	220	16	7	6	2	0	0	0	0	0	0	198	90
	White	1,101	140	12	49	4	9		0	0	0	0	903	82

[a] Fiscal year is the fiscal year the child was returned home from substitute care.

[b] Number of children who were living at home during the fiscal year and had previously in substitute care.

[c] From the time returned home.

Reentry into care differs by age (Table 3.17). For most years, the younger children were at the time of returning home, the more likely they were to reenter care. For example, for those children who returned home in FY 91, 46% of those up to age 3 returned to care compared to 35% of those 6 to 9 years of age and 41% of those 12 to 15 years of age. In more recent years, the youngest children and those between the ages of 12 and 15 had a higher rate of reentry into substitute care. For example, for those children returned home in FY 99, 28% of those less than 3 years of age and 25% of those between 12 and 15 returned to care. For children between the ages of 3 and 12 these percentages were between 15% and 18%.

Table 3.18 shows reentry rates by regions. Differences between Cook County regions and those in the rest of the state have changed over time. For those children returned home from FY 91 through FY 95 a smaller percentage of children returned to care outside of Cook County. For example, for those children returning home in FY 91, 45% of those from Cook County reentered care compared to 37% for the rest of the state. For those children returned home in FY 99, a smaller percentage of those from Cook County (16%) returned to care compared to 27% for the rest of the state.

Table 3.17 Reentry to Substitute Care by Time to Reentry by Age by Fiscal Year.

		Children Return Home [c]	Children Reentering Substitute Care [d]													
			7 Days or Less		7 Days - 6 Months		6-12 Months		12-18 Months		18-24 Months		More Than 24 Months		Have Not Reentered Care	
		N	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Fiscal Year [a]	Age [b]															
1991	Up to 3 yrs	1,141	6	0.5	199	17.4	104	9.1	49	4.3	28	2.5	134	11.7	621	54.4
	3 - 6 yrs	746	10	1.3	100	13.4	51	6.8	40	5.4	10	1.3	104	13.9	431	57.8
	6 - 9 yrs	534	5	0.9	55	10.3	25	4.7	24	4.5	8	1.5	69	12.9	348	65.2
	9 - 12 yrs	437	3	0.7	51	11.7	26	5.9	18	4.1	19	4.3	48	11.0	272	62.2
	12 - 15 yrs	400	8	2.0	66	16.5	27	6.8	20	5.0	14	3.5	29	7.3	236	59.0
	15 - 18 yrs	396	17	4.3	57	14.4	19	4.8	13	3.3	5	1.3	1	0.3	284	71.7
1993	Up to 3 yrs	1,078	12	1.1	164	15.2	72	6.7	53	4.9	33	3.1	86	8.0	658	61.0
	3 - 6 yrs	865	8	0.9	123	14.2	55	6.4	40	4.6	28	3.2	80	9.2	531	61.4
	6 - 9 yrs	574	3	0.5	63	11.0	38	6.6	16	2.8	18	3.1	44	7.7	392	68.3
	9 - 12 yrs	489	6	1.2	51	10.4	34	7.0	22	4.5	16	3.3	49	10.0	311	63.6
	12 - 15 yrs	508	13	2.6	86	16.9	35	6.9	18	3.5	11	2.2	25	4.9	320	63.0
	15 - 18 yrs	511	6	1.2	112	21.9	27	5.3	18	3.5	7	1.4	4	0.8	337	65.9
1995	Up to 3 yrs	947	8	0.8	132	13.9	64	6.8	24	2.5	25	2.6	55	5.8	639	67.5
	3 - 6 yrs	911	7	0.8	86	9.4	49	5.4	36	4.0	21	2.3	64	7.0	648	71.1
	6 - 9 yrs	647	7	1.1	72	11.1	43	6.6	17	2.6	22	3.4	36	5.6	450	69.6
	9 - 12 yrs	548	10	1.8	66	12.0	26	4.7	7	1.3	11	2.0	29	5.3	399	72.8
	12 - 15 yrs	568	15	2.6	89	15.7	28	4.9	13	2.3	16	2.8	18	3.2	389	68.5
	15 - 18 yrs	588	11	1.9	104	17.7	41	7.0	11	1.9	2	0.3	4	0.7	415	70.6

[a] Fiscal year is the fiscal year the child was returned home from substitute care.
[b] Age of child at the time he/she was returned home.
[c] Number of children who were living at home during the fiscal year and who had previously lived in substitute care in their first care.
[d] From the time returned home.

Table 3.17 Reentry to Substitute Care by Time to Reentry by Age by Fiscal Year.

		Children Return Home [c]	Children Reentering Substitute Care [d]													
			7 Days or Less		7 Days - 6 Months		6-12 Months		12-18 Months		18-24 Months		More Than 24 Months		Have Not Reentered Care	
		N	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Fiscal Year	Age [b]															
1997	Up to 3 yrs	745	8	1.1	112	15.0	48	6.4	24	3.2	20	2.7	37	5.0	496	66.6
	3 - 6 yrs	971	4	0.4	90	9.3	54	5.6	24	2.5	15	1.5	43	4.4	741	76.3
	6 - 9 yrs	839	2	0.2	60	7.2	39	4.6	18	2.1	15	1.8	38	4.5	667	79.5
	9 - 12 yrs	577	1	0.2	55	9.5	32	5.5	10	1.7	12	2.1	26	4.5	441	76.4
	12 - 15 yrs	536	5	0.9	69	12.9	26	4.9	12	2.2	7	1.3	18	3.4	399	74.4
	15 - 18 yrs	555	12	2.2	74	13.3	29	5.2	15	2.7	3	0.5	4	0.7	418	75.3
1999	Up to 3 yrs	778	11	1.4	123	15.8	41	5.3	26	3.3	13	1.7	6	0.8	558	71.7
	3 - 6 yrs	892	0	0.0	66	7.4	40	4.5	17	1.9	11	1.2	15	1.7	743	83.3
	6 - 9 yrs	768	2	0.3	51	6.6	37	4.8	8	1.0	10	1.3	6	0.8	654	85.2
	9 - 12 yrs	666	6	0.9	49	7.4	31	4.7	18	2.7	7	1.1	7	1.1	548	82.3
	12 - 15 yrs	539	6	1.1	72	13.4	34	6.3	18	3.3	10	1.9	4	0.7	395	73.3
	15 - 18 yrs	478	5	1.0	60	12.6	18	3.8	6	1.3	3	0.6	2	0.4	384	80.3
2001	Up to 3 yrs	633	9	1.4	77	12.2	22	3.5	3	0.5	0	0.0	0	0.0	522	82.5
	3 - 6 yrs	575	3	0.5	52	9.0	29	5.0	3	0.5	0	0.0	0	0.0	488	84.9
	6 - 9 yrs	504	2	0.4	36	7.1	27	5.4	1	0.2	0	0.0	0	0.0	438	86.9
	9 - 12 yrs	476	3	0.6	31	6.5	16	3.4	0	0.0	0	0.0	0	0.0	426	89.5
	12 - 15 yrs	385	8	2.1	46	11.9	15	3.9	0	0.0	0	0.0	0	0.0	316	82.1
	15 - 18 yrs	338	5	1.5	47	13.9	8	2.4	3	0.9	0	0.0	0	0.0	275	81.4

[a] Fiscal year is the fiscal year the child was returned home from substitute care.
[b] Age of child at the time he/she was returned home.
[c] Number of children who were living at home during the fiscal year and who had previously lived in substitute care in their first care.
[d] From the time returned home.

Table 3.18 Reentry to Substitute Care by Time to Reentry by Cook/Non-Cook Regions by Fiscal Year

		Children Return Home [c]	Children Reentering Substitute Care [d]											
			6 Months or Less		6-12 Months		12-18 Months		18-24 Months		More Than 24 Months		Have Not Reentered Care	
		N	N	%	N	%	N	%	N	%	N	%	N	%
Fiscal Year [a]	County													
1991	Cook	1,651	257	15	140	8	93	5	32	1	207	12	922	55
	Non-Cook	2,032	320	15	112	5	71	3	52	2	179	8	1298	63
1992	Cook	1,563	199	12	136	8	85	5	71	4	143	9	929	59
	Non-Cook	2,254	316	13	126	5	62	2	46	2	179	7	1525	67
1993	Cook	1,682	227	12	135	8	85	5	64	3	132	7	1039	61
	Non-Cook	2,396	422	17	126	5	82	3	49	2	157	6	1560	65
1994	Cook	1,251	173	13	103	8	45	3	34	2	61	4	835	66
	Non-Cook	2,302	349	14	104	4	88	3	36	1	140	6	1585	68
1995	Cook	1,727	170	9	113	6	50	2	46	2	89	5	1259	72
	Non-Cook	2,620	439	16	139	5	58	2	51	1	117	4	1816	69
1996	Cook	1,763	126	6	88	4	60	3	32	1	74	4	1383	78
	Non-Cook	2,307	365	15	136	5	73	3	30	1	120	5	1583	68
1997	Cook	2,128	155	6	97	4	52	2	31	1	76	3	1717	80
	Non-Cook	2,251	342	14	131	5	52	2	41	1	90	3	1595	70
1998	Cook	2,337	159	6	83	3	35	1	37	1	57	2	1966	84
	Non-Cook	1,982	314	14	124	6	52	2	24	1	73	3	1395	70
1999	Cook	2,378	178	7	80	3	47	1	34	1	19		2020	84
	Non-Cook	1,857	277	14	122	6	46	2	21	1	21	1	1370	73
2000	Cook	1,916	154	7	72	3	39	2	21	1	2		1628	84
	Non-Cook	1,563	242	14	79	5	55	3	17	1	4		1166	74
2001	Cook	1,299	93	6	41	3	2						1163	89
	Non-Cook	1,712	229	12	76	4	8						1399	81

Note: Blank cells represent less than .5%.

[a] Fiscal year is the fiscal year the child was returned home from substitute care.

[b] Region returned to

[c] Number of children who were living at home during the fiscal year and who had lived in substitute care in their first care.

[d] From the time returned home.

Chapter 4

CHILD WELL-BEING OUTCOMES

The Adoption and Safe Families Act of 1997 clearly establishes child well-being as an important child welfare outcome (PL 105-89). The Department of Health and Human Services when seeking comments on proposed measures and indicators to satisfy the requirements of AFSA recognized the necessity of beginning the reporting process with safety and permanency using existing data (Federal Register/vol. 64, No. 21 February 2, 1999). Since existing management information systems do not normally include well-being data, development of measures and indicators will take considerable time and effort. Children and Family Research Center child well-being outcome reporting efforts have experienced similar problems. Center reports to date have mainly included child safety and permanency outcomes derived from administrative data.

Defining child well-being is one challenge. Obtaining well-being data is another. When HHS proposed the AFSA outcome indicators they suggested that child well-being included education and health (Federal Register 64, No. 21 February 2, 1999). This is similar to the Center's efforts to define well-being where consensus building efforts resulted in agreement that physical health, mental or behavioral health and education were the most important elements of child well-being.

Center staff met with several interest groups across the state to develop this consensus. The exercise focused on determining what dimensions of children's lives are most important to include in a definition of well-being. Each group quickly agreed that physical health, mental health and education were critical dimensions of children's lives. Many members of each group also thought that these dimensions were insufficient and that others such as moral development needed to be included. However, none of the groups could agree on other dimensions of children's lives that should be added to the definition of well-being.

A literature review was conducted to identify dimensions of children's lives that child welfare researchers typically include in their definitions of well-being (Children and Family Research Center, 1998). This review resulted in identification of health status including both physical and mental health as dimensions of well-being. In the area of mental health, the literature includes examination of cognitive functioning, developmental delay, behavioral disturbance, and emotional disturbance. Education was also identified as a part of well-being. In addition, resilience, coping, and overall functioning were included in well-being research.

Defining child well-being is easier than collecting data and developing outcome reports. For example, to report on physical health as an outcome it is necessary to determine a child's health status upon entering care and determining how it has changed while under the care of the public child welfare agency. The child welfare literature shows that compared to the general pediatric/adolescent population, children placed in foster care have significant deficits in their health status. For example, according to one report, approximately 20% of all foster children nationally exhibited some type of disability, as compared to 16% of children in the general pediatric population (Hill, Hayden, Lakin, Menke, & Amado, 1990). Upon entering care, children in non-related foster care have scored approximately ten points below the general population of children on IQ tests, with minority children and children from lower socioeconomic levels scoring significantly lower (Dumaret, 1985; Fanshel & Shinn, 1978; Fox & Arcuri, 1980).

The Center has conducted studies aimed at obtaining well-being data on children who are the responsibility of the Department that provide information that is not otherwise available. While none of these have been longitudinal and therefore not outcome studies, they provide insights into the difficulties and the promise of collecting data on children throughout their time in the child welfare system. Results from these special studies were reported in previous reports (e.g. CFRC, 2001).

Another strategy for obtaining well-being outcome measures is to use administrative data from systems outside of DCFS. The Center with the cooperation of the Department, has completed data sharing agreements with the Chicago Public Schools and the State Board of Education to obtain educational data on DCFS wards. Analysis of these data sets is just beginning and should be a part of future outcome reports.

In addition, the Center has data sharing agreements that allows access to Medicaid claims data. Children in placement with the Department receive medical and mental health services that are financed through Medicaid. The records of these transactions are called claims and are maintained by the Department of Public Aid. The Center is using these data to explore the development of health and mental health outcome indicators. While use of health or mental health services by itself does not constitute an outcome, it is envisioned that these types of data can lead to development of health and mental health well-being measures. For example, if a child is identified as having an acute condition upon entry into care, a pattern of service use that shows professional attention for this condition soon after entry into care and little or no additional services for this condition while in care is considered appropriate care. For chronic conditions the pattern of service use would be different. In these cases, appropriate care might be indicated by intensive services for the condition upon entry into care and a lower level of service intensity while in care. This lower level of service use might be an indicator of appropriate monitoring and management of the chronic condition.

Center staff is exploring the use of Medicaid data to identify and describe health and mental health service use by children who are the responsibility of the Department. This report includes results from two preliminary studies. The first presents descriptive data regarding use of mental health services by Department wards. While this does not include mental health outcome measures at this time, it is anticipated that well-being outcomes measures will be derived from this data. The second study reports preliminary results of a study of the medical management of asthma using Medicaid claims data.

Mental Health Service Use of Children in Out of Home Care [19]

The research has established that children in foster care are at increased risk for mental health problems. Many children in foster care have a background of chronic poverty and associated familial disruptions, stresses, and social problems. The experience of maltreatment has also been linked to emotional problems (Egeland, Sroufe, & Erickson, 1983), as has the separation from family associated with foster care. Available evidence suggests that 35-85% of

[19] This section was prepared by Tamara Fuller and Martin Nieto.

children entered foster care have significant mental health problems, with the variability between studies reflecting difference in sample characteristics and definitions of mental health problems.

While the prevalence of mental health problems among children in foster care is well documented, fewer studies have examined the mental health service use by foster care populations. An early study in California found that children in foster care represented 41% of mental health service users but less than 4% of California's Medicaid-eligible population (Halfon, Berkowitz, & Klee, 1992). Children in foster care in California were 20 times more likely to receive outpatient mental health services and 9 times more likely to be hospitalized for psychiatric conditions than non-foster children receiving Medicaid services. Older children (12-17 years) had the highest rates of mental health service utilization, followed by the youngest children (0-6 years). Similar results were found in Washington, where 25% of the children in foster care received mental health services, compared with 3% of non-foster care children eligible for Medicaid through AFDC (Takayama, Bergman, & Connell, 1994).

More recent studies have compared the mental health utilization rates of children in foster care with another group of Medicaid recipients, those who receive Supplemental Security Income (SSI), in addition to those who are Medicaid eligible through AFDC. Children qualify for SSI if there is a medically determinable physical or mental impairment that results in marked and severe functional limitations. As in past studies, children in foster care were more likely to be diagnosed with a mental health problem than those on AFDC (Harman, Childs, & Kelleher, 2000). They were more likely to suffer from depression (5.9% vs. 1.1%), anxiety disorders (2.5% vs. .8%), ADHD (14.7% vs. 3.9%), conduct disorder (9.4% vs. 1.9%), bipolar disorder (1.0% vs. .1%), and oppositional defiant disorder (9.4% vs. 1.9%). After controlling for demographic differences, significantly more children in foster care (34.6%) received a mental health service compared with children eligible for Medicaid through AFDC (8.7%). Children in foster care were 7.5 times more likely to experience inpatient psychiatric services.

The rates of mental health diagnoses among children in foster care were more similar to those eligible for Medicaid than through SSI, although still significantly higher. When rates were adjusted for demographic factors, children in foster care were significantly more likely to be diagnosed with an anxiety disorder (2.5% vs. 1.8%), conduct disorder (3.7% vs. 2.7%), and oppositional defiant disorder (9.8% vs. 8.2%). Although there was no significant difference

between the two groups in the probability of having a mental health claim, children in foster care were more likely to experience a psychiatric hospitalization (6.1% vs. 4.9%), while children on SSI had a greater number of mental health service claims during a year (12.8 vs. 8.5).

An additional study (dosReis, Zito, Safer, & Soeken, 2001) compared these three groups and found that the prevalence of mental health disorders among children in foster care (57%) was twice that of children receiving SSI (26%), and nearly 15 times that of children receiving Medicaid through AFDC. Attention deficit hyperactivity disorder (ADHD) and depression were twice as prevalent among foster children as in the SSI group, and adjustment disorders were more than 10 times as prevalent. Children in foster care were much more likely to receive mental health services (62%) than those receiving SSI (29%) or AFDC (4%).

Beyond the basic comparisons of the rates of mental health diagnoses and service utilization of children in foster care to other groups, little research has been done to examine the factors that are associated with mental health service use among children in foster care. One study (Leslie, Landsverk, Ezzet-Lofstrom, Tschann, Slymen, & Garland, 2000) looked at the factors that predict outpatient mental health service use (number of visits) and found that number of visits increased with age, Whites and blacks had higher service use than Latinos or Asians, males had more visits than females, children in family foster care had more visits than those in kinship care, children with CBCL scores of 60 or more had more visits, and maltreatment history was not a significant predictor of mental health service use.

Medicaid Paid Claims as a Source of Mental Health Service Use

For this descriptive study data from the Illinois Medicaid Paid Claims Longitudinal Database have been linked to the DCFS Integrated Database to provide a record of all paid medical claims (include mental health services) for children in substitute care in Illinois, who are categorically eligible for Medicaid. The present analysis includes all children who had their first case opening during the period between fiscal year 1995 and fiscal year 1998 excluding cases opened under adoption assistance. The case and demographic information of this sample was then linked to the Medicaid Paid Claims Longitudinal Database. Each claim in the Medicaid database includes dates indicating the time when services were provided and when the billing for the given service took place.

The purpose of this preliminary study was to identify those children in out of home care in Illinois who were receiving Medicaid billed mental health services within two years of entering care. Once these children were identified, variables of interest including first mental health diagnosis, the first service that was provided to them, and the length of time to service provision. These variables were selected for cohorts of children entering the care of the Department. As is the case with all Center data analysis, these indicators were further reported by gender, age, race, and Department region.

Each Medicaid claim includes an International Classification of Diseases, 9th Revision (ICD-9) diagnostic code as well as a service type code. The diagnostic codes were used to identify the claims related to mental health services by selecting claims made under a diagnostic code that appears in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). The mental health diagnostic codes were then grouped into a more manageable set of categories, such as conduct and oppositional disorders depression disorders, etc. A similar process was followed to reduce the number of service codes into a manageable number of categories. For this purpose, the categories previously defined by Early and Mooney (2001) were used.

The claims for services provided under mental health diagnostic codes were then sorted by date and only the first service coinciding or following the opening date of the case was selected for the present analysis. A two year follow-up after case opening was set in order to have comparability across years. Thus, only children who received their first mental health service within two years of their case opening are counted as receiving mental health services. This study used Medicaid information through June 2000.

Mental health service use by fiscal year

Table 4.1 displays the number of first child case openings during each fiscal year from FY 95 to FY 98, followed by the number of children receiving mental health services within two years of case opening, the proportion (percent) of children with first case openings receiving mental health services, and the mean number of days to first service within two years of case opening. The number of children in their first substitute care placement receiving mental health services within two years of entering care rose from 17% in FY 95 to 20% in FY 98. In addition to a larger percentage of children receiving mental health services, the mean number of days to first service (within two years) for children receiving mental health services dropped from 301 days to 260 days.

At this time it is not possible to compare results for Department wards to those of other studies. Other studies report that 35% to 85% of children entering substitute care have significant mental health problems. This is a very large range and is an indication of the incomplete state of our knowledge. These studies have used a variety of definitions and methodologies that make it impossible to compare rates. For example, the time period used in the various studies is not always clear. The longer children remain in care the larger the percent that are likely to receive mental health services. In this study, a two year time period from case opening is used to make reasonable comparisons across years.

In addition, the degree to which children in out of home care are receiving mental health services that are not billed through this Medicaid system is unknown. It is likely that some DCFS purchased mental health services are not reimbursed through Medicaid. It is also likely that some other local mental health service providers are not being billed through Medicaid. Continuing Center research will explore the degree to which Medicaid claims data under represents mental health service use.

Table 4.1 Number, Percent and Time to First Mental Health Service Use for Children Entering Care by Fiscal Year

	Number of Children with First Child Case Openings	Number of Children Receiving Mental Health Services	Percent Receiving Mental Health Services	Mean Days to First Service Within Two Years of Case Opening
Fiscal Year				
1995	13,224	2,191	17	301
1996	9,672	1,822	19	264
1997	8,591	1,707	20	258
1998	6,910	1,356	20	260

Similarly, it is not possible to make a judgment about the time to first service use. It appears that the decrease by more than a month to first service use is positive since it may indicate that children with mental health needs are being identified more rapidly. However, at this time there is insufficient research in this area to draw conclusions. Finally, the connection between mental health service use and need is unknown. This analysis assumes that because mental health services were provided that they were needed. For example, the difficulty of accurately diagnosing children particularly young children and distinguishing mental health conditions from temporary developmental problems is an area needing additional study.

Mental health service use by child age

In general, the proportion of children in substitute care receiving mental health services increases with child age (Table 4.2). The proportion of children ages 0 to 3 who received mental health services within two years of entering care ranged from 6% in FY 95 to 7% in FY 98, while the proportion of children ages 12-15 who received services ranged from 35% in FY 95 to 44% in FY 97. In addition, the number of days to first service decreased with age. The average time to first service ranged from 335 to 387 days for children ages 0-3 and from 149 to 211 days for children ages 15-18.

Similar to these results, Takayama et al. (1994) found that a larger proportion of older children received mental health services than younger children. This may be in part because of differential onset of certain mental conditions by age. It may also be due to the difficulty of diagnosing mental health conditions in very young children.

4.2 Mental Health Services Within Two Years of First Case Opening by Age

Fiscal Year	Child's Age at opening	Number of First Child Case Openings	Number of Children Receiving Mental Health Services	Percent Receiving Mental Health Services	Mean Days to First Service Within Two Years
1995	**Up to 3 yrs**	5,301	334	6	387
	3 - 6 yrs	2,585	374	14	359
	6 - 9 yrs	1,701	323	19	329
	9 - 12 yrs	1,360	350	26	287
	12 - 15 yrs	1,368	482	35	248
	15 - 18 yrs	895	326	36	211
1996	**Up to 3 yrs**	4,175	279	7	335
	3 - 6 yrs	1,722	318	18	291
	6 - 9 yrs	1,205	303	25	292
	9 - 12 yrs	1,018	320	31	242
	12 - 15 yrs	955	397	42	227
	15 - 18 yrs	582	204	35	192
1997	**Up to 3 yrs**	3,742	273	7	378
	3 - 6 yrs	1,504	308	20	318
	6 - 9 yrs	1,170	293	25	274
	9 - 12 yrs	836	283	34	242
	12 - 15 yrs	828	361	44	171
	15 - 18 yrs	505	189	37	155
1998	**Up to 3 yrs**	3,062	223	7	382
	3 - 6 yrs	1,080	225	21	317
	6 - 9 yrs	931	240	26	256
	9 - 12 yrs	756	243	32	234
	12 - 15 yrs	672	278	41	199
	15 - 18 yrs	409	147	36	149

Mental health service use by child race

There are differences in mental health service use by race (Table 4.3). A larger percentage of White children in substitute care received mental health services within two years of entry into care (28% to 29%) than Hispanic (18% - 24%) or African-American children (12% - 16%). Also, White children in substitute care received services faster than both Hispanic and African-American children. The mean number of days to first service for those children receiving mental health services within two years ranged from 187 (FY 98) to 248 (FY 95) for White children, from 245 (FY 98) to 335 (FY 95) for Hispanic children, and from 283 (FY 97) to 339 (FY 95) for African-American children. Consistent with the overall trend, children of all races received their first service faster in FY 98 than in FY 95.

Many African American children are placed with relatives and this may partially explain differences in mental health service use by race. Early & Mooney (2001) demonstrated in their analysis that children in kinship care were less likely to receive mental health services. The reasons for his are not known at this time.

Mental health service use by region (Cook versus non-Cook counties)

In Illinois, race and region are highly related, with most African American children in the care of the Department living in Cook County. To better understand racial differences in mental health service use, comparisons are presented by region as well as by region and race. Table 4.4 reveals a consistent trend that fewer children in Cook County receive mental health services within two years of case opening (13% - 18%) than children in non-Cook Regions (23% - 25%).

It should be noted that the current analyses only accounts for services billed through Medicaid and it is possible that this occurs less frequently in Cook County than in the rest of the state. Children in substitute care may be receiving additional mental health services through providers that may not be required to submit Medicaid claims on individuals. These services would not be included in this analysis.

4.3 Mental Health Service Case Within Two Years of First Child Case Openings by Race

		Number of First Child Case Openings	Number of Children Receiving Mental Health Services	Percent Receiving Mental Health Services	Mean Days to First Service Within Two Years
Fiscal Year	**Child's Race**				
1995	**African American**	9,206	1,123	12	339
	Hispanic	719	131	18	335
	White	3,075	885	29	248
1996	**African American**	6,347	930	15	286
	Hispanic	649	158	24	276
	White	2,486	701	28	235
1997	**African American**	5,579	874	16	283
	Hispanic	560	135	24	255
	White	2,233	654	29	227
1998	**African American**	4,307	684	16	324
	Hispanic	516	98	19	245
	White	1,904	548	29	187

4.4 Mental Health Service Case Within Two Years of First Child Case Openings by Cook/ Non-Cook

Fiscal Year	Cook vs. Non-Cook	Number of First Child Openings	Number of Children Receiving Mental Health Services	Percent Receiving Mental Health Services	Mean Days to First Service Within Two Years
1995	**Cook County**	8,970	1,199	13	338
	Non-Cook Counties	4,254	992	23	256
1996	**Cook County**	6,248	990	16	285
	Non-Cook Counties	3,424	832	24	240
1997	**Cook County**	5,319	948	18	275
	Non-Cook Counties	3,272	759	23	238
1998	**Cook County**	4,060	653	16	314
	Non-Cook Counties	2,850	703	25	209

Children in substitute care in non-Cook regions receive mental services faster than in Cook County, although the numbers for both groups of children are dropping over time. In FY 95, children in Cook County received services an average of 338 days after case opening and children in non-Cook Regions received services in an average of 256 days. By FY 98, these numbers dropped to an average of 314 days in Cook county and 209 days outside of Cook County.

Mental health service use by race and region

When examining differences in mental health service use by race and region it appears that there are larger differenced by race than region. For example, in FY 97 there were equal proportions of African-American and White children in substitute care receiving services in Cook versus non-Cook Regions (Table 4.5). For African American children entering care in FY 97, 16% were receiving mental health services within two years regardless of their entry from Cook County or the rest of the state. Across the four years of this study, these differences tend to be small. Similarly, 29% of White children entering care in FY 97 from Cook County or the rest of the state received mental health services. These differences also tend to be small over the 4 years included in this study.

There were differences by region for Hispanic children entering care in FY 97 with 27% of those from Cook County receiving mental health services, this compares to only 15% of those entering care from non-Cook Regions. However FY 97 was the only year showing these differences.

Mental health service use by diagnostic category

Children under the care of the Department who receive mental health services are diagnosed with a variety of mental health conditions (Table 4.6). The distribution of mental health services by diagnostic categories is presented for one year, FY 97. There does not appear to be large variations between years.

4.5 First Child Case openings by Cook / non-Cook by Race

			First Child openings	Children Receiving Mental Health Services	Percent Within Cook vs. Non-Cook	Mean Days to First Service Within Two Years
Fiscal Year	**Cook vs. Non-Cook**	**Child's Race**				
1995	**Cook County**	**African American**	7,596	912	12	348
		Hispanic	556	105	19	340
		White	684	150	22	280
	Non-Cook Counties	**African American**	1,610	211	13	300
		Hispanic	163	26	16	316
		White	2,391	735	31	242
1996	**Cook County**	**African American**	5,087	707	14	289
		Hispanic	516	129	25	286
		White	555	138	25	269
	Non-Cook Counties	**African American**	1,260	223	18	273
		Hispanic	133	29	22	231
		White	1,931	563	29	226
1997	**Cook County**	**African American**	4,303	669	16	291
		Hispanic	419	115	27	259
		White	465	133	29	226
	Non-Cook Counties	**African American**	1,276	205	16	258
		Hispanic	141	20	14	233
		White	1,768	521	29	227
1998	**Cook County**	**African American**	3,256	487	15	343
		Hispanic	367	70	19	264
		White	364	82	23	204
	Non-Cook Counties	**African American**	1,051	197	19	278
		Hispanic	149	28	19	198
		White	1,540	466	30	184

4.6 First Child Case openings by First Diagnostic Category

		Number of Children Receiving Mental Health Services	Percent In Diagnostic Category	Mean Days to First Service Within Two Years
Fiscal Year	**First Mental Health Diagnosis**			
1997	**Attention-Deficit Hyperactivity Disorders**	375	22	287
	Conduct & Oppositional Disorders	304	18	215
	Depressive Disorders	287	17	171
	Adjustment Disorders	244	14	229
	Other Disorders of Infancy, Childhood, or Adolescents	136	8	439
	Anxiety Disorders	90	5	219
	Communication Disorders	69	4	336
	Other conditions V codes	47	3	203
	Learning Disorders	42	2	361
	Low Frequency Diagnoses	35	2	245
	Substance Related Disorders	27	2	294
	Schizophrenia and Other Psychotic Disorders	19	1	405
	Mental Retardation	18	1	282
	Impulse-Control Not Elsewhere Classified	6	0.4	215
	Bipolar Disorders	5	0.3	237
	Motor Skills Disorder	3	0.2	359

There are four conditions that are the most frequently diagnosed: Attention Deficit Hyperactivity disorders (22%), Conduct and Oppositional disorders (18%), Depressive disorders (17%) and Adjustment disorders (14%). Together these represent more than 70% of the diagnosed mental conditions among children in substitute care. These findings are similar to those of Harman, Childs and Kelleher (2000) who found these same conditions to be the most frequently diagnosed.

The data in Table 4.6 suggest that children in substitute care who are identified with a Depressive Disorder receive services more quickly (171 days) than children with the other disorders. Children diagnosed with ADHD tend to receive mental health services more slowly (287 days) than children with the other disorders. On average, children identified with Conduct and Oppositional Disorders received services in 215 days, children with Adjustment Disorders received services in 229 days.

Mental health service use by race by diagnostic category

Some research has indicated differences between races in the type of diagnostic label used. Table 4.7 displays the mental health service use for African-American, Hispanic, and White children in substitute care broken down by the four main diagnostic categories (Attention-Deficit Hyperactivity Disorders, Conduct and Oppositional Disorders, Depressive Disorders, and Adjustment Disorders). To simplify the presentation only the data for FY 95 and FY 98 are presented.

White children receiving mental health services are more frequently diagnosed with ADHD than African-American or Hispanic children. For those White children entering care in FY 95, 30% were diagnosed as ADHD compared to 16% of African-American and 14% of Hispanic children. These differences narrowed for children entering care in FY 98, where 28% of White, 19% of African American, and 14% of Hispanic children were diagnosed with ADHD.

White children with ADHD diagnosis received their first mental service more quickly than other children. For those White children entering care in FY 95 and diagnosed with ADHD, it was an average of 260 days until the first mental health service was received. It took longer for similarly diagnosed African-American (384 days) and Hispanic children (372 days) to receive services.

4.7 First Child Case openings by Race by Selected Diagnostic Categories

			Children Receiving Mental Health Services	Percent Within Race	Mean Days to First Service Within Two Years
Fiscal Year	**Child's Race**	**First Mental Health Diagnosis**			
1995	**African American**	**Attention-Deficit Hyperactivity Disorders**	184	16	384
		Conduct & Oppositional Disorders	218	19	307
		Depressive Disorders	185	16	299
		Adjustment Disorders	195	17	340
	Hispanic	**Attention-Deficit Hyperactivity Disorders**	18	14	372
		Conduct & Oppositional Disorders	27	21	251
		Depressive Disorders	19	14	265
		Adjustment Disorders	14	11	275
	White	**Attention-Deficit Hyperactivity Disorders**	269	30	260
		Conduct & Oppositional Disorders	203	23	222
		Depressive Disorders	110	12	223
		Adjustment Disorders	132	15	254
1998	**African American**	**Attention-Deficit Hyperactivity Disorders**	133	19	343
		Conduct & Oppositional Disorders	146	21	347
		Depressive Disorders	79	12	282
		Adjustment Disorders	103	15	314
	Hispanic	**Attention-Deficit Hyperactivity Disorders**	14	14	340
		Conduct & Oppositional Disorders	20	20	262
		Depressive Disorders	17	17	202
		Adjustment Disorders	9	9	307
	White	**Attention-Deficit Hyperactivity Disorders**	151	28	200
		Conduct & Oppositional Disorders	97	18	170
		Depressive Disorders	78	14	165
		Adjustment Disorders	126	23	186

The time to first mental health service was similar for children entering care in FY 98 and diagnosed with ADHD: 200 days for White children compared to, 343 days for African-American children and 340 days for Hispanic children.

Differences in the percentages of children from each racial group receiving the other three major diagnoses were small. However, the time to first mental health service use for children with these diagnoses does differ by ethnicity, with White children receiving services more quickly. For example, for children entering care in FY 98 and diagnosed with conduct and oppositional disorders, White children received their first mental health service in an average of 170 days, while this average was 347 days for African-American children and 262 days for Hispanic children. At this time it is not possible to explain these differences. It may be that there are racial / ethnic differences between groups in seeking mental health treatment. Mental health professionals may treat groups differently. The distribution of mental health services within communities may result in some groups not having equal access to services.

Mental health service use by first type of mental health service

In most cases, good mental health practice suggests that the first service a child in substitute care should receive is a diagnostic interview. In FY 97 approximately 30% of the children in substitute care received a diagnostic interview as their first mental health service, followed by evaluation/management (16-20%), office visit at hospital (10-15%), and individual therapy (9-10%) (Table 4.8). However, children who do receive a diagnostic interview are not being interviewed until well into their stay in substitute care. On average it was 261 days after case opening until the diagnostic interview occurred.

The mental health service use results reported here are a first step in using Medicaid claims data to describe the mental health conditions of children who are placed in out of home care. Center staff will continue to analyze these data to gain insights into which children enter care with which mental health conditions. Analysis will also be done to examine the course of treatment for these conditions. For example, for children diagnosed with ADHD upon entering care might be expected to have a stable course of treatment that demonstrated appropriate management of this condition.

4.8 Mental Health Service Case Within Two Years of First Child Case Openings by First Mental Health Procedure

		Number of Children Receiving Mental Health Services	Percent of Those Receiving Services	Mean Days to First Service Within Two Years
Fiscal Year	**First Mental Health Procedure**			
1997	**Diagnostic Interview**	494	29	261
	Evaluation/Management	327	19	300
	Office Visit at Hospital	254	15	210
	Therapy--Individual	150	9	283
	Emergency/Crisis	109	6	183
	Consultation	69	4	132
	In-patient/Residential	64	4	475
	Stabilization	61	4	154
	Case Management	45	3	247
	DCFS Comp. Rehab Services	31	2	268
	Medication Management	29	2	304
	Treatment Planning	30	2	283
	Therapy--Family	23	1	292
	Therapy--Group	16	0.9	173
	Partial Hospital	5	0.3	542

Patterns of Health Care Utilization of Foster Children with Asthma[20]

A second exploratory child well-being study using Medicaid claims data was an examination of children diagnosed with asthma. This study sought to identify where and when asthma was diagnosed for children in out of home care. An attempt was also made to determine if the data provided insights into the treatment of asthma after diagnosis.

Children enter the foster care system with multiple medical needs and even as problems are identified, may not receive adequate services (Horwitz, Owens & Simms, 2000; Risley-Curtis & Combs-Orme, 1996). A few clinical studies have specifically documented health problems active and symptomatic at the time of entry into foster care, suggesting under-identification and/or under-treatment for these medical problems prior to entry into foster care. Among 5,181 children entering custody in Chicago, 44% had an identified health problem, including acute infections (ear infections, sexually transmitted disease), anemia, lead poisoning, and 5% had an unsuspected bone fracture (Flaherty & Weiss, 1990). In a study of 2,419 children entering custody in Baltimore, 92% had at least one abnormality on exam, including 66% of the upper respiratory tract, 61% skin, 10% genitals, 8% eyes; 23% failed a developmental screening; and 22% of older children were already enrolled in special education (Chernoff, Combs-Orme, Risley-Curtis & Heisler, 1994).

Some evidence points to under-referral for needed services following entry into foster care. Under situations in which a multidisciplinary team proactively provides medical evaluations and case management, the number and variety of services obtained by children increases. One hundred twenty children in Wisconsin received either customary community-based services or had multidisciplinary team follow-up. Children in the intervention group were more likely to be identified with developmental (57% vs. 9%) and mental health problems (37% vs. 14%) than the comparison group. Children in the intervention group were more likely to be referred for health services at baseline (71% vs. 43%) than the comparison group (Horwitz, Owens & Simms, 2000).

[20] This section prepared by Madeleine Shalowitz and Deborah Dobrez.

In an unique pre-post comparison using Illinois administrative data, Bilaver, Jaudes, Koepke & Goerge (1999) studied children living in their families of origin who received Aid to Families with Dependent Children (AFDC: the predecessor to Temporary Aid to Needy Families, TANF). At a later time and for reasons of documented abuse or neglect, a subset of these children would leave their families of origin and enter foster care. The authors compared those children who remained with their families of origin throughout the study period to those who began with their families of origin but later entered foster care. While still with their families of origin, children who later enter foster care had a general higher level of medical need than children who did not leave their family of origin. These children were 27% more likely to have been diagnosed with a chronic condition (particularly a chronic psychiatric condition, developmental disorders and mental retardation) than those who never entered foster care, but less likely to have been diagnosed with a chronic physical condition (suggesting under-identification). Children who later entered foster care received more mental health services than other poor children, particularly inpatient psychiatric hospitalization.

Children with chronic medical conditions often require daily treatment regimens, frequent medical care and ongoing case management. Given the known burden of illness documented at entry into child welfare, we know little about how caregiving systems mobilize to address these needs. Asthma among foster children is a logical choice for study in this context. Asthma is increasingly common, placing a disproportionate burden on individuals living in indigent circumstances. Population-based analyses point toward a rise in the frequency of severe asthma among urban dwellers living in poverty, especially among African-Americans. The mortality rate has risen three-fold in this population, while remaining relatively unchanged in Caucasians (Arrighi 1995; Chang, Phinney, Halpern & Gershwin 1993; Fuller 1996; Greenberger, Miller & Lifschultz 1993; Hefflin & Etzel 1995; Sinclair, Allwright & Prichard 1995; Targonski, Persky, Orris & Addington 1994) A further complication is the widespread under-diagnosis of asthma in children, suggesting that the magnitude of the disparities may be even greater (Joseph, Foxman, Leickly, Peterson & Ownby, 1996) Current screening data suggest that asthma symptoms occur in roughly 28% of urban elementary-aged schoolchildren from low income families (Berry, Shalowitz, Quinn & Wolf, 2001).

Many factors, both measured and unmeasured, may influence patterns of health care utilization. Among these are disease co-morbidities. The pathophysiology of the co-morbid condition may interact with the disease under study and its treatment may interfere or act synergistically with the treatment of the disease under study. Characteristics of other co-morbidities, such as physical or intellectual handicaps, may limit the patients' understanding of complex treatment regimens or otherwise affect how patients access care. Thus, significant co-morbidities may change observations on patterns of health care utilization.

Policy analysts and clinicians generally agree that an optimal model of medical care, particularly for chronic illness, provides routine health supervision across a continuum of sites and services. Such a model provides regular opportunities for preventive care, ongoing assessment and management of the chronic illness, early intervention for exacerbations and case management. These strategies serve to keep patients out of intensive medical services necessitated by crises and promote an optimal functional outcome.

If a health care system is working well, we should see signs that children receive care regularly and consistently in non-acute care settings, even if these visits are interspersed with acute care visits. Thus, if the foster care system is successful with respect to children's medical care we would expect an appropriate number of visits and movement from acute care to routine outpatient management. Further, some children face multiple medical challenges that may influence the amount, kind and sequence of visits to physicians. A responsive care system should reflect these additional challenges by a shift in the pattern of claims. In the exploratory study we anticipated that children in foster care access an array of services whose sequences suggest consistent routine health supervision.

Data Analysis Methods

A longitudinal approach to utilization data is warranted. Simple tallies of services do not provide sufficient information about the quality of care. This project therefore focused on the sequence of visits made by children entering their first episode of foster care. Routine health care supervision was defined in two ways: (1) children receive care

primarily in an outpatient setting (as opposed to in a hospital or emergency room); and (2) children receive appropriate outpatient follow-up to hospital or emergency room visits. We generated predictive models for each to identify characteristics of the children and their utilization patterns that are related to improved routine health care supervision.

Data Sources and Sample Construction

Data for the study was obtained from the Child and Youth Centered Information System (CYCIS; provided by the Illinois Department of Children and Family Services) and the Illinois Medicaid paid claims longitudinal database. The CYCIS child database contains basic demographic information for each child, including date of birth, sex, race, and school status. The master spell file contains foster care tenure data, including placement number, and beginning and end date for each foster care placement. The claims database contains records of all child medical services paid for by the Illinois Department of Public Aid and reimbursed through Medicaid. Detailed information regarding type of service, service date and length (for hospitalizations), ICD-9-CM diagnosis, provider specialty and type, and procedure code is included for each claim. Since different departments maintain different databases, no single identifier represents the child in all systems with perfect accuracy. The data are therefore linked using probabilistic record-matching, a technique that calculates the likelihood that a record belongs to the same person by matching as many demographic variables as possible from each database.

Physician-related medical claims for children meeting the following criteria were identified: (1) first foster care placement; (2) foster care placement initiated between 1994-1997; (3) observed diagnosis of asthma (ICD-9-CM codes 493.0, 493.9, 493.1, 466.0, 491.2, 491.21); (4) in foster care for at least one year following first observed asthma related claim; and (5) age at first observed asthma-related claim between eighteen months and twelve years. Claims for the first year following the first observed asthma-related claim were included. The initial visit for asthma-related care marks the beginning of the one year study period. All physician-generated asthma-related claims were included for analysis regardless of site of care. Outpatient and total claims were included for non asthma-related physician services because any physician contact presents an

opportunity to review asthma symptoms and care, even if the purpose of the visit (and its coding) does not reflect the asthma diagnosis.

Five percent of the final claims meeting the eligibility criteria were not the sole claim filed on the same service date. To prevent double counting of related services, we included only one physician-related claim per child per service date, retaining only the service with the highest level of acuity. For example, a child may visit the outpatient clinic first, then is transferred to the emergency room because of acute illness and is later hospitalized. The service with the highest acuity (the hospitalization) also returns the highest reimbursement. We therefore followed a strategy similar to hospitals that are paid only for a single physician-related service per service date. Our strategy will slightly underestimate the total eligible claims, but removes a source of ambiguity in the data.

ANALYSIS

The analysis was conducted with STATA, 7.0. Multiple analytic techniques were used to evaluate patterns of service utilization. First, the intensity of physician-related visits during the year is summarized by type: outpatient (any reason), and asthma-related hospitalizations and emergency room visits. Regression (ordinary least squares and negative binomial) models identified characteristics of the child that have an impact upon the number of outpatient, emergency room, and hospitalization visits, and total claims during the year following the first visit. Because the site of the first visit was an independent variable, the dependent variable captured the number of visits in each category subsequent to the first visit. Ordinary least squares regression was appropriate for modeling the number of outpatient visits and total claims because the counts were distributed over a wide range, and could be reasonably approximated as continuous variables. However, because most children have zero emergency room and hospitalization claims, and the remaining children had few, negative binomial (count) regression was used to model the number of subsequent emergency room and hospitalization claims.

Each physician-related visit provides the opportunity for asthma management planning. The first asthma-related visit for the children in our sample marks the first observed opportunity for planning while in foster care. Dummy variables indicated site

of initial visit as independent variables in the model. Other independent variables were age, sex, race (African American or other), time in foster care prior to observed initial asthma-related claim, and year of initial foster care placement (1994 used as the base case). Since children in this sample entered foster care anytime between 1994 and 1997, year of entry likely modifies the effect of time in foster care prior to initial claim on the number of claims. A child entering foster care in 1994 can be in foster care for up to three years prior to the initial asthma-related claim and still be eligible for the study, while a child entering foster care late in 1997 must have the initial asthma-related claim filed almost immediately in order to be eligible. Children beginning foster care earlier in the study period (e.g. 1994) therefore had more opportunity to have the asthma-related claim and to still meet the other inclusion criteria. Therefore it was expected that children included in the study sample would differ both by the year in which they began foster care (controlled for with the year of foster care placement dummy variables) and in the time in foster care prior to diagnosis. The time in foster care prior to diagnosis will be longer on average for children beginning foster care earlier than for children beginning foster care later in the study period. Consequently, interaction terms between the year of foster care placement dummy variables and time spent in foster care variable were included. The impact of time spent in foster care therefore depends on both the time in foster care and the year in which foster care began, and is measured jointly by the coefficient on the foster care time variable and the coefficient on the relevant interaction term. The appropriate test of statistical significance is one that considers both terms, testing the hypothesis that "the time in foster care" and "the interaction between time and year of foster care placement" taken together do not affect the dependent variable.

The second set of analyses focused on follow-up medical care after asthma-related emergency room visits or hospitalizations. Based on clinical experience, a population of children who are well served medically should have outpatient follow-up within one month after an acute care visit. Further, a pattern of repeated sequential acute care visits is undesirable. In the sample as a whole, repeated sequential emergency room visits or hospitalizations were relatively rare, but their occurrence suggests a failure of outpatient continuity of care and may indicate problems of access to outpatient care, poor asthma management and/or severe asthma. Therefore, for both emergency room visits

and hospitalizations occurring in the first eleven months of the study period, the rate of outpatient follow-up within one month was calculated. For any asthma-related emergency room visits, the rate of 72-hour repeat asthma-related emergency room visits was calculated.

Results

The database contained 2020 children meeting the study eligibility criteria. These children were between 1.5 and 12 years of age, with an average of 5. Slightly more than half were male (53%). Approximately three quarters were identified as African American, nearly one-fifth (19%) were White, and 6% were Hispanic. On average, over the one year study period children had 4.96 claims (range 1-51), of which 4.3 (range 0-36) were for outpatient visits (Table 4.9). The average number of emergency room visits was 0.11 (range 0-3) and hospital stays 0.03 (range 0-2). The site of the first observed asthma claim varied among the 2,020 children with asthma as follows: 125 (6%) in the emergency room, 26 (1.3%) during hospitalization, 148 (7.3%) at the time of Medichek[21], 1,086 (53.8%) at an outpatient visit, and 635 at other sites.

[21] On a statewide level, the Department of Children and Family services in Illinois implemented two initiatives in the early 1990's. The Department mandated standardization of initial services, specifically instituting a brief, general medical screen at entry that focuses on injury, acute problems or communicable diseases requiring immediate treatment (MediChek); and a comprehensive medical evaluation three weeks later. It also established a health passport program focused on improving primary care for children in foster care (Healthworks).

One year claims history following the initial observed diagnosis

Using t-tests, subsequent claims were examined by type based on the initial site of care. Compared to all other initial sites of care, children seen first in the emergency room had three times the number of subsequent emergency room visits (p=.0009) and four times the number of subsequent hospitalizations (p=.0098). Children seen first at an outpatient visit had somewhat more subsequent outpatient visits (p=.0002). Children whose diagnosis was first made during a hospitalization had eight times the number of subsequent hospitalizations (p=.0056), more subsequent outpatient claims (p=.0007), and consequently, more subsequent total claims (p=.0000). Interestingly, the 198 children who had an asthma diagnosis first noted at the time of the Medichek visit had fewer subsequent total claims (p=.0077) and specifically less than half the number of subsequent outpatient claims (p=.0000) (Table 4.10).

Table 4.9 Medicaid Claims for Asthma for Children in the Care of the Department between 1994 and 1997.*

	Number of Claims
TYPES OF VISITS	
?? Outpatient	8743
?? Hospitalization	54
?? MediChek	770
?? Emergency room	220
?? Other	235
MEAN NUMBER OF VISITS PER CHILD (RANGE)	
?? Total claims	4.96 +/- 4.11 (1-51)
?? Outpatient	4.33 +/- 3.77 (0-36)
?? Hospitalization	.03 +/- .17 (0- 2)
?? Emergency room	.11 +/- .36 (0- 3)
SITE WHERE DIAGNOSIS OF ASTHMA OR ASTHMA/SICKLE CELL DISEASE FIRST RECORDED	
?? Outpatient	1986
?? Hospitalization	26
?? MediChek	148
?? Emergency Room	125
?? Other	635

*Data is for 2,020 children between ages of 1½ and 12.

Table 4.10 Site of Initial Visit

	Total Claims	Emergency Room	Hospitalization	Outpatient
Hospitalization ? ? All other	7.27*** 3.92	.04 .05	.08** .01	6.23*** 3.76
Emergency Room ? ? All other	3.70 3.98	.12*** .04	.04** .01	3.22 3.83
Outpatient ? ? All other	4.27*** 3.60	.05 .04	.02 .01	3.93 3.63
MediChek ? ? All other	3.09** 4.03	.02 .05	.01 .01	1.90*** 3.94

*p<.05; **p<.01; ***p<.001

Immediate follow-up after an emergency room visit

All emergency room visits occurring during the one year claims history were examined. These visits occurred independently of hospitalizations, as previously described. The first visit following this acute care visit was then noted along with when and where this next claim occurred. Of166 emergency room visits analyzed, three emergency room claims followed within 72 hours. Four additional emergency room visits were followed by another emergency visit within thirty days (without an intervening outpatient visit). Only seven emergency room visits were followed by an outpatient visit within 30 days (mean 11 days, range 4-21 days). Of note, 54 emergency room visits had no recorded follow-up claim in the one year study period. Some of these emergency room visits may not have had the opportunity for observed follow-up because the visit occurred close to the end of one year sampling time frame.

Child characteristics and initial asthma claim types to subsequent claim history

Ordinary least squares and negative binomial regression models identified the impact of child characteristics and initial asthma claim types to the number and type of subsequent claims. Among the child characteristics, African American children had fewer total claims (p=0.000) and had fewer outpatient claims (p=0.000)(Table 4.11). However, they also had more emergency room visits (p=0.006) subsequent to the diagnosis of asthma than other children. Younger children had more total claims (p=.000); specifically they had more outpatient visits subsequent to a diagnosis of asthma (p=.000), and more subsequent hospitalizations (p= .037). Boys had more total claims than girls (p=.025); specifically boys had more subsequent outpatient visits (p=.023). Among the claim types, compared to receiving asthma care first in the outpatient setting, hospitalization was positively and significantly associated with more total subsequent claims (p=.000) and more subsequent outpatient visits (p=.001). Receiving care for asthma initially at the time of medichek was negatively and significantly associated with total subsequent claims and fewer subsequent outpatient visits (p=.000). Duration of foster care placement prior to diagnosis was negatively associated with number of subsequent total claims (joint p-values < .000 for all years), subsequent emergency room visits (joint p-values < .000 for all years), and hospitalizations (joint p-values < .05 for all years) for each year in the study sample.

Table 4.11 Regressions on One Year Claims History following Initial Observed Diagnosis

Independent Variables	Total Claims	Hospitalization	Emergency Room	Outpatient
	Coefficient (t-stat)	Coefficient (t-stat)	Coefficient (t-stat)	Coefficient (t-stat)
Sex (female=0; male=1)	.3961* (2.24)	-.7788 (-1.95)	.0181 (.07)	.3619* (2.27)
Age (years)	-.1615*** (-5.49)	-.1619* (-2.08)	.0466 (1.16)	-.1844*** (-6.96)
African-American race (AA=1)	-1.2546*** (-6.16)	.6071 (1.20)	.9016** (2.72)	-1.3714*** (-7.48)
Duration of foster care prior to first observed diagnosis (years)	-.0013*** (-3.92)	-.0060* (-2.26)	-.0056*** (-3.67)	-.0003 (-.99)
Duration*year of entry 1995	-.0005 (-.86)	.0021 (.58)	.0019 (.95)	.0002 (.35)
Duration*year of entry 1996	-.0013 (-1.52)	.0028 (.77)	.0021 (.98)	-.0006 (-.82)
Duration*year of entry 1997	-.0013 (-.78)	-.0324 (-1.44)	.0016 (.53)	-.0004 (-.28)
Year of entry 1995	.8435* (2.49)	-.1085 (-.16)	.0806 (.19)	.3194 (1.05)
Year of entry 1996	.7501* (2.02)	-.1550 (-.23)	.0950 (.20)	.3615 (1.08)
Year of entry 1997	.8069 (1.62)	1.6889* (2.01)	.0159 (.03)	.3354 (.75)
Site of initial observed diagnosis: ER	-.4089 (-1.10)	1.0465* (2.03)	.6018 (1.66)	-.5723 (-1.71)
Site of initial observed diagnosis: MediChek	-.9792** (-2.84)	-.1350 (-.18)	-1.1996 (-1.89)	-1.8834*** (-6.06)
Site of initial observed diagnosis: hospitalization	3.0926*** (3.93)	1.3049 (1.67)	-.6277 (-.56)	2.3433** (3.31)
Constant	5.8137*** (19.58)	-2.788*** (-4.15)	-3.100*** (-6.67)	5.6928*** (21.29)

*p<.05; **p<.01; ***p<.001

DISCUSSION

Two types of relationships among medicaid claims for children in their first spell of foster care placement were demonstrated: 1) type and quantity; and 2) sequence. First, children who are African American used more acute care resources (emergency room visits) and fewer non-acute visits (outpatient services). Overall, they visited a physician less often than other children subsequent to the diagnosis of asthma. Younger children had more total claims, more outpatient visits, and were hospitalized more often subsequent to the initial diagnosis of asthma. Boys were seen in the outpatient setting more frequently than girls, but did not require more frequent acute care visits.

Second, two different types of children with asthma emerge by looking at the pattern of subsequent claims following the initial site of observation of asthma. Children whose first observed diagnosis occurs in the course of hospitalization are subsequently hospitalized much more frequently. They are also seen more frequently in the outpatient setting (note that emergency room visits that led to hospitalization would not be retained in our analytic sample). This may be due to several follow-up appointments for these sicker children as the inpatient care team establishes avenues for routine health supervision at discharge. These children may also represent a biologically more unstable group.

The data suggest that having the initial diagnosis made at the time of the Medichek signals a relative advantage for these children. These visits represent foster children who either came into foster care with the diagnosis of asthma or the physicians conducting the Medichek were astute enough to make the diagnosis up front. The children required fewer follow-up claims across the board, with no difference in the number of emergency room visits or hospitalizations. It is possible that the children were better served medically, either because they had better medical care prior to entry into foster care or because routine health supervision was quickly established following the Medichek. Alternatively, these children may represent a biologically more stable group.

Subsequent healthcare utilization observed when the first diagnosis occurs early during foster care placement presents an interesting conundrum when interpreting the reasons for the number of claims. In a well-served population, fewer acute care claims, and ultimately, fewer total claims suggest that a chronic illness is more stable, less symptomatic, and/or under better control. This interpretation may help to explain why fewer claims follow an asthma diagnosis observed first at medicheck, if in fact, these children had prior access to care for asthma. For most children entering foster care, however, it is expected that these conditions were suboptimal prior to placement. Therefore, for children entering foster care, especially perhaps early in the first episode, we predict a spike in the number of claims initially as the child receives "catch-up" care. Thus, under these circumstances, more is better. If over time the foster care system has succeeded in establishing better ongoing health supervision, then it would be expected that a new diagnosis of asthma made later during foster care placement might not generate as large an increase in number of visits. Thus the inverse relationship we observed between foster care tenure and number of claims indirectly supports improved routine health supervision over time after entry into foster care.

Lastly, back-to-back emergency room visits within 30 days occurred only about four percent of the time, split roughly evenly between immediate treatment failures (revisit within 72 hours) and repeat exacerbations requiring emergency room care within 30 days. Likewise, few children (4%) had short term outpatient follow-up after the acute care visit within 30 days. This data suggests that children in foster care do not use the emergency room as regular site of care, but early return to routine outpatient management was likewise rare. The elimination of 54 emergency room visits from the analysis because no follow-up was observed is likewise of concern. These findings represent a mixed review for access to routine health supervision in the outpatient setting.

The observation that African American children receive care more frequently in acute care settings and less frequently in non-acute settings with fewer visits overall may reflect geographical differences (urban versus rural), differences in health care-seeking behavior, access to care or disease characteristics. This finding is consistent with the previously mentioned studies documenting increased asthma morbidity among

African Americans. It is disturbing to note fewer outpatient services, a finding that implies less consistent routine health supervision. Nonetheless, the use of outpatient services was not small. While it is certainly possible that the children actually required more frequent visits to the doctor, the mean number of outpatient visits was 4.3 after elimination of service date duplications. This implies that, on average, children received regular services and that great increases might constitute a real caregiver (and child) burden. It is not possible to determine whether the types of services and providers were appropriate, well-configured and timely.

The greater number of outpatient claims among younger children may relate in part to the increased frequency of visits in the usual schedule of pediatric primary care for younger children. Another contributing factor maybe the increased visits at younger ages that may or may not be associated with asthma, but present the opportunity to review asthma management. As asthma in younger children may be associated with infection and other co-morbid conditions, as premature birth and bronchopulmonary dysplasia, it is not surprising that subsequent hospitalizations are increased in younger children.

It was not possible to compare children in foster care to a matched group of children on medicaid residing with natural parents, legal guardians or adoptive parents. Without this comparison, statements about the relative nature of health care utilization patterns cannot be made. Likewise, without a measure of disease severity (other than the number of claims themselves) we cannot begin to benchmark care against any standard expectations. Comparison groups are necessary in order to make statements regarding the health care utilization patterns relative to other children receiving medicaid, to other meaningful comparison groups or to the general population of children. Finally the number of children in this study receiving medical care that is not billed to Medicaid is unknown. It is likely that some medical services were received outside of the Medicaid system. The degree to which this might change the results of the analysis is a matter for further research.

REPORTING ON CHILD SAFETY AND PERMANENCY WITHIN THE CHILDREN AND FAMILY RESEARCH CENTER, SCHOOL OF SOCIAL WORK, UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

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Reporting on Child Safety and Permanency Within the Children and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign

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THE ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES INTEGRATED DATABASE

The Children and Family Research Center (CFRC) assesses permanency and safety outcomes of children served by the Illinois Department of Children and Family Services (DCFS). The data used to perform these tasks is derived from two separate DCFS administrative data systems. The Child Abuse/Neglect Tracking System (CANTS) data track allegations and findings of abuse and neglect reported to and investigated by DCFS. The Children and Youth Centered Information System (CYCIS) maintains detailed client, service provision, and payment records for children and families who receive DCFS child welfare services.

Four times a year DCFS sends data from CANTS and CYCIS to the Chapin Hall. Chapin Hall processes these data and sends them to the CFRC 4 to 6 weeks after the end of each quarter. The most important step in the processing conducted by Chapin Hall is linking and integrating data from the two systems. The CANTS and the CYCIS databases are maintained as separate information systems. One result of this separation is that, at present, there is no single and no consistently reliable identifier that can be used to

link records from one database to the other[22]. Chapin Hall relies on an automated probabilistic linking procedure to match the records from CANTS to those of CYCIS. The result is the Integrated Database, which contains in addition to the records represented in CANTS and CYCIS, several files representing linking variables. More recently, the Integrated Database has also included a series of files that contain a variety of codes representing geographic information about DCFS clients and providers.

The Integrated Database consists of millions of associated records. It contains information about abuse/neglect investigations, reports, and allegations; information regarding the individuals, both child victims and perpetrators who are, or are reported to be, involved in those allegations; information about both child and family cases; information on each placement for each case opened for each child in the care of DCFS; information regarding DCFS supervisors, case managers and service providers; information on the changing legal status of the child; adoption information; and information on payments to providers. Figure 1 (presented at the end of this paper) is an entity relations (ER) diagram representing the information contained in the Integrated Database and the relationships between various elements it contains.

The Integrated Database contains current and historical information on both child cases, that is, cases involving children who are wards of the Department, the majority of whom are in substitute care, and family cases. A family case file is one in which DCFS provides services to the family unit as a whole, some of whom have may have children in child cases, others of whom have no children in substitute care, and some of whom may be at imminent risk of having their children removed from the home.

Among information included in the Integrated Database are records from unfounded investigations, and older investigations subjected to expungement or

[22] Since December 1997, all workers are required to enter on the form opening a CYCIS case, the CANTS ID NUMBER that the child is given at the time of the investigation. Our reviews of the data indicated that compliance with that policy was initially substantially below 100 percent. More recently compliance has been quite good, and for the vast majority of cases there "reciprocal ids" exist. That is a CANTS ID in the CYCIS data and a CYCIS ID in the CANTS data for each child. Because this has not been a policy throughout the years and because that policy has not been uniformly applied since its inception, we continue to rely on the automated probabilistic linking procedure described.

purging[23]. Identifying information (names and addresses) regarding child victims and child and adult perpetrators are periodically removed from the CANTS data systems according to a schedule that is dictated by policy, has changed and continues to change, and contains a number of exceptions; the balance of information (including birth dates, demographic information, and subject identification numbers) for these records is retained. For example, after 39 days identifying information on individuals involved in unfounded allegations involving all but the most severe allegations expunged from CANTS. Likewise, identifying information is purged from indicated allegations after a specified number of years have passed, the number of years depending upon the severity of the indicated allegation.

These data systems of DCFS were developed as administrative information systems at a time when child welfare outcomes were not a high priority. In many cases data elements that would make outcome reporting or other research straightforward are not included in these systems. Consequently, when the CFRC reports on child safety and permanency, these reports reflect a variety of decisions made to translate existing data elements to desired outcomes measures. It is important to understand these decisions when interpreting outcome results. This paper presents the decision made in collaboration with DCFS and the Chapin Hall Center for Children (Chapin Hall) to produce safety and permanency outcome indicators.

CYCIS DATA

A Note About Units Of Analysis And Unduplication Of Records

The outcome measures the CFRC provides when reporting on the safety and permanency of wards of DCFS are generally presented at the level of the individual child. However, the basic level of measurement within CANTS is the allegation and in CYCIS,

[23] According to Patty Sommer (DCFS Quality Assurance, May 31, 2001): "Expungement is what happens to unfoundeds after X number of days (39 at a minimum, up to one year for more serious types of unfounded reports). Purging is what is done to indicated investigations after X number of years (5 at a minimum, up to 50 for most serious)."

the placement. In order to provide outcomes that characterize the child, records must be aggregated over several dimensions within each data set.

The "Spell." Generically, a "spell" is a measure of time - the period of time beginning with the child's placement in one particular living arrangement until the time the child is placed in a different living arrangement. How that living arrangement is defined determines how the "spell" is defined and how the data are aggregated.

At the lowest level of observation, a spell is defined as a living situation with a specified provider providing a specified type of service. The types of services are characterized under the rubric of "placement type." Each placement type is defined on the basis of a combination of two elements taken from CYCIS: type of service code (i.e., board payment code) and type of living arrangement, with type of service code given priority in defining child placement type. Twelve mutually exclusive and exhaustive placement types result: 1) Relative Care, 2) Family Foster Care, 3) Specialized Foster Care, 4) Group Home 5) Institutional Care, 6) Independent Living, 7) Subsidized Guardianship, 8) Adoption Subsidy (or Adoption Assistance), 9) Home of Parent, 10) Successor Guardian, 11) Adoptive Placement, and
12) Runaway/Missing/Unknown/Other. Defining spell in this manner, a spell is identified **both** by the type of service and by the provider of that service. Thus, for example, if a child moves, in succession, from foster care with one foster parent to foster care with another foster parent, the period of time spent with each foster parent is considered a separate spell. Similarly, if a child is placed into a foster home with a given provider, and that provider is subsequently licensed and paid as a "specialized foster care provider," if the child remains with the same provider, he or she experiences two separate spells as he or she "moves" from a regular foster care spell to a specialized foster care spell.

Spells may be aggregated or collapsed into conceptually "larger" spells. Take the two examples just presented in which a child moves in succession from one provider to another or from one type of service to another. The example, in which the child is cared for under a different type of service categorization but remains with the same provider, may be thought of as constituting one "provider spell." Likewise, the example in which a

child changes providers but remains in foster care may be conceived of as one "foster care spell."

Placement spells are often collapsed to define "Substitute Care[24] spells." As an example, if a child moves from one foster parent to another foster parent to institutional care in succession, the period of time beginning with the first foster care placement to the end of the child's tenure in the institution would constitute one "substitute care spell."

Spells may be "summed up" to create yet even larger categories of spells in care. For instance, an out-of-home[25] spell may be defined as beginning when a child enters substitute care, continuing after he or she moves to independent living, and ending when the child is placed in an in-home living arrangement or the case is closed.

Spells can be defined at the "case" level. "Case" and "child" are not synonymous. A given child may have one or more cases opened and/or closed discontinuously during his or her history with DCFS; a case is active during the time a child is a ward of DCFS. The beginning of the first placement/placement spell within a case and the end of the last placement/placement spell within a case correspond to the opening and closing, respectively, of a case. A child can experience from one to many placements/placement spells during the course of an open case. The period of time from the opening of a case until the close of a case defines a "case spell" and can therefore bracket multiple placement, provider, substitute care, and/or out-of-home spells.

This explanation has implications for considering what tabulated figures may represent in outcomes reports emanating from the CFRC. For example, where a table presents the total number of children in a given placement type in a given fiscal year, it is important to be aware that this number is the total number of children who had a least one placement spell of the type listed that lasted at least one day during the fiscal year in question. Calculations of this type represent aggregation over all placement spells over all cases for that child in a given fiscal year. Similarly, a table presenting the total number of children served by DCFS in a given fiscal year represents aggregation over all

[24] The following placement types are considered "Substitute Care": "Relative Care," "Family Foster Care," "Specialized Foster Care," "Group Home," "Institutional Care," and "Adoptive Placement'.

[25] Out of home placement include substitute care placements but also include such living arrangements as independent living.

placement spells and cases for a particular child in that fiscal year. It is the number of children who had at least one placement spell of any type that lasted at least one day during that fiscal year.

CANTS Data

Levels of observation in the CANTS system

Within CANTS, the basic unit of analysis is not the child; it is the allegation. More specifically, it is a particular allegation (one of a number of possible allegations) made against a particular caretaker toward a particular child. For a given report of a given investigation, a child may have up to 6 caretakers listed and for each caretaker there may be up to 11 allegations listed. Moreover, a given child may be part of multiple investigations in a given fiscal year (the time period outcomes are typically reported). Therefore, in order to report the number of children who were indicated victims of neglect in a given fiscal year, it is necessary to identify children who were part of at least one report in that fiscal year, who were involved in at least one allegation of neglect by at least one caretaker, and where that allegation of neglect was founded or indicated.

Linking reports to case opening

One consequence of maintaining separate CANTS and CYCIS separately is that there is no direct link between a given investigation of a given child to a child welfare case opening on that child. Therefore, to link case opening to an investigation a decision rule is used based upon DCFS policy. DCFS policy mandates that the final disposition of an investigation must be filed to the State Central Registry (SCR) within 60 days of the initial report of an allegation. Allowing 10 more days to make it to the data system, a report made from 60 days before until 10 days after a given case opening is considered to be the report of the investigation associated with that case opening. If there is more than one such report under this rule the most recent report is considered.

Identifying Lapsed Protective Custody Cases

Police and other "mandated" reporters[26] are empowered to take protective custody of children they deem at risk of abuse and/or neglect. However, if subsequent investigation and adjudication results in finding no credible evidence of abuse or neglect and/or no convincing reason to keep the child from his or her home, the child is returned home. Such situations are labeled "lapsed protective custody cases" and are typically excluded from our analyses of both safety and permanency. In order to exclude "lapsed protective cases" a seven-day rule is applied to the data: cases open less than 7 days are typically excluded from analyses of both safety and permanency. While this rule may eliminate some very short-term cases that should be counted, the number of these cases is thought to be very small relative to the number of lapsed protective custodies.

Multiple Allegations/Severity

Frequently, it is necessary to link a given case opening to a specific type of maltreatment. However, the number of alleged perpetrators (up to 6) and the number of allegations (up to 11) that can accompany one investigative report makes it difficult to associate a particular type of maltreatment with one incident. In these cases the "latest and greatest" decision rule is applied. In the application of this rule, for a given child, only the most severe allegation within a given investigation is retained. When there are multiple investigations that may be associated with a case opening, the rule, described above to link reports and case openings, is applied, and the most severe allegation within that investigation is selected.

Absence of Incident Date

Within CANTS, the date that a given report is made is recorded, but neither the actual nor approximate date of the reported incident is recorded. Among the reasons for this are 1) the inability of a party to identify when an alleged incident occurred; and 2) the abuse or neglect may have occurred over a period of time, rather than a definable

[26] Mandated reports include, but are not limited to teachers, medical personnel, DCFS and other social services personnel.

date. Therefore, report date is used as an approximation to incident date. The report date, however, only provides a rough estimate of the date that the incident occurred.

Since some maltreatment reports are retrospective, measures of abuse that rely on the incident date may overestimate the true rate of abuse. Of particular concern are those reports of maltreatment that are made during a child's placement in substitute care. Current empirical analyses on samples collected at two one-year intervals suggest a high rate of retrospective reporting within substitute care. Because sexual abuse is the most prevalent type of abuse reported retrospectively, rates of abuse/neglect in substitute care are reported as a range. The high end of the range includes all allegations and the low end of the range excludes sexual abuse allegations. The "true" rate of abuse/neglect within a given type of substitute care placement is thought to lie somewhere within that range.

Defining Recurrence

In the literature and in various reports from the CFRC, recurrence of abuse/neglect has been defined in different ways. In the annual outcome reports recurrence is defined as an indicated allegation followed by another indicated allegation over some period of time. In the analyses of DCFS's Child Endangerment and Risk Assessment Protocol (CERAP), recurrence is defined differently as an indicated allegation subsequent to an earlier investigation, whether or not the child was a victim in the initial investigation. In evaluating results, it is therefore important to consider how recurrence is operationally defined in the specific analysis.

Incomplete Data

One challenge in working with these and other secondary data sources is incomplete data. Data are missing or otherwise unreliable for a variety of reasons. Some elements of CANTS and CYCIS are incomplete because workers omit completing parts of DCFS forms. For example, at the time children enter care, information is typically recorded on the child's school status, educational level, and school progress. However, this information seems to be rarely updated over the case history. As a result, education information in CYCIS is treated as missing data.

A related example involves the CYCIS data element, "reason for placement termination." Information provided by Chapin Hall suggests that there is some inconsistency in the entering of this information and the codes used are often not very descriptive. Thus, this variable is treated as missing and not used in analyses performed by the CFRC.

Yet another example concerns missing birth dates. At times, a worker may not or cannot get the birth date of a particular individual, be he/she a child, a perpetrator, or another client. Or, the birth date may be incomplete, as for example, where a month and year of a child's birth date is recorded, but his/her day of birth is not. In the latter example, analytic software will treat the entire birth date as missing. Therefore, if the month and year are included in a birth date, but a day of birth is missing, birth date is "completed" by assigning the fifteenth day of the month as the birth day. In analyses where age is a crucial determinant of inclusion, applying this rule allows identification of more individuals.

Identification of a family case and differentiating intact from non-intact family cases

DCFS serves children in both substitute care and at home with their parents, distinguishing between two types of at home cases: intact family cases and nonintact family cases. Intact family cases are those in which no child in the family is concurrently in substitute care[27]. Conversely, a nonintact family case[28] is one in which at least one child in the family is concurrently in substitute care. The characterization of a family case can, however, change over time. As children leave a family case for substitute care and/or are returned from substitute care, a family case may change from intact to nonintact or nonintact to intact. Typically, CFRC reports on outcomes for family cases use the intact versus nonintact designation based upon the status of the case at the time

[27] A child may be living in an intact family and have a concurrent child case. This is because children with open child cases are sometimes cared for by their parents, in their homes. This typically occurs at the beginning of a case or at the end of a case. This practice is rare in Cook County and is more common in other areas of the state.

[28] The accepted label for family cases in which at least one child is in substitute care has changed several times over the course of the last few years. By agreement with IDCFS we have variably labeled these cases as "nonintact," "mixed," and "split custody" cases.

the case first opened. Therefore, if a family case opened concurrent with the placement of a child from that family, the family case is labeled a nonintact family case.

Most children with open child cases in the CYCIS system are also have concurrent family cases; services are typically provided to parents and to other children not placed. The converse is not true, however. Most children with open family cases do not have concurrent child cases. At any given time, DCFS serves approximately three times the number of children in intact family cases as they serve in substitute care. A significant number of children in both intact and nonintact family cases subsequently move to substitute care[29] and a large proportion of children in substitute care were placed via family cases.

Identifying Children in Family Cases

While DCFS works with many children and their adult family members as part of family-based, in-homes services, the Integrated Database does not currently include a reliable role identifier for who is who within these cases. The lack of a role identifier makes it difficult to compute safety and permanency results for this group of children because it is in fact difficult to tell which family members are children and which are adults. A series of logical inclusion and exclusion rules is used to distinguish between adult and child members of family cases.

All clients in the database who are part of a given family case are identified by linking the CYCIS Family Case Table (containing family case histories) to the Client Registration Table (containing all clients, adult and children, contained in CYCIS) and the Family Case Head of Household Table (containing information about the head of household for each family case). Selecting who among the family is a child is then a process of elimination.

First, to separate children from parents and other adults who are part of a given family case individuals identified as head of household are eliminated. Second, in some older CYCIS records, adult men and adult women with a given family case identification code were coded as "MM" and "WW" respectively; these are eliminated. Third, if the

[29] The number vary by race and other characteristic. Refer to Chapter 3 of the 2002 outcomes reports.

individuals less than fourteen years younger than the head of household are eliminated from the data set. Fourth, individuals over twenty-one years of age at case opening are eliminated. Fifth, individuals sixteen years or older and who were coded as "married," "divorced," "separated," or "widowed" are eliminated. However, individuals with a child case open on or after the family case open date, are by definition considered a child and preemptively retained in the dataset. Finally, all children born after the family case closed are not considered subjects for family case analysis.

Adoption

Changes in id number associated with adoption subsidies. Within the CYCIS system, adoption is usually accompanied not only by a change in a child's name, but in his or her CYCIS identification number as well. This made it virtually impossible to link historical CANTS and CYCIS information to adopted children. Recently, however, the Office of the Research Director of DCFS was able to obtain a "translation table" from DCFS that relates children's identification numbers within CYCIS both before and after the opening of adoption assistance cases. This has allowed investigation of the relationship between investigation and placement histories and post adoption outcomes.

Adoptive placements/adoption disruption. An adoptive placement is a placement in which the providers have agreed to consider or have formally decided to adopt a DCFS ward in their care. The adoption, however, has not been legally completed. In earlier versions of the Integrated Database, it was difficult to determine how many kids were in adoptive placements at a given time. The Integrated Database contains an indicator for an adoptive placement (a specific value of type of living arrangement), but adoptive placements are not routinely identified as such by workers. This is due to the fact that a change in living arrangement status of, for example, "foster home" to "adoptive placement" does not result in a change of payment code. Thus, there is not a real incentive for the worker to change the living arrangement code. The result has been that the number of children living in adoptive placements was significantly undercounted in earlier reports. In the last two years, a new dataset has been made available to as part of the Integrated Database. Derived from CMS Screens 46 and 47 of

the administrative data systems, a dataset was created that tracks adoptive placements. For each child in an adoptive placement, this dataset provides the date of the adoptive placement, characteristics of his/her adoptive families, and the finalization date of the adoption, where appropriate. However, this file does not contain historical information. Although not every adoptive placement results in a finalized adoption, there is no evidence of multiple adoptive placements in this adoption dataset; these data appear to be overwritten at the time of each new adoptive placement. While some historical information is therefore lost, CMS 46/47 data, in combination with placement data provide a rough assessment of pre-adoptive disruption. Adoption disruption is defined as occurring when, for a given child, a pre-adoptive placement does not convert to an adoptive home.

Adoption displacement. The Integrated Database does not contain an specific indicator for the number of former DCFS wards who are, at any given time, living at home with adoptive parents, nor does it contain an indicator of how many of these adoptions are temporarily or permanently disturbed. At the present time, over 90% of adoptions completed through DCFS are subsidized, typically until the children reaches 18. Therefore, the number of open adoption subsidy cases is used as an indicator of the number of children living with adoptive parents. In order to measure displacement,[30] defined as the movement of a child from a post-adoptive home, for any period of time, children in adoption subsidized cases were identified who fit at least one of two criteria. A child was identified as being displaced from a post-adoptive home if 1) during the adoption subsidy case, the child had a placement other than in the home of his/her adoptive parents; and/or 2) the adoption subsidy case closed before the child reached eighteen. Children in adoption-subsidized homes may be placed temporarily in "institutions," which include among other facilities, hospitals and other health care facilities. Because these adopted children are subsidized and have, in essence, open cases

[30] Displacement is the disturbance of an adoptive home post adoption. Displacement is the generic term for such disturbances, both temporary, as when a child is placed in a medical institution for some period of time and returns to his or her adoptive home and permanently, as when an adoption is terminated due to the death of adoptive parents. The latter is also referred to specifically as "adoption dissolution." Another term, "adoption disruption" describes disturbances in pre-adoptive placements that may occur when a substitute care provider considers adopting a child in his/her care but later reconsiders.

with DCFS, they are eligible for Medicaid; it is actually the Medicaid payment that is tracked in an institutional placement. While these children are counted in adoption displacement, other children, those adopted from IDCFS rolls and not receiving adoption subsidies, are excluded. These latter children are not counted in either the baseline number of children in adoptive homes nor in the number of children hospitalized (or otherwise institutionalized) but not covered by Medicaid.

Measurement of Safety in Substitute Care

Because there is no specific incident date, three 7-day decision rules are employed to maximize the chance that an incident of abuse and/or neglect is accurately linked to a stay in a particular placement. They are

1. All cases less than 7 days in duration are excluded. This is a common rule used in nearly all analyses; the rationale was described above.

2. Placements of less than 7 days in duration are excluded. This rule is imposed to eliminate very short-term placements, including normal hospital procedures.

3. Only reports made at least 7 days after the start of a given placement are considered as having occurred during that placement; reports made within 7 days of placement are excluded. A report recorded within 7 days of placement may, in fact, be a report of the incident(s) that prompted the removal of the child and placement into out-of-home care in the first place. This rule is also used to solve the problem of multiple reports being made for the same incident. Report date is not necessarily incident date; report date is used as a proxy for incident date, but the actual relationship between report and incident date is not discernible from CANTS. The actual incident data may have occurred quite some time before maltreatment was reported.

The Construct "Child Care Years"

When comparing outcomes across years, across placement types, across regions, age categories, or gender, simple percentages – the number of children who experienced a given outcome per 100 children (i.e., percentage) does not account for time

variations across the categories compared. Time is a factor that may covary significantly across comparison groups in addition to the number of children experiencing a given outcome across groups. For example, children placed in relative care tend to stay somewhat longer than do children in regular family foster care. Time in and of itself is a significant risk factor for maltreatment potential. For that reason it is useful to consider another rate in making these comparisons. To meaningfully assess the relative risk of maltreatment in relative versus family foster care requires constructing a rate that holds time constant across the two placement types. That rate is the number of children per 100 children who were in care for one full year.

A specific example using DCFS Fiscal Year 2000 data may make this clearer. In Fiscal Year 2000, the simple percentages of children maltreated in family foster care versus relative care were 1.7% and 1.2%, respectively. That is for every 100 children in care, there were 1.7 and 1.2 children maltreated in family foster and relative foster care, respectively. The conclusion is that family foster care is approximately 42% "riskier" for maltreatment. However, when it is entered in that children spent, on average, around 20 days less in family foster placements in FY 2001 than they did in relative care, the relative risk increases. In family foster care 2.6 children per 100 children in care for a full year were maltreated versus 1.7 children per 100 children in care for a full year in relative care- a 53% greater risk of maltreatment in family foster care versus relative care.

The mathematical formula to convert simple percentages to per childcare year rates is simple: Percentage x (365.35/mean duration in care). Examining the formula reveals the following relationship between simple percentages and per childcare year rates: To the extent that the mean duration of a group approaches a full year, the adjusted rate will approach the simple percentage; the lower the mean duration in care a given group experiences, the more the value of the adjusted rate will rise above the value of the simple percentage.

APPENDIX A

OPERATIONAL DEFINITIONS

OPERATIONAL DEFINITIONS FOR USE WITH THE IDCFS INTEGRATED DATABASE

Most of the safety and permanency outcomes indicators are constructed, directly or indirectly[31], from fields contained in the IDCFS Integrated Database. This joint project between the Department of Children and Family Services and Chapin Hall Center for Children permits tracking of indicators over a period of several years as well as providing a rich database for research purposes. To better assure consistent analysis across research projects, representatives from the Department, the Children and Family Research Center, and Chapin Hall Center for Children meet regularly to determine how best to define the important indicators and other variables used in the analyses presented in this report. We have agreed upon the following operational definitions.[32]

ADOPTED

A child was defined as adopted if
(1) he or she had a case closing reason (CLOSRSN) that was coded as 'CA' or 'RA' ("Completed Adoption" or "Relative Adoption," respectively) **AND** a next living arrangement type (ENDEVENT) coded as 'ZZZ' or 'ZZA'[33] (signaling case closed) **AND**
if case opening reason (opencode) was not coded as 'AA' ("Adoption Assistance")
OR
(2) he or she had a case closing reason was coded as 'SC' ("Services Completed") and current living arrangement (EVENT) was coded as 'HAP' ("Home of Adoptive Parent") **AND**
if case opening reason (OPENCODE) was not coded as 'AA' ("Adoption Assistance")

ADOPTIVE DISPLACEMENT

An adoptive displacement occurs when a child who is formally adopted comes back into the custody of the Illinois Department of Children and Family Services. Operationally, a child is recorded as adopted if he/she has a case opening code of 'AA' or 'RA'. A displacement is viewed to have occurred when 1) an adopted child appears in any placement type other than home of parent, regardless of the length of time she/he spent out of the home of the parent; or 2) when an adoption assistance case is closed before the child reaches the age of 18.

[31] In conducting analyses on child safety and permanency, the Children and Family Research Center made use of two datafiles derived from the IDCFS Integrated Database. These two files, the "HMR Monitoring File" and the "Master Events File," were created by Lucy Mackey-Bilaver of Chapin Hall who has provided much-welcomed support regarding their construction and use.

[32] The CFRC would like to acknowledge and thank Jim Gregory, Patty Sommer, Lucy Mackey-Bilaver, and Mark Testa for their work in constructing these definitions.

[33] These are codes in the "HMR Monitoring" and "Master Events" files only.

ADOPTION DISRUPTED

A child was designated as part of a disrupted adoption if his or her placement type was defined, as described herein, as an "Adoptive Placement (see below under Placement)" **AND**
if his or her next living arrangement (ENDEVENT) was not coded as 'HAP', 'HMA', 'FHA', or 'CEN'[34] **AND**
if the case closing date was missing (i.e., case is open).

ADOPTION DISSOLUTION

A subcategory of adoption displacement, that is, when the adopted child is placed out of the home, but he/she does not return to that home. An adoption is coded as dissolved when a CYCIS case opens under an 'AA' or 'RA' (adoption assistance) categorization and the case ends before the child reaches majority. These cases are categorized as adoption dissolutions under the assumption that the state is expected to provide the subsidy until the adoptive child reaches the majority of age.

AGE

While the calculation of a child's age at any point in time is a straightforward and trivial matter, determining a child's age over a period of time required adopting the following decision rules:

Age during a Placement Spell in a Fiscal Year. A child's age (in years) in a placement spell is defined as the difference between the last day of the placement of interest or, if the placement continued beyond the fiscal year in question, the last day of that fiscal year, and the child's birth date, divided by 365.25.

Age for a Placement Type in a Fiscal Year (In general) . The age of a child in a given type of placement in a given fiscal year is defined as the mean of a child's age in all placement types in that fiscal year.

Age for a Placement Type in a Fiscal Year (For safety analyses of child cases) . In the child case safety analyses, a child's age for a placement type in a fiscal year is determined by the last indicated report occurring within a given placement type in a given year. The formula = date of last indicated report during a given placement type in a given fiscal year– child's birth date / 365.25.

Age for a Child during a Fiscal Year (In general). The age of a child in a given fiscal year is defined as the mean age of the child across all placement spells in the fiscal year of interest.

Age for a Child during a Fiscal Year (For safety analyses of child cases). In the child case analysis, a child's age is determined by the last indicated report occurring while a child is in out of home placement in a fiscal year (i.e., the last placement in a given fiscal year). The formula = date of last indicated report occurring in a given fiscal year while the child is in placement – child's birth date / 365.25.

[34] "CEN" is a code used in the "HMR Monitoring" and "Master Events" files only to designate a continuing placement at the time the data were extracted or "pulled" from the administrative systems files.

Age Groupings. For presentation purposes, mean age is broken down into seven categories based upon increment of 3 years:

(1) Greater than 0 years and less than 3 years;
(2) Greater than or equal to 3 years and less than 6 years;
(3) Greater than or equal to 6 years and less than 9 years;
(4) Greater than or equal to 9 years and less than 12 years;
(5) Greater than or equal to 12 years and less than 15 years;
(6) Greater than or equal to 15 years and less than 18 years;
(7) Greater than or equal to 18 years.

ALLEGATION OF ABUSE/NEGLECT, SEVERITY OF

The 85 allegation codes from the Department's Child Abuse and Neglect Tracking System (CANTS) were grouped into 8 categories and ranked in terms of severity[35]. The 8 categories, in order of severity, from most severe to least severe are: Death, Sexual Abuse, Physical Abuse, Substance Exposed Infant, Emotional Abuse, Lack of Supervision, Environmental Neglect, Other Neglect, and Substantial Risk of Harm. In the Integrated Database they are coded from "1" to "8," with "1," "Sexual Abuse," being the most severe and "8," EnvironmentalNeglect" being the least severe.

(MOST RECENT AND MOST SEVERE) ALLEGATION TYPE LINKED TO A PLACEMENT

For purposes of unduplicated tabulation, the type of abuse or neglect linked to a particular placement is that which occurred most recently during the placement (the "latest") and the one that is the most severe (the "greatest.") Thus, among the allegations associated with the most recent report date, the most severe allegation was chosen based upon the severity ranking described above.

(IDENTIFYING A) CHILD IN A FAMILY CASE

We identify all clients in the database who are part of a given family case by linking the Family Case Table to the Client Registration Table by CASEID to CASEID and CASENO to CASENO and then linking the resulting file to the Family Case Head of Household Table by CASEID to CLIID and CASENO to CASENO. Selecting who among those clients is a CHILD is achieved by a process of elimination. To separate out children from parents and other adults who are part of a given family case we, first eliminate individuals identified as head of household by comparing CASEID, CASENO from the Client Registration Table to CLIID, CASENO of the Family Head of Household Table. If CASEID=CLIID and CASENO=CASENO, the individual is eliminated. Second, some older CASENO codes for adults are coded as "MM" for men and "WW" for women; we eliminate individuals with such codes for CASENO. Third, if the individual's birth date is less than fourteen years less than that of the head of household, he or she is eliminated from the data set. Fourth, if the individual's birth date is greater than twenty-one

[35] The severity rankings are courtesy of Lucy Mackey Bilaver of the Chapin Hall Center for Children.

years less that the date of the opening of the case, he or she is eliminated. Fifth, if the individual sixteen or more years greater than the date of the case opening and he or she is married, divorced, separated, or widowed, he or she is eliminated. Steps three through five however, are subject to one caveat. If the individual has a child case opening date that is the same or later than the family case opening date, he or she is preemptively considered a child and retained in the dataset despite fitting any of the above characteristics. Finally, all children with birth dates after the date the family case closed are not considered subjects for analysis.

COOK COUNTY/REGIONS VERSUS NOT COOK REGIONS/COUNTYIES

This variable was defined from the region variable found in CANTS and CYCIS. A value of COOK was defined as regions 2B, 6A, 6B, 6C, 6D, and 6N. All other regions were defined as NOT COOK.

EXIT TYPE (OUTCOME)

Exit type is more appropriately a measure of current status in the CYCIS system. At the time of each quarterly download of the administrative data systems, the child's status within the system is checked by examining the child's last placement record. Based upon this most recent placement within the most recent case for the child, exit type (or current status) is categorized into one of 15 exhaustive and mutually exclusive types:

1) If case closing reason is coded 'CD' then OUTCOME is coded "Child Deceased"

2) If the case is closed and the case closing date minus the child's birth date is greater than or equal to 18.00 years or the case closing reason is coded 'RM' then OUTCOME is coded as "Reached Majority"

3) If the case is closed and the last placement is coded as "Home of Parent" then OUTCOME is coded as "At Home, Case Closed"

4) If the child's last placement is "Home of Parent" and the case is coded as open and/or the child is listed as still in placement then OUTCOME is coded as "At Home, Case Open."

5) If the child's last placement is coded as "Adoption Assistance" or the case closing reason is coded as completed adoption or relative adoption then OUTCOME is coded as "Adopted."

6) If the child's last placement is "Subsidized Guardianship" or "Guardian Successor" and the case is open, then OUTCOME is coded as "Guardianship, Case Open."

7) If the child's last placement is "Independent Living" and the case is closed, then OUTCOME is coded as 'Case Closed in Independent Living."

8) If the child's last placement is coded as "Runaway," "Missing," "Unknown," or "Other" and event type is coded as "Runaway" and the case is closed, then OUTCOME is coded as "Case Closed as Runaway."

9) If the child's last placement is coded as "Relative Care," "Adoptive Placement," "Family Foster Care," Specialized Foster Care," "Group Home," or "Institution" and the case is closed, then OUTCOME is coded as "Case Closed in Substitute Care."

10) If the child's last placement in "Runaway," "Missing," "Unknown," or "Other" and event type is not coded as "Runaway" and the case is closed, then OUTCOME is coded as 'Case Closed for Other Reasons."

11) If the child's last placement is coded as "Relative Care," "Adoptive Placement," "Family Foster Care," Specialized Foster Care," "Group Home," or "Institution" and the case is open, then OUTCOME is coded as "Still in Substitute Care."

12) If the child's last placement is in "Independent Living" and the case is open then OUTCOME= "Case Open, Independent Living."

13) If the child's last placement is coded as "Runaway," "Missing," "Unknown," or "Other" and event type is coded as "Runaway" and the case is open then OUTCOME is coded as "Case Open, Child Runaway."

14) If the child's last placement in "Runaway," "Missing," "Unknown," or "Other" and event type is not coded as "Runaway" and the case is open then OUTCOME is coded as "Case Open for Any Other Reason."

15) Any other OUTCOME not coded above is coded as "All Other Outcomes."

DURATION IN CARE

Duration in care is defined as the number of days in a given fiscal year a child is in a particular type of care until the status of care under consideration changes. A change in care status may be precipitated by a change in placement (e.g., from Home of Parent to Substitute Care placement), or by a change in case type (e.g., from Intact Family Care to Substitute Care).

EXPOSURE ADJUSTED RATE

Exposure adjusted percentages are calculated as the number of children (who moved home, were placed in substitute care, were adopted, etc.) per 100 child years (in a particular placement type, in a given fiscal year, etc.). Alternatively stated the exposure-adjusted rate is the number of children (who moved, etc.) per 100 children in placement for 365.25 days (in a given fiscal year, placement type, etc.).

GUARDIANSHIP

Delegated Relative Authority**.** If a placement has a type of service code among the following: '0136', '3136', '4136', '6136', '8136', '9136','0137', '6137', '8137', or '9137' **OR**
the living arrangement is coded as 'DRA',
then the guardianship arrangement was defined as "Delegated Relative Authority."

Subsidized Guardianship. If the type of service arrangement was coded among the following: '0188', '0189', '0194', '0150', '0186', '0193' **OR**
the type of living arrangement was coded as 'SGH,'
then the guardianship arrangement was defined as "Subsidized Guardianship."

Successor Guardian.. If a placement had a type of service code among the following: '0126, '5126' '6126', '8126', '9126', '0176', '3176', '4176', '5176', '6176', '8176', or '9176' **OR**
the type of living arrangement was coded as 'GDN,'
then the guardianship arrangement was defined as "Successor Guardian."

INDICATED REPORT DURING A PLACEMENT

Only those indicated reports (FINDING='I") that were dated 7 or more days after the start of a placement and on or before the end of a placement were considered to have been indicated reports during the placement in question.

INTACT FAMILY CARE (AT FAMILY CASE OPENING)

A child was defined as being in intact family care if, at the time his/her family case opened, neither the child, nor any other children who were members of that family case also had a concurrent open child case. (A child case concurrent with a family case opening was: (1) a child case that lasted at least 7 days and (2) a child case that opened within 7 days before or within 7 days after the opening of the family case and closed more than 7 days after the opening of the family case, or a child case that opened any time before the family case opened and closed more than 7 days after the family case opened.)

INTACT FAMILY CASE

An intact family case was defined as an open family case in which no children who were members of that family case also had a concurrent open child case.

LINKING A CANTS INVESTIGATION TO A CYCIS CASE OPENING

A given CYCIS case opening for a particular child is linked to a CANTS investigation of that child and vice versa by the association in time between the investigation report date (REPTDATE) and the CYCIS case opening date (family case or child case OPENDATE) . For a particular child, an investigation is taken to be the investigation that initiates a case opening if the investigation report date falls within 60 days before up until 10 days after case opening. If more than one such report date fits this description, the most recent report date is selected.

LIVING ARRANGEMENT (see PLACEMENT)

(CHILD) MOVED FROM HOME TO SUBSTITUTE CARE

Children in Child Cases. A child was defined as moving from home to substitute care if he or she had a placement type of 'HMP' followed by a next living arrangement type (ENDEVENT) of among the following:
'DRA', 'HMR', 'HRA', 'HRL',
'FHB', 'FHI', 'FHP', 'FOS',
'FHS',
'DET', 'HHF', 'ICF', 'IDC', 'IMH', 'INS', 'IOP', 'IPA',
'IRS', 'NCF', 'YES', or
'GRH' **AND**
not having a case opening reason (opencode) of 'AA' or 'RA.'

Children in Family Cases**.** A child was defined as moving from home to substitute care if he or she was part of a family case and did not have a child case opening within seven days before or after the opening of the family case **AND**
after seven days of the opening of the family case, had a child case placement type of one of the following:
'DRA', 'HMR', 'HRA', 'HRL',
'FHB', 'FHI', 'FHP', 'FOS',
'FHS',
'DET', 'HHF', 'ICF', 'IDC', 'IMH', 'INS', 'IOP', 'IPA',
'IRS', 'NCF', 'YES', or
'GRH' **AND**
the child case opening did not have an opening reason (OPENCODE) of 'AA' or 'RA.

NONINTACT FAMILY CARE (AT FAMILY CASE OPENING)

A child was defined as being in nonintact family care if, at the time his/her family case opened, at least one other child member of the family case other than him/herself, also had a concurrent open child case at the time the family case was opened. (A child case concurrent with a family case opening was (1) a child case that lasted at least 7 days and (2) a child case that opened within 7 days before or within 7 days after the opening of the family case and closed more than 7 days after the opening of the family case, or a child case that opened any time before the family case opened and closed more than 7 days after the family case opened.)

NONINTACT FAMILY CASE

A family case was defined as a nonintact custody family case if at least one child, but not all children, who were members of that family case also had a concurrent open child case. Also known as "split custody" or "partially intact" family case.

OPEN CASE

An open case was defined as a case for which there is a missing case closing date ("CLOSDATE") at the time the data are extracted from the system. Applies to both child and family cases.

OUT-OF-HOME SPELL

If a spell in care began in any living arrangement type other than the following: 'HAP', 'HMP', 'SGH', 'RNY', or 'HHF', and ended in a living arrangement of among 'HAP', 'HMP', 'SGH', 'RNY', or 'HHF',
the spell was defined as an out-of-home spell.

OUTCOME (see EXIT TYPE)

PERPETRATOR LINKED TO AN INDICATED REPORT DURING A PLACEMENT

For purposes of unduplicated tabulation, the perpetrator linked to indicated report of abuse or neglect is the first listed involved caretaker who is associated with the most recent and the most severe allegation reported during a given placement.

PLACEMENT (LIVING ARRANGEMENT)

The variable "Placement" was defined on the basis of two fields from the Department's CYCIS database: type of service categorization ("TYPESERV") and child living arrangement type ("EVENT"[36]). In constructing each placement type, type of service categorization was given priority over child living arrangement type. Thus, placements were first defined on the basis of TYPESERV, and where type of service codes were not available for a given living arrangement, living arrangement type was used to define the placement. A set of 12 mutually exclusive and exhaustive placement types was created:

Relative Care. If the type of service arrangement was coded among the following:
'5106', '5115', '5136', '5153', '5154', '5191', '5192', '5193',
'5195', '5196', '9104', '9105', '9106', '9115',
'9136', '9153', '9154', '9161', '9176',
'0179', '5194',
'9903', '9904', '9905', '9914', '9944', '9959', '9103',
'9114', '9144', '9159',
'3179', '4179', '6179',

[36] A variable from the "HMR Monitoring" and the "Master Events" files, somewhat equivalent to the "typecode" field in the main IDCFS Integrated Database.

'8179', '8903', '8914', '8959',
'6903', '6904', '6905', '6914', '6944', '6959',
'0106', '0115', '0136', '0153', '0154', '0161',
'0176', '0179', '3106', '3136', '3153', '3154', '3161', '3176',
'4106', '4136', '4153', '4154', '4161', '4176', '5176', '6106',
'6115', '6136', '6153', '6154', '6161', '6176',
'8106', '8115', '8136', '8153', '8154', '8161', '8176', '8904', '8905',
'9137', '9140', '9160', '2940', '2960',
'9909', '9943', '9958', '7909', '7943', '9143', '9158',
'0169', '5179', '9179',
'7809', '7609', '7643',
'6169', '6909', '6943', '6958', '7609', '7643',
'7843', '8909', '8943', '8958',
'0137', '0140', '0141', '0160', '2140', '2160', '2640', '2669', '2840', '2860',
'6137', '6140', '6160', '8137',
'8140', '8160', '8169' **OR**
there was no type of service code **AND**
the type of living arrangement was coded as 'DRA', 'HMR', 'HRA', or 'HRL',
then placement was define as "Relative Care" or "Home of Relative."

Family Foster Care. If the type of service arrangement was coded among the following:
'0101', '0104', '0107', '0146', '0151', '0152', '0156', '0162',
'0211', '4026', '5101', '5104', '5107', '5126', '5151', '5152',
'5161', '9101', '9107', '9151', '9152', '9156',
'6101', '6104', '6107', '6126', '6151', '6152', '6156', '8101',
'8104', '8107', '8126', '8151', '8152', '8156',
'0102', '0155', '8102', '9102', '9155', '2902', '2102',
'6102', '6155', '2602', '9104' **OR**
there was no type of service code **AND**
the type of living arrangement was coded as 'FHB', 'FHI', 'FHP', or 'FOS,'
then placement was defined as "Family Foster Care."

Specialized Foster Care. If the type of service arrangement was coded among the following:
'0103', '0105', '0114', '0144', '0159', '5103', '5105', '5114',
'5159', '5144',
'6103', '6105', '6114', '6144', '6159', '8103', '8105', '8114',
'8144', '8159',
'0109', '0143', '0158', '7109', '7143', '7543', '9109',
'9169', '9103', '9105', '9114', '9143', '9144', '9158', '9159',
'6109', '6143', '6158', '7309', '7343', '7409', '7443',
'8109', '8143', '8158',
'7110', '7709', '7710', '7743' **OR**
there was no type of service code **AND**
the type of living arrangement was coded as 'FHS,'
then placement was defined as 'Specialized Foster Care."

Group Home. If the type of service arrangement was coded among the following:
'0203', '0222', '7202', '7203' **OR**
there was no type of service code **AND**
the type of living arrangement was coded as 'GRH,'
then placement was defined as "Group Home."

Institutional Care. If the type of service arrangement was coded among the following:
'0201', '0202', '0221', '0223', '0901', '7201', '0210', '0213', '0251', '7251',
'0206', '0207', '0216', '0217', '0218') **OR**
there was no type of service code **AND**
the type of living arrangement was coded as 'DET', 'HHF', 'ICF', 'IDC', 'IMH', 'INS', 'IOP',
'IPA', 'IRS', 'NCF', or 'YES,'
then placement was defined as "Institution" or "Institutional Care."

Independent Living. If the type of service arrangement was coded among the following:
'0163', '0167', '7267', '0267', '7167',
'0208', '0701', '0704', '0705', '0706', '0708', '0720',
'0723', '0724', '0725', '0801', '0804', '0805', '0806',
'0204', '7204', '7205', '9167' **OR**
there was no type of service code **AND**
the type of living arrangement was coded as 'ILO', 'ASD', or 'CUS,'
then placement was defined as 'Independent Living."

Subsidized Guardianship. If the type of service arrangement was coded among the following:
'0188', '0189', '0194', '0150', '0186', '0193' **OR**
there was no type of service code **AND**
the type of living arrangement was coded as 'SGH,'
then placement was defined as "Subsidized Guardianship."

Adoption Subsidy (or Adoption Assistance). If the type of service arrangement was coded among the following - '0126', '0301', '0313', '0314', '0315', '0316', '0300', '0324', '0326', '0323', '0331', '0333', '0332', '0334',
'0335', '0304', '0337', '0302', '0303', '0338', '0336', '0327' **AND**
the **case opening reason** (opencode) was coded as either 'AA' or 'RA',
then placement was defined as "Adoption Subsidy" or "Adoption Assistance."

Home of Parent. If there was no type of service code **AND**
the type of living arrangement was coded as 'HMP,'
then placement was defined as "Home of Parent."

Successor Guardian. If there was no type of service code **AND**
the type of living arrangement was coded as 'GDN,'
then placement was defined as "Successor Guardian."

Adoptive Placement (old). If there was no type of service code **AND**
the type of living arrangement was coded as 'FHA', 'HAP', or 'HMA,' or
"PREADOPT" was equal to 1, then placement was defined as "Adoptive Placement."
Because there appears to be much inconsistency in the entry of 'FHA', 'HAP', and 'HMA' codes by caseworkers and there are no specific type of service codes for adoptive placements, this definition of adoptive placements significantly undercounts the number of children in such placements. Therefore, another method, using another data table was instituted.

Adoptive Placement (revised). A child was counted as being in an adoptive placement if he/she had an adoptive placement date as entered in CMS screens 46 and 47. The duration of the adoptive placement extended from the adoptive placement date until the adoption finalization date, if there was a finalized adoption on record, or, from the adoptive placement date until the end date of the living arrangement in which the adoptive placement began.

Runaway/Missing/Unknown/Other. If there was no type of service code **AND** the type of living arrangement was coded as 'RNY', 'MIS', 'UNK', or 'OTH,' then "PLACEMENT" was defined as "Runaway/Missing/Unknown/Other."

PRIVATE (PAYMENT OF SERVICES) VS DEPARTMENT PLACEMENT

If type of service arrangement was coded as one of the following: '9137',
'9140','9160', '2940', '2960', '9909', '9943', '9958', '7909', '7943',
'9143', '9158,
'0169', '5179', '9179',
'7809', '7609', '7643,
'6169', '6909', '6943', '6958', '7609', '7643,
'7843', '8909', '8943', '8958,
'0137', '0140', '0141', '0160', '2140', '2160', '2640', '2669', '2840',
'2860,
'6137', '6140', '6160', '8137',
'8140', '8160', '8169',
'0102', '0155', '9102', '9155', '8102', '2902', '2102',
'6102', '6155', '2602',
'0109', '0143', '0158', '9109', '7543', '0243', '7109', '7143', '9169',
'8109', '8143', '8158', '7409', '7443',
'6109', '6143', '6158', '7309', '7343',
'0163', '0167', '0208', '0720', '0704', '0705', '0706',
'7204', '0204', '7205', **OR**
if living arrangement type was coded as 'FHP' **AND** there was **no** type of service code, then the placement was defined as under the auspices of a private agency.

'5106','5115','5136','5153','5154','5191','5192','5193',
'5195','5196','9104','9105','9106','9115',
'9136','9153','9154','9161','9176',
'0179', '5194',
'9903','9904','9905','9914','9944','9959','9103',
'9114','9144','9159',
'3179','4179','6179',
'8179','8903','8914','8959',
'6903','6904','6905','6914','6944','6959'
'0106','0115','0136','0153','0154','0161',
'0176','0179','3106','3136','3153','3154','3161','3176',
'4106','4136','4153','4154','4161','4176','5176','6106',
'6115','6136','6153','6154','6161','6176',
'8106','8115','8136','8153','8154','8161','8176','8904','8905',
'0101','0104','0107','0146','0151','0152','0156','0162','0211','4026',
'5101','5104','5107','5126','5151','5152','5161','9101',
'9107','9151','9152','9156',
'8101','8104','8107','8126','8151','8152','8156',
'6101','6104','6107','6126','6151','6152','6156',
'0103','0105','0114','0144','0159','5103','5105','5114', '5144','5159',
'8103','8105','8114','8144','8159',
'6103','6105','6114','6144','6159',

'0163','0167','7267','0267','7167','0208','0701','0704','0705',
'0706','0708','0720','0723','0724','0725','0801','0804',
'0805','0806', '0203','0222','7202','7203','0201','0213','0221','0223',
'0901','7201','0251','0202',
'0186','0193','0188','0189','0194','0150', **OR**
if type of living arrangement was coded among one of the following:
'HMR','DRA','ASD','CUS','ILO', 'FHA','FHB','FHI','HAP','FHS', 'HMP',
'DET','HHF','IMH','IDC','GRH','OTH','RNY','IPA','NCF',
'IRS','ICF','YES','MIS','PND','UNK','SGH','FOS','HRA',
'HRL','INS','IOP','GDN','IND' **AND** there was **no** type of service code,
then the placement was defined as under the auspices of the Department of Children and Family Services,.

RACE

Seven codes defined ethnicity: 'AO' for Asian; 'BL' for African-American; 'HI' for Hispanic; 'NA' for Native American; 'OT' for Other; 'UK' for Unknown; and 'WH' for White.

RECURRENCE OF ABUSE/NEGLECT

In the annual report, we take a strict definition of recurrence. Abuse/neglect is accepted as recurring when an initial indicated allegation of abuse or neglect is followed by another indicated allegation at some time in the future. In this report, we identify the number of children with at least one indicated allegation ("FINDING" = "I") occurring in a given fiscal year followed by at least one subsequent indicated allegation six months and 12 months after the initial indicated allegation. We then compare this number to the total number of children with indicated allegations in the fiscal year.

REGION

In analyses by region, a new six-category variable was derived by collapsing some and eliminating some of the 50 codes DCFS assigns to their "Assigned Region" ("REGION") field. Region is defined in this report as:

The Northern Region, created from the Rockford region ('1A') and the Aurora region ('2A');

The Central Region, created from the Peoria region ('1B'), the Springfield Region ('3A'), and the Champaign Region ('3B');

The Southern Region, created from the East St. Louis region ('4A') and the Marion region ('5A');

The Cook County North Region, created from Cook County North region ('6B'), and of the following Chicago region/site/field combinations:
'2B0113'-'2B0158','2B0204','2B0207'-'2B0209','2B0212','2B0216',
'2B0231'-'2B0232','2B0236','2B0238','2B0264','2B0267',
'2B0270','2B0274','2B0515','2B0540'-'2B0541','2B0549',
'2B0552','2B0554'-'2B0555',
'2B0560'-'2B0561','2B0564','2B0568','2B0570','2B0598','2B0731','2B0766',
'2B0767'

The Cook County Central Region, created from Cook County Central region ('6C'), and of the following Chicago region/site/field combinations:
'2B0403'-'2B0490','2B0502','2B0518','2B0544','2B0548','2B0553','2B0551',
'2B0557'-'2B0559','2B0565'-'2B0566','2B0569','2B0573','2B05- ',
'2B0756','2B0757'

The Cook County South Region, created from Cook County South region ('6D'), and of the following Chicago region/site/field combinations:
'2B0201'-'2B0203','2B0206','2B0210','2B0211','2B0213'-'2B0215',
'2B0217'-'2B0219','2B0221'-'2B0230','2B0234'-'2B0235','2B0237',
'2B0261'-'2B0263','2B0265',
'2B0268'-'2B0269','2B0271'-'2B0272','2B0273','2B0275'-'2B0399',
'2B0516','2B0542'-'2B0543','2B0545'-'2B0547','2B0550','2B0556',
'2B0562'-'2B0563','2B0567','2B0572','2B0574','2B05--',
'2B0768','2B0787'

REENTRY INTO SUBSTITUTE CARE

A child was defined as reentering substitute care if his/her case opening reason (opencode) was not coded as 'AA' or 'RA', the child had been placed in at least one substitute care placement (See below under "Substitute Care" for definition.) previously, was reunified into a home-of-parent placement (See above under "Placement" for definition.) and then subsequently placed into a substitute care placement at a later time. There need not be direct replacement into substitute care from home of parent to be recorded as a reentry into substitute care. For the purposes of the report, only the first reentry from the first return from the first substitute care placement in the child's first case is recorded.

(CHILD) RETURNED HOME FROM SUBSTITUTE CARE

A child was defined as returning home from substitute care if the case opening reason (OPENCODE) was not coded as 'AA' or 'RA', the child had been placed in at least one substitute care placement (See below under "Substitute Care" for definition.) and was reunified into a home-of-parent placement (See above under "Placement" for definition.). There need not be a direct substitute care placement to home-of-parent placement transition, nor does the case need to have been closed at reunification. For the purposes of the report, only the first return from the first substitute care placement in the child's first case is recorded.

SUBSTITUTE CARE

Substitute Care was defined as encompassing the following Placement types:
"Relative Care," "Family Foster Care," "Specialized Foster Care," "Group Home," "Institutional Care," **OR**
having a type of living arrangement ("EVENT") of 'FHA.' (Foster Home Adoption)

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