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

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

Children and Family Research Center

2008

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A report by the
Children and Family Research Center
School of Social Work
University of Illinois at Urbana-Champaign

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2008

ACKNOWLEDGEMENTS

The production of this report is the culmination of efforts on behalf of many, if not most, of the staff at the Children and Family Research Center, and we thank each of them for their contributions to this report.

This year will be the last year when Mark Testa will serve as co-editor of this report, as he is stepping down as Center Director and has accepted a position as the Spears-Turner Distinguished Service Professor in the School of Social Work at the University of North Carolina at Chapel Hill. This report is a result of Mark's dream to present research in a way that would be meaningful to both researchers and field staff, and meet the reporting requirements of the B.H. consent decree. Under Mark's direction we have been guided by foster youth and front line staff at DCFS and POS agencies who keep our work grounded, and by our colleagues at DCFS and at other universities who have collaborated with us. We are grateful to these individuals and institutions for their contributions, but particularly to Mark for his leadership and commitment to making this report meaningful to so many. We will miss working with him on a daily basis, but look forward to our continued collaboration with him at UNC.

Also departing from the Center this year are Catherine Cutter, Christine Bruhn and Mary Gomberg. Catherine has, among her many tasks, assisted in the editing, proofing, and design of the Conditions of Children report and her expertise and humor will be missed. Chris has led the Center's work on well-being for the many years, and the depth of her knowledge and commitment will be sought out as she continues as a Center Research Fellow while at Aurora University. Mary's work has been less obvious, but without her diligence in ensuring that each and every piece of data that comes to the Center is accurately counted and accounted for, we would not have such secure and clean data, and our work would be far more difficult. We will miss her "heart of a librarian" and her inspiring quilts.

We would also like to acknowledge the contributions of our colleagues at the Illinois Department of Children and Family Services, specifically James A. Gregory, Patty Sommers, and Richard Foltz who have, for a number of years, consulted with us on data-related issues. We would also like to acknowledge that our colleague Jim Gregory will be retiring this year, and we are indebted to him for helping us understand the ins and outs of DCFS data. He has been a wonderful colleague and friend.

Thank you to our reviewers Alan Dettlaff, Sonya Leathers, Jess McDonald, and John Poertner for their assistance prior to publication, and to Rod Roberts, of Roberts Design Company, for the graphic design of the report.

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ACCOUNTABILITY FOR CHILD WELFARE OUTCOMES

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

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

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

- **Safety:** Children's safety is the primary concern of all child welfare services, particularly the safety of children who have been identified as maltreatment victims.[1]
- **Stability:** Children are entitled to a stable and lasting family life and should not be deprived of it except for urgent and compelling reasons.[2]
- **Continuity:** Children should be placed in a safe setting that is the least restrictive (most family like) and in close proximity to the parents' home.[3]
- **Permanence:** Every child is entitled to a guardian of the person, either a natural guardian by birth or adoption or a legal guardian appointed by the court.[4]
- **Well-Being:** Children should receive adequate services to meet their educational, physical and mental health needs.[5]

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

Missing from this year's report is the youth voice. In prior years the Center operated a program that sought youth voice on a variety of topics, and we used their input to guide our research agenda and to bring our research to life.

1 U.S. Department of Health and Human Services. (2004). *Child welfare outcomes 2001: Annual report. Safety, permanency, well-being*. Washington, DC: U.S. Government Printing Office.
2 First White House Conference on the Care of Dependent Children, January 25, 1909.
3 U.S. Social Security Act, Sec. 475. [42 U.S.C. 675].
4 U.S. Children's Bureau (1961) *Legislative guides for the termination of parental rights and responsibilities and the adoption* of children, No. 394, Washington, DC: U.S. Department of Health, Education, and Welfare.
5 U.S. Department of Health and Human Services. (2003). *Child and Family Services Reviews onsite review instrument and instructions*.

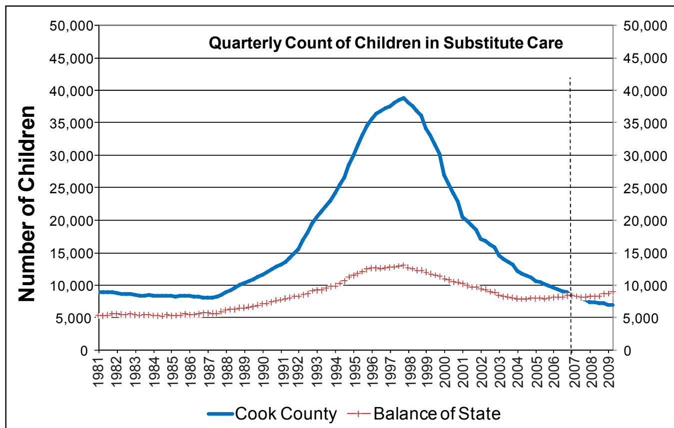
Regrettably, this program lost funding and our report lacks their profound insights. It is our hope that this work will be funded again in the future.

Another change with this report is that we have tried to limit the focus of the report to trends over the past seven years. In previous reports we have begun each chapter with a summary of the history of the subject. We have done this for three years and will focus on more current trends in this report. For readers who seek the historical perspective, we direct you to previous reports available on our website: http://www.cfrc.illinois.edu

CASELOAD DYNAMICS

While the focus of this report is the state of child welfare in Illinois over the past seven years, in this section we find it useful to go back to the early 1980s to lend some perspective and understanding of where we have been and where we may be headed. One of the biggest changes in Illinois' child welfare history is the increase in children in foster care in Cook

Figure I.1 Quarterly Count of Children in Substitute Care



County in the decade spanning 1987 to 1997 -- an increase of 359%, from approximately 8,500 children to 39,000 children, and the subsequent 457% decrease in Cook County to just under 7,000 children in 2007. In addition, the most recent data the caseload outside Cook has surpassed the number of children in care in Cook (*see Figure I.1*). By comparison, the change in the caseload in the rest of the state (or Balance of the State (BOS) increased from 6,000 to 13,000 between 1987 and 1997, an increase of 117% and declined 44% to just over 7,000 children in 2007. Currently there are more foster children living outside of Cook than there are living in Cook – a trend the state has not seen in quite some time.

Figure I.2 Cook County Caseflow Dynamics

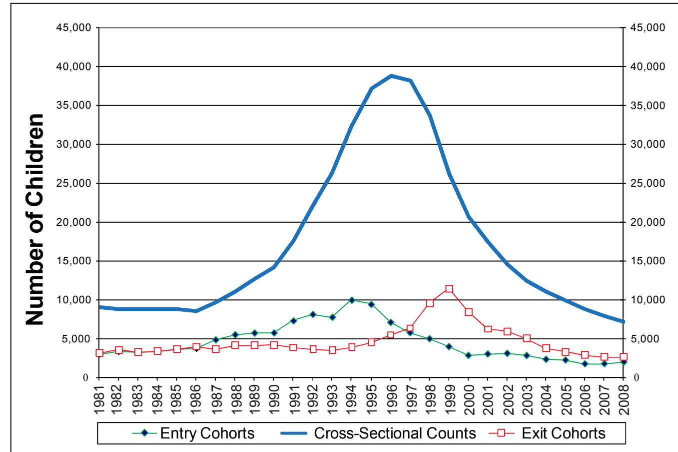
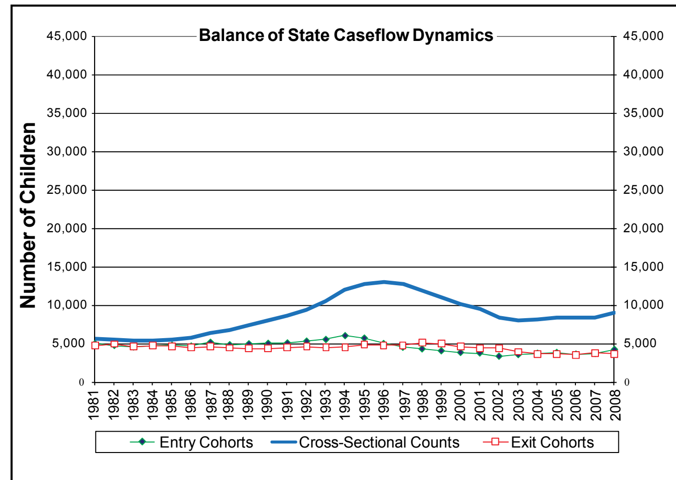


Figure I.3 Balance of the State Caseflow Dynamics



In Cook County we see that the decrease in caseload began when exits from foster care began to exceed entries into foster care (*see Figure I.2*) in 1997, and exits have been higher than entries in Cook each year since 1997. By contrast, the BOS (*Figure I.3*) has not reached this milestone – entries into foster care and exits from foster care have remained remarkably stable and as a result, the number of children in care has not decreased as drastically in the BOS as it did in Cook. The BOS caseload went from approximately 6,000 in 1987 to 13,000 in 1997, and is currently about 9,000. Clearly the reforms of the past decade which resulted in the drastic change in caseload have had a much larger impact on the caseload in Cook than they did in the BOS.

Figure I.6 Cook County Exits from Foster Care

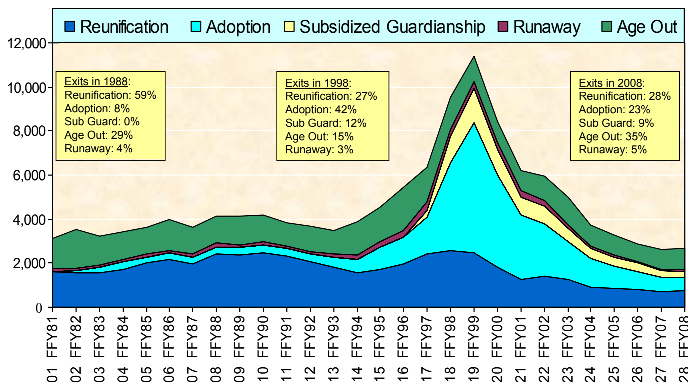
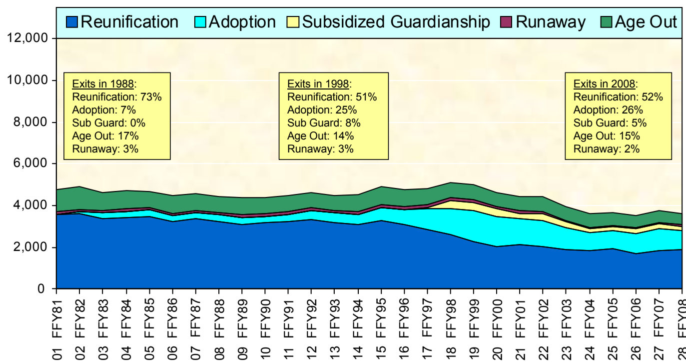


Figure I.7 Children Exiting from Foster Care Balance of the State



To explore these dynamics, we looked at the type of exits from foster care. In Cook County, in 1988, 59% of exits were reunifications, 29% were youth who aged-out of care, 8% were adoptions and 4% were runways. A decade later, by 1998, reunifications made up 27% of all exits, adoptions and guardianships 54%, age-out 15% and runaways 3%. More recently, reunifications make up 28% of exits, 32% are adoptions or guardianships, 35% are age-out and 5% runaways.

As shown in *Figure I.7,* exits from foster care in the BOS have not changed as dramatically, but the overall numbers have steadily decreased, from about 4,500 in 1987 to 3,600 exits in 2008, and the makeup of the exits has changed. In 1988, 73% of exits were reunifications, and 7% adoptions. By 2008 this changed to about half of all exits were reunifications (52%) and 31% adoptions or guardianships and 15% were youth who aged-out of foster care.

One question this raises is what is the correct mix of type of exits from foster care? Is it better for children to exit to adoption or guardianship where their stability of placement is more guaranteed, or should our focus be on increasing reunifications, and working to make those placements more stable? Given the large percentage of children ageing out of care we need to ask whether we are adequately preparing the children for adulthood. Chapin Hall Center for Children has taken the lead in identifying and assessing the needs of this population. Chapin's research on this issue helped inform provisions of the Fostering Connection Act that impact this population. Understanding the needs of children and youth as they exit foster care – through any of these pathways – is critical if we want to successfully assist vulnerable children and families.

FOSTERING CONNECTIONS TO SUCCESS AND INCREASING ADOPTIONS ACT

Passage of the Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351) in October, 2008 is the most significant piece of child welfare legislation in the past decade. The legislation promotes the finding of permanent families for foster children by supporting relative guardianships and adoptions. In addition, provisions in the legislation support the improvement of health care, education, and the extension of federal support for youth to age 21. The law also provides significant protections and supports for American Indian children. Many of the components of this federal legislation were a direct result of research from Illinois and key provisions of the act were crafted by Illinois U.S. Reps. Danny Davis, Timothy Johnson, and Jerry Weller. Research out of the Children and Family Research Center formed the foundation for the relative guardianship provisions. For the past decade, Center Director Mark Testa has led a study in Illinois, later replicated in Tennessee and Wisconsin, which introduced the idea of Subsidized Guardianship. This research showed that providing kin with an alternative to adoption, when reunification can not be achieved, was successful in increasing the number of children exiting foster care to permanent homes. Based on this research, the Fostering Connections Act provides all states the option to implement a subsidized guardianship program. Testa predicts that nationally over 20,000 foster children could find safe, permanent homes each year with the support of federal funds to support caregivers' becoming legal guardians. In addition, research from Chapin Hall Center for Children has consistently shown that foster children exiting the system at the age of 18 were not ready to emancipate, and needed additional support from the child welfare system. These findings were instrumental in the components of the legislation that allow states to provide funding to support youth up to the age of 21.

Box I.1—**Provisions of the Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351)**

The passage of the Fostering Connections to Success and Increasing Adoptions Act is a significant step forward in helping children and youth in foster care or at risk of entering the formal foster care system. The legislation promotes the finding of permanent families for foster children by supporting relative guardianships and adoptions. In addition, provisions in the legislation support the improvement of health care, education, and the extension of federal support for youth to age 21. The law also provides significant protections and supports for American Indian children. The Act has many components and the provisions are outlined below.

I. Relative Care

A. Kinship Guardianship Assistance (Effective October 7, 2008) States will have the option of using federal Title IV-E funds to support kinship guardianship payments for children living in the homes of relative foster parents who become the children's legal guardians. To be qualified for this program, a child must be living in the home of the relative for six consecutive months and be eligible for federal foster care maintenance payments for those same six months. In addition to qualify for the program, adoption and reunification must be ruled out as viable permanency alternatives for the child. As long as one member of the sibling group living in the same home qualifies for guardianship assistance, other siblings in the home may receive guardianship assistance even if they do not meet all of the criteria. Children eligible for guardianship assistance are eligible for Medicaid and those that exit the system to kinship guardianship after age 16 will be eligible for independent living services such as education and training vouchers.

B. Notice to Relatives (Effective October 7, 2008) The act requires state agencies to provide legal notice to a child's grandparents and adult relatives within 30 days of being removed from his or her home. State agencies may get information from the Federal Parent Locator Service.

C. Licensing Standards The act states that on a case by case basis, states may waive non-safety licensing standards, such as square footage and required bedrooms per person. The waiver of such requirements should eliminate barriers to placements with relatives. The act requires USDHHS to submit a report to Congress that examines the use and impact of the waivers on children in foster care.

II. Adoption

A. Special Needs Adoptions (Phase in October 1, 2010-October 2018) The act increases the number of special needs children who meet the criteria to qualify for adoption assistance by de-linking the child's eligibility for adoption assistance from AFDC income requirements. In sum, the child's eligibility is no longer tied to the income of the parent(s) from whom he or she was removed. Children who are eligible for SSI because they meet medical and disability criteria will automatically be considered children with special needs without consideration of SSI income requirements. The expansion of the population of children who are eligible for adoption assistance payments will be phased in over a nine years.

The Adoption Incentive Grant Program is renewed for another five year period, it doubles incentive payments for special need and older ward adoptions, updates to FY 2007 the adoption baseline used to determine incentive payments, and allows states 24 months to use the incentive payments. Additional payments will also be made available to states if the adoption rate exceeds the highest recorded adoption rate since 2002.

B. Supports for Older Youth (Effective October 7, 2008) Children age 16 years and older who are adopted from foster care or exit care to a relative guardian are eligible for independent living services.

C. Tax Credit (Effective October 7, 2008) States are required to notify all prospective adoptive parents of children in state custody that they may be eligible for the adoption tax credit.

III. Siblings and Family Connection

A. Placements for Siblings (Effective October 7, 2008) States must make reasonable efforts to place siblings together unless it is determined not to be in the best interest of the siblings. If siblings cannot be placed together efforts must be made to provide frequent visitation as long as it does not adversely affect the siblings' safety and well-being.

B. Family Connection Grants (Available 2009) New grant programs designed to help families of children in foster care or at risk of entering foster care will be funded through Subpart 1 of Title IV-B. The programs include: 1) kinship navigator programs; 2) intensive family-finding efforts; 3) family group decision making meetings; and 4) residential family substance abuse treatment programs.

IV. Older Youth

A. Federal Support (Effective October, 2010) States will be allowed to receive IV-E reimbursement for providing care and financial support to youth in foster care until 19, 20, or 21 if the youth is completing high school or an equivalency program, enrolled in post secondary or vocational school, participating in a program designed to remove barriers to employment, employed no less than 80 hours per month, or incapable of doing the above because of a medical condition. This applies to youth living in independent living settings as well as foster family and group homes. Adoption and guardianship assistance can also be extended for this same population.

B. Transition Planning (Effective October 7, 2008) During the 90 day period prior to a youth aging out of foster care, the child's caseworker and other professional staff as appropriate must help the youth develop a transition plan that includes details on housing, health insurance, education, local opportunities for mentoring, continuing support services, work force support, and employment services.

V. Health and Education

A. Health Oversight (Effective October 7, 2008) The state child welfare and Medicaid agencies must collaborate to develop a plan for on-going oversight and coordination of health care services for children in foster care.

B. Educational Stability (Effective October 7, 2008) States are required to coordinate with local education agencies to ensure that children remain enrolled in the school that they attend at the time of entry into the foster care system unless it is contrary to the child's best interest. To support this provision, increased dollars have been made available to support education related transportation costs. States must also ensure that all children receiving adoption and guardianship subsidies are enrolled as full-time students or they have completed their secondary education.

VI. Professional Quality Improvement

Training (Effective October 7, 2008) The availability of federal Title IV-E training dollars has been expanded to cover staff from private child welfare agencies, court personnel, attorneys, guardian ad litems, and court appointed special advocates. Dollars can also be used to train prospective relative guardians and foster and adoptive parents.

VII. American Indian Children

Direct access to Federal Funds (Effective October 1, 2009) Tribes or tribal consortia no longer need an agreement with state government to access IV-E funds. In addition to the continued use of agreements, the act allows for direct access and administration of Title IV-E foster care and adoption assistance funds by tribes. The act also allows tribes to access a portion of the state's Chafee Foster Care Independence Program funds and requires the tribe, in turn, to provide independent living services for eligible tribal youth.

This summary was provided by Leslie Cohen, CFRC based on a summary of the legislation by the Children's Defense Fund and the Center for Law and Social Policy (October 14, 2008): HYPERLINK "http://www.clasp.org/publications/FINAL_FCSIAA_LongSummary.pdf"

IMPACT OF THE FOSTERING CONNECTIONS ACT IN ILLINOIS[6]

The impact of the new Fostering Connections Act's on Illinois' child welfare system, and how the Department will meet new guidelines (where applicable), are discussed below.

I. Relative Care

A. Kinship Guardianship Assistance The Fostering Connections to Success and Increasing Adoptions Act will allow Illinois to continue to offer subsidized guardianship as a permanency option for children who leave foster care to guardianship with a relative. It is important to note that this requirement differs from the criteria outlined in the Illinois Subsidized Guardianship Waiver Demonstration Program. Under the waiver, guardianship with a non-relative is permitted and federally supported. The new legislation makes no provision for federally supported guardianships with non-relatives. Under the federal definition, children will be eligible for the new Kin Guardianship Assistance Program if they have lived with their relative for six consecutive months and are eligible for Title IV-E maintenance payments. The legislation further stipulates that in order for the state to claim federal dollars, the child must live in the home of the licensed caregiver for six months. However, Illinois has stipulated that children who are 14 years old or older who have lived with a licensed non-relative for at least 6 consecutive months immediately prior to establishing a subsidized kinship guardianship would be eligible, and paid for with state funding (not federally reimbursed). Furthermore, Illinois has stated that children will not need to be IV-E eligible to be eligible for guardianship (again this would not be federally reimbursed).

The law makes it easier for relatives to obtain licensure by allowing states to waive non-safety requirements such as square footage, number of bedrooms, etc. The significance of this provision for Illinois cannot be understated. Since the beginning of the waiver program, 79% of subsidized guardianships have been with relative caregivers. Illinois will implement the Kinship Guardianship Assistance Program (KinGAP) beginning November 1, 2009.

Continued Federal Support for Children in Post Permanence Subsidized Guardianship arrangements

States with Title IV-E Waiver Demonstration Programs like Illinois will continue to receive federal reimbursement for the subsidies of thousands of children in guardianship arrangements. Illinois will be able to claim federal dollars for any child who exited care to subsidized guardianship prior to September 30, 2008 even if they do not meet the new federal eligibility criteria.

B. Notice to Relatives Beginning October 7, 2008, the Act requires state agencies to provide legal notice to a child's grandparents and adult relatives within 30 days of being removed from his or her home. State agencies may get information from the Federal Parent Locator Service. Current IDCFS Administrative Procedure 22 meets this requirement.

C. Licensing Standards Presently, more than three quarters of relative caregivers in Illinois are not licensed. A caregiver must be licensed for the state to receive federal reimbursement. The act states that on a case by case basis, states may waive non-safety licensing standards, such as square footage and required bedrooms per person. The inclusion of this provision can put Illinois in a stronger position to maximize federal dollars for foster care and for the continuation of guardianship assistance. IDCFS has a "waiver" process for licensing standards that pre-dated the legislation, although the process is not specific to relative caregivers. This process requires a licensing worker to submit a waiver request to the IDCFS director or designee to determine the appropriateness of the request. IDCFS has a workgroup charged with addressing barriers to kinship licensure. Some activities of this workgroup include a review of licensing policy and procedure, a statewide communication campaign to educate the professional and caregiver community about the legislative change, and the facilitation of the medical exam process for caregivers. In addition, DCFS has modified SACWIS to track the submission and outcomes of waiver requests.

II. Adoptions

A. Special Needs Adoptions More children with special needs will now be eligible for adoption assistance due to an important component of the Fostering Connections Act.

6 Our thanks to Leslie Cohen, Jennifer Bradburn and Michelle Rosenberg, CFRC, for compiling this information.

A child's eligibility for federal adoption assistance will no longer be tied to the AFDC income requirements of their biological parents or caregiver with whom they lived prior to removal. Per the law, IDCFS will begin to phase the plan in for designated populations of children beginning October 1, 2010. This will apply to all children by October 2018.

B. Supports for Older Youth Who Leave Care to Permanence The Act recognizes the importance of permanence and transition services for older youth by making Chaffee Independence Funds available to youth aged 16 and older who are adopted or go to guardianship with a relative. Specifically, older youth who are adopted or go to guardianship with kin will now be able to access Chafee supported services. IDCFS currently makes Education and Training Vouchers, housing advocacy, and educational advocacy available to this population. IDCFS has not yet determined if this service package will include other independent living services such as life skills training, Youth in College, Housing Cash Assistance, the Employment Incentive Program, and Education and Training Vouchers.

C. Tax Credit Beginning October 7, 2008, The Act requires States to notify all prospective adoptive parents of children in state custody that they may be eligible for the adoption tax credit. IDCFS will be informing caseworkers that this information must be shared with families as they prepare them for adoption/guardianship. In addition, the requirement will be covered through Families Now and Forever document which is mailed to all foster, adoptive, guardianship parents. Ultimately, this will be defined in IDCFS rule and procedure.

III. Siblings and Family Connection

A. Placements for Siblings Beginning October 7, 2008, The Act requires that States make reasonable efforts to place siblings together unless it is determined not to be in the best interest of the siblings. If siblings cannot be placed together efforts must be made to provide frequent visitation as long as it does not adversely affect the siblings' safety and well-being. This provision is consistent with institutionalized DCFS practice as documented in DCFS Administrative Rule 301.

B. Family Connection Grants New grant programs designed to help families of children in or at risk of entering foster care will be funded through Subpart 1 of Title IV-B. The programs include: 1) kinship navigator programs; 2) intensive family-finding efforts; 3) family group decision making meetings; and 4) residential family substance abuse treatment programs. DCFS currently funds and operates the Extended Family Support Program (EFSP) for Relative Caregivers. This program provides intensive short term supports and services to caregivers who are supporting related children outside the foster care system. It is unclear at this juncture if IDCFS will pursue these grant opportunities.

IV. Older Youth

A. Federal Support Beginning October 2010, States will be allowed to receive IV-E reimbursement for providing care and financial support to youth in foster care until 19, 20, or 21 if the youth is completing high school or an equivalency program, enrolled in post secondary or vocational school, participating in a program designed to remove barriers to employment, employed no less than 80 hours per month, or incapable of doing any of the preceding because of a medical condition. This applies to youth living in independent living settings as well as foster family and group homes. Adoption and guardianship assistance can also be extended for the same population.

B. Transition Planning As of October 7, 2008, the Act requires that during the 90 day period prior to a youth ageing out of foster care, the child's caseworker and other professional staff as appropriate must help the youth develop a transition plan that includes details on housing, health insurance, education, local opportunities for mentoring, continuing support services, work force support, and employment services. Current IDCFS Procedure 302 Appendix M provides for these transition activities. The worker is required to discuss the topics outlined in the Act six months prior to release of guardianship rather than the 90 days prescribed in the law.

V. Education and Health

A. Health Oversight As of October 7, 2008, the state child welfare and Medicaid agency must collaborate to develop a plan for on-going oversight and coordination of health care services for children in foster care.

B. Educational Stability Beginning October 7, 2008, States are required to coordinate with local education agencies to ensure that children remain enrolled in the school that they attend at the time of entry into the foster care system unless it is contrary to the child's best interest. This component of the Act is consistent with DCFS Rule 314 which requires IDCFS to determine if it is in the child's best interest to remain at their "home" school. If in the child's best interest, DCFS will advocate with the school system to ensure the child's enrollment. To support this provision, increased dollars have been made available to support education related

transportation costs. States must also ensure that all children receiving adoption and guardianship subsidies are enrolled as full-time students or have completed their secondary education. DCFS Rule 314 already provides that a child's case record must include current information on school enrollment and progress.

VI. Professional Quality Improvement

The Fostering Connections to Success and Increasing Adoptions Act extends federal Title IV-E training dollars to support short term training for private agency staff, court personnel, and relative caregivers. Historically, full federal support for training was available to public sector employees and current and prospective foster parents. The legislation phases in funding over the next five years so that private agency workers, attorneys, judges, CASAS can be trained. This provision is of critical importance to Illinois because approximately 70% of the child welfare workforce is employed by purchase of service contractors. Prior to the law's passage, Illinois' efforts to train and support the private sector were not fully supported by Title IV-E dollars. The new act can also support cross training efforts between DCFS and the dependency courts.

FUTURE CHALLENGES

Over the past decade, the make up of the child welfare caseload in Illinois has shifted from a Cook County dominated caseload to one where there are more children in care from the Balance of the State (BOS) than there are from Cook. In addition, the caseload has gone from over 50,000 children in care to under 16,000 children in care. Illinois has been recognized nationally for innovations and changes that have helped reduce caseloads, but with these changes also comes challenges. How does the system continue to improve? How do we understand the positive national attention to the state for good practices while the state continues to fail the federal review? How do we ensure that the changes that have been implemented are in the long-term best interest of children and families?

The vision for the Department, as articulated in a vision statement prepared jointly by the Department and the Center[7], suggests that DCFS Director McEwen's vision is to support vulnerable families in their communities by building upon their strengths. To this end the Department is looking into the Differential Response model (discussed in Chapter 1 of this report) that will support families in their communities and thereby prevent maltreatment reports and removals. As policies and practices are developed in this area, monitoring and evaluation of these efforts is critical to assure that the intended goal of protecting children while supporting families is met.

In addition, for those children who must be removed, the Department seeks to increase the engagement of biological families; an idea that is supported in the Fostering Connections Act. Specifically, the Department looks to engage more fathers and paternal kin in caring for vulnerable families. For this to occur the Department will have to make significant policy and practice changes. The Department is also funding research that looks into the needs of children who are dually involved – involved in both the child welfare and juvenile delinquency systems – and seeks to improve services, safety, permanence and overall well-being of these families.

In an effort to better understand the well-being of children in foster care, Center and Department staff are joining efforts with a national survey of children and caregivers involved with child welfare (the National Survey of Child and Adolescent Well-Being or NSCAW) to learn in greater detail how children in Illinois compare to children nationally on educational progress, mental health, cognitive and social development and other well-being topics not currently collected in administrative data. NSCAW cases in Illinois have been increased to create a large enough within-state sample to support accurate Illinois estimates. With this new project, we will be able to directly compare well being findings from Illinois with national results that use identical research methods. In addition, this study will increase the amount of administrative data available on well-being issues in Illinois. Full funding for this research has not yet been secured, but we are hopeful that future Conditions reports will feature this data. Because NSCAW data are not yet available, the well-being chapter this year uses data from the Illinois Child Well-Being Study that were also analyzed in the previous two Conditions reports. Rather than briefly surveying a range of well-being topics, however, the well-being chapter here features new, more rigorous, in depth analysis on a single topic – mental health.

7 Vision and Priorities for the Illinois Child Welfare System, unpublished manuscript, DCFS and the Children and Family Research Center.

Box I.2—**The Child and Family Services Review: Foster Care Utilization Review Program (FCURP)**

As Illinois prepares to undergo Round II of the Child and Family Services Review (CFSR), thought has already gone into the program improvement planning (PIP) aspect of the review. The continuous quality improvement (CQI) nature of the process has kept the Illinois child welfare community focused on building upon the strengths of the PIP efforts implemented after the first CFSR. While there were several key cross-cutting initiatives that served as hallmarks of the Illinois PIP, such as the Integrated Assessment Program, the Enhanced Concurrent Planning and Reunification Model, and the restructuring of private child welfare agency performance contracts, one major feature of the PIP process in Illinois was the establishment of an ongoing statewide public-private continuous quality improvement (CQI) framework. Over the course of the first CFSR PIP period and the non-overlapping evaluative year (December 2004 to March 2008), the Center's Foster Care Utilization Review Program (FCURP) played a vital role in helping the Department build this public/private CQI framework by putting the necessary systems and processes in place to measure, monitor, and report progress toward the CFSR outcomes and identified PIP goals at both the state and regional levels.

Following initial PIP implementation, FCURP, in conjunction with the Departments' Division of Quality Assurance (QA), developed and implemented a statewide qualitative review tool and process, similar to the CFSR process, to monitor progress toward PIP goals. Subsequently, Regional PIP Workgroups, comprised of DCFS and POS agency representatives, were created and supported in utilizing the data from the review to address region-specific practice level issues that might be impacting statewide performance. Regional PIP Workgroups were established in each region of the state and met on a quarterly basis.

Over the course of the first CFSR PIP period, the regional PIP process laid a firm foundation for 1) ongoing communication and collaboration between DCFS and its private sector partners; 2) targeting key casework practices for improvement efforts based on both internal (peer review) and external (OER and permanency performance) data sources; and 3) distinguishing the systemic versus practice related issues impacting outcomes, and ensuring the delegation of identified issues to the appropriate resources for action. Products from the regional PIP workgroups continue to focus on training; the review, clarification and summarization of key policies and procedures through "Practice Memos" for field staff; the development of supervisory support tools and forums; and the alignment of peer review processes between DCFS and the private sector.

Illinois' Round II CFSR will provide a fresh platform from which the inroads that were made during round one around statewide CQI processes, community collaboration, the use of data and research, and field level practice changes can continue to be built upon. With a heightened focus on the development of specific measures of effectiveness for all PIP initiatives, FCURP will continue to support the Department in the implementation and monitoring of Illinois' Round II CFSR PIP.

Thanks to FCURP staff for this update: Yolanda Green-Rogers, Christy Levine, Jennifer Eblen Manning, and Geraldine Rodriguez

Finally, the Department seeks to provide for families after they formally leave the foster care system – through expansion of the post-adoption and guardianship efforts, and through supporting families after reunification. As discussed in Chapters 2 and 4 of this report, Illinois now has the lowest removal rate in the nation – fewer children per capita are removed in Illinois than in any other state. In addition, Illinois has one of the lowest reunification rates in the country (as measured by AFCARS data).

Understanding the trade off between a low removal rate and a low reunification rate is essential (see chapter 4 for more discussion on this). Illinois may remove only the neediest cases and therefore take longer to reunify than states that remove high numbers of low risk children and quickly reunify them. While Illinois has earned national recognition for the number of permanencies achieved in this state, the push nationally for reunifications to occur prior to a child's one year anniversary of foster care entry means that Illinois may face federal penalties after their second round of the federal review. Balancing the need to ensure that families are ready for reunification with the need to meet federal requirements will continue to be of concern for DCFS in the future.

Illinois has led the nation in adoptions and guardianships. It is one of a small number of states with thousands of children living in state supported post permanency arrangements. In 2000 Illinois reached a critical milestone, for the first time ever the number of children in post permanency arrangements exceeded the number of children in foster care. While research conducted by the Children and Family Research Center suggests that the majority of these placements are stable, a small percentage of families have unmet service needs that require support. Continued research in this area is critical to ensure that these permanency arrangements remain stable homes for the children and families involved.

In addition, attention and support to the youth who emancipate from the system will be guided in the future by the Fostering Connections Act. Research from Illinois has begun to illuminate the pathway towards understanding the needs of these youth, but additional research is needed to ensure that these youth are prepared for adulthood as they exit foster care.

CHILD SAFETY

Tamara Fuller and Martin Nieto

AT HOME AND IN SUBSTITUTE CARE

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

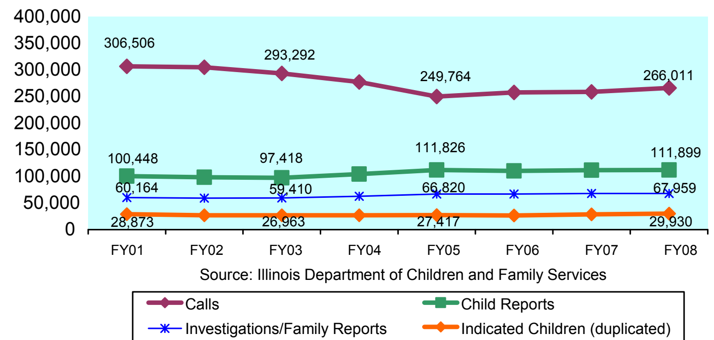
Once a child comes into contact with the child welfare system, his or her safety becomes the primary concern of Child Protective Services (CPS). Most child welfare systems respond to allegations of child maltreatment through a series of decision points, although variations in state CPS policy and practice are widespread[2]. In Illinois, as in most states, contact usually begins when a mandated reporter or concerned community member initiates a report of abuse or neglect to the State Central Register (SCR), colloquially known as the "child abuse hotline." Not every call, letter, or in-person report to the SCR constitutes a report of child abuse or neglect, however. The first decision point in child protective services involves the screening of reports to determine whether they meet the criteria for a CPS investigation (i.e., they are "screened-in"). For those reports that are accepted or screened-in, additional criteria determine the immediacy of the investigation response that is required.

Child protective services investigations are the means through which it is determined if a child has been maltreated and if services are needed to ensure that the child will not be harmed in the future. During the investigative process, child protection workers collect several kinds of information or evidence to determine whether credible evidence exists that maltreatment occurred, such as: in-person contacts with the alleged victim(s), adult members of the household, alleged perpetrator(s), and other collateral contacts; formal safety and/or risk assessment; and background checks on alleged perpetrators. Several decision points occur within the investigation process:

1) whether to take a child into protective custody;
2) whether a child is safe or unsafe from immediate danger (safety decision);
3) whether credible evidence exists that maltreatment occurred (case disposition); and
4) what level of services, if any, are required to ensure child safety.

In FY2008, approximately 266,000 calls were made to the Illinois State Central Register (SCR) and screened for suspected abuse and neglect (*see Figure 1.1*). This is down from 306,500 in 2001, but represents an increase from approximately 250,000 in 2005. A little over one-fourth of these calls (25.5%) were determined to warrant further action and referred for investigation. These 67,959 investigations involved approximately 111,899 child reports of suspected abuse and neglect. The percentage of referrals in Illinois that are "screened-in" for investigation (25.5%) is quite low when compared to the national average of 61.7% in FFY2007.[3]

Figure 1.1 Illinois Child Protective Services (CPS) caseload volume



Source: Illinois Department of Children and Family Services

In slightly more than one out of four child reports of abuse and neglect (26.7%), DCFS investigators find credible evidence that a child was maltreated. In 2008, almost 30,000 children in Illinois were indicated[4] for abuse or neglect, an increase in the past two years which may point to the beginning of a new trend.

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

2 U.S. Department of Health and Human Services, Administration for Children and Families/Children's Bureau and Office of the Assistant Secretary for Planning and Evaluation. (2003). *National study of child protective service systems and reform efforts: Review of state CPS policy.* Washington, DC: U.S. Government Printing Office.

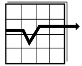
3 U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2009). *Child Maltreatment 2007.* Washington, DC: U.S. Government Printing Office.

4 Indicated and substantiated are both used in this report to mean that, at the time of an investigation, the child welfare staff found credible evidence that child abuse or neglect had occurred.

CHILD SAFETY AT A GLANCE

We will know children are safer:

If more children are protected from abuse or neglect:

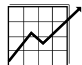


Of all children living in Illinois, the number that did not have an indicated report of abuse or neglect has remained constant at 992 per 1,000 from 2002 to 2008.

If more children are protected from repeated abuse or neglect:

Of all children with a substantiated report of abuse or neglect, the percentage that did not have another substantiated report within a year has improved from 86.8% in 2001 to 88.6% in 2007.

If more children are protected from repeated abuse or neglect, even if no services are provided after an indicated investigation:

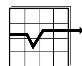


Of all children with initial substantiated reports that did not receive either intact family or substitute care services, the percentage that have not experienced another substantiated report within one year has increased from 86.7% in 2001 to 89.4% in 2007.[5]

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

Of all children who were served at home in an intact family case, the percent that did not have another substantiated report within a 12-month period has decreased from 90% in 2001 to 88% in 2007.

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

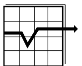


Of all children ever served in substitute care during the year, the percentage that did not have a substantiated report[6] during placement has decreased slightly from 98.8% in 2002 to 98.4% in 2008.

If more children with an initially unfounded report of abuse or neglect are protected from additional maltreatment reports:

Of all children with an initial unfounded report of maltreatment, the percentage that did not have another report within a year increased from 76.7% in 2001 to 81.4% in 2007.[7]

If more children with an initially unfounded report of abuse or neglect are protected from additional substantiated maltreatment reports:



Of all children with an initial unfounded report of maltreatment, the percentage that did not have another substantiated report within a year remained relatively stable between 95 – 96% from 2001 and 2007.[8]

5 Note: this is a new indicator
6 Administrative data received by CFRC does not distinguish between report date (the date the incident was reported to the Department) and incident date (the date the incident occurred), so the effects of retrospective reporting error must be estimated. The most common "retrospective reporting" errors are reports of sexual abuse. We have, therefore, excluded recurrence reports of sexual abuse from this indicator.
7 Note: this is a new indicator
8 Note: this is a new indicator

CHILD SAFETY IN ILLINOIS

The challenges inherent in measuring child safety within the context of public child welfare are evident when one examines the numerous methods and measures that have been used to do so. Almost all "official" measures of the incidence or prevalence of child maltreatment are based on counts of children who come to the attention of the formal Child Protective Services (CPS) system. However, results from the Third National Incidence Study of Child Abuse and Neglect (NIS-3) suggest that only a very small portion of maltreated children (28-33%) receive a CPS investigation, either because they are never reported or because their reports are "screened-out" without an investigation.[9]

Others have raised concerns about the use of only substantiated maltreatment in child welfare monitoring and research. They suggest that children in substantiated and unsubstantiated investigations are more alike than different and that any differences between the two groups are unrelated to the presence of maltreatment.[10] However, recent research by the Center suggests that substantiated children look significantly different on one important criterion – rates of maltreatment re-reporting (see Box 1.1), suggesting underlying differences in maltreatment or harm. Thus, despite its limited nature, the use of official CPS statistics to monitor trends in the prevalence of child maltreatment seems reasonable, and the safety indicators used in this chapter focus on children with indicated reports of maltreatment. This does not mean, however, that children with initially unsubstantiated maltreatment reports do not experience maltreatment recurrence or would not benefit from preventative services. Thus, the final section of this chapter examines select safety indicators for children with initially unsubstantiated reports.

Maltreatment prevalence rates are not commonly used in state and federal child welfare monitoring efforts, except occasionally to provide a context for viewing other safety measures. Primary prevention of child abuse and neglect often falls outside the mandate of public child welfare systems, although there are signs that this philosophy may be changing in some states, including Illinois. Thus, the first indicator of child safety reported in this chapter is the prevalence of child maltreatment. In keeping with the convention used throughout this report, all indicators are computed and displayed so that increases over time correspond to improvement and decreases correspond to worsening performance.

According to the most recent federal child welfare monitoring report, the "primary objective of State child welfare systems is to ensure that children who have been found to be victims of abuse or neglect are protected from further abuse or neglect, whether they remain in their own homes or are placed by the State child welfare agency in a foster care setting" (p. II-1).[11] Once a child becomes involved in an indicated report of child abuse or neglect, the child welfare system assumes partial responsibility for the safety and protection of the child from additional abuse or neglect (e.g., maltreatment recurrence). Maltreatment recurrence is therefore viewed as the primary indicator through which child safety can be assessed. However, definitions of maltreatment recurrence vary widely, often making it difficult to compare results from one report or evaluation to the next.

The most common definition of recurrence is a substantiated report following a prior substantiation that involves the same child or family. However, some studies have included all subsequent reports (sometimes called re-referrals) following an initial report, regardless of the substantiation status of the report. Another important dimension along which definitions vary is the length of time over which recurrence is monitored. Studies of safety assessment focusing on immediate safety of children during the investigation typically use short recurrence follow-up periods, i.e., 60 – 120 days, while the federal recurrence measure examines maltreatment recurrence within 6 months following an initial indicated report. The current report uses a 12-month recurrence period for the majority of the safety indicators, although a special analysis on the impact of the Child Endangerment Risk Assessment Protocol (CERAP) on child safety replicates the federal recurrence measure using a 6-month recurrence period.

9 U.S. Department of Health and Human Services, Administration on Children and Families. (1996). *The Third National Incidence Study of Child Abuse and Neglect (NIS-3).* Washington, DC: Author.

10 Drake, Jonson-Reid, Way, & Chung. (2003). Substantiation and recidivism. *Child Maltreatment, 8,* 248-260.

11 U.S. Department of Health and Human Services, Administration on Children and Families. *Child Welfare Outcomes Report 2003 Annual Report: Safety, Permanency, and Well-Being.* Washington, DC: Child Welfare Information Gateway.

Box 1.1—**Substantiation and Maltreatment Rereporting**

Although it is one of the most widely used indicators in child welfare, the use of substantiation in both practice and research is not without critics. At the heart of this debate rest questions concerning the validity of substantiation, that is, its ability to accurately distinguish between cases in which maltreatment occurred and those in which it did not. If substantiation status meaningfully distinguishes between children for which maltreatment did and did not occur, these two groups should differ in meaningful ways on future outcomes known to be associated with maltreatment (i.e., it should have predictive validity).

One of the most important future outcomes for child welfare practitioners, policy-makers, and researchers is repeat maltreatment. Repeat maltreatment is most usually defined as either maltreatment re-reports, which include subsequent investigations regardless of the eventual substantiation decision, or recurrences, which refer to subsequent substantiated reports. Although most children do not experience repeat maltreatment following an initial report, one would predict that if substantiation is a meaningful construct, all else being equal, children with initially substantiated maltreatment should experience re-reporting and recurrence at a greater rate than children whose maltreatment was initially unsubstantiated.

Sample

The sample was drawn from the population of child investigations that occurred during fiscal years 1999 to 2004. Excluded from the sample were children with any previous investigation in 1990 or after. In addition the sample was limited to cases that were investigated but did not receive child welfare post-investigation services (i.e., intact family services or substitute care) within 12 months of the maltreatment report. One child per family was randomly selected so that the final sample consisted of 188,471 children.

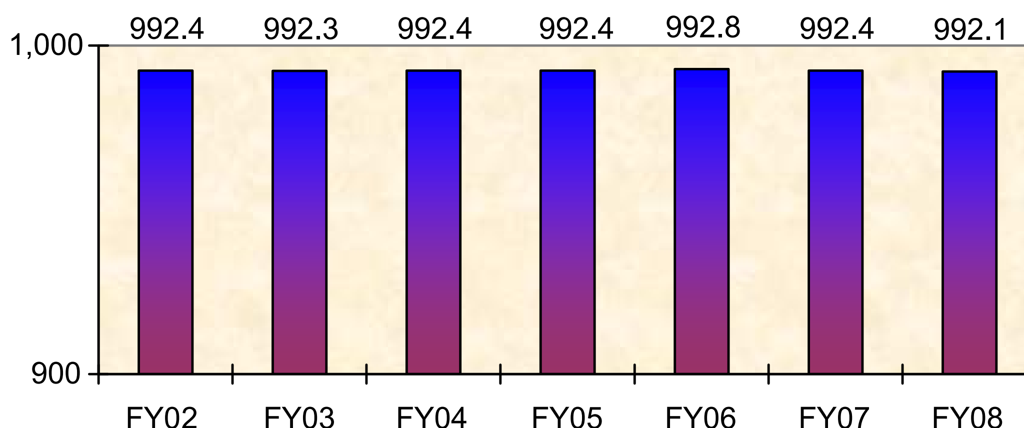
Key Findings

This study found that substantiated cases were 71% more likely than unsubstantiated cases to have a re-report of maltreatment within 12 months:

- Ten percent of the substantiated cases and six percent of unsubstantiated cases are re-reported within 3.5 months of the initial report.
- At the end of the 12 month observation period, 22% of the substantiated cases and 13% of the unsubstantiated cases have been re-reported.

Results from this study were published as: Fuller, T.L., and Nieto, M. (2009). Substantiation and maltreatment rereporting: A propensity score analysis. Child Maltreatment, 14, 27-37.

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



Prevalence of Child Maltreatment

Figure 1.2 displays the number of children without an indicated report of maltreatment in relation to the overall population of children in the state. This number has remained fairly constant at approximately 992 per 1,000 for the past several years.

However, not all children in the state are equally likely to experience maltreatment. When this data is examined by DCFS region (see Appendix A, Indicator 1.A), the rate of children without an indicated report is much higher in Cook County (995.0 in 2008) and the Northern region (993.8) than in the Southern (987.5) and Central (985.5) regions. The only region that has shown improvement in this indicator is Cook County – rates have increased from 994.6 per 1,000 in 2002 to 995.1 per 1,000 in 2008. Rates of non-maltreatment have dropped slightly (about 1 per 1,000) in both the Northern and Southern regions of the state, and have dropped more noticeably in the Central region, from 989.4 per 1,000 in 2002 to 985.5 per 1,000 in 2008. In addition, rates of non-maltreatment have significantly improved among African-American children – from 983.6 per 1,000 in 2001 to 986.1 per 1,000 in 2008 – and to a lesser degree among Hispanic children – from 995.7 to 997.3 per 1,000. Despite this increase, rates of non-maltreatment among African-American children (986.1 in 2008) are considerably lower than those for both Caucasian (993.1) and Hispanic (997.3) children (see Appendix A, Indicator 1.A).

Maltreatment Recurrence Among Children with Indicated Maltreatment Reports

The state has several methods through which it attempts to prevent maltreatment recurrence. All investigated households, regardless of the eventual disposition (substantiated or not), receive a safety assessment at the beginning of the investigation that allows the investigator to determine whether the children in the household are in immediate danger of a moderate to severe nature. If it is determined that the children are unsafe, the investigator then works with the family to develop a safety plan that will eliminate the threats to child safety that are present. The effectiveness of this process has been the subject of ongoing evaluation in the state of Illinois, and recent results suggest that investigator use of the CERAP at the conclusion of the investigation is significantly associated with reduced maltreatment recurrence among indicated children (see Box 1.2).

Although all investigated households receive a safety assessment, not all cases—even families where indicated maltreatment has occurred—received child welfare services. Some cases are closed immediately following the investigation. Others receive services while the children remain in the home in what are known as intact family cases. Finally, if less intrusive options to keep the child(ren) safe are not feasible, one or more of the children can be removed from the home and placed into substitute care. Each of these system responses has consequences for the family and their risk for maltreatment recurrence; therefore, separate indicators will examine the absence of

maltreatment recurrence among 1) all children with indicated reports, 2) indicated children with no service case following investigation, 3) indicated children served in intact family cases, and 4) indicated children in substitute care.

Figure 1.3 displays the rate of all children with an indicated maltreatment report that did not have another indicated report within 12 months (see Appendix A, Indicator 1.B). This includes children that did not receive services, those in intact family cases, and those in substitute care.

Figure 1.3 Percent of children with a substantiated report of abuse or neglect that did not have another substantiated report within a year

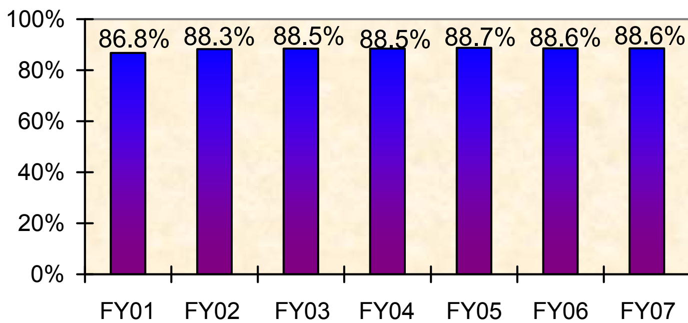


Figure 1.3 reveals that the number of children who do not experience maltreatment recurrence within 12 months of an initial substantiated report increased from 86.8% in 2001 to 88.5% in 2003, and has remained almost constant since then. Examination of 12-month maltreatment non-recurrence rates by region reveals that Cook County has the highest rate of non-recurrence (91.9 in 2007), followed by the Northern region (89.8%), with lowest rates in the Central (85.9%) and Southern (85.4%) regions. When non-recurrence rates are examined by child race, Hispanic children (91.7%) and children of other ethnicities (92.6%) had the highest rates in 2007, followed by African-American children (89.7%), with Caucasian children having the lowest rates (87.2%). Non-recurrence rates demonstrate a positive relationship with child age, i.e., non-recurrence rates go up as child age increases: the rate among children less than three years was 88.2% in 2007, compared to 92.5% among children 15 to 17 years (see Appendix A, Indicator 1.B).

Maltreatment Recurrence Among Children with an Indicated Report who Do Not Receive Services

Figure 1.4 displays the 12-month maltreatment non-recurrence rate for children with an indicated maltreatment report who did not receive services (either intact family or substitute care) following the investigation. This percentage has remained fairly constant at approximately 89% since 2002. When non-recurrence rates for children that did not receive services following an indicated report are examined by region (see Appendix A, Indicator 1.C), it is clear that rates in the Cook region and Northern region are much higher (approximately 91%) than those in the Central and Southern regions of the state (approximately 86%). Non-recurrence rates were slightly higher for boys than girls, and for Hispanic children (92.5% in 2007) compared to African-American (90.3%) or Caucasian (88.1%) children. As with most safety indicators, rates of non-recurrence increase with child age: the rate for children less than 3 years was 86% in 2007, compared to 94% among those 15 to 17 years.

Figure 1.4 Percent of children that did not receive services following a substantiated report of abuse or neglect without a second indicated report within 12 months

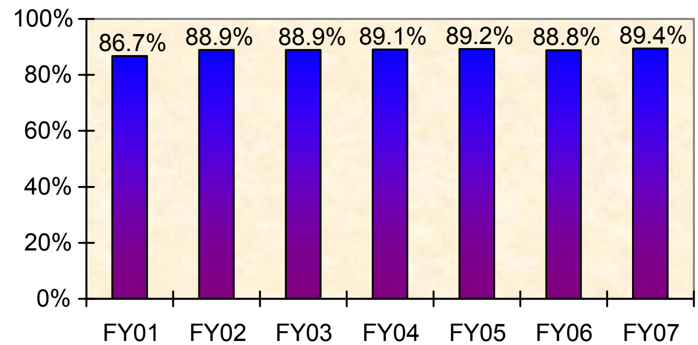
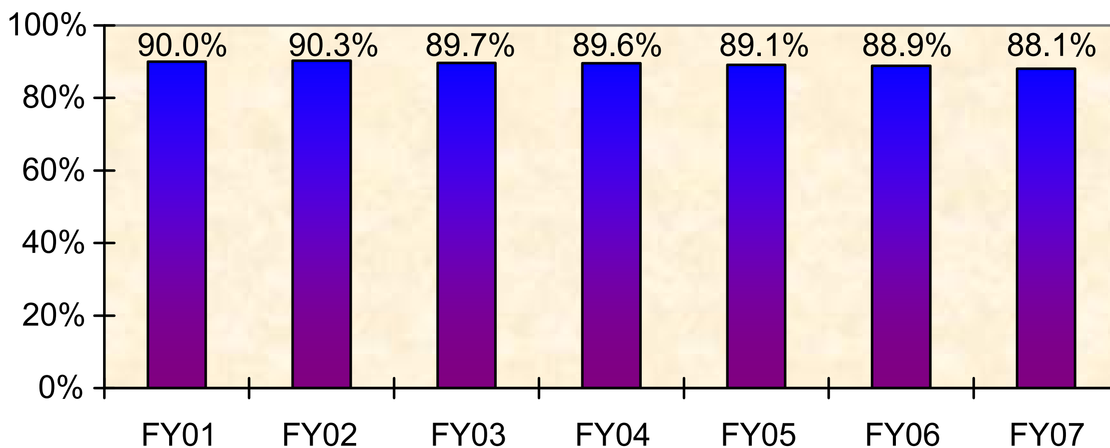


Figure I.8 Percent of children served at home in intact families that did not have a substantiated report within 12 months



Maltreatment Recurrence Among Children in Intact Family Cases

In some instances, the Department will indicate a family for child maltreatment, but decide that it is in the best interest of the child and family to receive services at home rather than place the child into substitute care. These cases, known as "intact family cases," are of special interest to the Department because their history of indicated maltreatment places them at increased risk of repeat maltreatment. The next indicator therefore examines maltreatment non-recurrence among children served at home in intact family cases (*Figure 1.8*; see Appendix A, Indicator 1.D).

This rate has slowly fallen from 90% in 2001 to 88% in 2007. When non-recurrence in intact families is examined by DCFS region, it is clear that rates in the Cook region are significantly higher (92.3% in 2007) than those in all other regions (Northern = 86.3%, Central = 84.4%, and Southern = 83.1% in 2007). Although rates have fallen slightly in the Cook regions in the past year, rates in each of the non-Cook regions, especially the Central and Southern regions, have fallen more dramatically, to their lowest point in years. Examination of this indicator by racial group reveals that non-recurrence rates for Caucasian children served in intact families were at their highest in 2001 (88%), but have since fallen to 82.5% in 2007, which is much lower than rates for either African-American (89.7% in 2007) and Hispanic children (91.7% in 2007). Rates of non-recurrence for African-American children served in intact families fell by 2% in 2007, which is also a cause for concern. Rates of non-recurrence among intact families increase with child age – older children are much less likely to experience recurrence in this setting than younger children (see Appendix A, Indicator 1.D and Box 1.3).

Box 1.2—**Increasing Maltreatment Non-Recurrence Among Children with Indicated Maltreatment: The Role of Safety Re-Assessment**

Since 1997, the Children and Family Research Center has conducted a program of research that examines the impact of safety assessment (using the Child Endangerment Risk Assessment Protocol or CERAP) on child safety in Illinois. Results from the early CERAP evaluations are clear: maltreatment non-recurrence rates increased significantly from 1995 (the year prior to CERAP implementation) through 2006, when measured as either non-recurrence within 60 days (47% increase) or 6 months (62% increase). Despite these improvements in child safety, Illinois fails to meet the federal standard set in the Child and Family Service Review (CFSR) for non-recurrence of maltreatment, which will trigger significant financial penalties for the Department until the standard is met.

Recent work by the Center has examined how CERAP's use in the field is related to maltreatment recurrence, in an effort to pinpoint areas of potential intervention. According to DCFS policy, during an investigation the first CERAP assessment should be completed "within 24 hours after the investigator first sees the alleged child victims" (see Procedures 300, Appendix G, page 3). Additional CERAP assessments should be completed during the investigation if and when any of the following milestones occur:

1) evidence or circumstance suggest that a child's safety may be in jeopardy;

2) every 5 working days following the determination that any child in the family is unsafe and a safety plan is implemented;

3) at the conclusion of the formal investigation, unless a service case is opened (this provision may be waived by the supervisor if the initial safety assessment was marked safe and no more than 30 days have elapsed since it was completed); and

4) at child welfare service intake within 24 hours of seeing the children.

Therefore, each investigated case can have from one to several CERAP assessments that are completed over the life of the investigation, and the number will vary depending on:

1) whether the case was determined to be safe or unsafe;

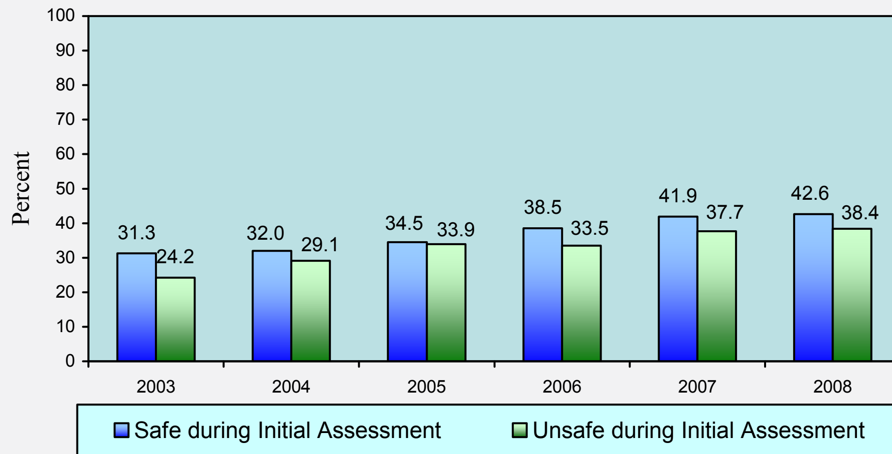
2) whether more than one investigator assesses the household;

3) whether circumstances in the household change, the length of time needed to complete the investigation; and

4) whether a child welfare service case is opened.

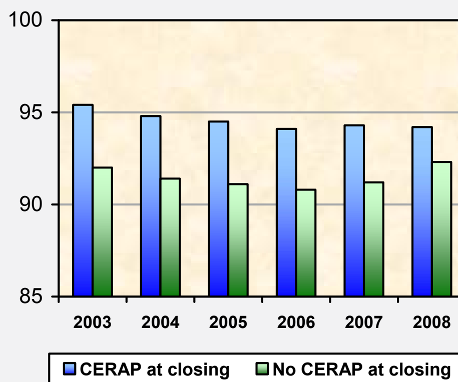
According to policy, all investigation cases should have a CERAP assessment completed "at the conclusion of the formal investigation,"[12] although several circumstances exist under which this requirement can be waived: **1)** if the investigation is completed within less than 30 days, **2)** if the investigation involves an already opened service case, or **3)** if a service case is opened during or immediately following the investigation. After excluding those cases that are not required to have a CERAP completed at the conclusion of the investigation, investigator compliance with CERAP re-assessment at this milestone was examined. The total number of indicated children each year was divided into those assessed as "safe" or "unsafe" during the initial CERAP assessment at the beginning of the investigation. As Figure 1.5 demonstrates, investigator compliance with this policy has been increasing each year, but there is considerable room for improvement. In 2003, 31.3% of "safe" cases had a CERAP assessment at the end of the investigation, and this has slowly increased to 42.6% in 2008. By contrast, 24.2% of "unsafe" cases had an assessment at the end of the investigation and this has also steadily increased to 38.4% in 2008.

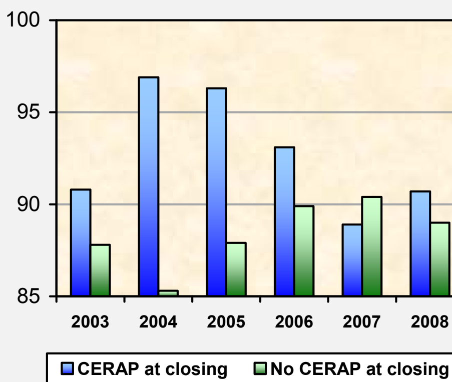
12 DCFS Procedures 300, Appendix G, p. 15



Further analysis found that CERAP re-assessment at the conclusion of the investigation resulted in more children being safe from maltreatment recurrence. This holds true regardless of the initial safety determination (safe or unsafe) made at the beginning of the investigation. As shown in Figures 1.6 and 1.7, in 2008, of the "safe" cases 94.2% of the children who had a CERAP assessment at the end of the investigation were safe from repeat maltreatment compared to 92.3% of the children who did not have a CERAP re-assessment. For those with an initial "unsafe" report, 90.7% of those with a CERAP re-assessment and 89.0% of those with no CERAP re-assessment were safe from repeat maltreatment.

Since a clear relationship exists between CERAP re-assessment at the conclusion of the investigation and increased child safety rates, and such re-assessment is already required by policy, one promising intervention for improving Illinois' safety outcome may be to increase compliance with this requirement above its current level.





Box 1.3– **Warning Signs: Child Safety in Intact Families Declining among African-American Children in Non-Cook Regions**

Rates of maltreatment non-recurrence among children served in intact families have fallen nearly 2% from 2001 to 2007, with about half of the decline occurring in the last year (2006-2007). Analysis of this indicator at the regional level indicated that rates have fallen in non-Cook regions much more than in Cook. Analysis by child race reveals that although non-recurrence is much higher among African-American children than Caucasian children, rates among African-American children declined 2% in the last year, which is a cause for concern. When non-recurrence is examined by region for African-American (*Figure 1.8a*) and Caucasian (*Figure 1.8b*) children separately, a number of trends become more apparent.

Figure 1.8a Percent of African-American children served in intact families that did not have a substantiated report within 12 months

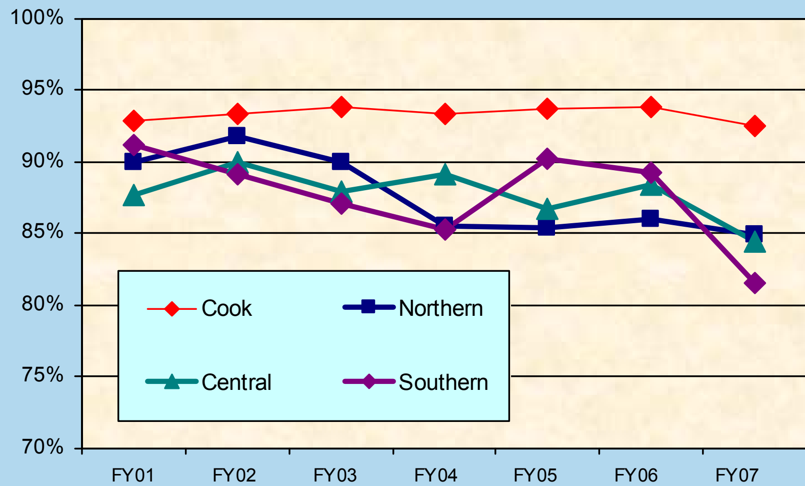
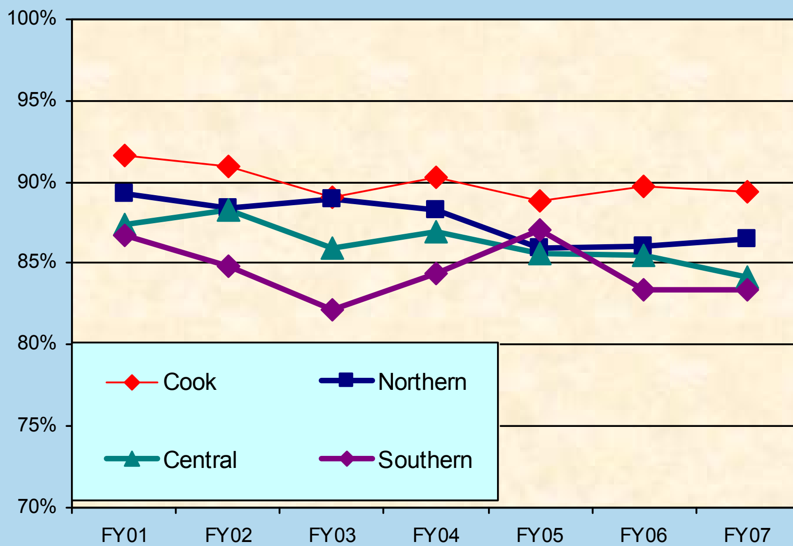


Figure 1.8b Percent of Caucasian children served in intact families that did not have a substantiated report within 12 months



From 2006 to 2007 among African-American children, non-recurrence rates declined slightly in the Cook region (-1.4%) and Northern region (-1.1%), and much more dramatically in the Central (-4%) and Southern (-7.7%) regions. Rates among Caucasian children during the same time period remain virtually unchanged in all regions of the state. The declining safety of African-American children served in intact families in non-Cook regions deserves careful monitoring in upcoming years.

Maltreatment Recurrence in Substitute Care

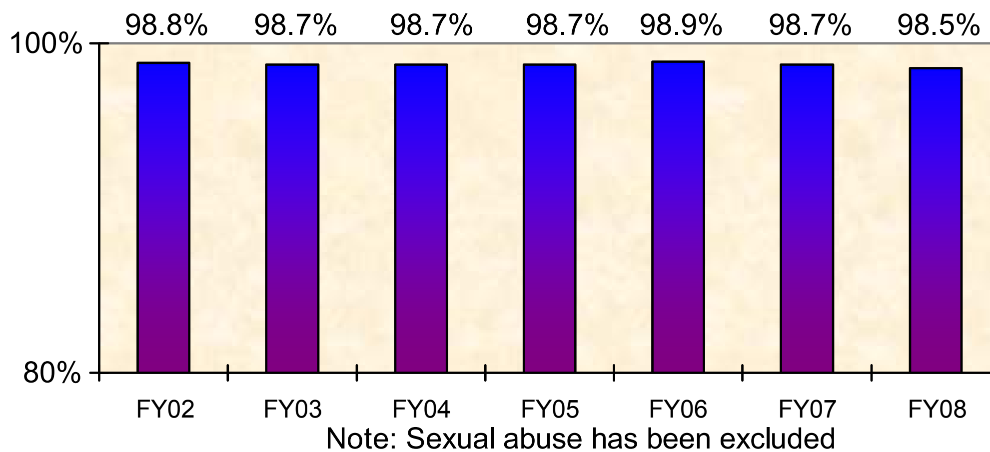
If children are taken from their home of origin and placed into substitute care for protective reasons, the expectation is that their new living arrangement will provide them with safety from additional abuse or neglect. The following indicator examines the safety of children in substitute care, (i.e.,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

The percentage of children living in substitute care who have not had a substantiated report of abuse or neglect while in placement dropped slightly, from 98.9% in FY06 to 98.5% in FY08, after remaining fairly stable over the past several years (*Figure 1.9*; see Appendix A, Indicator 1.E). This data excludes reports of recurrence that involve sexual abuse. Recurrence rates are calculated using data that contains the date the incident was reported to the Department (report date) rather than the date the incident occurred (incident date). Research conducted by the CFRC has revealed that use of the report date rather than the incident date results in an overestimation of abuse and neglect in substitute care.[13]

According to this research, a portion of the maltreatment that is reported while children are in substitute care actually occurred prior to a child's entry into care, i.e., the incident occurred prior to entry but the report occurred during substitute care. The most common "retrospective reporting" errors are reports of sexual abuse. DCFS administrative data does not distinguish between report date and incident date, so the effects of retrospective reporting error must be estimated. We have, therefore, excluded recurrence reports of sexual abuse from this indicator.

There are no significant differences between groups when the percentage of children who have not experienced substantiated maltreatment recurrence in substitute care is examined by age, race, and gender (see Appendix A; Indicator 1.E). However, rates of non-recurrence were higher (i.e., more children were safe from additional maltreatment while in substitute care) in the Cook County regions (99.1% in 2008) than in the Southern (96.9%), Northern (98.0%) and Central (98.1%) regions.

Figure 1.9 Percentage of children served in substitute care that did not have a substantiated report during placement

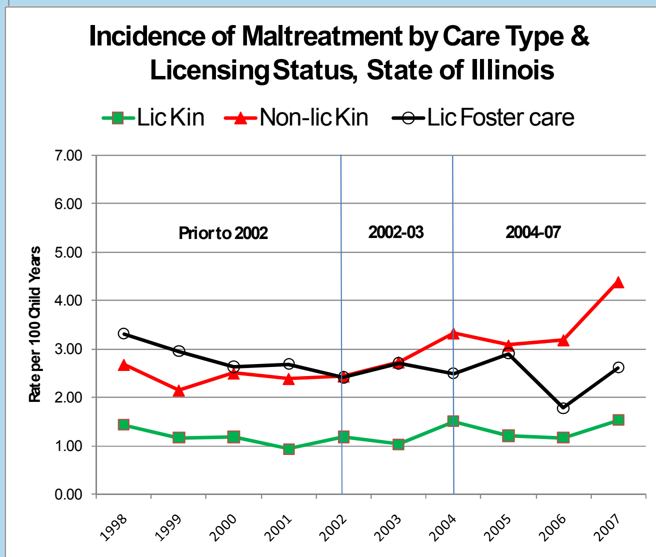


13 Title, G., Poertner, J., and Garnier, P. (2001). *Child maltreatment in foster care: A study of retrospective reporting*. Urbana, IL: Children and Family Research Center.

Box 1.4– **Warning Signs: Child Safety of Children in Unlicensed Kinship Foster Care**

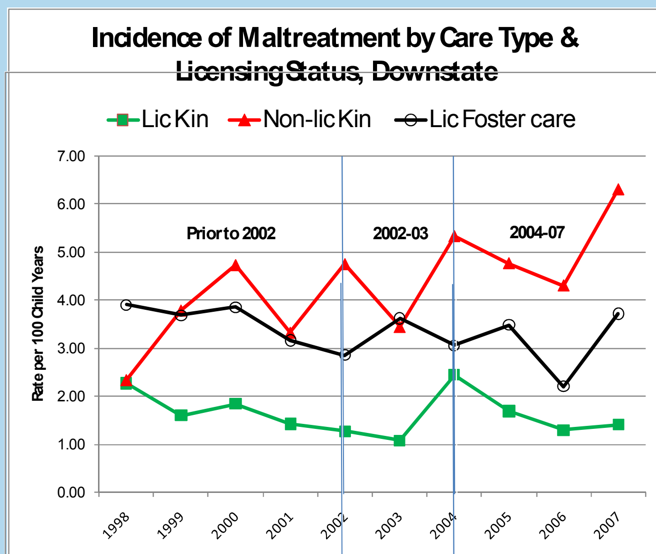
The last *Conditions of Children in or at Risk of Foster Care in Illinois: An Assessment of their Safety, Stability, Continuity, and Well-Being* report contained a "warning sign" that, while the vast majority of children do not experience repeat maltreatment, for the small subset who experience repeat maltreatment, there is a recent trend for those children to be living in kinship foster care.

Figure 1.10 Incident of Maltreatment by Care Type and Licensing Status, State of Illinois



When Illinois advanced its HMR Reform Plan in 1995, the evidence at the time was that kinship foster care was the safest substitute care setting that DCFS could make available to children. Although licensed kinship care was the most safe, non-licensed kinship care was still safer than licensed unrelated foster care prior to 2002. The safety situation in non-licensed kinship homes began to change during the 2002-03 period so that the safety record converged with the safety situation in licensed unrelated foster homes (*see Figure 1.10*).

Figure 1.11 Incident of Maltreatment by Care Type and Licensing Status, Downstate



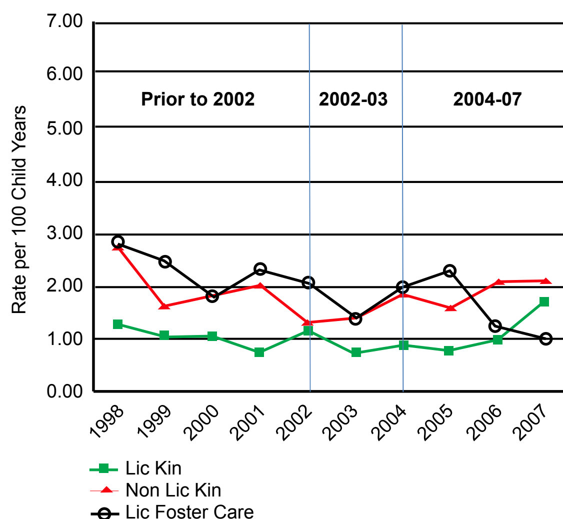
Beginning in 2004, the incidence of maltreatment in non-licensed homes began to rise and soon exceeded the incidence in non-related homes. Meanwhile the safety record in licensed kinship homes remained relatively unchanged. Disaggregating the data revealed that the deteriorating safety conditions in non-licensed care were most pronounced in the downstate regions of the state. The increased reliance on kinship homes in downstate regions may be resulting in differences in the way homes are screened, which could be remedied by concerted efforts to license relative homes for kinship foster care *(see Figures 1.11 and 1.12)*.

The recent passage of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110-351) into law on October 7, 2008, increased the Department's interest in the licensing of relative foster homes. An internal DCFS workgroup focusing on kinship licensing expressed an interest in learning more about the safety of children in licensed and unlicensed kinship foster homes.

Researchers at the Center conducted a series of analyses to examine causes and correlations between safety and placement type (kin or non-kin), license status, and demographic characteristics such as child's age, child's race, number of other children in the home, or regional location. Several child characteristics were significantly related to risk of maltreatment in care:

- African American children were at a significantly lower risk than white children;
- Younger children were at higher risk than older children;
- Children in placements with one to four siblings placed together were at a higher risk when compared to those without siblings;
- Children outside of the Cook regions, especially those in the Southern region, are at significantly higher risk of maltreatment than those who live within the Cook regions;
- Children in unlicensed kinship homes are at 30.1% higher risk of an indicated maltreatment report compared to non-kin licensed foster care spells
- Children in licensed kinship settings are 29.9% less likely to experience maltreatment in care compared to licensed non-kin foster care spells

Despite the higher financial payments that relatives can receive after they become fully licensed and trained foster parents, less than 30% of relative caregivers in Illinois currently avail themselves of this option. The



State's heavy reliance of non-licensed kinship care not only costs the state millions in lost federal reimbursements but will also close off non-licensed families to the new federal Guardianship Assistance Program (GAP) once the federal waiver expires in October 2009. Additional information is needed about the factors that discourage or prevent unlicensed kin providers from becoming licensed, and, for the small percentage for whom repeat maltreatment occurs, what makes unlicensed kin placements less safe than licensed kin placements. To be certain, the majority of kin placements (licensed or not) are safe from maltreatment. In addition, placement with kin (whether licensed or not) have many benefits that should not be overlooked when making placement decisions (see Chapter 3 of this report for additional information on kinship). However, better understanding of the relationship between unlicensed foster care and repeat maltreatment is warranted.

Box 1.5– **Recovery Coaches and Reducing Substance Exposed Infants (SEI)**

The Illinois Alcohol and Other Drug Abuse (AODA) Waiver Demonstration began in April 2000. To date, the AODA project has worked with 2,501 substance abusing parents and their children. Through random assignment, the AODA demonstration tests the effectiveness of the recovery coach model. Recovery coaches work with the parent, child welfare caseworker and AODA treatment agency to remove barriers to treatment, engage the parent in treatment, provide outreach to re-engage the parent if necessary and provide constant support to the parent and family throughout the life of the child welfare case. The recovery coach model has increased the likelihood of reunification and decreased the time it takes families to achieve reunification. In 2008 researchers at the Center investigated whether families receiving recovery coach services would be less likely to have a subsequent substance exposed infant (SEI). This is an important issue as approximately 70% of the women in the AODA demonstration were associated with at least one SEI prior to random assignment.

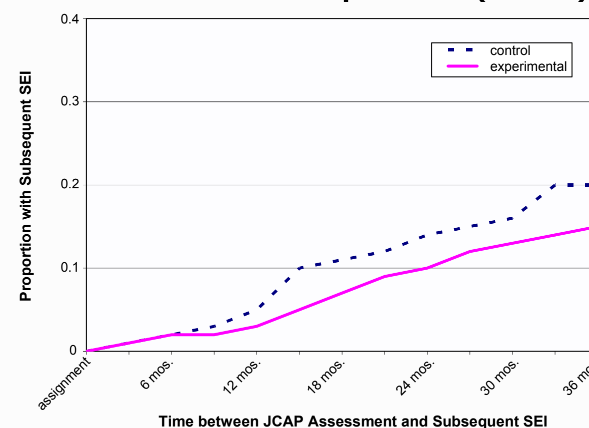
Sample

The study of SEIs utilized a sample of 931 women enrolled in the Illinois AODA waiver demonstration as of June 30, 2004. Subsequent to the temporary custody hearing, these women were randomly assigned to either a control (n=261) or experimental (n=670) condition. Parents in the control group received traditional substance abuse services. Parents in the experimental group received traditional services plus the services of a recovery coach. The recovery coaches assist parents with obtaining needed treatment services and in negotiating departmental and judicial requirements associated with drug recovery and concurrent permanency planning. This study focused specifically on SEIs that were substantiated as of June 30, 2005. Thus, at a minimum, each female caregiver had at least one year of observation. A comparison of the control and recovery coach group showed that the two groups are similar in terms of caregiver age, race, education, income, household composition.

Findings

Overall, 151 (16%) of the mothers were associated with a subsequent SEI. However, mothers assigned to the experimental group (recovery coach group) were significantly less likely to be associated with a subsequent SEI (15% vs. 21%). This difference emerges even after considering the caregiver's demographics, primary drugs of choice, co-occurring family problems, and prior SEI history. Specifically, the women in the recovery coach group are 28% less likely to have a subsequent SEI. *Figure 1.13* is presented as a visual representation of these differences. Note that for approximately 6 months after the JCAP assessment (represented as 0 days) the two lines follow a similar trajectory. Shortly thereafter however, the difference becomes quite noticeable. Within the control group approximately 10% of caregivers are associated with a new substance exposed infant within 15 months as compared to 7% of caregivers in the experimental group.

Figure 1.13 Life Table: Time between JCAP Assessment and Subsequent SEI (n=931)



Integrated and comprehensive approaches are necessary for addressing the complex and chronic needs of families involved in child protection.

The integration of services is not limited to substance abuse but also includes mental health, domestic violence, juvenile justice, and housing. Yet only through rigorous evaluation will child welfare systems fully comprehend the potential benefits associated with each individual approach. Title IV-E waiver demonstrations are proving to be a great resource in these endeavors.

For more information on key project staff and access to AODA related publications, you can visit our new website at HYPERLINK "http://cfrcwww.social.uiuc.edu/AODA/"http://cfrcwww.social.uiuc.edu/AODA/ The complete citation for the study of recovery coaches and substance exposed infants is: Ryan, J. P., Choi, S., Hong, J., Hernandez, P. & Larrison, C. (2008). Recovery Coaches and Substance Exposure at Birth. *Child Abuse and Neglect,* 32, 1072-1079.

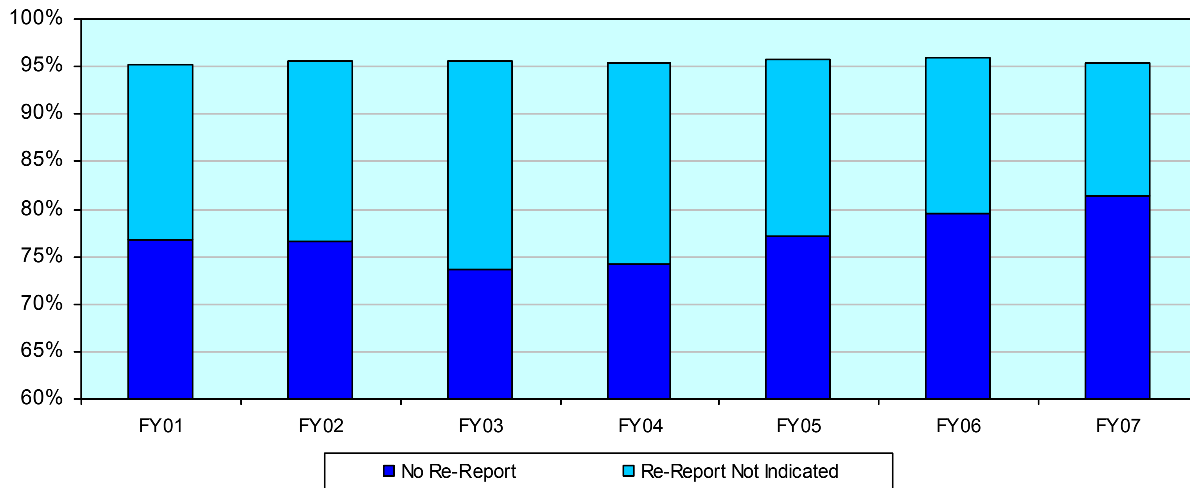
THE SAFETY OF CHILDREN AFTER AN INITIALLY UNFOUNDED REPORT

The majority of investigations —about 75% –– conclude with a case disposition of unsubstantiated (also called unfounded in Illinois). Although children with an initially unsubstantiated maltreatment report are at lower risk for re-reporting than those with initial substantiated reports (see Box 1.1), they are still at increased risk of further contact with child protective services when compared to children in the general population. The extent of that risk is worth exploring for one obvious reason investigated re-reports constitute additional use of the Department's limited resources. Resources could be re-allocated to provide additional families with services at the point of the initial investigation which, in turn, could reduce the risk of re-reports. This section explores the safety of children with initially unsubstantiated maltreatment reports by looking at the portion that experiences a re-report (regardless of disposition) or recurrence (a substantiated re-report) within 12 months.

Each year, children with an initially unsubstantiated report were examined after excluding those that received services (either intact family or substitute care) from the Department either at the time of the initial report or within 60 days. In 2001, about 15% of children in unsubstantiated investigations had a service case opened within 60 days of the initial investigation; by 2007 that proportion had declined to around 10%. Thus, of the over 75,000 children with an unsubstantiated report in 2007, about 68,000 received no further service from the Department during or immediately following the investigation.

Figure 1.14 displays both the percent of children who do not experience a maltreatment re-report (dark blue segment of the bars) and those children who do not experience an indicated maltreatment recurrence (entire bar, up through the light blue segment) within 12 months of an initially unsubstantiated investigation. The percent of children with initially unfounded investigations that do not experience a subsequent maltreatment report within a year has steadily increased from 73.6% in 2003 to over 81% in 2007. When examined by region (see Appendix A, Indicator 1.F), rates of are much higher in Cook than in the Central and Southern regions, with rates in the Northern region falling approximately in the middle. However, rates in the Central and Southern regions have shown a greater improvement, from 68% in 2004 to 77% in 2007, compared to those in the Cook region, which increased from 80% in 2004 to 86% in 2007. When examined by child race, rates among both Latino and Caucasian children increased 9% from 2004 to 2007, compared to a relatively smaller 7% increase among African-American children. In general, rates were highest among Latinos, followed by African-Americans and then Caucasians.

Figure 1.14 Percent of children with an initially unfounded maltreatment report that did not have a re-report or indicated recurrence within 12 months



The light blue bars in *Figure 1.14* display the percent of children that do not experience a substantiated maltreatment report within 12 months of an initially unsubstantiated investigation. For the state as a whole, this percentage has remained fairly stable between 95-96% for the past several years. If the rates of indicated recurrence among children with initially unsubstantiated reports are compared to those for children with initially substantiated reports (*see Figure 1.3*), children with initially unsubstantiated reports are about half as likely to experience a second indicated report within one year.

When rates of 12-month maltreatment non-recurrence among initially unfounded investigations are examined by region (see Appendix A, Indicator 1.G), rates are much higher in Cook than in the Central and Southern regions, with rates in the Northern region falling approximately in the middle. For example, in 2007, the non-recurrence rate was about 97% in Cook, compared to 95.8% in Northern region, 93.7% in Central region, and 94.1% in Southern region. Rates in all regions have neither dramatically increased or decreased over the past 7 years. Difference in non-recurrence by child race were small, with Latinos and African-American children having slightly higher rates than Caucasian children (96.8%, 95.9%, and 94.8 in 2007, respectively).

Box 1.6– **Moving Forward: The Promises of Differential Response**

As many children continue to remain vulnerable to abuse and neglect, Child Protective Services (CPS) agencies and states seek innovative reforms to more effectively address the large volume of maltreatment reports and prevent maltreatment by engaging and strengthening families.[14] Differential response (DR) is an approach that answers this call. This front end reform arose out of the need for CPS agencies to: better support low risk families who need services; decrease the rising number of families being reported and investigated; engage the community in supporting families with the recognition that families who experience a supportive process will more likely engage in services; and positively impact fiscal resources that are rapidly decreasing. It is also argued that differential response offers solutions to the troubling issue of racial disproportionality in child welfare as it primarily targets cases of neglect which are highly correlated to issues of poverty and racial disparity.[15] [16] [17]

What is Differential Response?

Differential response is an alternative means to respond to allegations of child abuse and neglect. Instead of solely relying on the traditional investigative process, DR allows cases of low to moderate risk of child abuse and neglect to be deflected from the investigative system while connecting families to necessary services. States and counties that have implemented differential response have reported very positive outcomes and have shown that DR does not compromise child safety. In the sixteen states or counties that have implemented DR, families who are assigned a differential response path reenter the system at a significantly lower rate than families who receive investigations, and that decreases hotline reports and the recurrence of abuse and neglect.[18] [19] [20] According to Waldfogal,[21]

> *"These initial reports were fairly positive, finding that a substantial share of families referred to CPS could be safely handled on the assessment rather than investigative track."*

Differential Response in Illinois

In its current form the Illinois Statute does not allow for differential response. It is an investigation based system with minimal room for multiple responses to child welfare maltreatment scenarios. While some components of DR are currently practiced in Illinois, differential response is not currently codified and is not the practice for handling the majority of hotline calls. By changing the current practice to one that would allow for DR, Illinois families would be able to voluntarily request help and services from DCFS without an investigation. DR would allow for all appropriate cases of alleged abuse and neglect of low to moderate severity, that are called into the hotline, to receive services without a formal investigation.

The idea behind differential response is to engage families with a strength based approach, assess families' needs, and connect families to adequate community based services in response to those needs. In Illinois, over the past four years, on average, 77% of investigated and indicated cases were considered neglect cases or substantial risk of harm cases. Out of the cases opened for investigation and indicated, almost 30% of families receive no services at all. If differential response were implemented in Illinois, cases that typically may have received a full investigation would not require an investigation. This would save considerably on the costs that the State spends on investigations and the appeals process. Scarce resources could be allocated to investigations of serious cases of maltreatment and for providing and connecting families to services that adequately strengthen and stabilize families.

Legislation is currently pending that would change Illinois statue to accommodate DR. Ultimately, the most important message about DR is that the biggest change any CPS agency has to make is what they believe about parents and how they should work with families. David Thompson, Program Manager of the Minnesota Department of Human Services summed it up this way,

> *"We have shifted from an external expert system that monitors parents and requires compliance to the CP agency's plan, to a safety focused family partnership where the CP agency and family work and plan in partnership to assure the safety and well being of all family members. All structure, process, policy and protocol then flow from this safety through engagement principle."*

A full report on DR is available at: "http://www.cfrc.illinois.edu/pubs/pdf.files/DiffResponse.pdf" http://www.cfrc.illinois.edu/pubs/pdf.files/DiffResponse.pdf This was written by Jennifer Richardson, CFRC.

14 Child Welfare Information Gateway. Children's Bureau. (February 2008) *Differential response to reports of child abuse and neglect.* Issue brief. www.childwelfare.gov/pubs/issue_briefs/differential_response

15 Fluke, J.D., Yuan, Y.T., Hedderson, J., & Curtis, P.A. (2003). Disproportionate representation of race and ethnicity in child maltreatment: investigation and victimization. *Children and Youth Services Review,* 25(5/6), 359-373.

16 Osterling, K.L., D'Andrade, A., & Austin, M.J. (2008). Understanding and addressing racial/ethnic disproportionality in the front end of the child welfare system. *Journal of Evidence-Based Social Work,* 5(1/2), 9-30.

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18 Loman, L.A., and Siegal, G.L. (2005). Alternative response in Minnesota: findings of the program evaluation. *Protecting Children,* 20, 78-92.

19 Loman, L.A., and Siegal, G.L. (2004). Differential response in Missouri after five years: final report. St. Louis, MO: Institute of Applied Research.

20 Johnson, C., Sullivan, E., Sutton, JD, & Thompson, D.M. (2005). Child welfare reform in Minnesota. Protecting Children, 20, 55-61.

21 Waldfogel, J. (2008). The Future of Child Protection Revisited. In Lindsey, D. and Shlonsky, A. (Eds.), *Child Welfare Research Advances for Practice and Policy.* Oxford University Press: Oxford.

OBSERVATIONS ON CHILD SAFETY

When examining child safety, the true litmus test of child welfare performance is how well it protects children from additional maltreatment after they become known to the system. The primary indicator used to assess performance in this area is the rate of maltreatment recurrence, typically measured as the occurrence of a second indicated report of maltreatment that occurs within a certain time period following an initial indicated report. When maltreatment recurrence within 12 months is examined over time for all children with an indicated report, rates have remained at a constant level for the past several years. However, this overall rate masks differences in recurrence rates among indicated children that receive different service responses from the Department.

Following an indicated report, one of several things can occur: the case can be closed without further services to the family, services are provided to the family while the children remain at home (intact family services), or one or more of the children can be removed from the home and served in substitute care. The safety of children in these groups varies. Safety (i.e., non-recurrence of maltreatment within 12 months of an initial indicated report of maltreatment) among children who do not receive services has remained stable around 89%. Children served in intact families have become less safe in recent years, however, with non-recurrence rates falling from 90% in 2001 to 88% in 2007. While the decline in the safety rates over the years is slow, the fact that the downward trend continues deserves closer attention.

Closer examination of these non-recurrence rates reveals large regional differences, with higher safety rates in Cook regions and lower rates in the Central and Southern regions of the state. Rates in the Cook regions range from 91.2% in Cook North to over 94% in Cook South, and have remained relatively stable or increased slightly since 2001. Rates of safety in each of the three regions outside of Cook County have decreased over time, from around 88-89% in 2001 to 83-84% in 2007. Additional information about regional variations in caseworker and supervisor practice may offer clues to the reasons for these differences.

Children served in substitute care are much safer from maltreatment recurrence than children served in intact families or those that receive no services at all. Although the overall number of children maltreated while in substitute care remains stable, recent trends suggest that children served in kin placements have become less safe than those in non-kin placements. Examination of this trend taking into account the license status of providers suggests children served by unlicensed relatives outside of Cook County have become less safe compared to children in traditional foster homes. However, children placed with licensed relatives remained safer then than both children in unlicensed relative homes and those in traditional substitute care. Fortunately the Department is already exploring interventions to encourage more kinship providers to become licensed.

Many have attributed the increased safety of children in Illinois to the implementation of a structured safety assessment protocol (the CERAP) in 1995. All investigated households should receive a safety assessment at the beginning of the investigation; within 24 hours after the investigator first sees the alleged victim. In addition, CERAP policy requires at least one more CERAP assessment at the conclusion of the investigation, although this requirement is waived for those investigations that involve open service cases. Data from the annual CERAP evaluation suggest that CERAP re-assessment at investigation close occurs in about 38% of investigations that require it. The low compliance with this policy is unfortunate, because comparison of maltreatment recurrence rates among cases with and without a safety re-assessment at investigation close finds that cases without additional assessment are at significantly higher risk of recurrence. The relationship between CERAP re-assessment and lower maltreatment recurrence is robust; holding true for cases regardless of the initial safety determination (safe or unsafe) that occurred at the beginning of the investigation. The consistency of this finding across several evaluations suggests that ongoing safety monitoring and assessment is crucial to child safety, and the Department should emphasize the importance of investigation compliance with CERAP re-assessment.

CHAPTER 2

STABILITY OF FAMILY LIFE

Nancy Rolock and Mark Testa

AT HOME AND IN SUBSTITUTE CARE

Home life is the highest and finest product of civilization. Children should not be deprived of it except for urgent and compelling reasons (First White House Conference on the Care of Dependent Children, 1909).[1]

Stability for the majority of children involved with the child welfare system in Illinois has been relatively high over the past several years. In this report we found that the majority of children served at home, after a maltreatment investigation, remain safely at home. In addition, the vast majority of children living in foster care are relatively stable while in foster care. Furthermore, older youth (aged 12 or older), those most likely to run away from a foster care placement, usually do not run away. However, with each of these groups of children, there is a subset of children who have experienced instability, and in a few cases great instability. At a meeting with DCFS and ACLU, the Center agreed to conduct a joint record review with the Department's Division of Quality Assurance of the "Top Multiple-Move Cases" and a matched sample of stable cases. This chapter will present the findings on stability in general, and then summarize the findings from this special study on instability requested by the Department.

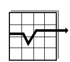
PRESERVING FAMILY STABILITY: KEEPING FAMILIES INTACT

The preference for children to remain at home, when safety can be ensured, can be quantified as the rate of child non-removal: that is, for every 1,000 children in Illinois, the number that have not been removed from their home. In Illinois, the overall rate of non-removal has increased from 998.3 per 1,000 children in 2002 to 998.7 in 2007, but has decreased in the most recent year to 998.5 per 1,000 children. This rate is significantly lower for African American children than for any other group of children (*see Figure 2.1*), and while this improved for African American children from 995.1

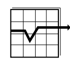
FAMILY STABILITY AT A GLANCE

We know children have more stability if:

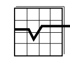
Fewer children are removed from their home of origin:


Of all children in Illinois, the rate of those who were not removed from their home of origin increased from 998.3 per 1,000 in 2002 to 998.7 in 2007 but decreased to 998.5 per 1,000 in 2008.

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


Of all children served in intact family cases, the percentage that did not experience an out-of-home placement within a 12-month period fluctuated between 94% and 95% over the past seven years.

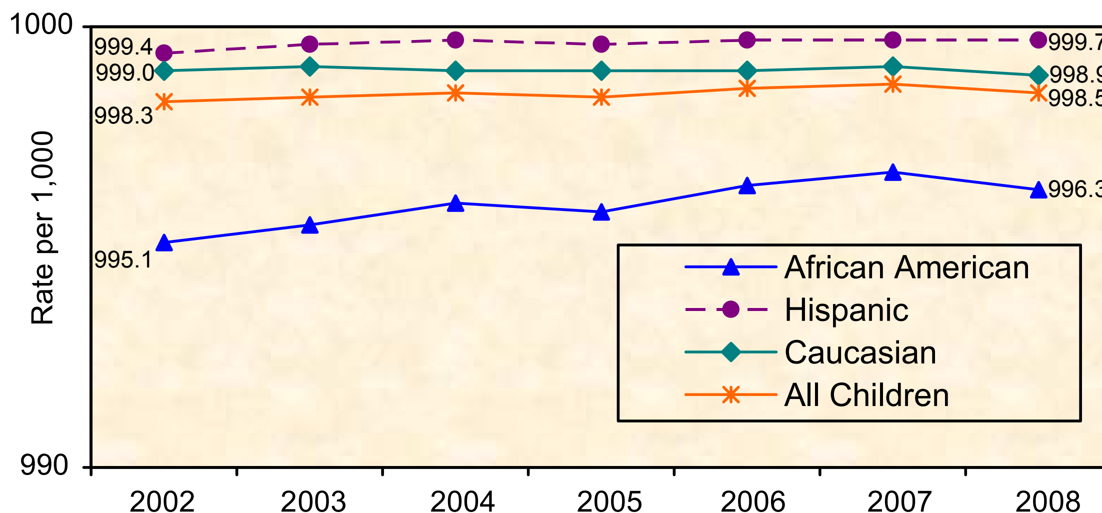
More children do not move from home to home while they are in foster care:


Of all children entering foster care and staying at least one year, the percentage that had no more than two placements within 12 months from the date of entry into foster care has fluctuated between 78% and 80% over the past seven years and is currently 79%.

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

Of all children entering substitute care at the age of 12 or older, the percentage that did not run away from a foster care placement within their first year in care has steadily increased from 76% in 2002 to 80% in 2007.

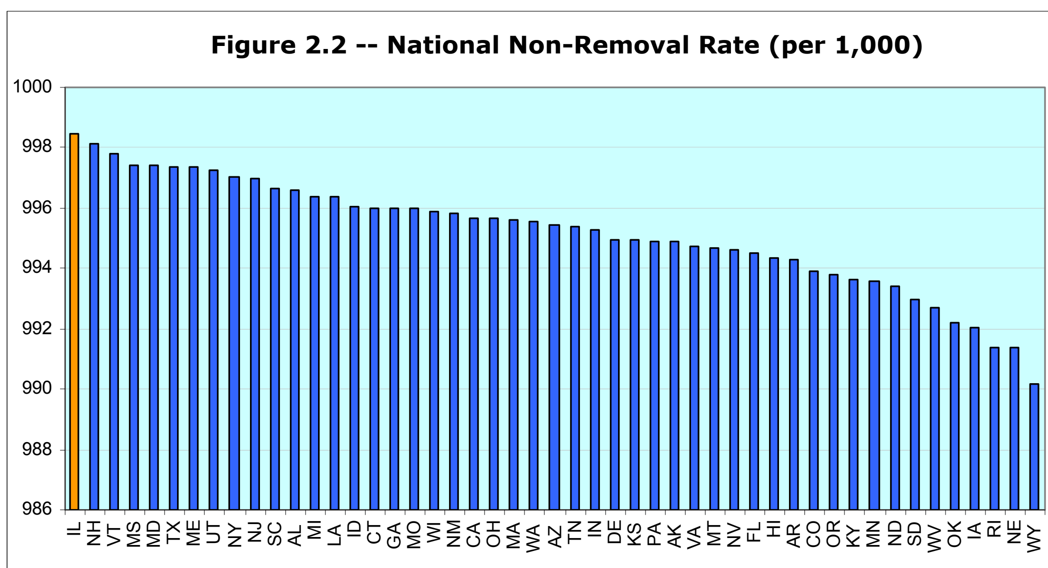
1 First White House Conference on the Care of Dependent Children, January 25, 1909.



in 2002 to 996.7 in 2007, in the past year it has dropped to 996.3 per 1,000. Center research shows that African American children in any region of the state are more likely to be removed from home and enter foster care than any other children in the state, and this disparity is greater than at any other decision point in the continuum of decisions made that impact a child's involvement in the foster care system.[2]

The rate of non-removal is central to understanding child welfare outcomes. Non-removal rates (the rate of children in a community who do not enter foster care) vary widely across the country. As shown in *Figure 2.2*, national data shows that Illinois now has the highest non-removal rate in the country at 998.4 per 1,000 children. Some states have a rate as low as 990.2 (Wyoming), with the median around 995.5 (as in Maine, Washington, Arizona and Tennessee)[3].

The non-removal rate impacts all outcomes for children who enter foster care. In states that remove many children, outcomes such as reunification may look very different than in states where few children are removed, and more are served at home. Having one of the highest non-removal rates



2 Rolock, N. (2008). Disproportionality in Illinois Child Welfare. *Children and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign.*

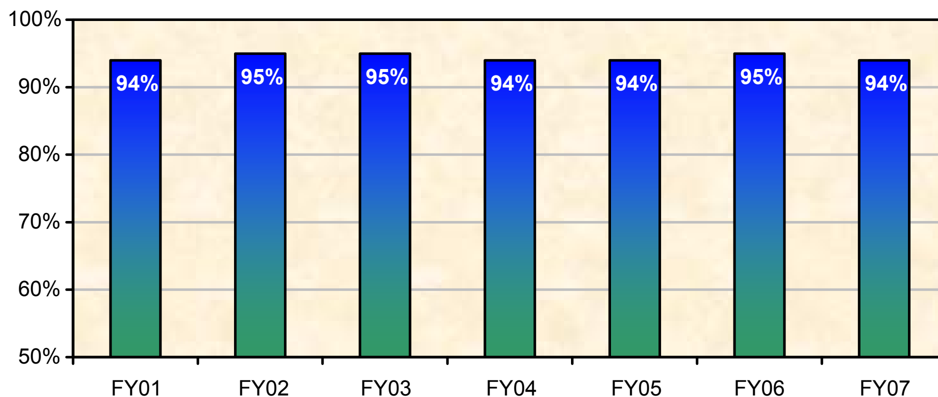
3 Center analysis based on data from: US Department of Health and Human Services, Adminsitration for Children and Families. (April 20, 2009). Statistics & Research. *In Adoption and Foster Care Statistics*. Retrieved May 11, 2009, from http://www.acf.hhs.gov/programs/cb/stats_research/index.htm.

County	Annual Removals (FFY08)	Non Removal Rate (per 1,000)
Table 2.1 County Removal Rate		
Low Removal Counties (996.4 to 980.8)		
DuPage	78	996.4
McHenry	36	996.4
Kane	115	992.8
Boone	13	991.6
DeKalb	22	991.6
Lake	166	991.6
Cook	1,261	990.4
Will	235	989.2
Macoupin	16	986.8
St. Clair	93	986.8
Fulton	12	985.6
Christian	14	983.2
Franklin	15	983.2
Bureau	16	982.0
Kankakee	55	982.0
Knox	20	982.0
Morgan	14	982.0
Woodford	19	980.8
Medium-Low Removal Counties (979.6 – 970.0)		
Clinton	19	979.6
Lee	18	978.4
La Salle	64	977.2
Randolph	16	977.2
Livingston	23	976.0
Madison	162	976.0
Coles	25	974.8
Effingham	25	974.8
Adams	45	973.6
Jackson	29	973.6
Moultrie	10	973.6
Whiteside	39	973.6
Iroquois	21	972.4
Carroll	11	971.2
McDonough	16	971.2
Clay	10	970.0
Montgomery	21	970.0
Sangamon	148	970.0
Medium Removal Counties (968.8-958.0)		
Wayne	12	968.8
Richland	12	967.6
Cass	12	966.4
Massac	12	965.2
Rock Island	121	965.2
Stephenson	40	965.2
McLean	152	961.6
Tazewell	127	960.4
Ford	15	959.2
Winnebago	327	959.2
Williamson	62	958.0
Medium-High Removal Counties (956.8-943.6)		
Mason	16	956.8
Saline	28	955.6
Champaign	186	954.4
Fayette	24	952.0
Union	21	950.8
Lawrence	18	949.6
Logan	35	946.0
Peoria	261	943.6
High Removal Counties (941.2-826.0)		
Vermilion	118	941.2
Jefferson	59	940.0
Marion	62	937.6
Macon	209	920.8
Brown	20	826.0
60 counties total; counties with less than 10 removals not included		

in the nation means that states like Illinois, New Hampshire and Vermont may profile very differently than low non-removal states like Wyoming, Nebraska and Rhode Island. We will explore the relationship between non-removal rates and other outcomes later in this report.

Often what happens at the community level is masked by trends at the state level. Recognizing the importance of looking at data at the community level, we examined county-level data from 10 states, made up of approximately 700 counties to put Illinois' counties in perspective. We then ranked the 700 counties into quartiles – from those with the highest non-removal rate (or lowest removal rate) to the lowest non-removal rate (or highest removal rate). We have displayed only the Illinois counties from this analysis in Table 2.1. This table shows that over half the counties in Illinois are low removal counties (60%). Eleven (18%) are medium removal counties, and 13 (22%) are high removal counties. Cook is the largest county in Illinois; it also removes relatively few children and has among the lowest removal rate in these 10 states. Also noteworthy are the following counties as they removed over 100 children in the past year and have either low or high removal rates: Kane (992.8), Lake (991.6) and Will (989.2), similar to Cook (990.4), have low removal rates while Macon (920.8), Vermillion (941.2), Peoria (943.6) and Champaign (954.4) have high removal rates. We will continue to discuss removal rates and their impact on outcomes later in this report and will track these eight Illinois counties as we do this.

Another measure of how well the state is doing in preserving family stability is the number of children served in intact family cases that do not experience a substitute care placement within a year of initial report (see Appendix A, Indicator 2.A). Examination of *Figure 2.3* shows that the number of children not removed from home when there is an open intact family case has remained between 94% and 95% since 2001. Additional analyses reveal that the age of the child at the time of intervention is important – older children are less likely to enter substitute care from intact family cases than younger children. Analysis of regional differences shows that children in Cook are more likely to stay home and not enter care than children in the remainder of the state. In the last year 97% of children in Cook were stable compared to 91% in Central and 92% in both Southern and Northern regions. There are virtually no gender or racial differences in this indicator.



STABILITY IN SUBSTITUTE CARE

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

Results in *Figure 2.4* reveal that placement stability in substitute care has fluctuated between 79% and 80% over the past several years. Examination of trends in specific subgroups of children reveals that African American children experience less stability than white children (78% and 81% respectively). There is little difference in stability rates by gender. For geographic breakouts, the Southern region and Cook County are less stable (both 76%) than the rest of the state (Central region is 82% and Northern is 79% stable). In addition, the data shows that children under 12 years of age experience greater placement stability than teens (see Appendix A, Indicator 2.B).

KINSHIP CARE AND PLACEMENT STABILITY

CFRC's program of research on kinship foster care shows that placement with kin, after appropriate safety checks, is the most stable form of substitute care available to children who are removed from parental custody.[4 5] This finding has been confirmed by researchers in California who found that children in kinship care had greater stability than those placed with non-kin[6] and more recently in the Center's study of multiple movers that found kin placements last longer than non-kin placements (see Box 2.2). In addition, placement with grandparents, aunts and uncles may help reduce the trauma of separation that accompanies child removal from the home and may preserve important connections to siblings, family, and local community. *Figure 2.5* shows that children initially placed with kin are much more likely to experience placement stability than those placed with non-kin[6]. An analysis of this at the regional level shows that there has been an increase in instability among children in non-kin homes while children in kin homes are consistently more stable (see Box 2.1).

4 Garnier, P.C., & Poertner, J. (2000). Using administrative data to assess child safety in out-of-home care. *Child Welfare,* 79, 597-613.
5 Testa, M. (2002). Kinship care and permanency. *Journal of Social Service Research,* 28, 25-43.
6 Webster, D., Barth, R.P., & Needell, B. (2000). Placement stability for children in out-of-home care: A longitudinal analysis. *Child Welfare,* 79, 614-632.

Figure 2.4 Children in substitute care for at least one year who had no more than two placements within a year of removal

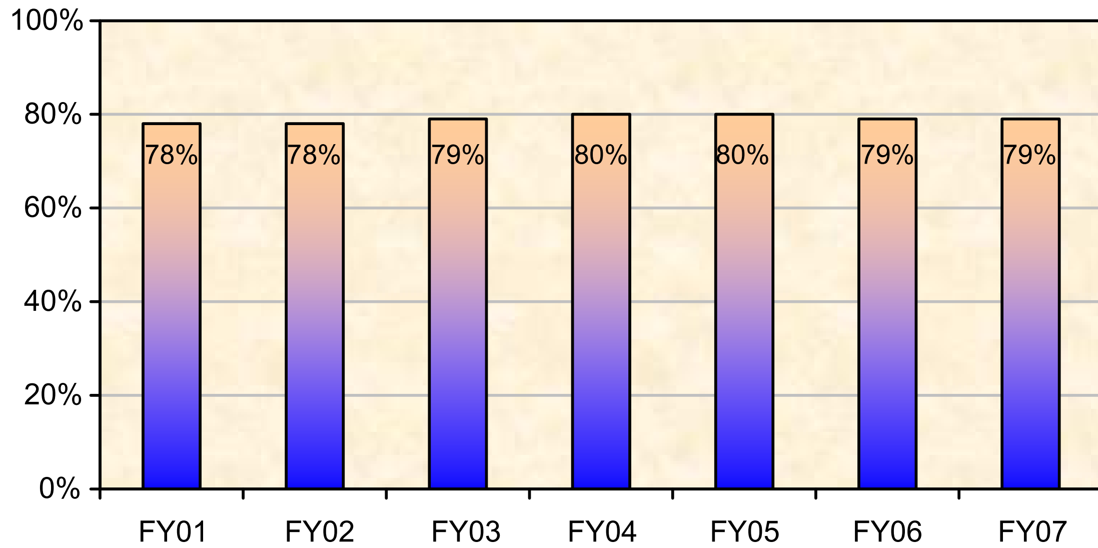
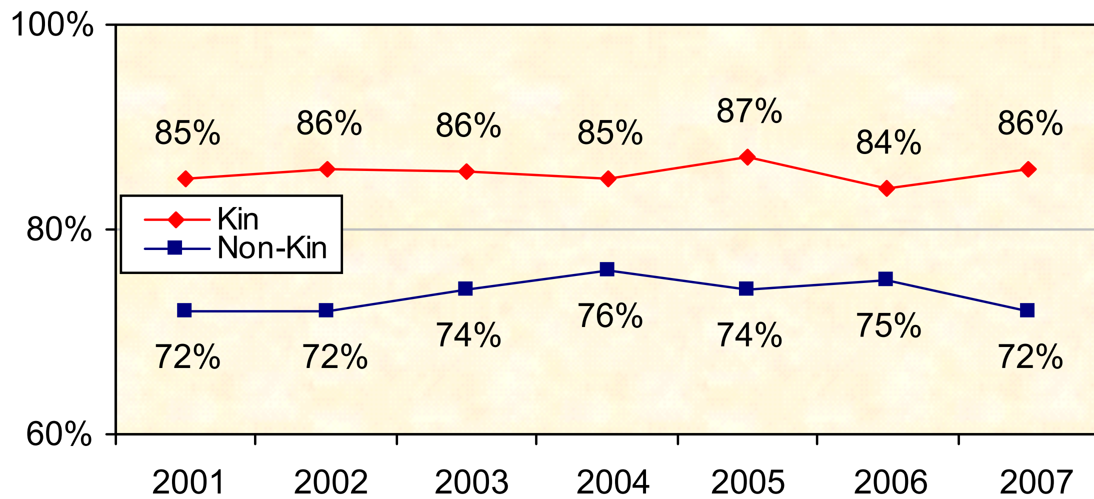


Figure 2.5 Percent of children with no more than two placements during their first year in care by first placement type ALL ILLINOIS



Box 2.1—**Warning Signs: Instability in Non-Kin Homes on the Rise**

Analysis of stability that looks at placements in kin and non-kin homes at the regional level shows a very different picture, depending on the region. When explored at the regional level we find a recent divergence in stability rates among kin and non-kin in Cook County and Northern regions. However in Central region, while children in kin homes are more stable than in non-kin homes, there has been an increase in stability among non-kin and a decrease in stability among kin providers. In the Southern region, the difference between stability in kin and non-kin homes is perhaps most pronounced; children in kin homes are over 10% more likely to be stable. Over the next year attention should be paid to these trends and stability in foster care should be closely monitored.

Figure 2.5a Percent of children with no more than two placements during their first year in care by first placement type

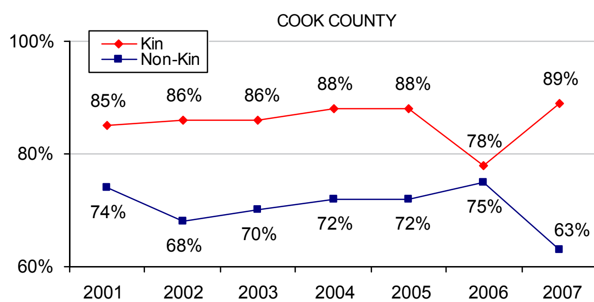


Figure 2.5b Percent of children with no more than two placements during their first year in care by first placement type

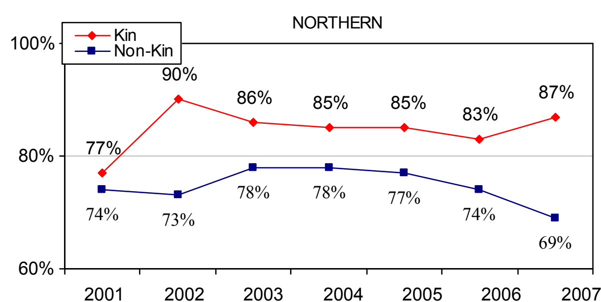


Figure 2.5c Percent of children with no more than two placements during their first year in care by first placement type

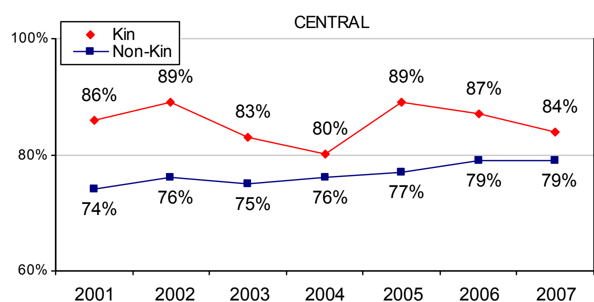
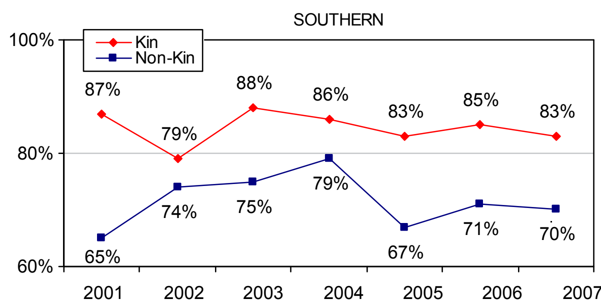
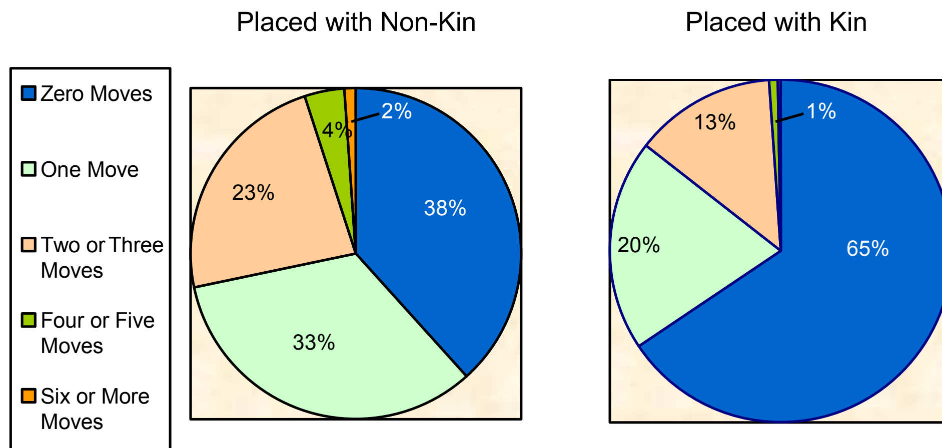


Figure 2.5d Percent of children with no more than two placements during their first year in care by first placement type



Research indicates that the timing of the first placement change can predict the likelihood of multiple moves for children in care. The Illinois data over the past seven years shows that, of the children that do move, 78% of those placed with non-kin experience their first move within the first 90 days of entry into substitute care compared with 60% of children placed with kin. This suggests that not only do children initially placed with kin experience greater overall stability than those placed with non-kin (65% of children placed with kin and 38% of children placed in non-kin homes have no moves within their first year in care; see *Figure 2.6*), they are more likely to experience at least 90 days of stability when first placed into care.

Figure 2.6—Number of moves within one year

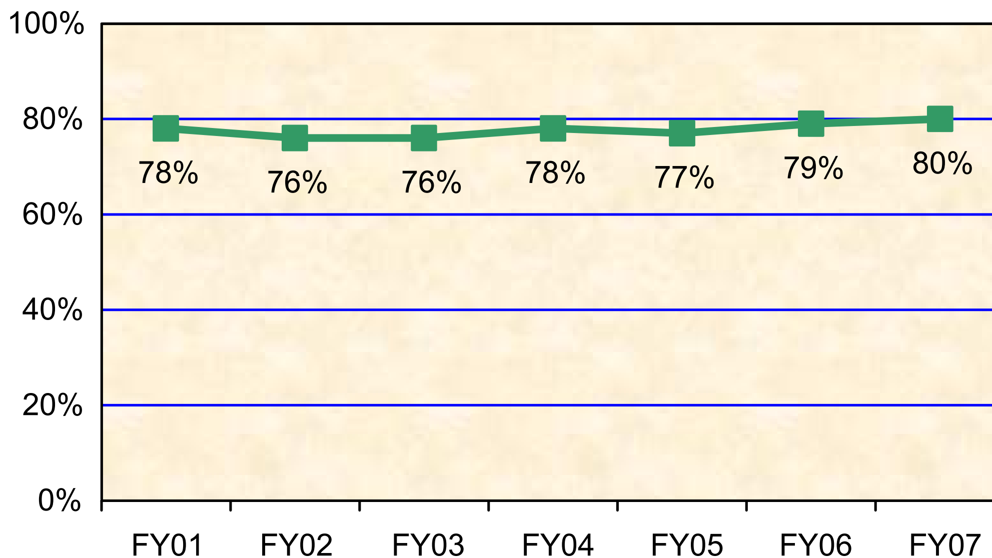


YOUTH WHO RUN AWAY FROM SUBSTITUTE CARE

Another way to measure stability in substitute care is to look at the number of children who run away from their foster home. In an effort to examine the population of foster children most likely to run away from placement, this indicator examines only those children who enter care at the age of 12 or older (see Appendix A, Indicator 2.C). *Figure 2.7* displays the number of children 12 or older who did not run away from substitute care during the first year of placement, and shows an increase from 76% in 2002 to 80% in 2007. While this is an improvement, the fact that one in five children run in their first year indicates a problem that needs to be addressed.

The age group most likely to run is children entering care at age 15 or older; while 87% of children aged 12 to 14 are stable, 74% of children 15 and older are stable. When looked at by race, African-American children and Caucasian children experience very different run away rates: while 86% of Caucasian children were in stable placements (did not run) in 2007, 76% of African-American children did not run. Children residing in Cook County are much more likely to run away than children in the remainder of the state. In Cook, 71v% did not run as compared to 83% in Northern, Central and Southern regions. In addition, teen girls are more likely to run (78%) than their male counterparts (83%). Efforts to increase stability, and prevent runs, among these youth should be targeted at African American children, teen girls and children in Cook County.

Figure 2.7–Percent of children 12 or older who did not run away during the year following entry



Box 2.2—**Multiple Move Study in Illinois**

At a meeting between DCFS and the ACLU in November, 2007, the Children and Family Research Center agreed to conduct a joint record review with the Department's Division of Quality Assurance of the "Top Multiple-Move Cases" and a matched sample of stable cases as determined from CYCIS data. The joint record review was conducted by staff from the CFRC Foster Care Utilization Review Program (FCURP) and the Division of Quality Assurance. This review addressed, among other things, the extent to which the Child and Youth Investment Team (CAYIT) process served the intended purpose when applied to children with multiple moves. CAYIT meetings evaluated here are those triggered once a child enters a third foster or kin placement within 18 months. The goal of these meetings is to minimize moves through improved assessment of needs and prompt provision of recommended services.

Methodology

Take two children who at one point look identical: from the same community, same age, race and gender, same length of time in foster care. However, the next 18 months prove largely different for these two children: ultimately one of these foster children experiences multiple moves while the other child is stable. What causes one foster child to experience multiple moves while another foster child experiences stability while in foster care? In an effort to understand this question, we examined the case records of two groups of children who profiled similarly at the beginning of the review period but ultimately had different stability outcomes.

The study selected a sample of 61 multiple-move cases (children who had three or more placements within an 18-month period). These cases were limited to children in foster family and kinship homes. The multiple-move sample was then matched to a sample of 61 stable cases (fewer than three placement moves during the same timeframe) who at the beginning of the review period profiled similarly to the 61 multiple-move cases in terms of age, race, gender, region, number of placements experienced, length of time in foster care, but subsequently remained stable over the following 18 month period. The purpose of the matching of multiple-move and stable cases is to ensure that the two samples were comparable at the beginning of the review period so that we could track and compare the two groups in the following 18 month period.

Key Findings

The study found that the reason children moved could be categorized by:

- 35% of the moves were foster-family related. Over half (52%) of these moves were a result of maltreatment allegations in the foster home, and 48% were at the request of the foster parent due to changes in their life situation. (For instance, the foster parent was getting divorced, or lost a job and could no longer care for the child.)
- 33% were related to the behavior of the child. This includes aggressive behaviors toward other children in the home or school, sexually inappropriate behaviors or threatening to harm the self.
- Finally, 26% of the moves were due to competing policy priorities. For instance, siblings were moved together due to the behavior of one. Additionally, the least restrictive care placement priority competed with the need for more intensive services to address specific child needs. An evaluation and understanding of these tradeoffs is essential to understanding stability.

The study also found that CAYITs were often convened too late, just after replacement into a new home. This results in the recommendation to remain in current placement (86%). Multiple move CAYITs are targeted at addressing the needs of children and infrequently recommend services targeted at foster parents (2%). Given the finding that 35% of moves are foster-family related and 26% are policy-related, perhaps a different trigger system for multiple move CAYITs is warranted.

The full report from this study will be available on the Center website by Fall, 2009.

OBSERVATIONS ON STABILITY IN ILLINOIS

Non-removal rates have a significant impact on outcomes for children in foster care. As the Illinois Department of Children and Family Services receives results from the second round of the federal Child and Family Services Review (CFSR), it is important that outcomes are understood in this context. Illinois removes fewer children per capita than any other state in the nation, and, as such, should not be held to the same standard as states with much higher removal rates. If it is true that Illinois serves more families at home without taking custody, that these families are safe, and as a result of these efforts many more children in Illinois are at home instead of in foster care, then perhaps the cases that do come into care in Illinois are different than the children that come into care in other states. Illinois may remove only the neediest cases, and it might take longer for these children to achieve stability and permanency than in states with higher removal rates where many more children are removed and quickly returned home. That being said, there are counties in Illinois that have high removal rates and this should be better understood and closely monitored over the next year.

Another cause for concern is the recent increase in instability among non-kin families, particularly in Cook County and Northern region. These outcomes should be monitored and assessed throughout the year.

Finally, new research from the Center suggests that for those children who experience instability while in foster care, targeted recruitment, training and support of foster parents may be helpful in preventing instability. The study also found that CAYITs were often convened too late, just after re-placement into a new home resulting in the recommendation to remain in current placement. Review of CAYIT triggers and implementation is also warranted. The study also suggests that competing Department priorities were the cause of some instability, and an evaluation and understanding of these tradeoffs are essential to understanding stability.

CHAPTER 3

CONTINUITY

Nancy Rolock and Mark Testa

KINSHIP, COMMUNITY, AND SIBLING TIES

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

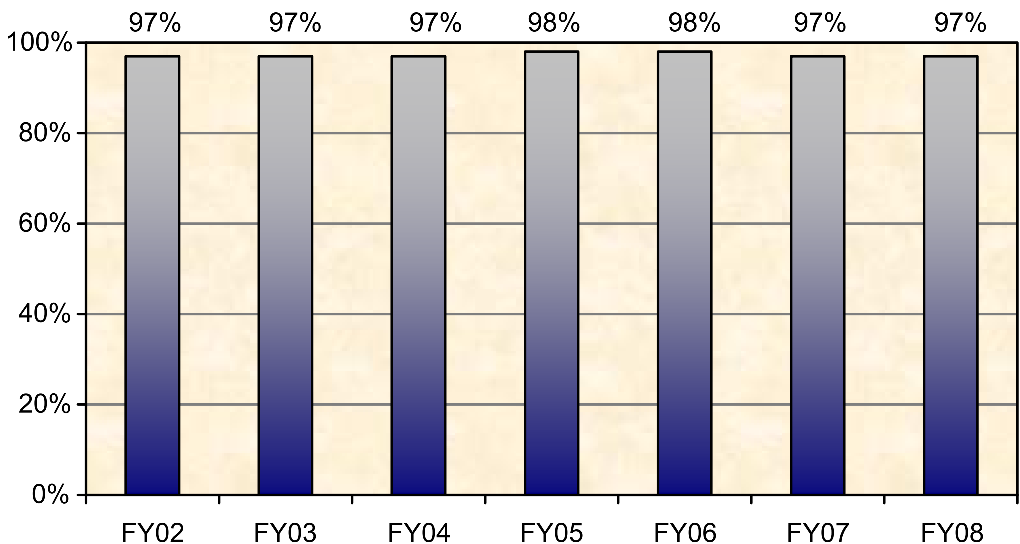
When substitute care is necessary to foster or protect children, federal and state policy favor placement in settings that conserve children's existing kinship, community, and sibling ties. State and federal policies also have a preference for "least restrictive" care—prioritizing foster family care over group homes, institutions, and other forms of congregate care, and for "kinship preference"—prioritizing placement with relatives over non-relatives[2]. As of the most recent data reported to the federal government, kinship foster care accounted for 24 percent of all substitute care in the United States[3] . Sometimes practice decisions need to be made which put these policies in conflict with one another. When, for instance, is it better to place a child with particularly difficult behavioral needs in a more restrictive setting? When is it better to split siblings to protect one sibling from another? In this chapter we will look at each of these issues to assess how Illinois is doing with regards to these policies and preferences.

In 2007, DCFS received a three year grant administered by the National Quality Improvement Center on the Privatization of Child Welfare Services housed at the University of Kentucky. This initiative extends Illinois' use of performance based contracting to residential, independent living and transitional living programs. Judge Kathleen A. Kearney, CFRC staff, is the principle investigator for this grant, and she has included an update of this project in this chapter (see Box 3.1).

LEAST RESTRICTIVE CARE

Although best practice recognizes a need for residential treatment for a residual segment of older wards who cannot be appropriately served in a family setting, there is general consensus that the institutionalization of young children interferes with normal developmental growth. Illinois made concerted efforts in the 1990s to prevent the institutionalization of young children. The percentage of foster children under the age of 12 years old who are not placed in a group home or institution has remained above 97 percent since 2002 (see *Figure 3.1* and Appendix A, Indicator 3.A). Whether further increases in the proportion of young children served in less restrictive settings are possible will depend on the availability of trained foster parents as well as "wrap-around" services to children in kinship and traditional foster care settings.

Figure 3.1 Percent of children under 12 not living in institutions or group homes at year end

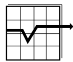


1 U.S. Social Security Act, Sec. 475. [42 U.S.C. 675].
2 U.S. Social Security Act, Sec. 471. [42 U.S.C. 671].
3 AFCARS data 2006

CONTINUITY AT A GLANCE

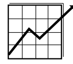
We will know if continuity is preserved:

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

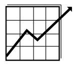


Of all children placed into their current placement setting before the age of 12, the percentage not placed into institutional or group home care has remained constant at 97% or 98% over the past seven years.

If more children are placed with kin:

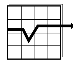


Of all children entering foster care, the percentage placed with kin in their first placement increased from 38% in 2002 to 51% in 2008.



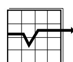
Of all children in substitute care, the percentage living with kin at the end of the year has increased from 37% to 40% over the past seven years.

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

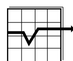


Of all children living in institutions or group homes at the end of the fiscal year, the percentage placed within the state has decreased slightly from 99.2% in 2002 to 99.0% in 2008.

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



Of all children entering **traditional foster care**, the median distance from home of their first placement in care has been between 9 and 10 miles over the past seven years, but the distance children are living from their home of origin has increased in recent years.

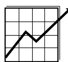


For children entering **kinship care**, their median distance from home is substantially lower (closer to home) than those placed in traditional care, between 3 and 4 miles. In addition, these placements are increasingly closer to home.

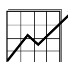
If more children are placed with their siblings:

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

For sibling groups of two or three:

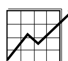


increased for siblings in traditional foster care from 48% in 2002 to 60% in 2008, and



is significantly higher and has increased for siblings in kinship foster care, from 64% in 2002 to 71% in 2008.

For sibling groups of four or more:



increased for siblings in traditional foster care from 12% in 2002 to 19% in 2008, and

is significantly higher and has increased for siblings in kinship foster care from 32% in 2002, up to 42% in 2008.

Box 3.1—*Striving for Excellence:* Extending Performance Based Contracting to Residential Treatment Services to Improve Outcomes for Children

Illinois seeks to improve placement stability for children in residential care. Behavior problems, prior institutionalization, and runaway incidents increase the likelihood of subsequent instability.[4] Residential care caseloads have changed over time to include an increasing number of youth experiencing multiple placement failures, longer stays in foster care and the lack of a permanent home before entering residential care.[5] Children discharged from residential care into a less restrictive setting are less likely to remain there; 51% of youth discharged from their first residential care setting to a less restrictive setting during the years 1995-2003 were eventually returned to higher levels of care during this time frame.[6] The average number of adverse events, such as runaways, psychiatric hospitalization and juvenile detention, prior to admission to residential care, has been steadily increasing.

Illinois was selected as a demonstration site by the National Quality Improvement Center on the Privatization of Child Welfare Services in January 2007 to evaluate the use of performance based contracting in residential treatment. DCFS, private provider agencies, and university partners have designed and implemented performance indicators that were incorporated in the FY 2009 contracts. The goals of this intervention are to: 1) Improve the safety and stability of youth during their residential stay; 2) Reduce the severity of clinical symptoms and increase functional skills effectively and efficiently; and 3) Improve outcomes at and following discharge from treatment.

The project established two performance indicators to measure these goals:

1. ***Treatment Opportunity Days Rate*** (TODR) which measures the percentage of time youth placed at each agency were available for active treatment and not in detention, on runaway or in a psychiatric hospital.
2. ***Sustained Favorable Discharge Rate*** (SFDR) which measures the percentage of the total residential episodes resulting in a sustained favorable discharge (defined as a positive "step-down" to a less restrictive setting) wherein the youth remains stable in their subsequent placement without disruption for 180 days.

Each residential provider serves a unique mix of youth with varying child specific characteristics which may affect agency performance outcomes. Provider specific factors, such as geographical location may also impact performance. Risk factors which were determined to have a statistically significant relationship to TODR and SFDR outcomes were examined. After determining the relative weight of each risk factor system wide, individual agency performance benchmarks adjusted for risk were incorporated into FY 2009 contracts. In addition, financial incentives were established to reward agencies that exceed their sustained favorable discharge SFDR benchmarks and fiscal penalties for agencies that fall below their TODR.

In preparation for these changes, DCFS redesigned its admissions process to establish a Centralized Matching Team to ensure proper matching of youth with providers and a Discharge and Transition Protocol was developed to clarify responsibilities for discharge planning and aftercare services. In addition, a web-based Residential Treatment Outcomes System (RTOS) is used to generate performance reports allowing agencies to reconcile their internal data with that of DCFS thereby enhancing accountability.

The evaluation of this project is currently underway by Center staff and preliminary outcomes should be forthcoming over the next year.

This was written by Judge Kathleen A. Kearney, CFRC

4 Zinn, A., DeCoursey, J., Goerge, R., & Courtney, M. (2006). A study of placement stability in Illinois. Chapin Hall Center for Children at the University of Chicago. Retrieved March 2, 2009 from: http://www.chapinhall.org/article_abstract.aspx?ar=1423.

5 Budde, S., Mayer, S., Zinn, A., Lippold, M., Avrushin, A., Bromberg, A., Goerge, & R. Courtney, M. (2004). Residential care in Illinois: Trends and alternatives. Chapin Hall Center for Children at the University of Chicago. Retrieved March 2, 2009 from http://www.chapinhall.org/article_abstract.aspx?ar=1367.

6 Ibid, Budde et al.

KINSHIP FOSTER CARE

While nationally 24% of children in foster care are living with kin, Illinois has a much higher rate: 40% of the foster child population is living with kin. To better understand kinship placement, however, we look first at the number of children initially placed with kin, and then the percentage of the foster care population placed with kin.

In 2002 there was a marked difference in the regional reliance on relatives as foster parents—38% of children initially placed in care were living with kin, with the highest percent in Cook County (44%), and this has increased statewide to 51% of initial placements in 2008. While the percent of children placed with kin in Cook County has remained at or around 40% over the past seven years, there has been an increase in the balance of the state—where placement with kin has gone from one-third (33%) to over half (54%) (see *Figures 3.2 and 3.3*, and Appendix A, Indicator 3.B.1). Given these regional differences, the racial breakout of children initially placed with kin has changed. The percent of kin placements of African American children decreased from 57% in 2002 to 42% in 2008 while the percent who are Caucasian has increased from 36% to 56%.

While *Figure 3.4* shows a relatively stable percent of the foster care population living with kin, what is masked by this aggregation are the changes in the make-up of the kin population. In 2002, 76% of the state-wide kin population was Black, and in 2008, the percent was down to 55% -- while the percent of the kin population who White increased from 17% to 37%. In addition, the same regional convergence reported for initial placements with kin also holds for the year-end proportions. In 2002, Cook County ranked highest at 41% of all foster children living with kin but now registers the lowest at 35%. Central region increased from 30% of the population to 48%, Northern region from 36% to 47%, and the Southern region from 30% to 39% (see Appendix A, Indicator 3.B.2). Illinois' success in converting long-term kinship foster homes among African Americans into legally permanent homes has also reduced the prevalence of kinship foster care. Many children who would have otherwise stayed in kinship foster care until the age of majority have exited foster care through adoption or subsidized guardianship.

Figure 3.2 Percent of children entering care and initially placed with kin

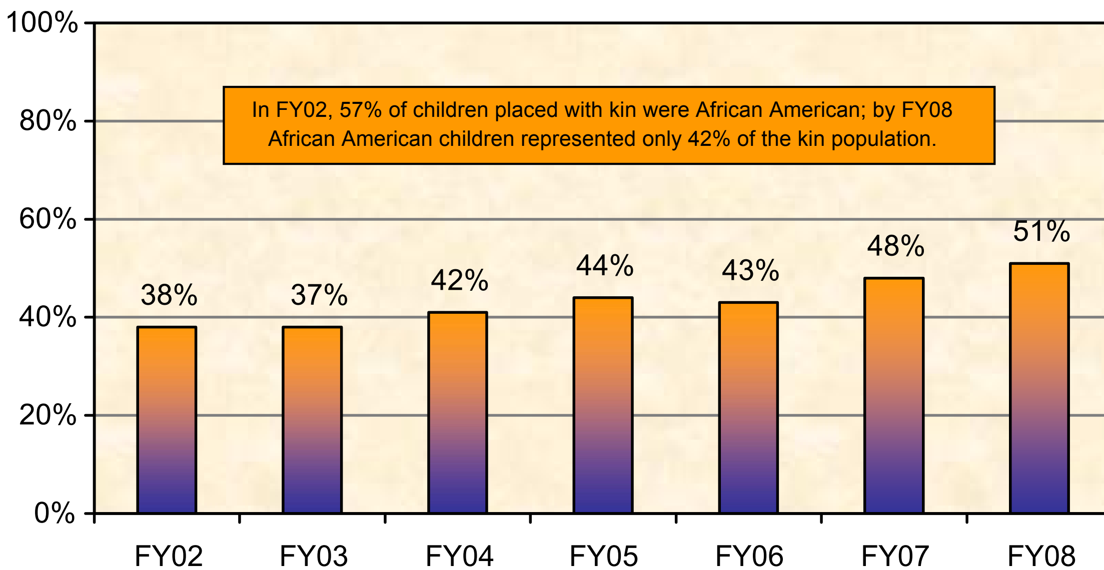


Figure 3.3 Percent of children entering care and initially Cook vs. Balance of the State

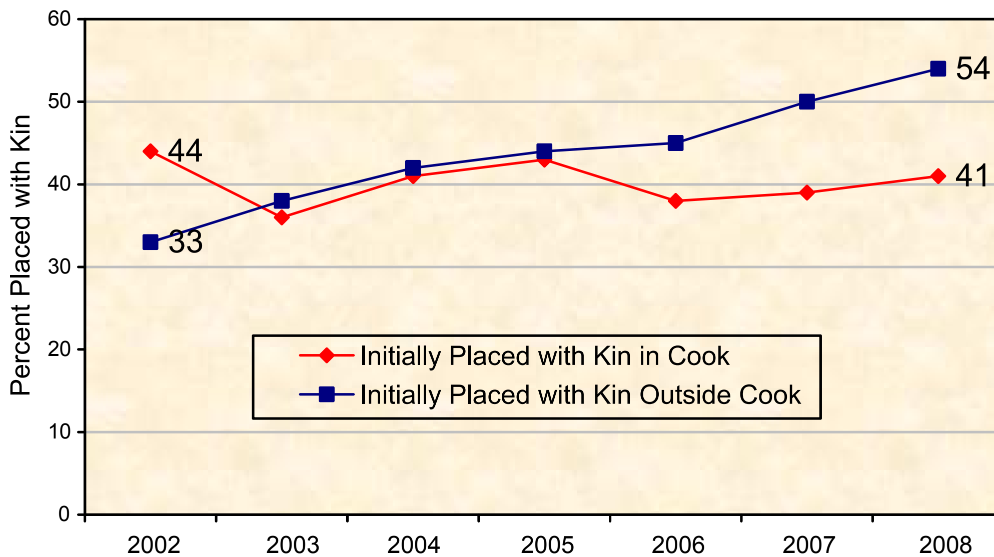
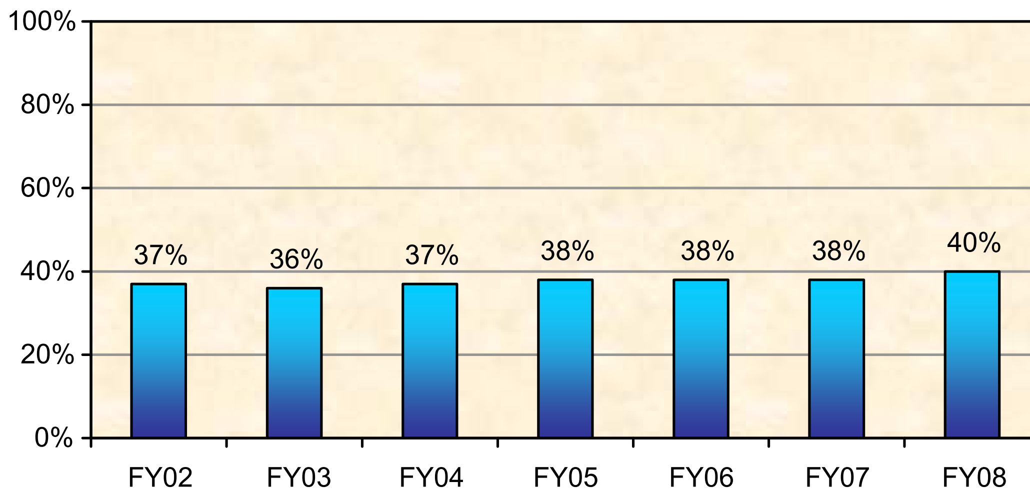


Figure 3.4 Percent of children living in kinship foster care at year end



Recent legislation, the Fostering Connections Act (see the introduction of this report), has put additional pressure on the state to ensure that kin homes are licensed. Even though there is higher reimbursement available to relatives whose homes are a licensed facility, over 70% of families have elected to receive the lower reimbursement as a non-licensed relative caregiver. Children in non-licensed care received the same services as children placed with licensed providers and until recently the federal government reimbursed states for the cost of placing these children. However new legislation disallows payment to non-licensed caregivers. DCFS is currently in the process of increasing the percent of children living in licensed homes. Whether this change will result in fewer kin homes being used in the future will need to be monitored. Certainly the research on the benefits of children living with kin needs to be considered when weighing these options.

Box 3.2—**Investigating the Link between Child Welfare and Juvenile Justice**

The findings from the maltreatment – delinquency literature are clear and consistent. Victims of physical abuse and neglect are at an increased risk of involvement with the juvenile justice system. This is especially true for African American youth in the child welfare system as their odds of experiencing at least one arrest are approximately two times greater than white adolescents in the child welfare system. Given the problem of overrepresentation in the child welfare system, the increased risk associated with African American youth is most certainly contributing to disproportionate minority contact in juvenile justice. A central question that remains however is what factors or mechanisms are responsible for this increased risk? In the broader delinquency literature, scholars, practitioners, and policy makers have long identified economic status, family structure, and neighborhood conditions as factors that help explain racial disparities in offending. But given that adolescents from different racial and ethnic groups involved with child protection come from fairly similar backgrounds (e.g. high rates of poverty, high risk neighborhoods, complex family problems) it is surprising that African American adolescents within the child welfare system continue to enter the juvenile justice system at such high rates.

As part of the MacArthur Foundation's Models for Change research initiative, researchers at the Center will pursue a series of issues focused on dually involved youth in DuPage and Peoria Counties, Illinois. The primary objectives of the proposed research is to determine whether the placement patterns more commonly associated with African Americans in child welfare in some way contribute to the increased risk of arrest and thus contribute to DMC in juvenile justice. It is well documented that African American youth are more likely to enter the child welfare system, remain in the child welfare system for significantly longer periods of time, and experience great instability. It is also well documented that African American youth experience different placements in child welfare. An important question to consider then is whether or not such variations in placement contribute to the likelihood of juvenile justice involvement and DMC. We will focus specifically on residential, group home, and kinship care placements because such placements are often utilized more often with African American youth and may be associated with characteristics that increase the likelihood of juvenile delinquency.

If in fact certain placement settings increase juvenile justice involvement (all other factors being equal), an important next step for state and county administrators is to determine how placement decisions are made, and why these particular placements increase the risk of delinquency. Are the policies or practices related to when staff can and should engage law enforcement different for group homes as compared with foster family settings? This would not be entirely surprising as the threshold for contacting law enforcement to resolve individual disputes in group homes was found to be lower in other states and even between social service agencies within the same state. Is delinquency more likely to emerge in kinship care arrangements because of service disparities? Such a finding would suggest that DMC in juvenile justice could be significantly reduced by addressing some of the service related differences between kin and non kin settings in child welfare. And if placement types contribute to judicial decisions making (e.g. probation vs. correctional placement), understanding why is important. Are there misperceptions about kinship care arrangements with regard to safety, child well-being, and the ability to provide adequate supervision?

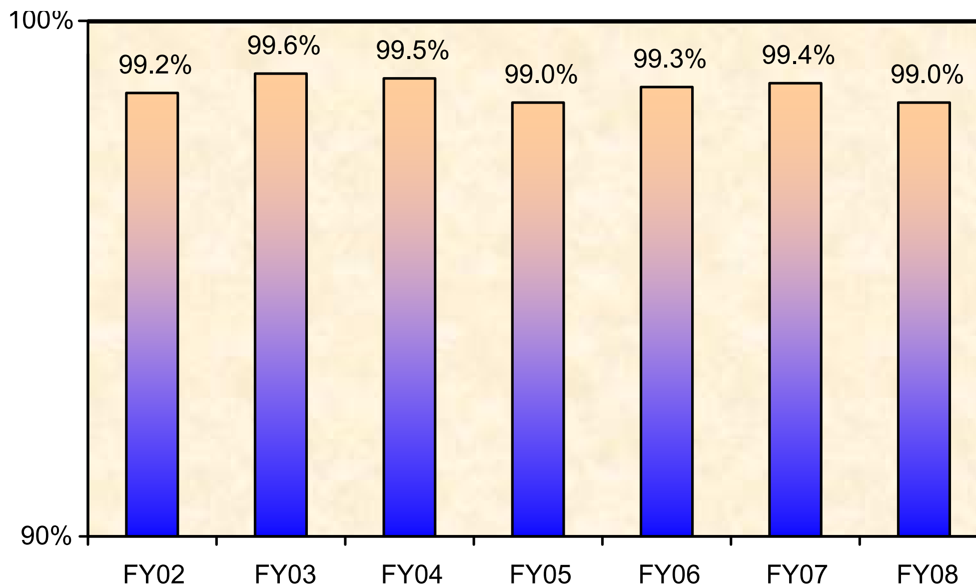
The proposed research will make a significant and unique contribution to the literature and knowledge base by focusing specific attention on child welfare policies and practices (related to placement) that may unintentionally contribute to DMC in juvenile justice. Moreover, the findings from the proposed research will help inform the larger national discussions and efforts focused on the integration of child welfare and juvenile justice systems. We anticipate producing a summary report by December 2009.

For more information on this project and other Models for Change Research, please visit: http://www.modelsforchange.net/about/research.html This was written by Dr. Joesph P. Ryan, CFRC

PRESERVATION OF COMMUNITY CONNECTIONS

Federal law mandates that foster children be placed in close proximity to the parents' home unless their best interests would be better served by a more distant setting. The federal Child and Family Services Review assessed whether Illinois made concerted efforts to ensure that children are placed in foster care placements that are in close proximity to the family and community of origin. They found this to be an area of strength in the first review. The percentage of children in group homes or institutions that are not located out of the state decreased slightly from 99.2 percent in 2002 to 99.0 percent in 2008 (see *Figure 3.5* and Appendix A, Indicator 3.C). This represents 18 children in 2008 who were placed outside of Illinois, and most (61% (11 children)) of these children were Black children from Cook County.

Figure 3.5 Percent of children living in institutions or group homes at year end placed within Illinois



Keeping Children Close to Home

In an effort to better understand how far children are living from their biological families when first placed into foster care, we looked at the median number of miles between the home of origin and the first placement in foster care for the year. Because placement priorities differ between placements into traditional foster care and placements with kin, these two populations are looked at separately.

As the graphs show on the next page, the typical child placed in a traditional placement lives 9 to 10 miles from home, compared to a typical child placed with kin, who would be much closer to their home of origin – between three and four miles over the past seven years. In addition, because the bars on these charts represent the middle quartile of the population—that is, the middle half of the population, excluding those that live quite close and those that live quite far, we get a sense of how far most children live from their home of origin. What these graphs show is that for the traditional caseload this range is growing—more children are living 20 to 25 miles away in 2008 than the children entering care in 2002. For the kinship caseload there was an increase in the higher end in 2003 and 2004 and again in 2008 (see *Figures 3.6 and 3.7* and Appendix A, Indicator 3.D).

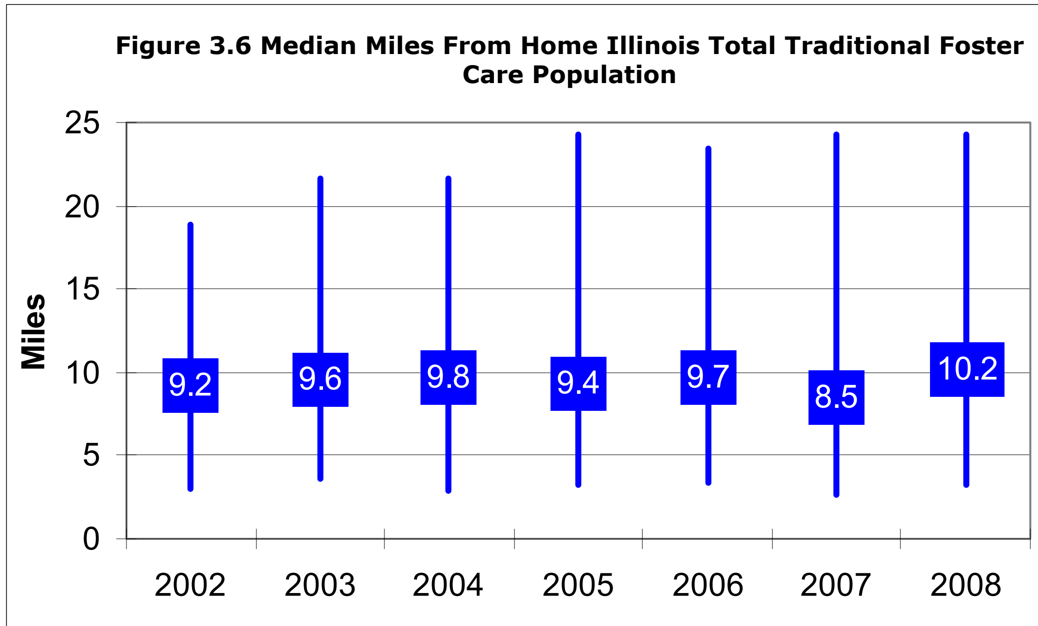


Figure 3.6 Median Miles From Home Illinois Total Traditional Foster Care Population
Miles
25
20
15
10
5
0
9.2
9.6
9.8
9.4
9.7
8.5
10.2
2002
2003
2004
2005
2006
2007
2008

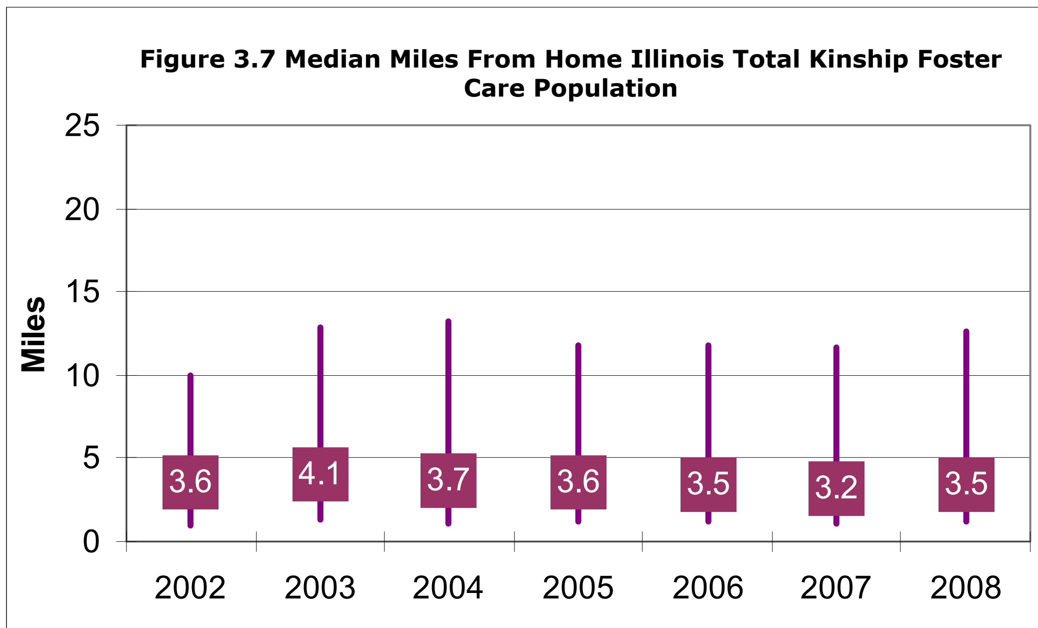


Figure 3.7 Median Miles From Home Illinois Total Kinship Foster Care Population
Miles
25
20
15
10
5
0
3.6
4.1
3.7
3.6
3.5
3.2
3.5
2002
2003
2004
2005
2006
2007
2008

The regional differences play a significant part in how one thinks of distance from home – in some communities living close to home would mean living within one or two miles, and in other communities it might mean living within ten miles. When the distance from home is evaluated, we see the following:

- Children placed in traditional foster care in the Central Region live much further from home (10.7 miles in 2004 and currently at 8.5 miles) than those placed with kin (about 3 miles), but the range of distance is as high as 40 miles in traditional settings.
- In Cook County over the past seven years the traditional caseload has remained constant at between 9 and 10 miles from home, and the kinship caseload while remaining closer to home than non-kin—has increased slightly from 4 to 5 miles.
- In the Northern region, the traditional foster care caseload has fluctuated between 9 and 15 miles, while the kinship caseload has decreased slightly from 6 miles in 2003 to 4 miles in 2008.
- In the Southern region, similar to Central, the range is quite large, extending to over 40 miles. In addition, the median averages between 12 and 15 miles for traditional care and between 2 and 6 miles for kin.

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

CONSERVATION OF SIBLING TIES

State officials are responsible for ensuring foster youths' future well-being by providing them with sufficient educational opportunity and holding their financial and social assets in trust so that these investments become available to them when they become adults. Economists call these three sorts of assets: financial, human, and social capital because they can be conceived of as inputs to a young person's future economic productivity and social well-being. Although the procedures for safeguarding a public ward's financial assets have been around for decades, the procedures for safeguarding the human and social capital of foster youth are only now being developed. An important, but until recently overlooked, source of social capital are the resources that arise from sibling bonds. Research shows that sibling relationships play a major role in how children develop and learn to interact with other people.[7] Sibling bonds, just like parent-child bonds, influence children's developing sense of attachment.[8] Siblings are an important source of emotional comfort during childhood, and in adulthood, siblings can also become a vital source of material and financial assistance.[9]

The opportunities for sibling association while in foster care are related to the type of care into which children are placed (see Appendix A, Indicator 3.E). *Figures 3.8 and 3.9* show that sibling groups of varying sizes are more likely to be placed together when they are living with relatives than when they are in unrelated foster care. Overall, there has been steady improvement – siblings are more often placed together in 2008 than they were in 2002, and this seems to be primarily due to increases in the Northern region. For sibling groups of 2 or 3, children placed with kin are 10% more likely to be placed together than children in non-kin homes. For larger sibling groups (four or more), there is about a 20% difference in the rate at which all siblings are placed together.

7 Begun, A.L. (1995). Sibling relationships and foster care placements for young children. *Early Child Development & Care,* 106, 237-250.
8 Hegar, R. (1988). Sibling relationships and separations: Implications for child placement. *Social Service Review,* 62, 446-467.
9 Cicirelli, V.G. (1991). Sibling relationships in adulthood. *Marriage & Family Review,* 16, 291-310.

Figure 3.8 percent of children placed with all their siblings in care by placement type with 2 OR 3 SIBLINGS IN CARE

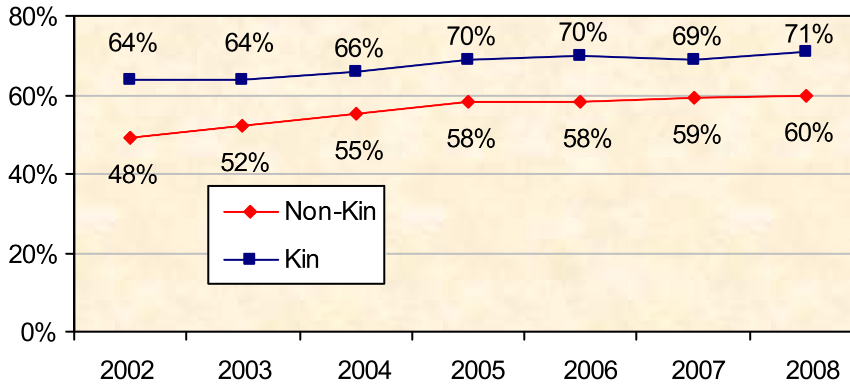
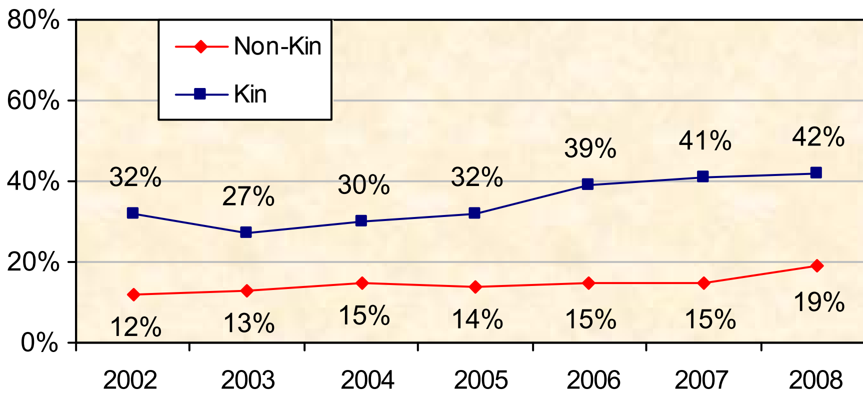


Figure 3.9 Percent of children placed with all their siblings in care by placement type WITH 4 OR MORE SIBLINGS IN CARE



OBSERVATIONS ON CONTINUITY IN ILLINOIS

The rise in kinship care in Illinois bodes well for many of the outcomes associated with continuity – children are more likely to be placed with their siblings in care, more likely to be placed closer to home, and therefore more likely to maintain the connections that will ultimately lead to permanence. As Illinois moves to make more of these kin homes licensed, it's imperative that we assess the impact of these efforts on the overall kin placement rates to ensure that children are provided with the continuity they deserve. While new research shows that a small percentage of the unlicensed homes cause reason for concern in terms of increased repeat maltreatment, the overall positive effect of children living with kin should not be overlooked.

CHAPTER 4

LEGAL PERMANENCE

Nancy Rolock and Mark Testa

REUNIFICATION, ADOPTION AND GUARDIANSHIP

Every child is entitled to a guardian of the person, either a natural guardian by birth or adoption or a judicially appointed guardian (U.S. Children's Bureau, 1961).[1]

Passage of the Fostering Connection to Success and Increasing Adoptions Act (P.L. 110-351) in October, 2008 is the most significant piece of child welfare legislation in the past decade, and many of the components of this federal legislation were a direct result of research from Illinois (see the Introduction for more specific information on this). A key component of the legislation is that it promotes the finding of permanent families for foster children by supporting relative guardianships and adoptions. Research out of the Children and Family Research Center formed the foundation for the relative guardianship and adoption provisions of this Act. For the past decade Center Director Mark Testa has led a study in Illinois, later replicated in Tennessee and Wisconsin, which introduced the idea of Subsidized Guardianship. This research showed that providing kin with an alternative to subsidized adoption, when reunification cannot be achieved, was successful in increasing the number of children exiting foster care to permanent homes. Based on this research, the Fostering Connections Act provides all states the option to implement a subsidized guardianship (kinship guardianship assistance) program. Testa predicts that, nationally, over 20,000 foster children could find safe, permanent homes each year with legal guardians if states opt to adopt the kinship guardianship assistance provisions of the Act.

LEGAL PERMANENCE IN ILLINOIS

Once a child enters foster care, finding a permanent home is essential. Ideally, this would be achieved through reunification with the family the child was removed from, and if that is not possible then through adoption or subsidized guardianship. While permanency options are straightforward, how to measure permanency is not. As mentioned in Chapter 2 of this report, Illinois has the lowest removal rate in the country, and it also has one of the lowest reunification rates in the nation. While the two may be linked—Illinois may remove only the neediest cases and therefore, take longer to reunify than states that remove high numbers of low risk children and in turn quickly reunify them with their families – these are not considerations used in assessments by the federal government and, as such, Illinois may not pass federal standards on permanency measures. Illinois has earned national recognition for the number of permanencies achieved in this state, yet the state continues to fail the federal permanency measures.

Figure 4.1 (also Appendix A, indicator 4.A.) shows the number of children entering care each year since 2000, and the percent of those children who have attained permanency. As discussed in Chapter 3 of this report, the number of children entering care decreased from 6,000 in 2000 to 4,500 in 2007. Permanency rates, however, have remained stable. One year after entry 20% of children have been reunified. Two years after entry, a little over one-third (36% to 37%) of children have attained permanency—largely through reunification but also through adoption. Three years after entering care approximately half of the children who have entered care have exited to permanency—through reunification, adoption or subsidized guardianship. Again, the majority of these permanencies are reunifications.[2]

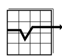
1 U.S. Children's Bureau. (1961). Legislative guides for the termination of parental rights and responsibilities and the adoption of children, No. 394. Washington, DC: U.S. Department of Health, Education, and Welfare.

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

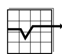
LEGAL PERMANENCE AT A GLACE

We will know if children have permanent homes:

If children are reunified with their parents more quickly:

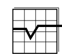
 Of all children who entered substitute care during the year and stayed at least 7 days, the percentage reunified within 12 months from the date of entry into care has fluctuated between 19% and 21% over the last seven years.

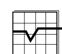
If children who cannot be reunified within 12 months find a permanent home in a timely fashion:

 Of all children who entered substitute care during the year and stayed for longer than 7 days, the percentage attaining permanence through reunification or adoption within 24 months from the date of entry into foster care has fluctuated between 36% and 38% over the past seven years.

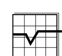
Of all children who entered substitute care during the year and stayed for longer than 7 days, the percentage attaining permanence through reunification, adoption, or subsidized guardianship within 36 months from the date of entry into foster care has fluctuated between 53% and 56% over the past seven years.

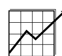
If more children who have attained permanence are not displaced from home:

 Of all children who attained permanence two years ago the percentage who have not experienced a rupture in permanence has remained stable over the past seven years: between 98% and 99% for adoptions, 97% for guardianships and 83% to 84% for reunifications.

 Of all children who attained permanence five years ago the percentage who have not experience a rupture in permanence stable for adoptions (96%), and reunifications (75 to 76%) but has

decreased for guardianships (from 90% to 87%).

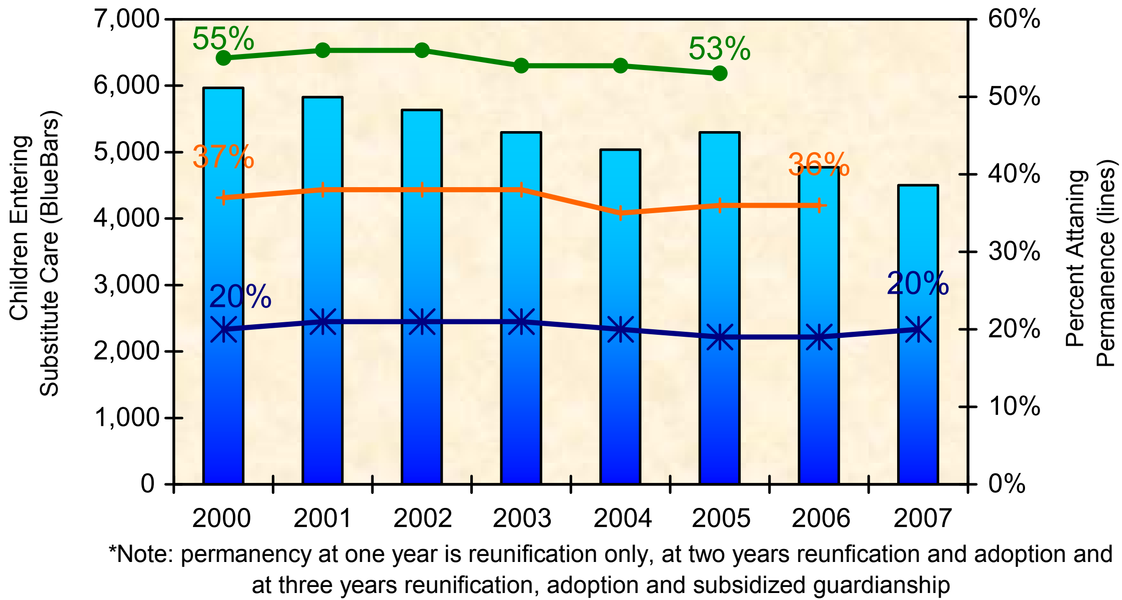
 Of all children who attained permanence ten years ago the percentage who have not experience a rupture in permanence has been stable for adoptions (90-91%) and has

 increased from 64% to 72% for reunifications over the past seven years.

If children spend less time in foster care:

Of all children entering care for the first time, the median number of months a child stays in care has become shorter: from 27 to 25 over the past seven years.

Figure 4.1 Children moving to permanent homes increases one (black), two (orange) and three (green) years after entry*



*Note: permanency at one year is reunification only, at two years reunfication and adoption and at three years reunification, adoption and subsidized guardianship

Box 4.1—**Special Focus: Reunification**

In Illinois, the number of children reunified after one year in care has hovered around 20% for most of the past decade. There are regional and racial/ethnic differences that show variations that may illuminate where efforts to improve these rates should focus. As depicted in *Figure 4.2* below, the one year reunification rate for children in Cook County has been about 10% over the past seven years while the rate in the Balance of the State (BOS) has decreased from 33% to 26%. After three years in care, these percentages have increased (*see Figure 4.3)* with almost half the children reunified in the BOS (45% in the most recent data) and much lower percentage in Cook County (19% in the most recent data) but the trend line is flat – there has not been much difference in these numbers over the past seven years.

Figure 4.2 Reunified within 1 Year Cook and the Balance of the State

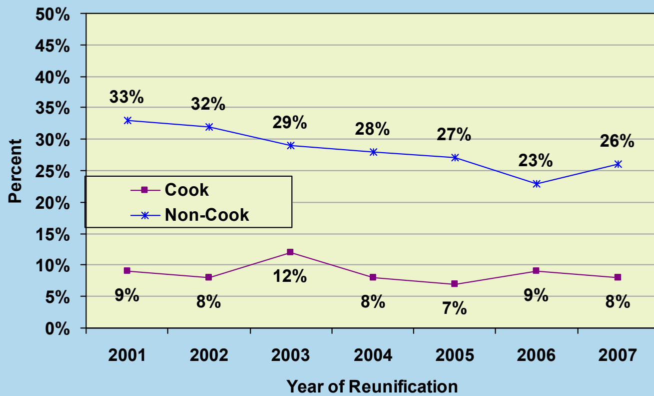
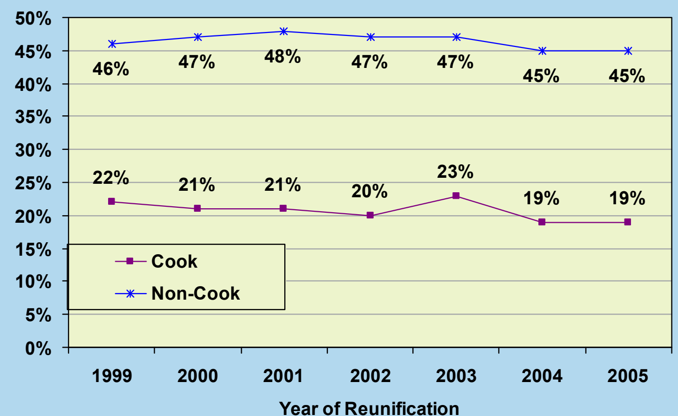
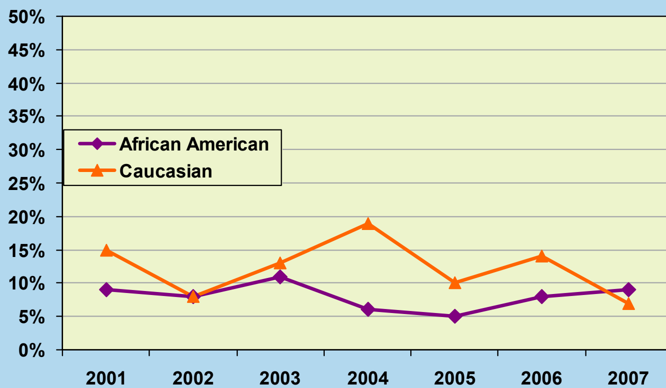
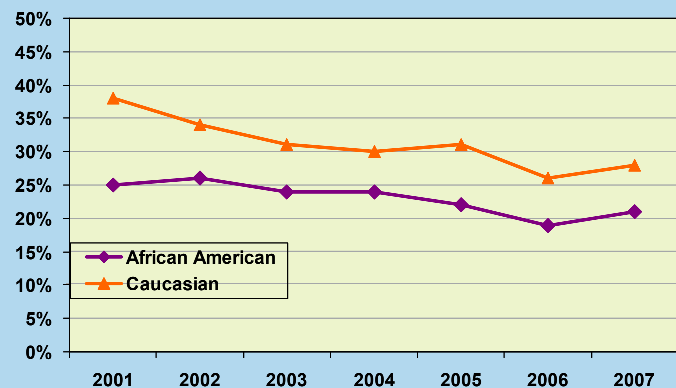


Figure 4.3 Reunified within 3 Years Cook and the Balance of the State

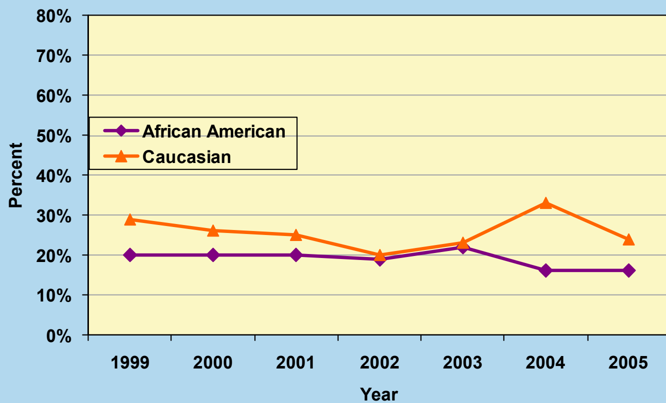


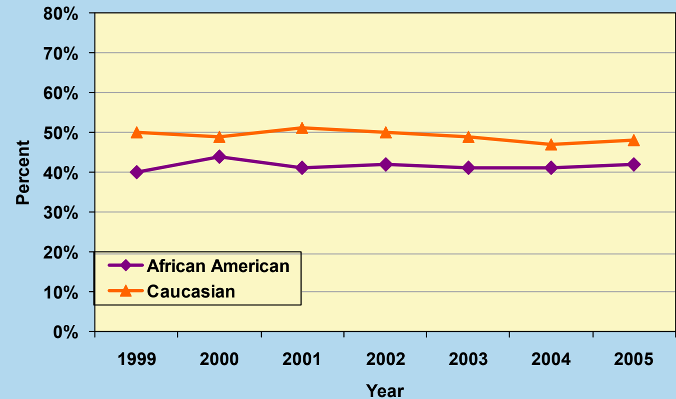
Looking at reunification in Cook County as compared to the remainder of the state, we see that reunification at one year is lowest in Cook, and among Black children in particular, although in the last year the difference between children of different ethnicities is small—9% for Black children and 7% for Caucasian children (*Figure 4.4*). Non-Cook rates are much higher—21% for African American children and 28% for Caucasian children (*Figure 4.5*).





The three year reunification rate shows a similar pattern – children in Cook County are least likely to reunify, and Black children have a lower rate (16%) than White children (24%) *(Figure 4.E)*. Outside of Cook the reunification rates are higher, but lower for African American children (42%) than White children (48%) (*Figure 4.F*).





Other research suggests that race is a strong predictor of the length of time to reunification. A 2005 study of reunification in Illinois[3] found that African American children take longer to reunify than other children and that the slower reunification times are correlated with living in Cook County. That is to say, African-American children in Cook County are slower to reunify than other children in the state, including African American children from Non-Cook Counties. While reunification rates outside of Cook are higher than in Cook, this racial difference persists there as well. Efforts towards improving the reunification rates in Illinois should be targeted at African American families across the state, with particular emphasis in Cook County.

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

Stability after reunification

Recent trends suggest that reunifications are more stable than in previous years when looking at reunifications that have lasted at least two years and at least ten years. This trend towards greater stability is due in large part to increased stability among children reunified from kin homes in Cook County (see the blue lines in *Figures 4.9 and 4.10*). In the most recent data, children most likely to have stability after reunification are those children who were reunified two years ago from Cook County (87%) and from relative homes (86%). But the largest increase in stability after reunification is with children reunified in Cook County 10 years ago (see the blue line in *Figure 4.8*)—over the past decade this figure began at 70% stable, decreased to 57% stable in 2001, and is now 82% stable. This rate has increased so dramatically that children reunified 10 years ago in Cook now have the same stability rate as children reunified just two years ago in the Balance of the State (BOS).

Figure 4.8 Percent of Children Who Did NOT Re-enter after Reunification BY COOK vs BALANCE OF THE STATE (BOS)

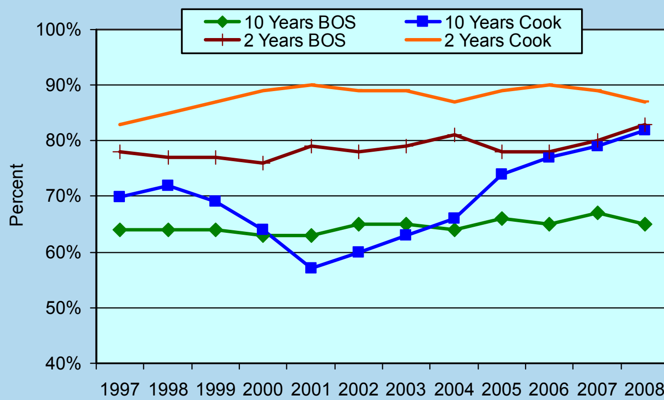
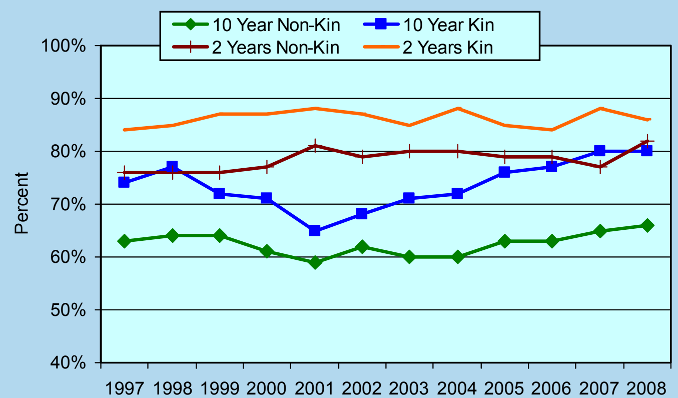


Figure 4.9 Percent of Children Who Did NOT Re-enter after Reunification BY PLACEMENT TYPE



What is unclear is the reason for this increase in stability after reunification. It could be that some of the more 'risky' reunifications are now exiting to Subsidized Guardianship instead of reunification, and therefore those children who are reunified are those children who are believed to be more likely to stay at home. Additional research into these findings is warranted in the upcoming years.

Note: Data reported here are entry cohort measures, and as such, these figures are different than what is reported for the CFSR measures to the federal government.

NATIONAL PERSPECTIVE: PUTTING ILLINOIS IN CONTEXT

Figure 4.10 illustrates the correlation between county non-removal rates and reunification rates. This plots the state's non-removal rate (per 1,000 child population) against the county reunification rate (using the CFSR measure C1.1: discharged to reunification or relative within 12 months of entry). While the two may not be highly correlated, this figure puts into perspective how removal and reunification rates are related. Counties that remove comparatively few children on a per capita basis, like many counties in Illinois, may reunify a smaller percentage of children within a year compared to counties that remove a larger proportion of children.

Perhaps the low reunification rates is a outgrowth of improvements in safety assessment and intact-family services which now bring fewer numbers of low-risk cases into state custody in Illinois. Alternately, communities with low removal rates may restrict foster care to the more difficult cases who cannot be safely served in the home, which reduces the proportion of removals who can be reunified quickly. States with high removal rates may bring less problematic cases into care, which increases the proportion of removals who can be returned quickly to the home.

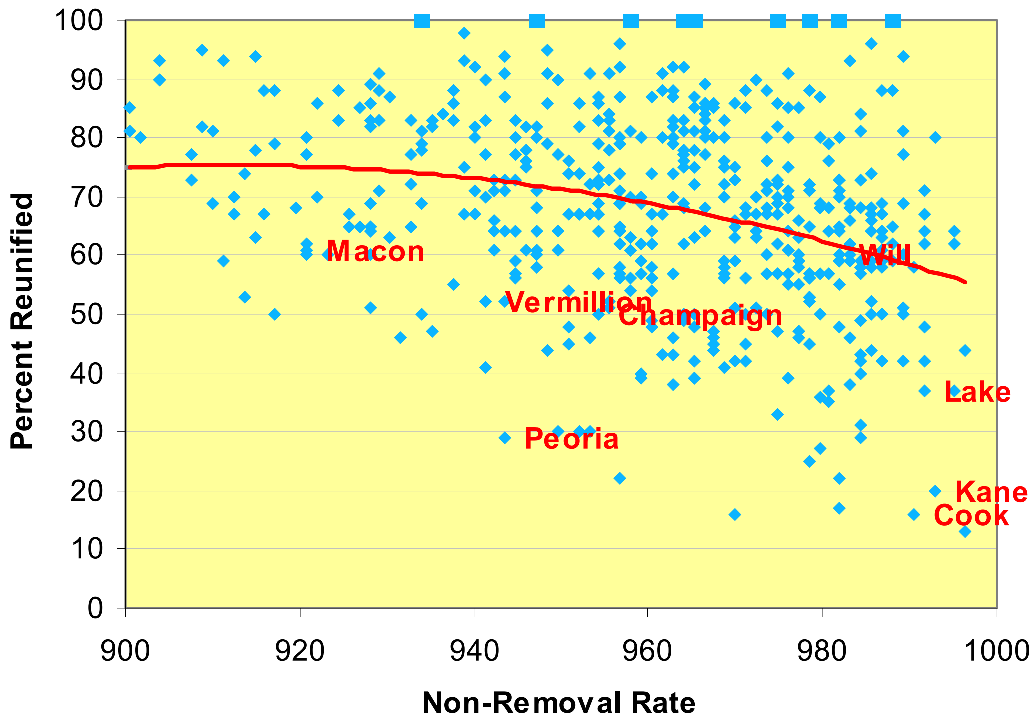
As shown in *Figure 4.10*, Cook County ranks among the lowest in these approximately 700 counties from 10 different states. Low removal counties in Illinois include:

- Kane (992.8; 20% reunified)
- Lake (991.6; 37% reunified)
- Cook (990.4; 16% reunified)
- Will (989.2; 60% reunified)

Illinois counties with high removal rates:

- Champaign (954.4; 50% reunified)
- Peoria (943.6; 29% reunified)
- Vermillion (941.2; 52% reunified)
- Macon (920.8; 60% reunified)

Figure 4.10 Non-Removal by Exit Cohort Reunification (%)



Achieving the right balance between removal and reunification rates is perhaps the biggest challenge in child welfare. Perhaps a closer look at practices in Will County, IL (or Madison County at 976.0 removals per 1,000 and 70% reunification) could shed light on how to achieve low removal rates and high reunification rates. If best practice suggests that the best way to help families is to keep them together and provide services to them at home, and only remove children when safety at home can not be guaranteed, then perhaps Illinois should not aim to meet the national standard on reunification set by the federal government looking at a national average, but instead do what is in the best interest of children and their families, and continue to remove fewer children with the expectation that those children who are removed may take longer than one year to reunify, or may not reunify at all.

Box 4.2—**Evaluating Subsidized Guardianship in Three States**

In 1994, Congress gave the U.S. Department of Health and Human Services (USDHHS) the authority to approve state demonstration programs that waived certain federal requirements related to child welfare services. These waiver demonstration programs test innovative practices while promoting the safety, permanence, and well-being of children in the child welfare systems. Since 1996, three states, Illinois (1996), Wisconsin (2005), and Tennessee (2006), have implemented subsidized guardianship waiver demonstration programs that have yielded positive results supporting subsidized guardianship as a means by which to improve permanence and other outcomes for children in foster care.

In 1996, Illinois received approval from the federal government to implement a subsidized guardianship program designed to improve permanency and safety outcomes for children and families in approved relative and kin settings. The state used the waiver authority to test whether the introduction of a subsidized guardianship benefit would result in an increase in permanence and safety for children, as well as improve a range of child outcomes such as reduced length of stay in foster care and improved stability of family care. Although the results from the final evaluation of Illinois waiver (2002) were positive, there was skepticism about the generalizability of the findings, concern that subsidized guardianship undermines potential adoptions, and worry about financial exposure for states utilizing the program.

Prior to the expiration of waiver authority in 2006, Wisconsin and Tennessee received permission from the federal government to test the efficacy of subsidized guardianship. The implementation of the two programs was an opportunity to test the external validity of the Illinois program, as well as to address other concerns about subsidized guardianship expressed by the legislators and the child welfare community. Both Tennessee and Wisconsin implemented programs similar to the one operated in Illinois and were evaluated by the same research team consisting of the University of Illinois Children and Family Research Center and Westat, Inc. All three states used a classic experimental design making it easy to attribute difference in outcomes between the intervention and comparison groups to the availability of guardianship. The findings were used to help support the creation and passage of The Fostering Connection to Success legislation signed into law on October 7, 2008.

The findings show that Subsidized Guardianship:

- increases family permanence;
- is cost effective and saves money;
- gives families choices around permanence; and
- does not impede reunification.

Subsidized Guardianship Increases Permanence

The three randomized clinical trials in Tennessee, Wisconsin, and Illinois all yielded an increase in permanence for the group that was offered subsidized guardianship. As of June 2007, Illinois had a 6.6% increase in permanence and as of November 2008, Tennessee found a 15% increase in permanence for children assigned to the intervention. The largest increase was demonstrated by Wisconsin, where as of November 2007, the intervention group at a 19.9% higher rate of permanence than the control group.

Subsidized Guardianship is Cost Effective and Saves Money

Research from Illinois and Wisconsin shows that subsidized guardianship is cost-effective, because it reduces the number of days in care for which a state is paying when a child in the foster care who does not have the option of subsidized guardianship. After 10 years of testing in Illinois, offering subsidized guardianship to families reduced the average length of stay in foster care by 22% (269 days). After three years in Wisconsin, offering the subsidized guardianship option reduced the average length of stay in foster care by 32% (133 days).

Although most of the foster care maintenance savings realized when a child exits foster care is used to cover the cost of the guardianship subsidy, the real savings can be attributed to reduced administrative costs resulting from case closing such as eliminated visits and decreased administrative oversight. After the first five years of the waiver in Illinois, the accumulated administrative savings amounted to $54.4 million.

Subsidized Guardianship Gives Families Choices Around Permanence

The demonstrations show that when offered a choice that many relatives prefer guardianship over adoption. This has resulted in a substitution effect (guardianship for adoptions) for both the Illinois and Tennessee waivers. Although the option of subsidized guardianship may result in fewer adoptions, long term follow up in Illinois shows no appreciable differences in stability and well-being among comparable groups of adopted and guardianship children.

Subsidized Guardianship Does Not Impede Reunification

Results from Wisconsin, Tennessee and Illinois demonstrate that reunification rates were not significantly different between families offered subsidized guardianship versus families who were denied this choice. As of June 2007 in Illinois the difference in the rate of reunification between the intervention and comparison group was 2.6% (5.2 vs. 7.7) and in Tennessee the difference was even smaller at .5% (13.2 vs. 13.7). In Wisconsin the rate of reunification in the intervention group was 1% greater (9.6 vs. 8.6%) than in the comparison group.

The full evaluation report is available on our website: http://www.cfrc.illinois.edu/pubs/Pdf.files/SG_Testing%20Effectiveness%20(2008).pdf Also see Testa, Mark: "Why States Should Implement the New Federal Guardianship Assistance Program (GAP)", unpublished Power Point, January 2009.

Box 4.3—**Evaluating Subsidized Guardianship in Illinois**

In 1996, Illinois received permission from the U.S. Department of Health and Human Services to test the effectiveness of a new program creating another important pathway to permanence for thousands of Illinois children. The Subsidized Guardianship Waiver Demonstration Program offered children who would have otherwise remained in long-term foster care, the stability of family life without the ongoing intervention of the state child welfare agency. Since the inception of the program more than a decade ago, over 11,000 children have exited foster care to live with their legal guardians. During the first five year period of the waiver, the evaluation results showed subsidized guardianship to be a safe, stable and cost effective permanency option for children.

Due to the success of the demonstration project, Illinois was granted a five year extension until October 2009. The extension continued the standard subsidized program and created the Enhanced Subsidized Guardianship and Adoption Program (ESGAP). ESGAP offers older youth (14 and not yet 18) who are adopted or enter subsidized guardianship arrangements access to key services including Youth in College, Life Skills Training, Education and Training Vouchers, Employment Incentives and Housing Cash Assistance. The program was first implemented in July 2005 in three demonstration sites (East St. Louis sub-region, the Peoria sub-region and Cook Central) before expanding to the entire state in April 2006. As of February 2009, 3,654 youth have been assigned to the demonstration project.

Widespread support for the concept of permanency for older youth as articulated by caseworkers, supervisors, and caregivers, did not translate into more youth moving into permanent living arrangements. Data from Westat, Inc., the independent evaluator, reveal that 19% of the youth in the demonstration sites were adopted or went to guardianship (12% adopted; 7% subsidized guardianship). Differences between the treatment and control groups were not statistically significant. The relationship between the caregiver's status and the achievement of permanency was significant. Youth placed with a relative were two times more likely to be adopted than youth placed with a non-related caregiver. Fifty-five percent of youth who attained subsidized guardianship were living with relatives compared to forty-five percent with non-relatives. Of the youth still in foster care as of December 2008, seventy two percent were in a non-relative placement compared to twenty eight percent living with a relative. Additional findings from Westat noted that discussions about permanence were more often held for younger youth ages 14 and 15.

In 2008, President Bush signed into law a groundbreaking piece of child welfare legislation: The Fostering Connections to Success and Increasing Adoptions Act. The legislation draws heavily from the findings of Illinois subsidized guardianship waiver program which demonstrated the viability of guardianship as a permanency option and will impact child welfare services across the country in important ways.

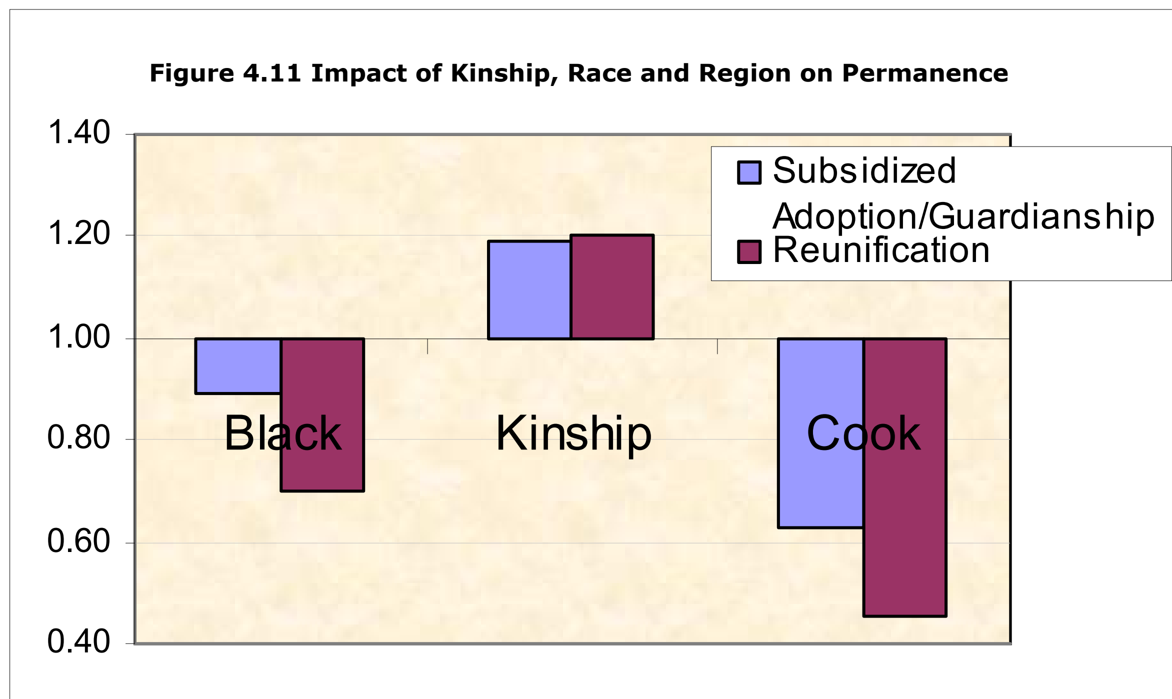
This was summarized by Jennifer Bradburn, CFRC. The full report is: Illinois Permanency for Older Wards Waiver Interim Report #2: Initial Youth and Caregiver Interviews and Administrative Case Reviews, Final Report. Rockville, MD: Westat, Inc.

The Changing Significance of Kinship for Permanence

Another factor that affects reunification and other permanency outcomes is the extent of public reliance on relatives as foster parents. Prior research shows that children placed with kin are less likely to be reunified with their parents than children placed with non-kin. The speculation is that the availability of relatives as foster parents enables workers and the courts to shy away from making risky reunification decisions by retaining children in the safe custody of kin. There is also suspicion that some parents are less likely to comply with service and treatment plans because they are secure in the knowledge that their children are safely and stably placed with a relative. Whatever the explanation, many children in kinship foster care never return to the homes of their parents and instead grow to adulthood in the homes of grandparents, aunts, uncles and other kin.

In an effort to understand the relationship between kinship, race and permanence, we looked at permanencies since 2000[3] . (Please note we evaluate subsidized adoptive and guardianship placements separately from reunification to illuminate the differences in these types of permanencies.)

3 Regression analysis was performed and the exponent of the parameter estimate was graphed



In general, we found that children placed with kin were 20% more likely to attain permanence—either reunification, adoption or guardianship than children placed with non-kin. We also found that African American children were 70% less likely to be reunified and 63% less likely to enter subsidized adoptive or guardianship homes than children of other races, and finally that children in Cook County are far less likely to be reunified (45% less likely) and less likely to be adopted or enter guardianship (63%). *Please note in reading the graphs, the further below the line the less likely it is to occur. In addition, the longer the bar, the more impact this variable has. In Figure 4.11, for example, living in Cook County has the strongest impact on these outcomes.*

In order to test the impact of each of these factors – race, living with kin, and geography, we applied a weighted risk ratio[4] to understand who was most likely to attain permanence. *Figure 4.12* shows that, across the board, Black children placed in non-kin homes are least likely to be adopted or enter subsidized guardianship homes, and, by contrast, Black children in kinship homes are much more likely to attain permanence through adoption and guardianship—they have an equal likelihood of being adopted or to enter subsidized guardianship as all other children in the state. For White children, these findings vary more widely from region to region: in Cook County White children placed with non-kin are less likely to achieve this type of permanence, yet White children placed with kin are more likely to achieve permanence through adoption and guardianship. By contrast, in all other regions, White children placed with kin are less likely to achieve adoption or guardianship than White children in non-kin homes. The results for Latino children living in Cook are just as likely as other children in the state to be adopted or enter guardianship, regardless of their placement type, but in the Southern region (albeit a small number) are most likely to be adopted or achieve guardianship if placed with non-kin and more likely if placed with kin in the Central region[5].

Figure 4.13 shows the same type of information for reunification. This reinforces the positive impact of children living with kin. In every region, with the exception of Southern, Black and White children are more likely to be reunified if they are living with kin. For those promoting placement with kin as a more stable option for children in

4 For additional discussion on weighted risk ratios please refer to the 2007 edition of this report.

5 Note that the number of Latino children placed with kin in the Southern region was too small for this analysis.

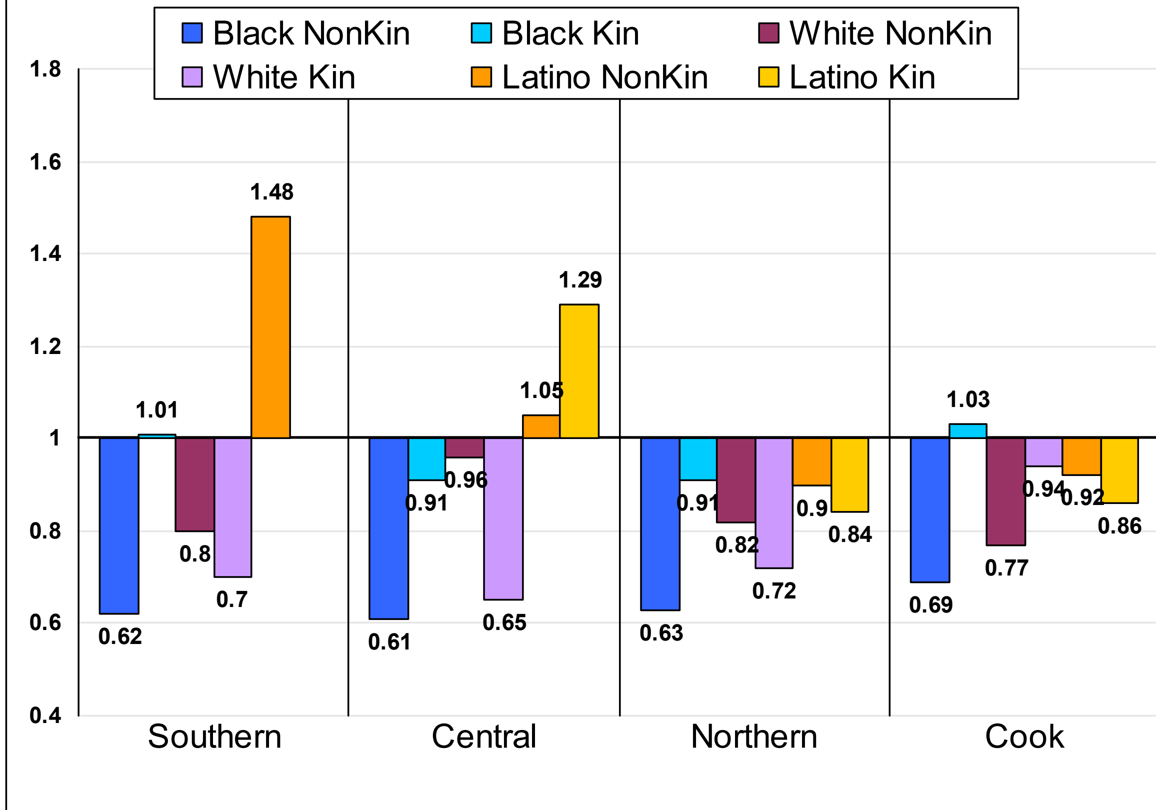


Figure 4.12 Likelihood of Attaining Subsidized Adoption or Guardianship (2000-2008)
Black NonKin
Black Kin
White NonKin
White Kin
Latino NonKin
Latino Kin
1.8
1.6
1.4
1.2
1
0.8
0.6
0.4
1.48
1.01
0.62
0.8
0.7
1.29
1.05
0.61
0.91
0.96
0.65
0.63
0.91
0.82
0.72
0.9
0.84
1.03
0.69
0.77
0.94
0.92
0.86
Southern
Central
Northern
Cook

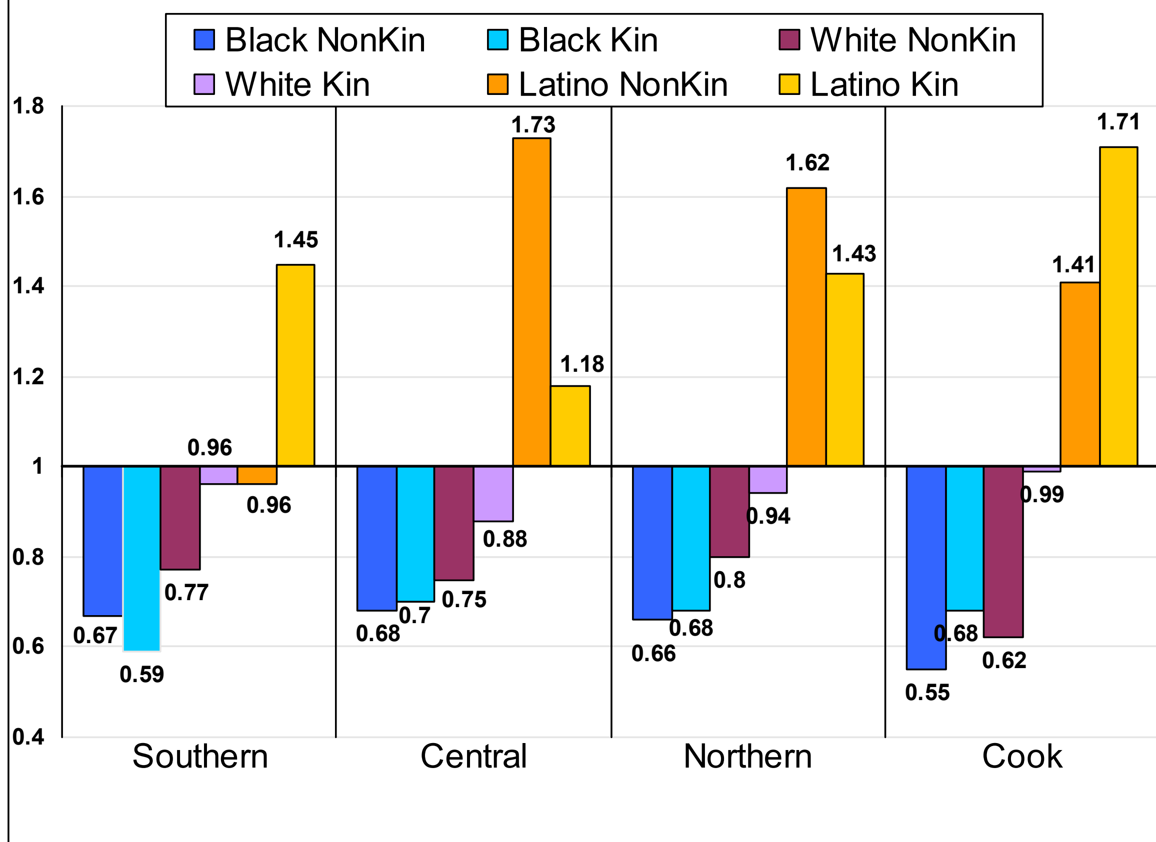


Figure 4.13 Likelihood of Children Being Reunified (2000-2008)
Black NonKin
Black Kin
White NonKin
White Kin
Latino NonKin
Latino Kin
1.8
1.6
1.4
1.2
1
0.8
0.6
0.4
0.67
0.59
0.77
0.96
0.96
1.45
0.68
0.7
0.75
0.88
1.73
1.18
0.66
0.68
0.8
0.94
1.62
1.43
0.55
0.68
0.62
0.99
1.41
1.71
Southern
Central
Northern
Cook

foster care, these findings refute earlier research that showed placement with kin was less likely to result in reunification. Placement with kin is more likely to result in reunification and other types of permanencies.

As discussed in the introductory chapter of this report, the makeup of permanencies in Illinois has changed over the past twenty years. In 1988, 66% of exits from foster care were reunifications, and currently less than half of the exits from care are reunifications (42%) state-wide, and this has primarily been a switch from reunification to subsidized adoption or guardianship (adoptions were 8% of exits in 1988, and adoptions plus guardianships were 31% of exits in 2008). As we will see later in this chapter, children who exit foster care to reunification are much more likely to re-enter foster care than are children who exit to subsidized adoption or guardianship. However, if we take a more narrow view of exits from foster care, and only focus on exits since 2000, we have a slightly different picture of this history (*see Figure 4.14*). What we have seen state-wide in more recent years is that the percent of exits from foster care are increasingly reunifications – from 29% of exits in 2000 to 42% of exits in 2008. This is due in large part to the reduction in the number of children exiting foster care to adoption or subsidized guardianship. So, that poses a different question: will we see a rise in the number of children re-entering foster care? The next section of this chapter focuses of the stability of permanence, and needs of families after they leave foster care. We have also seen the percentage of children ageing-out of foster care increase from 13% to 24%. As this population becomes a greater percentage of foster care exits, what is being done to ensure that these youth are prepared for the future, and are ready to make the transition to adulthood?

Figure 4.14 State-Wide Exits from Foster Care (2000-2008)

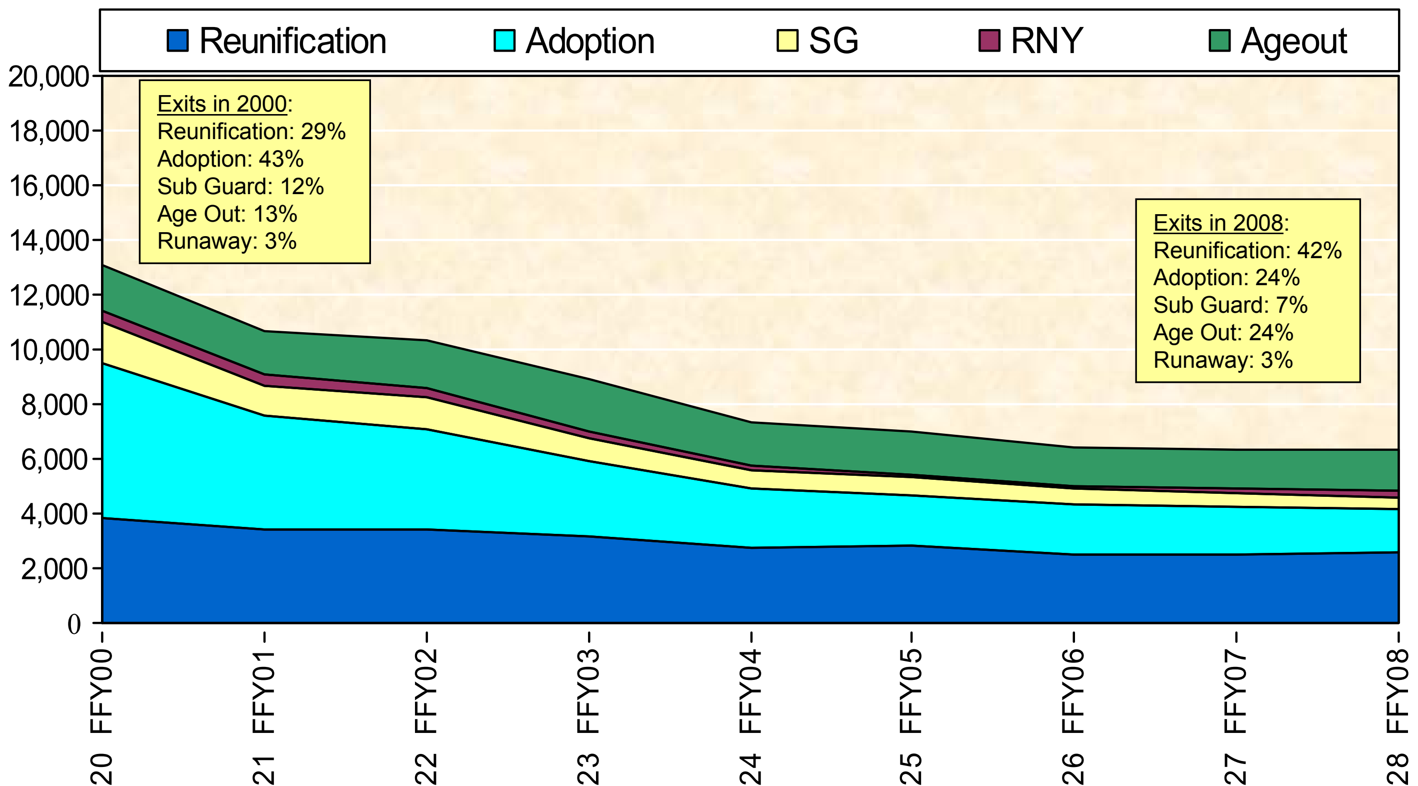
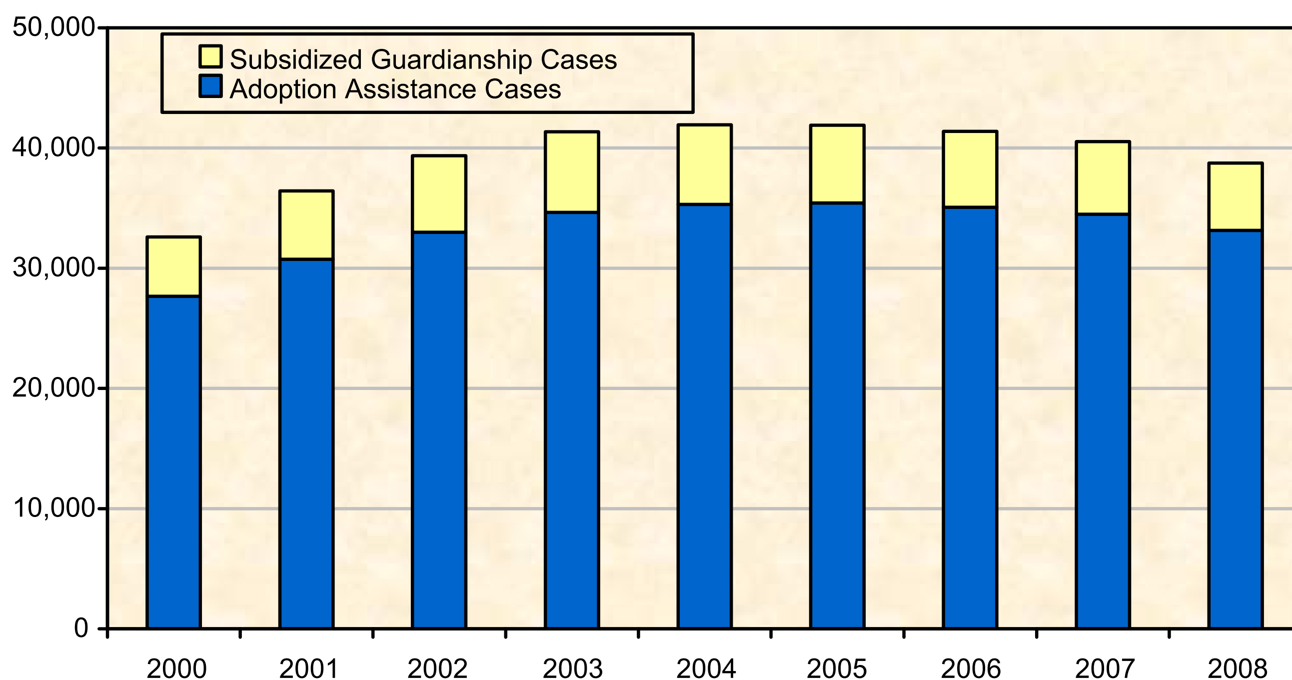


Figure 4.15 Active Adoption Assistance or Subsidized Guardianship Case (End of the Year)



STABILITY OF PERMANENCE

In 2000, the number of children in publicly-assisted homes with adoptive parents and legal guardians in Illinois surpassed the number of children in foster care. Rick Barth and colleagues report that by 2004 a similar cross-over had also occurred in Michigan, Missouri, New Jersey, and New York[6] . Although the balance is shifting from foster care to family permanence is generally regarded as salutary, there continue to be reservations about the abilities of families to access post-permanency services to meet the special needs of children that were previously handled by agency workers. Currently in Illinois there are approximately 16,000 children in foster care and 39,000 children living in state-subsidized homes (6,000 in guardianship homes and another 33,000 adoptive homes; *see Figure 4.15*).

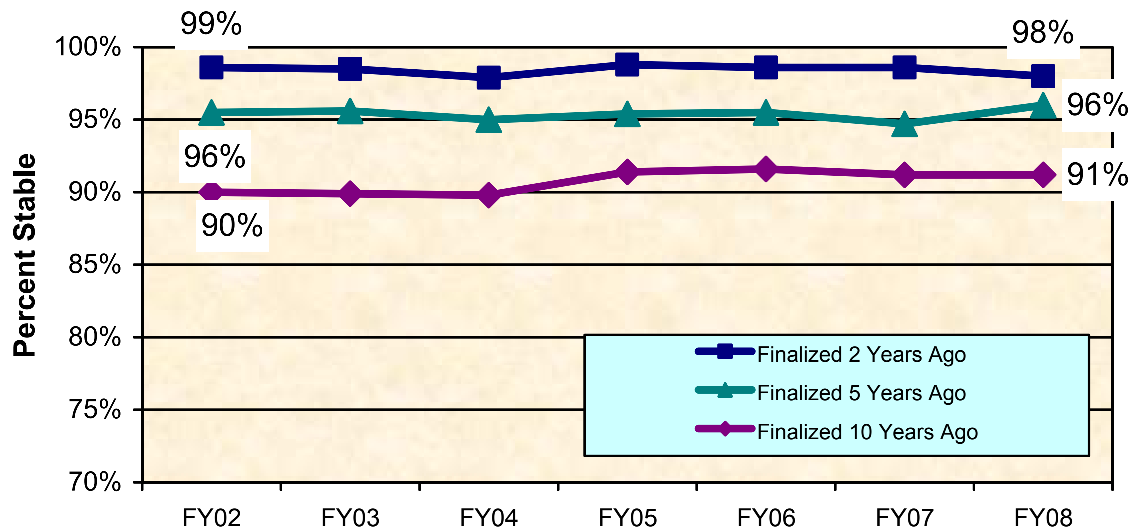
Fortunately, the best available evidence to date shows that ruptures of adoptive and guardianship placements are rare, particularly when compared to re-entries from reunification and the instability that children experience when they remain in care. However, these findings are not without their critics. Field staff, court personnel and many involved in the provision of services to this population assert that many of these permanencies were made in haste and that many of these state-subsidized placements are temporary and will eventually result in children returning to care. In 1997 (the year subsidized guardianship was introduced in Illinois), approximately 12,000 children were in the subsidy class, and by 2008 this number had grown to approximately 39,000 children. If 5% of 12,000 children returned to foster care in 1997, and 5% of 39,000 in 2007, there would be a big increase in the number of cases returning to care even though the rate had remained constant. Therein lies the problem: the front line staff and court personnel working with this group of families has seen a dramatic increase in this caseload and, while this should not be construed as poor system performance, because the rate has remained constant, it does signal a need for attention since the number of children in need of services is growing. Clearly, this population has needs and the risk of some of these children returning to foster care is real and should be addressed.

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

Adoption: For children who have been in adoptive placements for two years, 98% to 99% are in stable placements; after five years 96% are in stable placements; and after ten years 90% to 91% are in stable placements (*Figure 4.16*). This pattern of stable adoptions has persisted despite the dramatic increase in the number of consummated adoptions.

6 Barth, R.P., Wulczyn, F., and Crea, T.M. (2005). From anticipation to evidence: Research on the Adoption and Safe Families Act. Virginia Journal of Social Policy and the Law, 12, 371–399.

Figure 4.16 Stability of Adoptions After Foster Care



Box 4.3—**Ruptures Defined**

Permanency Rupture: A permanency rupture occurs when a child for whom a permanent guardianship or an adoption has been finalized is no longer living in the home of the original guardian or adoptive parent. A rupture can be characterized as follows:

- ***Displacement*** occurs when a child is no longer in the physical care of his/her guardian(s) or adoptive parent(s), but guardianship / parental rights remain intact.
- ***Dissolution*** occurs when guardianship is vacated or adoptive parent(s)' rights are terminated for a reason other than 'death or incapacitation' of guardian or adoptive parent.
- ***Death/incapacitation*** occurs when a caregiver or adoptive parent can no longer exercise guardianship of a child because the guardian dies or is incapacitated and there is no other guardian or parent.

Ruptures can also be distinguished from:

- ***Disruption*** occurs when a child is removed from a prospective guardian's or adoptive parent's home prior to finalization.

Subsidized Guardianship: Approximately 97% of guardianships are stable for at least two years, but recent trends shown an increase in the number of ruptured guardianships in the most recent data. The five year stability rate dropped from 90% in FY03 to 87% in 2008 (*Figure 4.17*) (see Box 4.4). While these percentages of ruptures are higher than adoption rates, they are slightly lower than the comparable rates among reunified children. Furthermore, additional research by Mark Testa[7] shows that when controlling for the age of the caregiver and other demographics, subsidized guardianship is no more likely to rupture than subsidized adoption – it's just that many of the guardianship caregivers are older and contingency plans should be made.

7 Testa, Mark, unpublished powerpoint: "Why States Should Implement the New Federal Guardianship Assistance Program (GAP)", January, 2009.

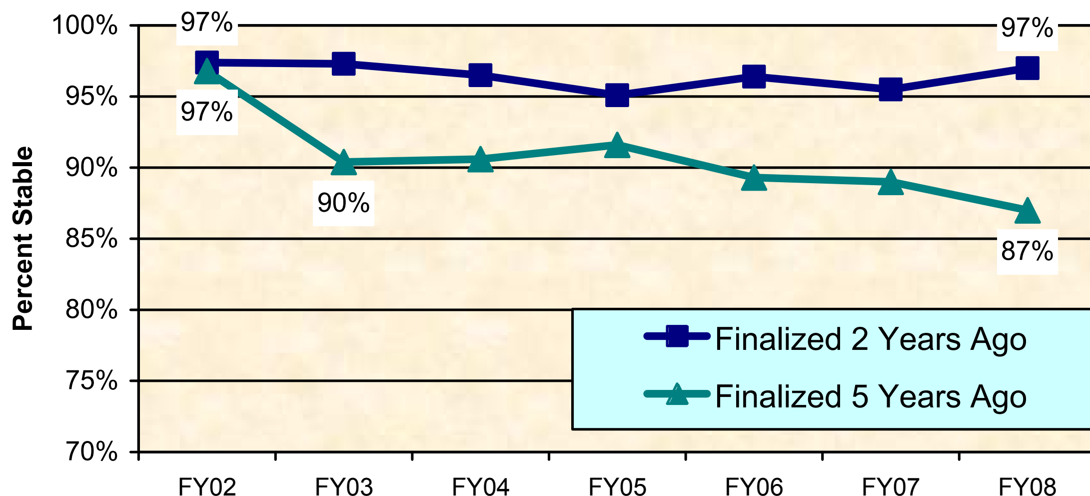
Box 4.4—**Warning Sign: Increase in Ruptures Among Subsidized Guardianship Caseload**

Recent years show an increase in the rate at which children are rupturing from Subsidized Guardianships, primarily among children living with non-kin. When looking at all children entering subsidized guardianship, those who experience the most stability five years after guardianship are those children living with kin in Cook County (94%), next are children living with kin outside of Cook (91%). Children in living with non-kin are less stable (88% in Cook and 89% outside of Cook County).

Understanding the needs of families that choose to end a subsidized guardianship is critical if we want to ensure that these permanencies are truly permanent homes for the children involved. Prior to 2008 DCFS funded the Center to staff the Post-Guardianship Unit in Cook County, but budget cuts resulted in the loss of this program. In previous years Center staff worked closely with these families to prevent ruptures in Cook County, but a similar program has not existed outside of Cook County.

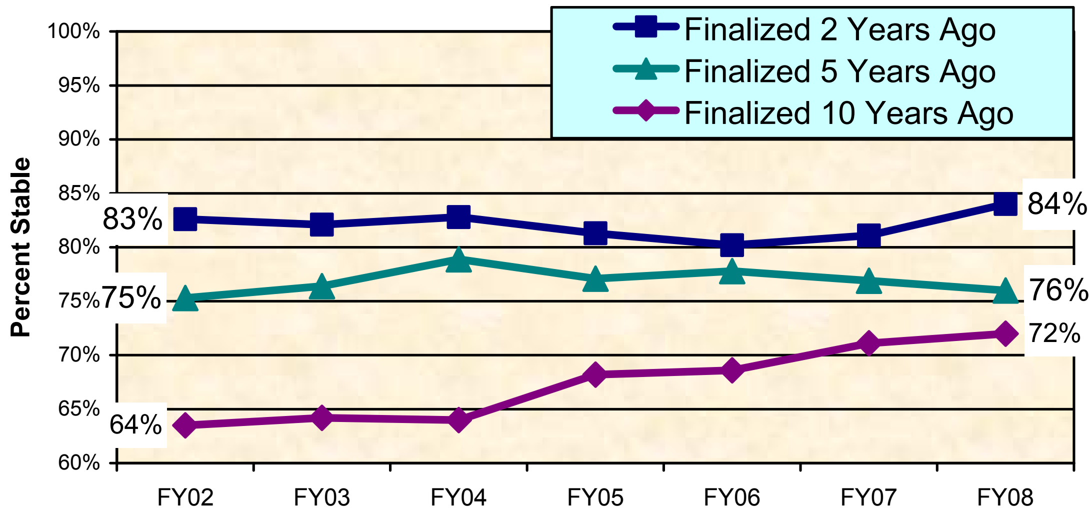
Attention should be paid to assisting families as they care for former foster children through subsidized guardianship and adoption.

Figure 4.17 Stability of Subsidized Guardianships After Foster Care



Reunification: When compared to adoption and subsidized guardianship, children reunified with their parents experience significantly less post-discharge stability (*Figure 4.18*). The two-year post-reunification stability rate has remained relatively stable between 83% and 84% over the past seven years, and the five years post-reunification stability rates have hovered around from 75% to 76% over this period. Improvement has been seen, however, in the ten years post-reunification rates, from 64% to 72%. This improvement is a result of increased stability after reunification particularly among children previously living with kin in care in Cook County (see Box 4.1 for a more information). Perhaps this is a result of the changing makeup of relatives who care for their kin in foster care, since more kin from outside Cook County are now providing foster care services. Perhaps those children who do go home go to less risky placements than they would have prior to the introduction of subsidized guardianship – and those children who would have been reunified and later re-entered foster care are now being cared for in the homes of grandparents, aunts and uncles through subsidized guardianship and adoption. Additional research is needed to fully understand this trend.

Figure 4.18 Post-Reunification Stability



POST-PERMANENCY SERVICES

Research published in 2006 by Center staff found that, while the majority of families living in subsidized adoptive or guardianship homes are able to meet the needs of these children on their own, a small percentage (16%) of families reported unmet service needs that require additional support. As a result of these findings, and the perception that the families of older youth have more intense service needs, in 2007 and 2008 DCFS funded the Adoption Preservation Assessment and Linkage (APAL) and Maintaining Adoption Connections (MAC) programs designed to provide targeted outreach to families of older youth, and funded CFRC to evaluate the program. As part of this evaluation, CFRC surveyed caregivers of older youth living in subsidized adoptive and guardianship homes to understand their service needs.

Similar to findings from the 2005 study, this recent study found that the majority of these caregivers of older youth reported no special needs or no problems in accessing post-permanency services they need (76%). The survey also found that most were dong well:

- 84% said that they would advise others to adopt/obtain guardianship; 8% said they would not and 7% answered "don't know."
- 83% said they "never" or "not very often" thought of ending the adoption or guardianship; 14% said sometimes, and 3% said they frequently thought about ending the relationship.
- 77% said that the overall impact of the child on the caregiver's family was positive; 19% gave 'mixed' reviews and 4% thought the impact was negative.

While we expect caregivers who had been assigned to the APAL/MAC intervention to have fewer needs, there were no significant differences in the distribution of child needs or services sought and received between the children receiving the APAL/MAC services and the comparison group of children who were similar in terms of age and where they lived. The study concluded that service needs among children adopted or taken into guardianship from foster care are no less efficiently accessed through annual certification mail-outs or telephone surveys compared to special outreach and assessment efforts by agency workers. The survey also found that the types of services sought determined the likelihood of receipt of that service. For instance, counseling was the most common service need – and most caregivers who sought counseling received it (88%). By contrast, caregivers who sought orthodontia were not very likely to receive it (42%), and 29% of caregivers who sought respite services did not received them (see Box 4.5).

Box 4.5—**Service needs of the families that with subsidized adoptive or guardianship cases**

In a Center-administered survey of caregivers of subsidized adopted or guardianship cases, we asked what service needs their children had, and if they had tried to get those services and if they were able to receive those services. Through this process we have documented those needs that were identified and sought out, and those needs that were identified but not sought. We have categorized service needs in terms of those that, if sought, would most likely be found and those that would most likely not be provided.

Sought and usually received: Counseling was the biggest need—42% of caregivers said that they needed this service, and most who sought it out received this service. The next most needed services were family therapy, day care, psychiatrist, support group and speech therapy which were all likely to be received if sought. If special medical care, physical or occupational therapy were sought, these services were always provided.

Not as likely to be received if sought: Camp, psychological, and educational services were not as likely to be received if sought—75 to 80% of the time caregivers were able to get these services if they sought them out.

Not likely to be received: Two types of services fall into this category, orthodontia where about half (51%) of caregivers who sought these serviced received them, and respite care (where 60% of caregivers who sought respite received it).

Table 4.1 Service Needs

Service	Caregiver Said Service was Needed	Caregiver did not Seek or Receive Service	Caregiver Sought Service but Did Not Receive Service
Most likely to be received:			
Counseling	42%	23%	12%
Family Therapy	25%	38%	7%
Day Care	22%	29%	10%
Psychiatrist	21%	23%	11%
Support Group	10%	41%	14%
Speech Therapy	9%	16%	11%
Special Medical Care	6%	7%	0%
Physical Therapy	6%	15%	0%
Not as likely to be received:			
Camp	26%	32%	21%
Psychological	22%	39%	18%
Educational	12%	57%	22%
Occupational	3%	50%	17%
Not likely to be received:			
Orthodontia	19%	56%	42%
Respite Care	6%	57%	29%

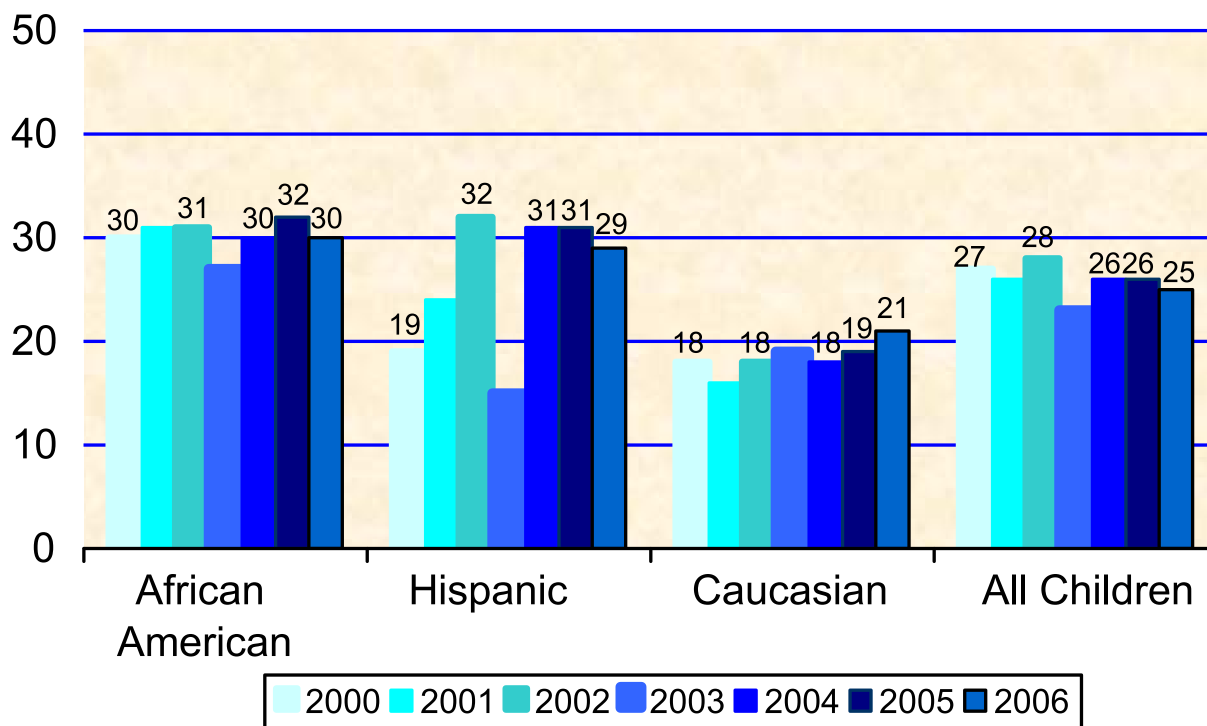
An additional finding was that 34% of families who sought services were unable to receive at least one of the services sought. However, there were no significant differences in services sought and received between the intervention and control groups. Unmet needs were highest among families who did not receive the intended intervention because of refusals or the inability of outreach workers to contact the family.

These findings suggest that the vast majority of caregivers report that their families are doing well. They have service need, but are confident that they are able meet the needs of their adopted or guardianship children on their own, and generally happy to have these children as part of their families. However, there is a subset of caregivers for whom this arrangement is not going well, and they need assistance. For caregivers involved with the APAL/MAC program, the additional outreach does not seem to have reduced the amount of unmet service needs of these families: about half the families from each group report unmet service needs. This suggests that future work targeted at this population should target those families most in need, but perhaps a different approach is warranted.

Length of Time in Substitute Care

Figure 4.19 shows the median number of months a child stays in foster care when entering for the first time. Across the board, and over time, African-American and Latino children spend more time in foster care than White children. When this is explored by region, children in Cook have the longest length of stay (25 to 37 months, depending on the year), Northern (24 to 28 months) Central (20 to 23) and Southern (13 to 17) all have much shorter lengths of stay. As far as racial/ethnic differences, it is difficult to comment on trends in the Latino population because outside of Cook County this population is quite small. That being said, in Cook, there is very little racial difference in median lengths of stay – the median for all children in Cook is about three years (35 months for Black children, 34 months for White children and 31 months for Latino children) (see Indicator 4.G).

Figure 4.19 The median number of months a child stays in care when entering for the first time



OBSERVATIONS ON PERMANENCE IN ILLINOIS

With Illinois gearing up for their second federal review, it is important to put permanency numbers in perspective when comparing Illinois to the rest of the nation. If best practice suggests that it is best for children when their families remain intact, when safety can be preserved, then states like Illinois, and counties like Cook, are to be commended for their work in this area. Illinois has the lowest removal rate in the country, and Cook County has one of the lowest county removal rates in the country. Going hand in hand with this low removal rate, however, may be a low permanency rate. Because Illinois removes relatively few children from home, those that are removed may take longer to find permanent homes for, either through reunification or subsidized adoption or guardianship. The standards used in the federal reviews are based on a numerical average – not necessarily what is in the best interest of children. Illinois should challenge these assumptions and work towards reform of the federal measures.

That being said, there is still room for improvement in Illinois' permanency rates. This report suggests that a focus on improving reunification rates should focus on improving reunification among African American children in Cook County. In addition, there has been a recent shift in Cook County in terms of the types of exits children are experiencing in foster care. In 2000, 12% of Cook exits were children who aged-out of foster care; in 2008 this makes up 35% of exits. In the balance of the state, this percentage has remained more stable, representing 15% to 17% of the population. How are we preparing these youth for a successful transition to adulthood? With the number of children currently living in subsidized adoptive or guardianship homes, what are we doing as a system to ensure that these placements are stable and to ensure that we reverse the trend of an increasing number of subsidized guardianships that end up back in foster care, and to ensure that we do not see an increased re-entry rate among this population?

CHAPTER 5

WELL-BEING

Theodore P. Cross & Christina Bruhn

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

In recent years, the Department of Children and Family Services has given considerable attention to the mental health of children in its care, developing new assessment and service initiatives (see below). The Department recognizes that the maltreatment most of the children in its care have suffered can seriously impair their mental health and that children's experience of placement and instability can cause further emotional harm, as a number of clinical studies have documented[2]. The Well-Being chapter in this year's *Conditions* report focuses on the mental health of Illinois children in care, examining how often they experience mental health problems and receive mental health services, and making a comparison with national averages to assess the magnitude of the problem in the state and the adequacy of the response. Like previous Center reports, it uses 2003 and 2005 data from Rounds 2 and 3 of the Illinois Child Well-Being study[3], but goes into much greater depth. Unlike previous *Conditions* reports, this report will not examine other aspects of child well-being. Center and Department staff are currently joining efforts with a national survey of children and caregivers involved with child welfare (the National Survey of Child and Adolescent Well-Being or NSCAW). With this new project, Center researchers will also be able to directly compare well being findings from Illinois with national results that use identical research methods. Because these NSCAW data are not yet available, the well-being chapter this year uses data from the Illinois Child Well-Being Study that were also analyzed in the previous two *Conditions* reports. Rather than briefly surveying a range of well-being topics, however, the well-being chapter here features new, more rigorous, in depth analysis on a single topic – mental health. This topic deserves in-depth study because children in foster care are at such risk of mental health problems, the negative effects of mental health problems can be severe and enduring, and effective treatments are available. We hope to return to the broader look at well-being in future reports with the new NSCAW funding. The results reported here will be an important baseline against which to compare service delivery post-2005, especially given DCFS and other state initiatives on children's mental health since 2005.

MENTAL HEALTH SERVICES AT A GLANCE[4]

Comparing Illinois foster children to foster children nationally:

- Both groups are about equally likely to be identified as having a mental health problem
- Illinois foster children are less likely to receive services from a range of specific mental health settings (e.g., outpatient services from a community mental health center, school-based services, residential treatment centers, etc.) than foster children nationally.
- Illinois foster children with mental health problems are less likely to receive specialty mental health services (i.e., those provided by a mental health professional rather than a guidance counselor, medical doctor, or other person), than foster children nationally.

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

2 See, for example, Clausen, J.M., Landsverk, J, Ganger, W., Chadwick, D. & Litrownik, J. (1998). Mental health problems of children in foster care. *Journal of Child and Family Studies*, 7, 283-296.

3 See Hartnett, M.A., Bruhn, C., Helton, J., Fuller, T. & Steiner, L. (in press). Illinois Child Well-being Study: Round 2 final report. Children and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign. Urbana, IL: CFRC. Bruhn, C., Helton, J., Cross, T.P., Shumow, L. & Testa, M. (2008). Well-being. In Rolock, N. & Testa, M. (Eds.) *Conditions of children in or at risk of foster care in Illinois: An assessment of their safety, continuity, permanence, and well-being. 2007.* (pp 5-1 – 5-17). Children and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign. Urbana, IL: CFRC.

4 Unlike the other chapters in this report, the outcomes in this chapter do not lend themselves to trend analysis. We provide a 'glance' at the major findings related to mental health services to Illinois' foster children instead.

For more than 30 years, studies from around the country have found that between 30% to more than 50% of children in foster care experience mental health problems.[5] Given this enormous risk, it is an essential part of the assessment of well-being of Illinois children in foster care to track mental health problems and receipt of mental health services. For analysis of services, it is useful to know overall what percentage of children receive services and also what percentage of those identified with mental health problems receive services, the latter to gauge met and unmet need. Following previous research across the country, we ask the following research questions:

1. What percentage of Illinois children in foster care have mental health problems and how does that compare to the percentage for children in foster care nationally?
2. What percentages of Illinois children in foster care receive services from a range of specific mental health settings (e.g., outpatient services from a community mental health center, school-based services, residential treatment centers, etc.), and how do these compare to percentages for children in foster care nationally?
3. What percentage of Illinois children in foster care with mental health problems receive specialty mental health services (i.e., those provided by a mental health professional rather than a guidance counselor, medical doctor, or other person), and how does that compare to the parallel national percentage?

The third question focuses on specialty mental health services because children with serious mental health problems are likely to need the services of a mental health professional. It should be mentioned at the outset that the analysis here concerns mental health services provided in dedicated mental health settings like community mental health centers or residential treatment centers or in other service settings like schools or doctors' offices. As discussed below, data were not available on private professional help to Illinois children in foster care.

The primary data analyzed here come from the Illinois Child Well-Being Study (IL-CWB). The IL-CWB is a statewide study of the well-being of Illinois children in foster care conducted to assist the state in determining whether the Illinois Department of Children and Family Services (DCFS) is complying with terms of a 1988 consent decree that governs child welfare practice in the state[6]. Only Rounds 2 and 3 of the IL-CWB are used here, because Round 1 did not include the range of measures needed for this analysis. Round 2 used a random sample of 655 Illinois children in foster care on March 31, 2003 and Round 3 a random sample of 697 Illinois children in foster care on December 31, 2004[7]. After sampling, field interviewers contacted caregivers and asked permission to interview their foster children. Confidential interviews were conducted with assenting youths age 7 or older during home visits. The Audio-CASI (Computer-Assisted Self-administered Interview) technology was used, in which youths used a touch-screen laptop computer and headphones to move from question to question (i.e., screen to screen) as they heard each question and all possible responses read aloud.[8] Telephone interviews were conducted with consenting caregivers and caseworkers as well. The interviews consisted mainly of standardized measures covering a wide range of variables related to child-well being and services. Interviewers contacted caregivers and asked permission to interview them about the selected children and to conduct interviews with those youths age 7 or older. The interviews included standardized questionnaires on child mental health problems completed by caregivers (the Child Behavior Checklist) and youths themselves (Youth Self-Report, Children's Depression Inventory, Post-Traumatic Symptoms Subscale of the Trauma Symptom Checklist for Children). We then calculated the percentage of children scoring in the range indicating mental health problems for each measure[9] . Caregivers also reported the specific mental health services the child received in their lifetime on a standardized measure (the Child and Adolescent Services Assessment). Because

5 See, for example, Clausen et al., ibid.; Swire, M.R., & Kavaler, F. (1977). The health status of foster children. *Child Welfare,* 56, 635-653. Heflinger, C., Simpkins, C.G., Combs-Orme, T. (2000). Using the CBCL to determine the clinical status of children in state custody. *Children and Youth Services Review,* 22, 55-73. Pilowksy, D.J. & Wu, (2006). Psychiatric symptoms and substance use disorders in a nationally representative sample of American adolescents involved with foster care. *Journal of adolescent health,* 38, 351–358.

6 Hartnett, M.A., Bruhn, C., Helton, J., Fuller, T. & Steiner, L. (in press). *Illinois Child Well-being Study: Round 2 final report.* Children and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign. Urbana, IL: CFRC.

7 Round 2 used stratified random sampling and Round 3 simple random sampling. See Hartnett et al., in press, and Bruhn et al., 2008 for more detail on sampling

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

9 A score of 60 or higher was used as an indication of a borderline clinical to clinical level of mental health problems on the Child Behavior Checklist and the Youth Self-Report. Children scoring above 65 were scored as in the clinical range on the Children's Depression Inventory; a borderline clinical range was not used for this measure. On the Post-Traumatic Symptoms Subscale, a score greater than 64 was used and indicate symptoms in the borderline clinical to clinical range.

of its focus on mental health services provided in settings (e.g., treatment centers, hospitals, schools and so forth), the IL-CWB interviews did not ask about private professional help from mental health professionals like psychiatrists, psychologist, social workers and nurses.

Comparison data were drawn from the National Survey of Child and Adolescent Well-Being (NSCAW), a national study of children involved with child welfare services that used almost identical research methods[10]. We used two different comparison groups from NSCAW's national samples. One was the One Year in Foster Care (OYFC) sample of children who had been in foster care for at least one year; the other consisted of children in the Child Protective Services sample who had been involved in child maltreatment investigation and were later placed in foster care. We used a strategy of comparing multiple IL-CWB samples to multiple NSCAW samples that would be relatively unaffected by differences in the composition of the samples. Two sets of IL-CWB results (Round 2 and Round 3) were compared to four sets of NSCAW results (two NSCAW samples with two follow-up periods each). The six samples used were as follows:

1) The IL-CWB Round 2 Sample, which included Illinois children in foster care on March 31, 2003
2) The IL-CWB Round 3 Sample, which included Illinois children in foster care on December 31, 2004
3) NSCAW OYFC Sample, Wave 3, which included children nationally who had been in foster care for at least one year at the beginning of the study (December 1999 through February 2000) and were also in foster care 18 months later
4) NSCAW OYFC Sample, Wave 4, which included children nationally who had been in foster care for at least one year at the beginning of the study (December 1999 through February 2000) and were also in foster care 36 months later
5) NSCAW CPS Sample, Foster Care subset, Wave 3, which included children nationally who were involved in child protective investigations between October 1999 and December 2000 and were in foster care 21 months after the completion of the investigation
6) NSCAW CPS Sample, Foster Care subset, Wave 4, which included children nationally who were involved in child protective investigations between October 1999 and December 2000 and were in foster care 39 months after the completion of the investigation

Figure 5.1 compares the two Illinois samples and the four national samples on the proportion of children with mental health problems based on the caregiver-completed Child Behavior Checklist. The percentage of Illinois children in foster care with mental health problems was substantial, 46.5% in 2003 and 55.9% in 2005, which was very similar to the national comparisons, which ranged from 45.3% to 56.8%. *Figure 5.2* shows results in the same format for the measure completed by youth (age 11 or older) about themselves, the Youth Self-Report. In the Illinois samples, 33% of youth reported mental health problems in 2003 and 30.8% in 2005. Thus youth were less likely to self-report mental health problems than caregivers were to observe that they had problems, although the percent of youth reporting was still substantial. Again, national results were similar, with percentages ranging from 28.5% to 37.2%. The

Figure 5.1 Percent of Children in Foster Care with Mental Health Problems on the Parent Checklist

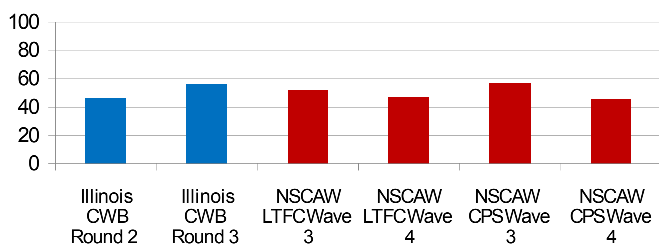
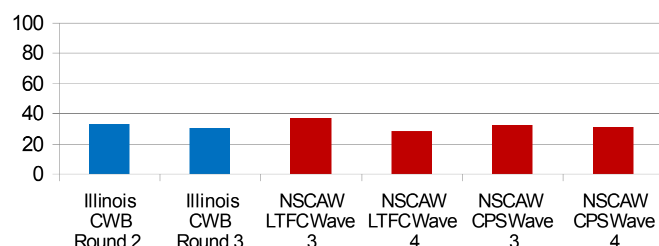


Figure 5.2 Percent of Children with Mental Health Problems on the Youth Self-Report Checklist



10 See NSCAW Research Group. (2002). Methodological lessons from the National Survey of Child and Adolescent Well-Being: the first three years of the USA's first national probability study of children and families investigated for abuse and neglect. Children and Youth Services Review, 24, 513-541. U.S. Department of Health and Human Services, Administration for Children and Families. (2003). National Survey of Child and Adolescent Well-Being (NSCAW). One Year in Foster Care Wave 1 Data Analysis Report, November 2003.Washington, DC: Administration for Children and Families. U.S. Department of Health and Human Services, Administration for Children and Families. (2005). National Survey of Child and Adolescent Well-Being: CPS sample component, Wave 1 data analysis report. Washington, DC: Administration for Children and Families.

differences between the Illinois and national samples on the percentages of children with mental health problems were not statistically significant, meaning that in all likelihood the differences were due to chance variation in sampling.

The Children's Depression Inventory (CDI) and the Post-Traumatic Stress Scale of the Trauma Symptoms Checklist measure a narrower range of problems and therefore the percentages with problems on these measures were smaller. This percentage on the CDI for Illinois was 7% in 2003 and 7.2% in 2005, with national percentages ranging from 4.1% to 11.5%. On the trauma scale, the Illinois percentages in this range were 5.8% in 2003 and 5.1% in 2005, with the national percentages ranging from 7.2% to 15.8%. None of the differences between these percentages were statistically significant, with chance variation in sampling the most likely explanation, especially given the small numbers of children in these categories for most of the samples.

Thus the percentages of Illinois children in foster care with mental health problems were generally within four points of the national percentages. The need for mental health services for children in foster care is great for both Illinois and the nation, with little difference between the two.

Table 5.1 shows the percentages of Illinois children in foster care who received any specialty mental health services that we counted and then any specialty or non-specialty services that we counted. It also breaks out these percentages for each of 10 different specific types of mental health services in 2003 and 2005. Specialty mental health services are called this because they are primarily provided by mental health professionals who provide only these types of services. These included psychiatric hospitalization, residential treatments centers, day treatment centers, mental health or community mental health centers. The different non-specialty mental health services were termed that because they used medical doctors, guidance counselors or other non-specialist professionals to address children's mental health problems.

Even though caregivers identified nearly half or more of children in foster care as having mental health problems, only about one-fifth (23.7%) of children were reported to have received a specialty mental health services. Only 38.9% reportedly received any mental health service in 2003. The sample percentage increased to 45.6% in 2005, although this difference was not statistically significant. By far the most frequent specific service, used by over 35% or more of the children sampled in both years, was a school-based service, which includes visits with a school guidance counselor, school psychologist or school social worker. In-home counseling or crisis services were also a relatively common category (17.4% to 22.2%). Use of community mental health centers (6.2% to 9.2%), residential treatment centers (6.6% to 12.1%), day treatment (3.9% to 5.9%), or different emergency services were fairly rare. For all the service variables in Table 1, the percentage receiving services was higher in 2005 than 2003, but these increases were only statistically significant for hospital medical inpatient unit and residential treatment center. We cannot rule out the possibility that other increases were due to chance variation in sampling. Perhaps these data reflect a trend toward increased mental health service delivery over the decade, but additional data from later years will be needed to assess this. Illinois children in foster care were significantly less likely to receive specialty mental health services and any mental health service than children in foster care nationally[11]. The Illinois samples received a specialty mental health service in 18.6% and 23.7% of cases, compared to 25.5% to 44.1% in the NSCAW samples. Similarly the Illinois samples received any mental health service in 38.9% and 45.6% of cases, compared to 57.8% to 65.5% in the NSCAW samples One or more of the Illinois samples was significantly less likely than one or more of the national samples to receive the following specific mental health services: residential treatment center; day treatment; mental health or community mental health center; in-home counseling; and mental health service from a family doctor or other medical doctor; mental health service from a school guidance counselor, school psychologist or school social worker. The differences on specific services were highest for residential treatment (11% to 30% higher nationally), mental health or community mental health services (10% to 25% higher nationally), and seeing a family or other doctor for mental health care (15% to 24% higher nationally). Differences were lower (but still statistically significant) for receiving services from a guidance counselor or other school professional. The Illinois-national gap remained even when we took into account differences in race, child age, and length of time in care. *Figures 5.3* through *5.9* depict a number of these comparisons.

11 The differences discussed in this paragraph were statistically significant. Because the 2 Illinois samples were compared to the 4 national samples, a Bonferroni-adjusted α of .00625 (.05/8) was used.

Table 5.1 Percentage of Illinois Children in Foster Care Receiving Mental Health Services in 2003 and 2005		
	2003	**2005**
Overall: Children Receiving Mental Health Services		
Any specialty mental health service	18.6%	23.7%
Any mental health service	38.9%	45.6%
Specialty Mental Health Services		
Psychiatric hospital	10.8%	16.0%
Residential treatment center	6.6%	12.1%
Mental health or community mental health center	6.2%	9.2%
Hospital medical inpatient unit	4.2%	9.5%
Day treatment	3.9%	5.9%
Non-Specialty Services		
Seen a school guidance counselor, school psychologist or school social worker	35.4%	39.7%
In-home counseling or crisis services	17.4%	22.2%
Seen a family doctor or other medical doctor	9.9%	11.6%
Emergency shelter	4.5%	3.3%
Hospital emergency room	3.1%	5.2%

Note. The differences between 2003 and 2005 are statistically significant ($p<.05$) for hospital medical inpatient unit and residential treatment center.

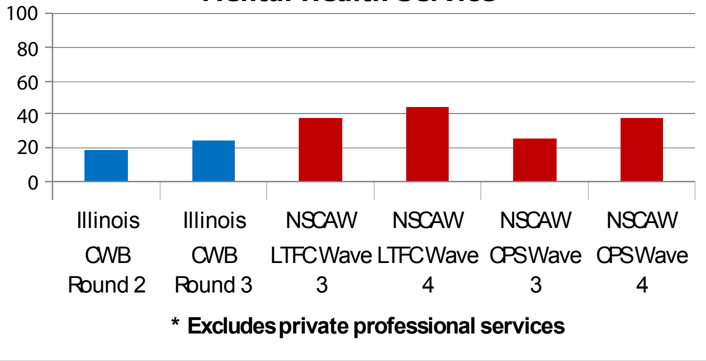


Figure 5.3 Percent Receiving Any Speciality Mental Health Service
100
80
60
40
20
0
Illinois CWB Round 2
Illinois CWB Round 3
NSCAW LTFC Wave 3
NSCAW LTFC Wave 4
NSCAW CPS Wave 3
NSCAW CPS Wave 4
* Excludes private professional services

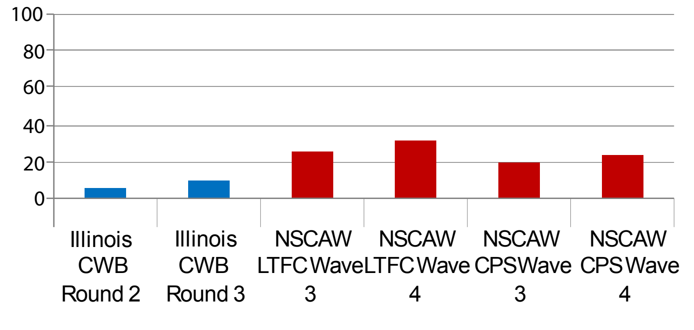


Figure 5.6 Percent Receiving Services from a Mental Health or Community Mental Health Center
100
80
60
40
20
0
Illinois CWB Round 2
Illinois CWB Round 3
NSCAW LTFC Wave 3
NSCAW LTFC Wave 4
NSCAW CPS Wave 3
NSCAW CPS Wave 4

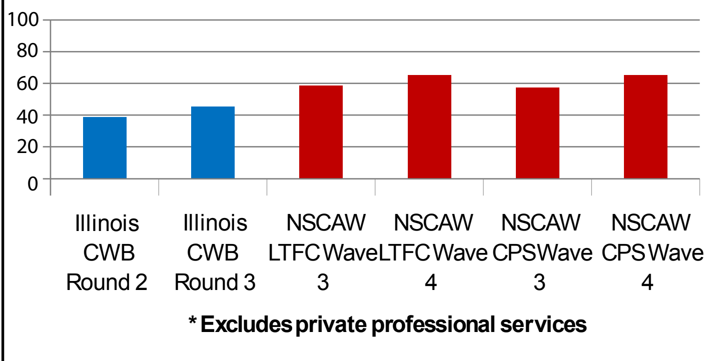


Figure 5.4 Percent Receiving Any Mental Health Service
100
80
60
40
20
0
Illinois CWB Round 2
Illinois CWB Round 3
NSCAW LTFC Wave 3
NSCAW LTFC Wave 4
NSCAW CPS Wave 3
NSCAW CPS Wave 4
* Excludes private professional services

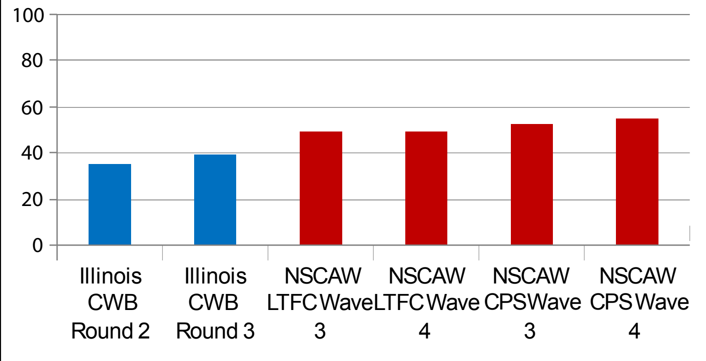


Figure 5.7 Percent Receiving Services from a Guidance Counselor or other School Professionals
100
80
60
40
20
0
Illinois CWB Round 2
Illinois CWB Round 3
NSCAW LTFC Wave 3
NSCAW LTFC Wave 4
NSCAW CPS Wave 3
NSCAW CPS Wave 4

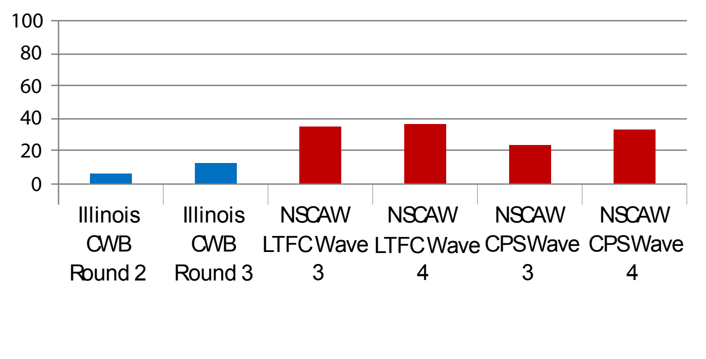


Figure 5.5 Percent Receiving Residential Mental Health Service
100
80
60
40
20
0
Illinois CWB Round 2
Illinois CWB Round 3
NSCAW LTFC Wave 3
NSCAW LTFC Wave 4
NSCAW CPS Wave 3
NSCAW CPS Wave 4

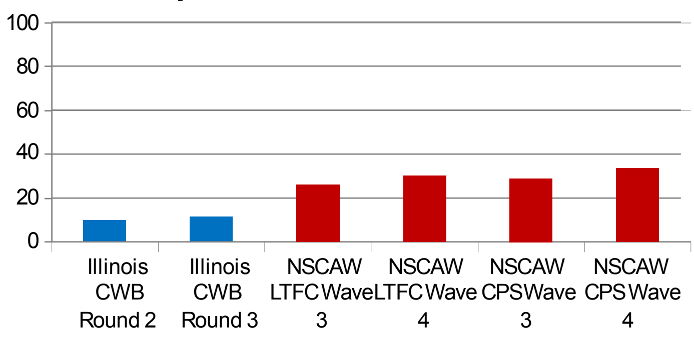


Figure 5.8 Percent Receiving Services from a Family Doctor or Other Medical Doctor
100
80
60
40
20
0
Illinois CWB Round 2
Illinois CWB Round 3
NSCAW LTFC Wave 3
NSCAW LTFC Wave 4
NSCAW CPS Wave 3
NSCAW CPS Wave 4

Service delivery in relation to need

Further analysis across the six samples examined mental health service delivery in relation to need. Specifically, we calculated the proportion of children where the caregiver checklist score indicated a mental health problem who then received a specialty mental health service. We focused on specialty mental health services because of the need for specialists when children have serious mental health problems and to make this analysis more comparable to the seminal study in this field. For comparison, we also examined the proportions of children not scoring in this range on the checklist who nevertheless received a specialty mental health service. The results of this analysis are presented in *Figure 5.9*.

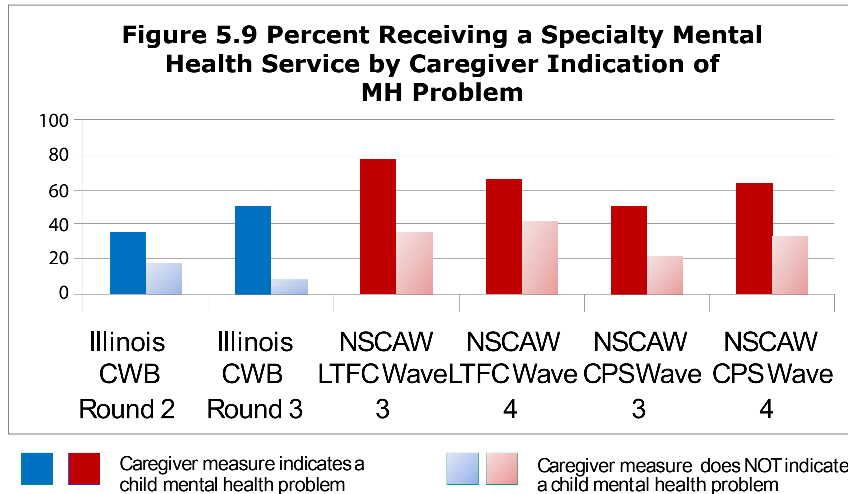


Figure 5.9 Percent Receiving a Specialty Mental Health Service by Caregiver Indication of MH Problem

The percentage of Illinois children with caregiver checklist scores indicating a mental health problem who had received specialty mental health services was lower in Illinois than nationally: 35.9% in 2003 and 50.4% in 2005 in Illinois versus 50.5% to 77.2% nationally. Interestingly, smaller but meaningful percentages of children whose caregiver checklist scores did not indicate a mental health problem did receive a mental health services: 18.2% in the 2003 Illinois sample, 9.2% in the 2005 Illinois sample and 21.6% to 41.4% in the national samples. The mental health problems measure may not have picked up these particular problems or the problems may have existed prior to the current caregiver; or caseworkers, other professionals or youths themselves may have identified the problems.

Box 5.1—**New Initiatives and Opportunities**

The data analyzed here date from 2003 and 2005, and therefore represent a snapshot of a moving picture. DCFS has developed new initiatives to improve children's mental health service delivery in the last several years, and other opportunities to improve services remain. Two in particular may affect the rate of children in foster care receiving mental health services. In 2005, DCFS implemented an Integrated Assessment Program (IAP) that pairs clinicians with caseworkers to augment assessment of children entering foster care. IAP aims to make screening and assessment comprehensive and streamlined, and to identify a range of child and family needs (mental health and other) that will then be addressed more effectively in service planning. An evaluation of IAP in its second year found that the assessments were excellent, but caseworkers often did not implement the specific recommendations in the assessment[12]. However, the evaluation was conducted early and the program may have developed substantially since then.

In 2008, DCFS inaugurated an online searchable database of mental health service providers that provides specific information about what treatment modalities individual agencies offer, what populations they serve and what assistance they provide to overcome barriers to access (e.g., transportation to families)[13]. The database also has a geomapping function that allows the system to display the distribution of different resources geographically. This helps make it a systems planning tool as well as a resource for individual cases.

Some small steps have been taken to change Medicaid to improve access to care. In 2007, state legislation provided the option of reimbursing clinical social workers for mental health care, although the state's Medicaid agency has not taken advantage of this option as of this writing. The Illinois Children's Mental Health Partnership (see below) advocated for more Federal Medicaid reimbursement, and was able to gain a modest increase[14]. It has recommended identifying new state and local mental health funds to draw in more matching Federal Medicaid dollars, and increasing Medicaid support for mental health services by greater use of the Early and Periodic Screening Diagnostic Treatment (EPSDT) program, the child health component of Medicaid. An EPSDT screening can expand the range of services available to a child through Medicaid, because the Federal government requires state Medicaid plans to cover service needs identified by EPSDT, even if the particular service option was not chosen by the state for its Medicaid coverage plan.

Through improved assessment and access to services and increases in the funds available for services, initiatives DCFS and other agencies are taking as well as new opportunities for system change may improve mental health care and increase the percentage of Illinois children in foster care who receive mental health services. On the other hand, it is difficult to overcome limitations in Medicaid dollars and the overall shortage of funds and children's mental health providers, and limitations on mental health services for children in foster care may remain a long-term problem. The direction that mental health services for Illinois children in foster care is taking will be clearer with the analysis scheduled for 2010 of new data on mental health problems and services from the new enhanced Illinois component of the second round of the National Survey of Child and Adolescent Well-Being, which will study both those DCFS-involved children who are in foster care and those who remain in their home.

12 Hartnett, M.A., & Hochstadt, N. (2007). *Evaluation of the La Rabida Children's Hospital Integrated Assessment Program: Phase I.* Chicago, IL: University of Chicago, Department of Pediatrics.
13 Weiner, D.A. (March 2008) *GIS for Service System Planning.* Presentation to the CBCAP-PSSF grantee meeting, Baltimore, MD.
14 Illinois Children's Mental Health Task Force, ibid

OBSTACLES TO MENTAL HEALTH SERVICES FOR ILLINOIS CHILDREN IN FOSTER CARE

This chapter is only the latest and most empirically grounded of several reports that identify a shortfall in mental health services for Illinois children in foster care. One was the 2003-2004 Child and Family Service Review (CFSR) of Illinois[15]. In the CFSR process, the federal government reviews the quality of services provided by state child welfare agencies. Performance on the CFSR is tied to eligibility for federal child welfare block grants. A second was the report of the Illinois Children's Mental Health Task Force[16], a grassroots, multidisciplinary organization formed to address the mental health needs of all the state's children (this group has since evolved into the Illinois Children's Mental Health Partnership). A third is a report by MidAmerican Institute on Poverty of the Heartland Alliance that discusses a deficit of public child mental health services. This last report concerns Illinois children generally, but its finding applies to children in foster care as well[17].

These sources and others, including interviews we conducted with stakeholders in the child welfare and children's mental health service systems in Illinois, suggest several reasons for the difficulty in providing children in foster care with mental health services. Though many states share these obstacles, the particular challenge Illinois has with them may help explain the gaps between Illinois and the rest of the country discussed above. A thorough causal explanation would require a detailed comparison of state systems, however, which is beyond our scope.

One difficulty is the overall shortage of funding and of children's mental health professionals to provide public mental health services. The MidAmerican Institute report cited national survey data showing that 37% of Illinois children with behavioral, developmental or emotional problems did not receive any mental health service in the year prior to the survey[18]. Part of the difficulty was that only 16% of the state's psychiatrists and psychologists accepted public health insurance. Similarly, the Illinois Children's Mental Health Task Force report stated "the system of care for children with severe mental health problems is grossly underfunded, resulting in a lack of capacity to serve the children and families most in need" (p. 8)[19]. Thus "most services are focused on the needs of children with severe mental health problems and disorders" (p. 8). In the 1980's and 1990's, considerable Illinois child welfare money was tied up in expensive, restrictive services like residential treatment and psychiatric hospitalization. In some cases there was insufficient flexibility in the money available because it was available for only certain categories of children and services. Not only has lack of funding impeded service delivery in individual cases, it has also contributed to a system in which there is a shortage of mental health centers and individual professionals capable of providing child mental health services.

Another problem has been inadequate assessment of children and families. The 1980's and 1990's saw an over-reliance on psychological testing at the expense of more comprehensive family assessments. In addition, there was inadequate coordination of mental health professionals doing the assessments and caseworkers developing and implementing service plans. A new Integrated Assessment Plan put into statewide practice in 2005 aimed for comprehensive evaluations, but an evaluation of the program in its second year found that caseworkers had difficulty making effective use of often very good assessments by service professionals (see Box 5.1).

A third problem is the difficulty of supporting mental health services through Medicaid, which is the health insurance coverage for children in DCFS custody. Many mental health services providers are not certified for Medicaid, and some of those that are certified decline to bill Medicaid for children in DCFS custody and look to limited DCFS funds to pay for treatment. There are several reasons for this: Medicaid's rates are low, agencies find billing Medicaid onerous and uncertain both in its set-up and day-to-day implementation, and some agencies, confronted with a fixed amount in Medicaid contracts, sometimes reserve these dollars for poor children who are not involved with DCFS and therefore not eligible for DCFS funding. In effect, children in foster care are in competition for Medicaid dollars with Medicaid-eligible children who are not in foster care. Finally, some agencies are not in a financial position to be able to manage the lengthy delays in Medicaid reimbursement.

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15 See U.S. Department of Health and Human Services, Administration for Children and Families (2004). Final report: *Illinois Children and Family Services Review*. Washington, DC: ACF.
16 Illinois Children's Mental Health Task Force (April, 2003). *Children's mental health: An urgent priority for Illinois*. Final Report. Chicago, IL: Illinois Violence Prevention Authority.
17 MidAmerica Institute on Poverty of Heartland Alliance. (2007). *Building on our success: Moving from health care coverage to improved access and comprehensive well being* for Illinois children and youth. Chicago: Author.
18 MidAmerican Institute, ibid
19 Illinois Children's Mental Health Task Force, ibid

OBSERVATIONS ON THE MENTAL HEALTH OF CHILDREN IN FOSTER CARE

This research demonstrates the substantial risk of mental health problems that Illinois children in foster care face, echoing the results of a number of previous studies across the country. Approximately half of Illinois foster children scored in a range indicating a mental health problem on a caregiver checklist. The percentages with indications of a mental health problem from the youth checklist were smaller but still substantial, about one-third of youth age 11 or older. These rates were about the same as the rates for children in foster care nationally, reflecting the enormous life challenges that children in foster care experience nationwide. The rates are substantially higher for children in foster care than for children in general, about one-fifth of whom have a mental health problem[20]. Clearly, providing mental health services is an important component of insuring the well-being of Illinois children in care.

According to caregiver reports, about 39% of Illinois children in foster care in the 2003 sample and about 46% of children in the 2005 sample had received a mental health service, either specialty or non-specialty. But smaller percentages received specialty services, about 19% in the 2003 sample and about 24% in the 2005 sample. The most frequent service by far was mental health service provided in schools, by guidance counselors, school social workers or other school staff. In-home counseling and crisis services were relatively frequent as well, but services in mental health centers were fairly rare. The percentage of children who received services from private practitioners was unmeasured in this study and therefore unknown, and this would push the percentage with any service and any specialty service higher. When we focused specifically on that portion of the population of Illinois children in foster care whose caregiver checklist scores indicated a mental health problem, just over a third had received a specialty mental health service in the 2003 and half in the 2005 sample. Both in Illinois and nationally, the percentage of children in need in foster care who receive services exceeded the percentage of children in need in the general population who received them, estimated at 20%[21], confirming previous research that suggests that child welfare agencies do indeed serve as a gateway to services[22]. Nevertheless, given the frequency of mental health problems among these children, unmet need for services is still substantial.

Although the gap in mental health services for children in foster care is a national problem[23], the shortfall in Illinois appears to be particularly pronounced, because significantly larger percentages of children in foster care nationally than in Illinois received a mental service, a specialty mental service, and a range of specific individual mental health services. The biggest differences were in community mental health and other mental health center services, residential treatment, and receiving mental health services from a family or other doctor. Likewise, the statistics on services for children in need showed that the percentage of Illinois children in foster care with unmet need was larger than the national percentage of children in foster care with unmet need. Because of increases between the 2003 and 2005 Illinois samples in receipt of mental health services, the Illinois-national difference was less in 2005, but all but two of the 2003 to 2005 increases were not statistically significant, and post-2005 data are needed to assess whether there is a trend toward greater mental health service delivery.

The study has some limitations that should be taken into account in interpreting the results. The lack of measurement

20 Bird HR, Canino G, Rubio-Stipec M, Gould MS, Ribera J, Sesman, M, Woodbury M, Huertas-Goldman S, Pagan A, Sanchez-Lacay A, Moscoso M: Estimates of the prevalence of childhood maladjustment in a community survey in Puerto Rico: the use of combined measures. Arch Gen Psychiatry 1988; 45:1120–1126; correction, 1994; 51:429
Costello EJ, Angold A, Burns BJ, Stangl DK, Tweed DL, Erkanli A, Worthman CM: The Great Smoky Mountains Study of Youth: goals, design, methods, and the prevalence of DSM-III-R disorders. Arch Gen Psychiatry 1996; 53:1129–1136. 3. Offord DR, Boyle MH, Szatmari P, Rae-Grant NI, Links PS, Cadman DT, Byles JA, Crawford JW, Blum HM, Byrne C, Thomas H, Woodward CA: Ontario Child Health Study, II: six-month prevalence of disorder and rates of service utilization. Arch Gen Psychiatry, 1987; 44:832–836

21 Kataoka, S.H., Zhang, L., & Wells, K.B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry,* 159, 1548-1555.

22 Barth, R.P., Wildfire, J., & Green, R.L. (2006). Placement Into Foster Care and the of Urbanicity, Child Behavior Problems, and Poverty. *American Journal of Orthopsychiatry,* 76, 358–366. Leslie, L.K., Hurlburt, M.S., James, S., Landsverk, J., Slymen, D.J., & Zhang, J. (2005). Relationship between entry into child welfare and mental health service use. Psychiatric Services, 56, 981-987.

23 Halfon N., Berkowitz G., & Klee L. (1992). Mental health services utilization by children in foster care in California. *Pediatrics,* 89, 1238-1244. Leslie, L.K., Hurlburt, M.S., Landsverk, J., Barth, R. & Slymen, D.J. (2004). Outpatient mental health services for children in foster care: A national perspective. *Child Abuse & Neglect,* 28, 697–712. Takayama, J.I., Bergman A.B., & Connell F.A. (1994). Children in foster-care in the state of Washington - health-care utilization and expenditures. *Journal of the American Medical Association,* 271, 1850-1855. U.S. Department of Health and Human Services, Administration for Children and Families. (2003). *National Survey of Child and Adolescent Well-Being (NSCAW). One Year in Foster Care Wave 1 Data Analysis Report, November 2003.* Washington, DC: Administration for Children and Families.

of services provided by private practitioners means that we cannot provide definitive percentages for receiving any service overall or any specialty service. Foster caregivers have limits as informants, because they may not necessarily know the child well enough to provide accurate reports of mental health problem, particularly if the child's time in their care has been limited. Foster caregivers may lack information about the mental health services children received before they arrived at the foster home, and some previous research suggests that caregivers do miss some services that the child actually received on the service measure we used[24]. Another limitation is that this study only measured whether or not a service was delivered. It could not measure whether the service was appropriate; delivered in an adequate dose; and used empirically-based, effective interventions; and whether it was coordinated with other interventions taking place in children's lives.

Unmet need suggests that even more should be done to provide services, both in Illinois and nationally. Maltreatment can have long-lasting effects[25] but can also respond to treatment[26].

Society owes it to these children all the more because it is acting in loco parentis. The shortfall in Illinois compared to the rest of the nation suggests the need for even greater urgency for action in the state.

24 Ascher, B.H., Farmer, E.M., Burns, B.J. & Angold, A. (1996). The Child and Adolescent Services Assessment (CASA): Description and psychometrics. *Journal of emotional and behavioral disorders,* 4, 12-20.

25 See, for example, Gillespie, C.F. & Nemeroff, C.B. (2005). Early life stress and depression: Childhood trauma may lead to neurobiologically unique mood disorders. *Current Psychiatry,* 4, 15-29. Turner, H., Finkelhor, D. & Ormrod, R. (2006). The effect of lifetime victimization on the mental health of children and adolescents. *Social Science & Medicine,* 62, 13-27.

26 See, for example, Cohen, J., Mannarino, A.P., & Knudsen, K. (2005) Treating sexually abused children: 1 year follow-up of a randomized controlled trial, *Child Abuse & Neglect,* 29, 135–145. James, S. & Mennen, F. (2001). Treatment outcome research: How effective are treatments for abused children? *Child and Adolescent Social Work Journal,* 18, 73-95. Kolko, D.J. (1996). Individual cognitive behavioral treatment and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes. *Child Maltreatment,* 1, 322-342.

APPENDIX A

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

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

1 This data was generated by the Children and Family Research Center from the December 31, 2008 data extract of the Illinois Department of Children and Family Services Integrated Database. Due to missing data on some variables, the sum of demographic breakouts may not always add up to the total for that indicator. For instance, data on geographic region is not always available for each child; therefore, the total number of children in Central, Cook, Northern and Southern regions will sometimes be less than the total for the state.

Prevalence of Child Abuse and/or Neglect

Indicator 1.A.	Of all children under age 18, what number and rate per 1,000 did not have an indicated report of child abuse and/or neglect?													
	2002		2003		2004		2005		2006		2007		2008	
	Illinois													
Children Under 18	3,308,490		3,340,467		3,372,754		3,405,352		3,438,266		3,471,497		3,505,050	
No Indicated Reports	3,283,283		3,314,717		3,347,103		3,379,512		3,413,513		3,445,085		3,477,189	
Rate	992.38		992.29		992.39		992.41		992.80		992.39		992.05	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	3,283,283	992.38	3,314,717	992.29	3,347,103	992.39	3,379,512	992.41	3,413,513	992.8	3,445,085	992.39	3,477,189	992.05
Central	538,401	989.39	537,090	988.98	535,123	987.34	534,019	987.29	533,278	987.91	531,101	985.87	529,809	985.45
Cook	1,414,888	994.61	1,427,550	994.75	1,440,737	995.17	1,453,779	995.41	1,466,890	995.61	1,479,422	995.35	1,491,999	995.05
Northern	1,043,758	995.47	1,067,083	995.34	1,091,116	995.39	1,115,536	995.3	1,140,585	995.28	1,165,258	994.45	1,190,676	993.81
Southern	293,740	990.13	292,814	989.78	291,938	989.6	290,875	988.78	290,314	989.65	288,951	987.77	288,048	987.46
African-American	610,211	984.89	616,259	985.24	622,753	986.20	628,823	986.38	635,268	987.06	640,978	986.50	646,840	986.10
Hispanic	611,625	996.05	645,372	996.77	680,595	996.93	717,876	997.27	756,970	997.31	798,109	997.25	841,588	997.31
White	2,163,734	994.30	2,166,471	993.78	2,169,984	993.61	2,173,573	993.48	2,178,258	993.84	2,181,222	993.41	2,184,322	993.05

Safety From Maltreatment Recurrence at 12-Months

Indicator 1.B	Of all children with a substantiated report, what percentage did not have another substantiated report within 12 months?													
	2001		2002		2003		2004		2005		2006		2007	
	Illinois													
Children with Substantiated Report	26,373		25,207		25,750		25,651		25,840		24,753		26,412	
Children without Substantiated Recurrence within 12 months	22,890		22,258		22,799		22,704		22,921		21,934		23,401	
Percent	86.8%		88.3%		88.5%		88.5%		88.7%		88.6%		88.6%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	22,890	86.8%	22,258	88.3%	22,799	88.5%	22,704	88.5%	22,921	88.7%	21,934	88.6%	23,401	88.6%
Central	5,095	84.8%	4,973	86.2%	5,052	84.4%	5,881	85.7%	5,971	86.9%	5,678	87.1%	6,547	85.9%
Cook	7,157	89.2%	6,978	91.1%	6,912	91.3%	6,373	91.1%	6,146	91.4%	5,897	91.4%	6,328	91.9%
Northern	4,090	88.6%	4,262	89.7%	4,503	90.2%	4,562	90.2%	4,714	89.4%	4,842	89.4%	5,840	89.8%
Southern	2,704	83.6%	2,428	83.1%	2,578	85.3%	2,612	85.4%	2,804	84.7%	2,603	85.3%	3,054	85.4%
Female	11,802	87.2%	11,583	88.9%	11,790	89.2%	11,528	88.8%	11,760	89.0%	11,305	89.6%	11,849	89.0%
Male	11,006	86.2%	10,583	87.6%	10,886	87.8%	11,001	88.1%	10,984	88.3%	10,468	87.5%	11,383	88.1%
Under 3	6,156	86.6%	6,101	88.2%	6,215	88.5%	6,268	88.2%	6,301	87.8%	6,335	88.7%	6,674	88.2%
3 to 5	4,204	84.2%	4,192	86.1%	4,309	87.1%	4,381	86.4%	4,594	87.4%	4,279	86.6%	4,686	87.0%
6 to 8	4,049	85.8%	3,820	86.9%	3,969	87.3%	3,859	87.8%	3,891	87.5%	3,738	86.7%	4,180	88.3%
9 to 11	3,651	87.2%	3,522	89.1%	3,511	88.4%	3,440	89.2%	3,240	89.5%	3,079	89.0%	3,126	88.3%
12 to 14	2,836	88.4%	2,818	89.7%	2,917	89.9%	3,021	90.7%	3,010	90.7%	2,668	91.0%	2,735	90.5%
15 to 17	1,961	92.2%	1,781	93.6%	1,852	93.1%	1,718	91.8%	1,871	93.1%	1,825	93.3%	1,981	92.5%
African-American	8,824	87.7%	8,448	90.3%	8,302	89.9%	7,812	89.6%	7,795	89.8%	7,485	89.9%	7,866	89.7%
Hispanic	2,287	90.8%	2,228	91.9%	1,910	91.3%	1,966	93.7%	1,830	93.2%	1,854	91.0%	2,016	91.7%
Other	951	85.4%	899	88.5%	764	88.6%	811	91.7%	830	90.0%	811	92.0%	908	92.6%
White	10,828	85.4%	10,683	86.1%	11,823	87.2%	12,115	86.8%	12,466	87.3%	11,784	87.3%	12,611	87.2%

Safety From Maltreatment Recurrence Among Families Receiving No Services

Indicator 1.C	Of all children with an initial substantiated report who did not receive intact or foster care services, what percentage did not have another substantiated report within 12 months?													
	2001		**2002**		**2003**		**2004**		**2005**		**2006**		**2007**	
							Illinois							
Number of Children not Receiving Services	13,503		13,267		13,891		13,592		13,569		13,845		15,759	
Children without Substantiated Report	11,711		11,794		12,345		12,107		12,108		12,297		14,093	
Percent	86.7%		88.9%		88.9%		89.1%		89.2%		88.8%		89.4%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	11,711	86.7%	11,794	88.9%	12,345	88.9%	12,107	89.1%	12,108	89.2%	12,297	88.8%	14,093	89.4%
Central	2,959	85.8%	2,945	86.8%	2,992	85.6%	3,468	87.4%	3,520	87.7%	3,356	86.4%	3,936	86.1%
Cook	3,934	86.2%	3,988	90.1%	4,165	90.8%	3,677	90.7%	3,267	91.5%	3,627	91.0%	4,037	92.4%
Northern	3,213	90.3%	3,374	91.0%	3,532	90.5%	3,346	90.8%	3,693	91.0%	3,796	90.6%	4,360	91.2%
Southern	1,605	83.0%	1,487	85.4%	1,656	86.9%	1,616	86.0%	1,628	84.6%	1,518	85.3%	1,760	86.4%
Female	6,185	87.5%	6,291	89.4%	6,518	89.5%	6,349	89.6%	6,311	89.6%	6,396	89.6%	7,229	89.8%
Male	5,455	85.7%	5,434	88.2%	5,750	88.1%	5,634	88.4%	5,676	88.7%	5,773	87.9%	6,716	88.9%
Under 3	2,614	82.3%	2,653	85.4%	2,730	85.4%	2,742	85.0%	2,647	85.3%	2,896	86.2%	3,407	86.0%
3 to 5	2,173	85.2%	2,274	87.9%	2,379	88.2%	2,455	88.3%	2,511	88.6%	2,388	86.7%	2,904	88.9%
6 to 8	2,131	86.4%	2,138	88.3%	2,232	88.3%	2,161	89.5%	2,156	89.1%	2,218	88.5%	2,618	90.2%
9 to 11	1,984	88.7%	1,915	90.1%	2,043	89.7%	1,924	90.6%	1,849	90.2%	1,911	89.8%	2,001	90.7%
12 to 14	1,550	88.9%	1,622	92.0%	1,729	91.1%	1,745	92.1%	1,779	91.9%	1,671	91.9%	1,794	91.4%
15 to 17	1,233	95.1%	1,176	95.2%	1,219	95.6%	1,070	93.9%	1,162	95.2%	1,211	94.8%	1,361	94.1%
African-American	3,954	85.3%	4,050	89.6%	4,066	88.5%	3,725	89.2%	3,608	88.8%	3,696	88.6%	4,370	90.3%
Hispanic	1,429	91.4%	1,404	92.0%	1,211	91.3%	1,204	93.4%	1,099	93.4%	1,270	91.4%	1,388	92.5%
Other	468	87.5%	454	90.1%	445	90.6%	483	92.7%	479	92.1%	505	93.5%	596	93.7%
White	5,860	86.6%	5,886	87.6%	6,623	88.6%	6,695	88.0%	6,922	88.7%	6,826	88.2%	7,739	88.1%

Safety From 12-Month Maltreatment Recurrence Among Intact Family Cases

Indicator 1.D.	Of all children with a substantiated report, what percentage did not have another substantiated report within 12 months?													
	2001		**2002**		**2003**		**2004**		**2005**		**2006**		**2007**	
							Illinois							
Number of Children in Intact Families	23,515		21,072		19,987		19,977		19,284		17,086		16,411	
Children without Sub-stantiated Report	21,153		19,028		17,918		17,895		17,184		15,191		14,448	
Percent	90.0%		90.3%		89.6%		89.6%		89.1%		88.9%		88.0%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	21,153	90.0%	19,028	90.3%	17,918	89.6%	17,895	89.6%	17,184	89.1%	15,191	88.9%	14,448	88.0%
Central	6,631	87.6%	6,053	88.5%	5,409	86.6%	5,905	87.8%	5,347	86.0%	4,906	86.3%	3,819	84.4%
Cook	8,443	92.6%	7,958	93.2%	7,864	93.3%	7,283	93.0%	7,215	93.4%	6,173	93.4%	6,659	92.3%
Northern	2,805	89.5%	2,334	89.7%	2,458	89.9%	2,531	88.3%	2,139	86.4%	1,985	86.2%	1,956	86.3%
Southern	2,809	87.9%	2,281	85.9%	1,915	83.7%	1,983	84.8%	2,289	87.6%	1,931	84.7%	1,837	83.1%
Female	10,439	90.3%	9,504	90.4%	8,964	89.7%	8,779	89.7%	8,459	89.4%	7,564	89.5%	7,208	88.4%
Male	10,703	89.7%	9,515	90.2%	8,944	89.6%	9,092	89.5%	8,697	88.9%	7,590	88.2%	7,211	87.7%
Under 3	4,530	86.5%	4,197	86.5%	3,975	85.3%	3,956	85.9%	3,919	84.2%	3,702	85.3%	3,478	83.9%
3 to 5	3,845	88.4%	3,453	88.1%	3,197	88.3%	3,204	86.7%	3,092	87.3%	2,879	86.6%	2,660	86.6%
6 to 8	3,948	90.0%	3,339	90.5%	3,124	89.4%	2,962	88.8%	2,866	88.2%	2,487	87.4%	2,456	87.2%
9 to 11	3,418	90.8%	3,145	90.6%	2,912	90.6%	2,873	91.1%	2,563	91.3%	2,165	90.0%	1,980	88.3%
12 to 14	2,769	91.3%	2,534	93.2%	2,501	92.0%	2,560	92.3%	2,431	91.9%	1,971	92.2%	1,894	91.0%
15 to 17	2,643	96.4%	2,360	97.5%	2,209	96.8%	2,340	97.1%	2,313	97.0%	1,987	97.6%	1,980	96.5%
African-American	9,485	91.6%	8,482	92.5%	7,826	92.4%	7,651	91.4%	7,461	91.6%	6,579	91.8%	6,552	89.7%
Hispanic	1,911	91.7%	1,898	91.6%	2,021	93.5%	1,562	92.8%	1,537	92.9%	1,321	91.5%	1,433	91.7%
Other	615	90.0%	552	87.6%	391	89.3%	470	91.4%	437	87.4%	386	93.7%	465	91.7%
White	9,142	88.0%	8,096	88.0%	7,680	86.1%	8,212	87.3%	7,749	86.2%	6,905	85.7%	5,998	85.2%

Safety From Maltreatment Recurrence in Substitute Care

Indicator 1.E. Of all children ever served in substitute care during the year, what percentage did not have a substantiated report during placement?

	2002		2003		2004		2005		2006		2007		2008	
	Illinois													
Children ever in Substitute Care	32,362		29,064		26,305		24,972		23,469		22,480		22,134	
Children without Substantiated Reports	31,964		28,682		25,974		24,648		23,207		22,179		21,787	
Percent	98.8%		98.7%		98.7%		98.7%		98.9%		98.7%		98.4%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	31,964	98.8%	28,682	98.7%	25,974	98.7%	24,648	98.7%	23,207	98.9%	22,179	98.7%	21,787	98.4%
Central	5,207	98.4%	4,979	98.4%	4,872	97.9%	4,935	97.7%	5,023	98.6%	5,274	98.1%	5,451	98.1%
Cook	19,943	99.1%	17,165	98.9%	14,706	99.1%	13,217	99.1%	11,494	99.2%	10,235	99.1%	9,536	99.1%
Northern	3,375	97.9%	3,115	98.1%	2,974	98.4%	3,082	98.7%	3,195	98.7%	3,183	98.4%	3,312	97.9%
Southern	2,038	98.4%	2,062	98.2%	2,156	98.6%	2,280	98.6%	2,382	98.1%	2,406	97.9%	2,443	96.9%
Female	15,169	98.6%	13,590	98.8%	12,255	98.8%	11,595	98.7%	10,939	99.0%	10,401	98.5%	10,234	98.4%
Male	16,776	99.0%	15,077	98.6%	13,708	98.7%	13,036	98.7%	12,240	98.7%	11,751	98.8%	11,518	98.5%
Under 3	11,931	98.7%	10,540	98.7%	9,418	98.6%	9,084	98.6%	8,714	98.7%	8,414	98.5%	8,289	98.3%
3 to 5	5,904	98.4%	5,228	98.5%	4,604	98.4%	4,319	98.3%	4,083	98.6%	3,842	98.2%	3,838	98.3%
6 to 8	5,298	98.9%	4,703	98.4%	4,223	98.6%	3,884	98.8%	3,561	99.1%	3,287	98.6%	3,111	98.0%
9 to 11	4,386	99.1%	3,998	98.7%	3,583	98.9%	3,242	98.8%	2,875	99.3%	2,665	98.9%	2,508	98.4%
12 to 14	3,295	99.0%	3,052	98.9%	2,935	99.1%	2,798	99.1%	2,645	99.1%	2,579	99.2%	2,543	98.9%
15 to 17	1,147	99.5%	1,158	99.5%	1,208	99.8%	1,320	99.5%	1,328	99.6%	1,392	99.4%	1,498	99.5%
African-American	22,140	98.9%	19,286	98.9%	16,881	98.9%	15,480	99.0%	14,126	99.1%	13,154	98.9%	12,521	98.7%
Hispanic	1,744	98.8%	1,598	98.4%	1,402	98.8%	1,417	98.8%	1,321	99.0%	1,287	99.0%	1,297	98.4%
Other	698	98.2%	663	97.2%	544	98.4%	519	98.5%	488	98.2%	498	98.8%	492	97.6%
White	7,382	98.4%	7,135	98.3%	7,147	98.3%	7,232	98.1%	7,272	98.5%	7,240	98.2%	7,477	98.1%

Safety From Maltreatment Recurrence

Indicator 1.F. Of all children with an initial unfounded report, what percentage did not have a report during the year?

	2002		2003		2004		2005		2006		2007		2008	
	Illinois													
Children with Initial Unfounded Report	55,178		56,488		62,344		67,684		67,425		67,726		66,158	
Children without Additional Reports	42,190		41,613		46,225		52,204		53,576		55,156		57,164	
Percent	76.5%		73.6%		74.2%		77.1%		79.5%		81.4%		86.4%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	42,190	76.5%	41,613	73.6%	46,225	74.2%	52,204	77.1%	53,576	79.5%	55,156	81.4%	57,164	86.4%
Central	9,208	70.9%	9,325	68.4%	10,401	68.6%	12,049	71.9%	12,690	74.1%	13,577	77.0%	15,514	86.8%
Cook	17,403	81.3%	17,004	79.9%	18,396	80.5%	20,034	83.0%	19,732	84.8%	19,179	86.1%	19,471	90.3%
Northern	10,274	76.4%	10,176	73.4%	11,326	74.3%	13,178	77.4%	13,989	79.8%	14,957	82.0%	15,514	86.8%
Southern	5,303	72.1%	5,088	65.9%	6,102	67.3%	6,943	71.1%	7,164	75.4%	7,443	77.7%	7,859	83.4%
Female	20,886	76.1%	20,514	73.2%	22,715	73.4%	25,510	76.6%	26,152	78.8%	27,247	81.0%	28,141	86.2%
Male	20,459	76.2%	20,195	73.4%	22,365	74.1%	25,212	76.8%	26,080	79.5%	26,848	81.5%	27,834	86.3%
Under 3	8,497	76.8%	8,180	73.2%	9,067	73.4%	9,983	77.2%	10,384	80.7%	10,832	82.5%	11,208	86.4%
3 to 5	8,287	74.6%	8,283	72.0%	9,088	72.3%	10,222	75.7%	10,213	77.6%	10,851	80.8%	11,110	86.1%
6 to 8	7,800	74.3%	7,655	72.3%	8,053	71.6%	9,376	75.7%	9,736	78.3%	10,024	80.0%	10,504	85.5%
9 to 11	6,792	74.4%	6,685	71.7%	7,388	73.6%	8,316	76.3%	8,427	78.7%	8,382	80.7%	8,775	86.4%
12 to 14	5,674	75.6%	5,948	72.6%	6,918	73.9%	7,685	75.4%	7,912	77.4%	8,043	79.7%	8,318	85.6%
15 to 17	5,119	87.7%	4,784	85.1%	5,676	84.4%	6,589	85.2%	6,882	85.9%	6,997	86.1%	7,233	89.3%
African-American	14,681	78.5%	14,870	76.9%	16,432	77.6%	18,156	80.2%	18,192	81.9%	18,381	83.2%	18,404	87.8%
Hispanic	4,657	82.0%	3,623	78.7%	4,054	80.3%	4,341	82.9%	4,562	84.0%	4,770	86.7%	4,635	90.5%
Other	2,340	84.5%	1,777	83.0%	2,175	82.9%	2,390	86.6%	2,390	87.4%	2,428	89.3%	2,615	90.6%
White	20,510	73.2%	21,323	70.1%	23,564	70.4%	27,317	73.7%	28,431	76.8%	29,577	79.1%	31,510	84.7%

Safety From Maltreatment Recurrence

Indicator 1.G	Of all children with an initial unfounded report, what percentage did not have a substantiated report during the year?													
	2002		**2003**		**2004**		**2005**		**2006**		**2007**		**2008**	
	Illinois													
Children with Initial Unfounded Report	55,178		56,488		62,344		67,684		67,425		67,726		66,158	
Children without *Substantiated* Reports	52,738		53,938		59,396		64,838		64,720		64,624		63,670	
Percent	95.6%		95.5%		95.3%		95.8%		96.0%		95.4%		96.2%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	52,738	95.6%	53,938	95.5%	59,396	95.3%	64,838	95.8%	64,720	96.0%	64,624	95.4%	63,670	96.2%
Central	12,239	94.3%	12,801	93.9%	14,167	93.4%	15,794	94.3%	16,164	94.4%	16,524	93.7%	16,349	94.6%
Cook	20,695	96.7%	20,644	97.1%	22,149	96.9%	23,498	97.3%	22,680	97.5%	21,614	97.1%	21,074	97.7%
Northern	12,861	95.7%	13,262	95.7%	14,625	95.9%	16,353	96.1%	16,868	96.2%	17,479	95.8%	17,230	96.4%
Southern	6,943	94.4%	7,231	93.6%	8,455	93.3%	9,193	94.2%	9,008	94.8%	9,007	94.1%	9,017	95.7%
Female	26,183	95.4%	26,750	95.4%	29,424	95.1%	31,853	95.7%	31,800	95.9%	32,092	95.4%	31,399	96.2%
Male	25,668	95.6%	26,253	95.4%	28,763	95.3%	31,430	95.7%	31,496	96.0%	31,412	95.3%	31,035	96.2%
Under 3	10,486	94.8%	10,563	94.5%	11,544	93.5%	12,229	94.6%	12,219	95.0%	12,370	94.2%	12,333	95.1%
3 to 5	10,596	95.3%	10,943	95.1%	11,951	95.1%	12,883	95.4%	12,543	95.3%	12,740	94.9%	12,378	95.9%
6 to 8	10,023	95.5%	10,120	95.6%	10,675	94.9%	11,837	95.5%	11,917	95.8%	11,896	94.9%	11,815	96.1%
9 to 11	8,717	95.5%	8,909	95.5%	9,613	95.7%	10,462	96.0%	10,311	96.4%	9,937	95.7%	9,776	96.3%
12 to 14	7,175	95.7%	7,864	95.9%	9,012	96.2%	9,818	96.3%	9,866	96.5%	9,703	96.1%	9,406	96.7%
15 to 17	5,711	97.8%	5,469	97.3%	6,559	97.6%	7,570	97.9%	7,840	97.8%	7,949	97.8%	7,945	98.1%
African-American	17,968	96.0%	18,640	96.4%	20,349	96.1%	21,832	96.4%	21,457	96.6%	21,187	95.9%	20,278	96.7%
Hispanic	5,494	96.8%	4,435	96.4%	4,882	96.7%	5,095	97.3%	5,272	97.1%	5,329	96.8%	4,992	97.5%
Other	2,675	96.6%	2,075	97.0%	2,540	96.8%	2,691	97.5%	2,680	98.0%	2,638	97.0%	2,811	97.4%
White	26,601	94.9%	28,788	94.7%	31,625	94.4%	35,220	95.1%	35,311	95.3%	35,470	94.8%	35,589	95.7%

Stability in Intact Family Homes

Indicator 2.A Of all children served in intact family cases, what percentage did not experience a substitute care placement within a 12-month period?

	2001	2002	2003	2004	2005	2006	2007
			Illinois				
Children in Intact Families	23,516	21,073	19,990	19,978	19,289	17,106	16,420
No Substitute Care Placement	22,198	19,949	18,940	18,867	18,111	16,185	15,371
Percent	94%	95%	95%	94%	94%	95%	94%

	2001 N	2001 %	2002 N	2002 %	2003 N	2003 %	2004 N	2004 %	2005 N	2005 %	2006 N	2006 %	2007 N	2007 %
Illinois	22,198	94%	19,949	95%	18,940	95%	18,867	94%	18,111	94%	16,185	95%	15,371	94%
Central	7,137	94%	6,498	95%	5,856	94%	6,348	94%	5,825	94%	5,305	93%	4,098	91%
Cook	8,614	94%	8,109	95%	8,092	96%	7,520	96%	7,431	96%	6,434	97%	6,966	97%
Northern	2,969	95%	2,449	94%	2,586	94%	2,637	92%	2,227	90%	2,131	92%	2,095	92%
Southern	3,006	94%	2,480	93%	2,119	93%	2,173	93%	2,409	92%	2,115	93%	2,032	92%
Female	10,954	95%	9,950	95%	9,500	95%	9,255	95%	8,928	94%	8,014	95%	7,669	94%
Male	11,233	94%	9,988	95%	9,429	94%	9,587	94%	9,154	94%	8,135	94%	7,670	93%
Under 3	4,810	92%	4,465	92%	4,288	92%	4,222	92%	4,248	91%	4,014	92%	3,758	91%
3 to 5	4,106	94%	3,710	95%	3,435	95%	3,470	94%	3,301	93%	3,125	94%	2,864	93%
6 to 8	4,158	95%	3,510	95%	3,328	95%	3,164	95%	3,074	95%	2,708	95%	2,652	94%
9 to 11	3,575	95%	3,294	95%	3,071	96%	2,997	95%	2,672	95%	2,299	95%	2,123	95%
12 to 14	2,856	94%	2,591	95%	2,582	95%	2,649	95%	2,499	95%	2,045	96%	1,961	94%
15 to 17	2,693	98%	2,379	98%	2,236	98%	2,365	98%	2,317	97%	1,994	98%	2,013	98%
African-American	9,760	94%	8,690	95%	8,039	95%	7,847	94%	7,687	94%	6,831	95%	6,874	94%
Hispanic	1,987	95%	1,970	95%	2,103	97%	1,633	97%	1,583	96%	1,411	98%	1,487	95%
Other	639	94%	574	91%	417	94%	479	93%	477	95%	398	97%	486	96%
White	9,812	94%	8,715	95%	8,381	94%	8,908	95%	8,364	93%	7,545	93%	6,524	93%

Stability in Substitute Care

Indicator 2.B — Of all children entering substitute care and staying for at least one year, what percentage had no more than two placements within a year of removal?

	2001	2002	2003	2004	2005	2006	2007
				Illinois			
Entering and staying one year	4,194	4,183	3,892	3,769	3,995	3,563	3,569
No more than two placements	3,255	3,265	3,064	3,016	3,210	2,831	2,824
Percent	78%	78%	79%	80%	80%	79%	79%

	2001 N	2001 %	2002 N	2002 %	2003 N	2003 %	2004 N	2004 %	2005 N	2005 %	2006 N	2006 %	2007 N	2007 %
Illinois	3,255	78%	3,265	78%	3,064	79%	3,016	80%	3,210	80%	2,831	79%	2,824	79%
Central	796	78%	808	81%	925	78%	910	78%	966	83%	978	82%	1,111	82%
Cook	1,513	79%	1,525	77%	1,177	77%	1,040	80%	1,147	80%	706	77%	656	76%
Northern	457	76%	500	80%	456	82%	517	81%	580	81%	594	79%	476	79%
Southern	346	71%	321	76%	378	80%	426	83%	412	75%	449	77%	477	76%
Female	1,613	79%	1,633	78%	1,478	79%	1,420	80%	1,592	80%	1,407	79%	1,390	79%
Male	1,641	76%	1,630	78%	1,586	79%	1,595	80%	1,611	80%	1,413	80%	1,433	79%
Under 3	1,502	85%	1,529	86%	1,469	86%	1,393	87%	1,524	88%	1,379	86%	1,315	85%
3 to 5	514	76%	523	77%	451	76%	462	79%	488	80%	440	74%	437	79%
6 to 8	405	79%	407	76%	384	77%	362	78%	389	80%	335	77%	350	78%
9 to 11	359	71%	352	73%	336	77%	309	78%	318	73%	228	77%	255	73%
12 to 14	303	65%	295	63%	267	65%	309	69%	293	67%	239	70%	244	69%
15 to 17	172	66%	159	65%	157	66%	181	65%	198	64%	210	72%	223	71%
African-American	1,903	78%	1,819	79%	1,639	79%	1,502	78%	1,635	80%	1,352	79%	1,268	78%
Hispanic	183	73%	218	72%	134	68%	148	82%	184	77%	122	71%	145	76%
Other	108	79%	86	74%	95	78%	49	84%	70	70%	64	85%	73	83%
White	1,061	77%	1,142	78%	1,196	80%	1,317	82%	1,321	82%	1,293	80%	1,338	81%

Youth Who Do Not Run Away from Substitute Care

Indicator 2.C — Of all children entering care at the age of 12 or older, what percentage did not run away from a foster care placement during the year?

	2001	2002	2003	2004	2005	2006	2007
				Illinois			
Entered Substitute Care at 12 or older	1,254	1,216	1,142	1,163	1,199	1,084	1,035
Did Not Run Away During the Year	975	925	871	906	926	855	832
Percent	78%	76%	76%	78%	77%	79%	80%

	2001 N	2001 %	2002 N	2002 %	2003 N	2003 %	2004 N	2004 %	2005 N	2005 %	2006 N	2006 %	2007 N	2007 %
Illinois	975	78%	925	76%	871	76%	906	78%	926	77%	855	79%	832	80%
Central	261	79%	233	78%	249	79%	245	82%	231	83%	251	87%	219	83%
Cook	312	74%	309	69%	245	65%	235	68%	283	67%	190	63%	218	71%
Northern	171	79%	175	81%	150	79%	155	76%	181	83%	154	77%	134	83%
Southern	134	81%	114	81%	117	84%	146	85%	142	84%	124	86%	132	83%
Female	493	76%	484	76%	428	74%	495	78%	490	76%	430	77%	429	78%
Male	481	80%	441	77%	443	78%	411	78%	436	79%	425	81%	403	83%
12 to 14*	636	84%	606	82%	571	84%	573	83%	556	83%	538	87%	468	87%
15 or older*	339	69%	319	66%	300	65%	333	71%	370	69%	317	68%	364	74%
African-American	460	75%	438	73%	413	72%	441	73%	482	72%	434	75%	428	76%
Hispanic	46	72%	52	74%	35	73%	31	66%	46	72%	41	66%	39	76%
Other	32	84%	30	75%	17	71%	6	50%	17	85%	16	85%	2	80%
White	437	81%	405	80%	406	82%	428	86%	381	85%	364	85%	353	86%

** Age at case opening*

Least Restrictive Setting

Indicator 3.A	Of all the children in out-of-home care at the end of the fiscal year who were under the age of 12 at the start of the placement, what percent were not placed in a group home or institution?													
	2002		2003		2004		2005		2006		2007		2008	
							Illinois							
Children under 12	15,292		13,391		12,410		11,937		11,422		10,773		11,090	
Not placed in Institution or Group Home	14,823		12,998		12,083		11,665		11,163		10,497		10,766	
Percent	97%		97%		97%		98%		98%		97%		97%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	14,823	97%	12,998	97%	12,083	97%	11,665	98%	11,163	98%	10,497	97%	10,766	97%
Central	2,363	99%	2,375	99%	2,485	99%	2,567	99%	2,683	99%	2,792	98%	2,948	98%
Cook	9,323	96%	7,732	96%	6,636	97%	5,983	97%	5,185	97%	4,465	96%	4,364	96%
Northern	1,596	97%	1,388	98%	1,434	98%	1,531	98%	1,680	99%	1,641	98%	1,836	98%
Southern	992	98%	997	98%	1,075	99%	1,156	98%	1,206	99%	1,232	99%	1,304	98%
Female	7,153	98%	6,263	98%	5,651	98%	5,454	99%	5,232	98%	4,940	98%	5,065	98%
Male	7,660	96%	6,729	96%	6,424	97%	6,197	97%	5,907	97%	5,535	97%	5,676	96%
Under 3	5,635	99%	5,202	99%	4,985	99%	5,019	99%	4,931	99%	4,702	100%	4,898	99%
3 to 5	3,268	99%	2,715	99%	2,576	99%	2,449	99%	2,422	99%	2,277	99%	2,349	99%
6 to 8	3,077	97%	2,597	97%	2,357	98%	2,202	97%	2,028	97%	1,925	97%	1,927	96%
9 to 11	2,843	91%	2,484	91%	2,165	92%	1,995	93%	1,782	92%	1,593	91%	1,592	90%
African-American	10,312	97%	8,712	97%	7,672	97%	7,092	97%	6,543	97%	5,919	97%	5,916	97%
Hispanic	859	96%	768	97%	726	97%	707	98%	667	97%	655	97%	650	97%
Other	384	97%	338	98%	300	98%	295	98%	289	98%	271	99%	275	98%
White	3,268	97%	3,180	97%	3,385	98%	3,571	98%	3,664	98%	3,652	98%	3,925	98%

Placing Children With Relative-First Placements

Indicator 3.B.1	Of all children entering substitute care, what percentage is placed with kin in their first placement?													
	2002		2003		2004		2005		2006		2007		2008	
							Illinois							
Entering Substitute Care	5,636		5,300		5,039		5,299		4,773		4,504		5,198	
Placed With Kin	2,149		1,958		2,102		2,349		2,052		2,161		2,631	
Percent	38%		37%		42%		44%		43%		48%		51%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	2,149	38%	1,958	37%	2,102	42%	2,349	44%	2,052	43%	2,161	48%	2,631	51%
Central	488	35%	594	39%	631	42%	717	47%	716	48%	943	57%	1,043	60%
Cook	1,074	44%	733	37%	667	41%	786	43%	467	37%	440	41%	567	40%
Northern	325	38%	348	46%	370	45%	416	46%	471	52%	389	51%	573	58%
Southern	208	32%	232	36%	356	48%	362	45%	336	41%	342	45%	399	49%
Female	1,070	39%	990	39%	1,007	42%	1,169	45%	1,055	45%	1,068	49%	1,304	52%
Male	1,076	38%	968	35%	1,095	41%	1,173	44%	993	41%	1,090	47%	1,317	49%
Under 3	816	38%	794	39%	805	43%	964	47%	841	44%	900	51%	1,063	52%
3 to 5	392	45%	345	43%	370	49%	421	52%	394	51%	398	58%	533	63%
6 to 8	334	46%	281	42%	301	47%	326	50%	300	52%	306	55%	379	61%
9 to 11	270	39%	226	35%	244	41%	276	46%	196	44%	238	52%	270	54%
12 to 14	205	28%	189	28%	248	36%	217	33%	197	32%	188	35%	226	39%
15 to 17	131	27%	122	27%	134	29%	145	27%	124	26%	131	27%	160	27%
African-American	1,234	41%	1,030	36%	996	39%	1,120	42%	912	39%	966	45%	1,103	46%
Hispanic	125	33%	86	30%	94	40%	125	41%	96	41%	103	43%	146	50%
Other	55	30%	62	37%	44	50%	63	50%	48	48%	57	57%	58	43%
White	735	36%	780	39%	968	44%	1,041	48%	996	47%	1,035	51%	1,324	56%

Placing Children With Relatives in Substitute Care

Indicator 3.B.2	Of all children in substitute care at the end of the year, what percentage is living with kin?													
	2002		**2003**		**2004**		**2005**		**2006**		**2007**		**2008**	
							Illinois							
In Substitute Care	22,882		20,144		18,460		17,599		16,715		15,560		15,696	
Living With Kin	8,537		7,278		6,833		6,734		6,303		5,958		6,304	
Percent	37%		36%		37%		38%		38%		38%		40%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	8,537	37%	7,278	36%	6,833	37%	6,734	38%	6,303	38%	5,958	38%	6,304	40%
Central	1,052	30%	1,076	31%	1,192	34%	1,314	37%	1,463	39%	1,671	45%	1,873	48%
Cook	5,930	41%	4,678	38%	3,972	38%	3,633	38%	2,924	36%	2,449	34%	2,399	35%
Northern	842	36%	794	37%	846	39%	919	41%	1,051	44%	1,008	44%	1,179	47%
Southern	433	30%	471	32%	586	38%	648	40%	661	40%	653	39%	696	39%
Female	4,335	40%	3,701	39%	3,395	40%	3,299	41%	3,021	39%	2,919	41%	3,092	43%
Male	4,191	35%	3,572	33%	3,433	34%	3,427	36%	3,267	36%	3,024	36%	3,195	38%
Under 3	1,444	41%	1,389	41%	1,377	43%	1,476	45%	1,473	46%	1,440	47%	1,602	50%
3 to 5	1,499	43%	1,311	42%	1,290	43%	1,360	46%	1,374	47%	1,305	48%	1,419	50%
6 to 8	1,297	41%	1,075	40%	1,022	42%	980	43%	950	43%	956	44%	1,020	46%
9 to 11	1,216	37%	1,003	37%	925	38%	880	40%	793	40%	708	40%	752	42%
12 to 14	1,078	30%	910	29%	824	30%	834	32%	682	30%	628	30%	614	32%
15 to 17	2,003	35%	1,590	31%	1,395	30%	1,204	28%	1,031	25%	921	25%	897	24%
African-American	6,492	41%	5,321	39%	4,667	39%	4,321	39%	3,753	37%	3,391	37%	3,464	38%
Hispanic	389	31%	336	30%	336	32%	359	36%	353	37%	374	40%	363	40%
Other	168	33%	140	31%	127	33%	128	33%	144	38%	129	36%	146	41%
White	1,488	29%	1,481	30%	1,703	34%	1,926	37%	2,053	39%	2,064	41%	2,331	44%

In-State Placements

Indicator 3.C.	Of all children placed in a group home or institution as of June 30th, what percentage is placed in Illinois?													
	2002		**2003**		**2004**		**2005**		**2006**		**2007**		**2008**	
							Illinois							
Placed in a Group Home or Institution	2,759		2,396		2,112		2,030		1,901		1,774		1,872	
Placed in Illinois	2,738		2,386		2,102		2,009		1,888		1,763		1,853	
Percent	99.2%		99.6%		99.5%		99.0%		99.3%		99.4%		99.0%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	2,738	99.2%	2,386	99.6%	2,102	99.5%	2,009	99.0%	1,888	99.3%	1,763	99.4%	1,853	99.0%
Central	328	100.0%	284	100.0%	275	100.0%	270	99.6%	314	99.7%	318	100.0%	376	99.7%
Cook	1,875	99.5%	1,595	99.6%	1,352	99.5%	1,262	98.9%	1,111	99.4%	1,006	99.3%	983	98.7%
Northern	240	100.0%	233	99.6%	232	99.6%	232	98.7%	231	99.1%	229	99.6%	260	98.5%
Southern	153	98.1%	150	100.0%	139	99.3%	146	99.3%	135	99.3%	117	99.2%	146	100.0%
Female	840	98.5%	710	99.2%	640	99.4%	623	98.9%	581	99.3%	563	99.6%	622	99.8%
Male	1,896	99.6%	1,675	99.8%	1,461	99.6%	1,385	99.0%	1,306	99.3%	1,200	99.3%	1,231	98.6%
Under 3	44	95.7%	50	100.0%	44	97.8%	33	100.0%	28	100.0%	20	95.2%	44	100.0%
3 to 5	31	100.0%	28	100.0%	24	100.0%	22	100.0%	23	100.0%	27	100.0%	27	100.0%
6 to 8	99	99.0%	72	98.6%	59	98.3%	60	98.4%	62	98.4%	61	98.4%	76	98.7%
9 to 11	289	99.0%	240	99.2%	196	99.0%	159	98.8%	143	98.6%	164	98.8%	171	99.4%
12 to 14	824	99.4%	704	99.9%	579	99.7%	516	98.9%	495	99.4%	475	99.6%	447	99.3%
15 to 17	1,451	99.3%	1,292	99.5%	1,200	99.7%	1,219	99.0%	1,137	99.4%	1,016	99.5%	1,088	98.7%
African-American	1,848	99.4%	1,642	99.6%	1,412	99.6%	1,353	98.8%	1,224	99.2%	1,132	99.1%	1,172	98.7%
Hispanic	159	97.5%	131	100.0%	106	98.1%	107	100.0%	106	100.0%	92	100.0%	96	99.0%
Other	46	100.0%	43	100.0%	31	100.0%	30	100.0%	28	100.0%	25	100.0%	30	100.0%
White	685	99.1%	570	99.5%	553	99.6%	519	99.2%	530	99.4%	514	99.8%	555	99.5%

Placing Children With Relatives

Indicator 3.D. Of all children entering substitute care, what is the median distance from their home of origin?

	2002	2003	2004	2005	2006	2007	2008
Illinois Traditional Foster Care							
Entered Substitute Care	2,392	2,350	2,114	2,032	1,869	1,704	1,740
Median Miles from Home	9.2	9.6	9.8	9.4	9.7	8.5	10.2
Illinois Kinship Foster Care							
Entered Substitute Care	2,249	2,039	2,091	2,364	2,060	2,108	2,649
Median Miles from Home	3.6	4.1	3.7	3.6	3.5	3.2	3.5
Central Region:Traditional Foster Care							
Entered Substitute Care	670	721	656	594	537	616	577
Median Miles from Home	5.8	9.4	10.7	10.0	8.5	5.3	8.5
Central Region: Kinship Foster Care							
Entered Substitute Care	496	599	628	720	757	871	992
Median Miles from Home	1.9	3.2	3.6	2.7	2.5	2.4	2.7
Cook County:Traditional Foster Care							
Entered Substitute Care	737	748	552	514	403	290	354
Median Miles from Home	8.7	8.9	9.3	9.1	10.0	9.1	9.1
Cook County: Kinship Foster Care							
Entered Substitute Care	1092	724	623	805	457	441	633
Median Miles from Home	4.3	4.5	4.2	4.2	4.5	5.0	5.1
Northern Region:Traditional Foster Care							
Entered Substitute Care	414	315	347	381	332	274	300
Median Miles from Home	10.8	11.0	9.8	8.8	8.8	10.2	15.4
Northern Region: Kinship Foster Care							
Entered Substitute Care	328	330	376	393	445	385	553
Median Miles from Home	4.6	5.8	2.6	2.9	4.3	3.2	3.8
Southern Region:Traditional Foster Care							
Entered Substitute Care	339	316	317	359	382	335	311
Median Miles from Home	15.3	12.3	8.4	9.0	15.0	10.6	9.4
Southern Region: Kinship Foster Care							
Entered Substitute Care	224	273	350	358	331	346	399
Median Miles from Home	3.0	2.1	3.7	4.6	1.9	5.6	2.7

Preserving Sibling Bonds

Indicator 3.E. Of all children placed into foster care at the end of the year, what percentage is placed with their siblings? (Children with no siblings in foster care are excluded from the analysis.)

	2002	2003	2004	2005	2006	2007	2008
Illinois							
Traditional Foster Care	**2-3 Siblings**						
Children with 2-3 Siblings	3,486	3,344	3,115	2,847	2,582	2,517	2,347
Placed with All Siblings	1,689	1,732	1,716	1,643	1,490	1,484	1,419
Percent	48%	52%	55%	58%	58%	59%	60%
Kinship Foster Care	**2-3 Siblings**						
Children with 2-3 Siblings	3,691	3,204	3,049	3,152	3,108	2,953	3,201
Placed with All Siblings	2,355	2,046	2,005	2,192	2,181	2,047	2,257
Percent	64%	64%	66%	70%	70%	69%	71%
Traditional Foster Care	**4 or More Siblings**						
Children with 4 or more Siblings	1,979	1,746	1,621	1,575	1,378	1,215	1,139
Placed with All Siblings	241	232	242	227	202	181	212
Percent	12%	13%	15%	14%	15%	15%	19%
Kinship Foster Care	**4 or More Siblings**						
Children with 4 or more Siblings	2,214	1,766	1,653	1,585	1,469	1,331	1,428
Placed with All Siblings	713	482	501	506	577	540	601
Percent	32%	27%	30%	32%	39%	41%	42%

Permanence at 12 Months: Reunification

Indicator 4.A.	Of all children who entered substitute care during the year and stayed for longer than 7 days, what percentage was reunified with their parents within 12 months from the date of entry into foster care?													
	2001		2002		2003		2004		2005		2006		2007	
							Illinois							
Entering Substitute Care		5,828		5,636		5,300		5,039		5,299		4,773		4,504
In a permanent home at 12 months		1,253		1,179		1,139		1,025		1,023		891		918
Percent		21%		21%		21%		20%		19%		19%		20%
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	1,253	21%	1,179	21%	1,139	21%	1,025	20%	1,023	19%	891	19%	918	20%
Central	487	33%	427	31%	447	29%	407	27%	389	26%	316	21%	430	26%
Cook	231	9%	204	8%	238	12%	127	8%	124	7%	116	9%	86	8%
Northern	269	31%	238	28%	194	26%	175	21%	194	22%	172	19%	136	18%
Southern	231	35%	254	40%	220	34%	279	38%	297	37%	245	30%	248	33%
Female	611	22%	563	20%	523	21%	499	21%	521	20%	419	18%	432	20%
Male	642	21%	616	22%	615	22%	526	20%	501	19%	472	20%	485	21%
Under 3	360	17%	378	18%	368	18%	311	16%	319	16%	301	16%	322	18%
3 to 5	209	23%	201	23%	208	26%	171	22%	203	25%	172	22%	174	25%
6 to 8	183	24%	163	23%	158	23%	165	26%	132	20%	133	23%	142	25%
9 to 11	190	26%	160	23%	147	23%	142	24%	147	25%	98	22%	105	23%
12 to 14	175	23%	160	22%	156	23%	163	24%	118	18%	125	20%	90	17%
15 to 17	136	28%	117	24%	102	22%	73	16%	104	20%	62	13%	85	17%
African-American	458	14%	418	14%	428	15%	334	13%	336	13%	329	14%	320	15%
Hispanic	60	18%	73	19%	73	26%	30	13%	60	20%	26	11%	50	21%
Other	53	25%	61	33%	49	29%	26	30%	18	14%	13	13%	28	28%
White	682	34%	627	30%	589	29%	635	29%	609	28%	523	25%	520	26%

Permanence at 24 Months: Reunification + Adoption

Indicator 4.B.	What percentage attained permanency (through reunification or adoption) within 24 months from the date of entry into foster care?													
	2000		2001		2002		2003		2004		2005		2006	
	Illinois													
Entering Substitute Care	5,970		5,828		5,636		5,300		5,039		5,299		4,773	
In a permanent home at 24 months	2,186		2,197		2,137		1,989		1,778		1,883		1,727	
Percent	37%		38% 38%		38% 38%		38% 38%		35% 35%		36% 36%		36% 36%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	2,186	37%	2,197	38%	2,137	38%	1,989	38%	1,778	35%	1,883	36%	1,727	36%
Central	860	51%	797	54%	709	51%	751	49%	691	46%	724	48%	674	45%
Cook	559	23%	532	21%	523	21%	473	24%	283	17%	302	17%	226	18%
Northern	406	43%	426	49%	413	48%	331	44%	302	36%	363	41%	327	36%
Southern	265	46%	316	48%	350	56%	319	49%	389	52%	412	52%	385	47%
Female	1,115	37%	1,047	37%	1,046	38%	939	37%	849	36%	955	37%	824	35%
Male	1,071	36%	1,150	38%	1,091	38%	1,049	38%	928	35%	925	34%	902	37%
Under 3	834	36%	800	37%	819	38%	780	38%	645	34%	728	36%	690	36%
3 to 5	368	40%	355	39%	353	41%	338	42%	304	40%	323	40%	317	41%
6 to 8	314	39%	309	41%	277	39%	260	39%	256	40%	259	40%	235	41%
9 to 11	240	34%	294	40%	281	41%	235	37%	232	40%	236	40%	170	38%
12 to 14	282	38%	268	35%	256	35%	244	36%	238	34%	200	30%	213	35%
15 to 17	148	31%	171	35%	151	31%	132	29%	103	22%	137	26%	102	22%
African-American	1,013	29%	958	29%	904	30%	855	30%	666	26%	708	26%	678	29%
Hispanic	117	41%	108	32%	131	35%	114	40%	56	24%	105	34%	59	25%
Other	83	48%	85	41%	83	45%	71	43%	39	44%	32	25%	33	33%
White	973	47%	1,046	52%	1,019	49%	949	47%	1,017	46%	1,038	47%	957	45%

Permanence at 36 Months: Reunification + Adoption+Guardianship

Indicator 4.C.	What percentage attained permanency (through reunification, adoption or subsidized guardianship) within 36 months from the date of entry into foster care?													
	1999		2000		2001		2002		2003		2004		2005	
	Illinois													
Entering Substitute Care	7,429		5,970		5,828		5,636		5,300		5,039		5,299	
In a permanent home at 36 months	3,993		3,296		3,276		3,169		2,859		2,730		2,798	
Percent	54%		55%		56%		56%		54%		54%		53%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	3,993	54%	3,296	55%	3,276	56%	3,169	56%	2,859	54%	2,730	54%	2,798	53%
Central	1,177	69%	1,159	68%	1,030	69%	970	70%	1,034	67%	1,019	68%	1,028	68%
Cook	1,566	43%	1,074	44%	1,059	42%	1,026	42%	773	39%	583	36%	622	34%
Northern	619	61%	587	63%	580	67%	569	67%	458	61%	470	57%	507	57%
Southern	438	65%	345	60%	434	65%	425	66%	425	65%	504	68%	527	66%
Female	2,005	54%	1,685	56%	1,592	57%	1,568	57%	1,355	53%	1,290	54%	1,391	53%
Male	1,987	53%	1,610	54%	1,684	56%	1,600	56%	1,503	54%	1,437	54%	1,400	52%
Under 3	1,713	58%	1,411	61%	1,295	60%	1,322	62%	1,200	59%	1,087	57%	1,190	58%
3 to 5	693	58%	533	58%	552	60%	514	59%	469	59%	468	61%	481	59%
6 to 8	559	54%	452	57%	448	59%	409	57%	381	57%	390	61%	380	58%
9 to 11	466	54%	351	50%	425	58%	391	57%	339	53%	338	58%	326	55%
12 to 14	359	44%	377	50%	372	49%	353	48%	325	48%	327	47%	265	40%
15 to 17	203	35%	172	36%	184	37%	180	38%	145	32%	120	26%	156	29%
African-American	2,077	47%	1,706	49%	1,608	49%	1,478	49%	1,295	46%	1,132	45%	1,164	43%
Hispanic	224	51%	161	56%	162	49%	184	49%	159	56%	107	45%	148	48%
Other	130	64%	111	64%	142	68%	117	63%	93	56%	50	57%	63	50%
White	1,562	65%	1,318	64%	1,364	68%	1,390	67%	1,312	65%	1,441	66%	1,423	65%

Stability of Permanence at Two Years

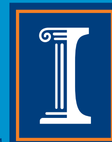
Indicator 4.D	Of all children who attained permanece during the year (excluding placements of less than 8 days), what percentage remain with their families after two years?													
	2000		2001		2002		2003		2004		2005		2006	
	Illinois													
Attained Permanence	11,301		8,391		7,421		6,423		5,158		4,844		4,399	
Stable Placements (two years)	10,571		7,789		6,836		5,888		4,705		4,395		4,025	
Percent	94%		93%		92%		92%		91%		91%		91%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	10,571	94%	7,789	93%	6,836	92%	5,888	92%	4,705	91%	4,395	91%	4,025	91%
Central	1,446	87%	1,360	87%	1,386	88%	1,197	86%	1,069	86%	1,110	87%	1,043	88%
Cook	7,128	96%	4,691	96%	3,834	96%	3,062	96%	2,198	97%	1,925	95%	1,572	95%
Northern	996	89%	889	90%	843	88%	802	90%	597	86%	563	87%	528	88%
Southern	528	85%	472	84%	440	85%	494	84%	500	87%	531	85%	584	89%
Female	5,343	94%	3,804	93%	3,321	93%	2,821	92%	2,337	92%	2,129	91%	1,970	92%
Male	5,219	93%	3,984	93%	3,515	91%	3,065	92%	2,367	91%	2,261	90%	2,053	91%
Under 3	986	88%	872	90%	967	89%	880	90%	772	89%	730	88%	695	90%
3 to 5	2,573	95%	1,794	94%	1,489	94%	1,359	94%	1,054	92%	1,035	91%	995	92%
6 to 8	2,524	95%	1,654	94%	1,298	94%	1,132	93%	829	93%	826	93%	744	94%
9 to 11	2,162	95%	1,559	95%	1,328	94%	1,071	94%	773	93%	725	94%	662	93%
12 to 14	1,494	92%	1,175	92%	1,049	91%	883	90%	766	91%	638	90%	556	89%
15 to 17	832	90%	735	87%	705	88%	563	87%	511	89%	441	86%	373	88%
African-American	7,888	95%	5,503	95%	4,530	94%	3,739	94%	2,852	94%	2,486	92%	2,182	93%
Hispanic	544	96%	393	96%	407	95%	353	93%	209	91%	263	92%	200	93%
Other	159	85%	169	88%	188	92%	163	89%	115	93%	110	95%	69	85%
White	1,980	88%	1,724	87%	1,711	88%	1,633	87%	1,529	87%	1,536	88%	1,574	90%

Stability of Permanence at Five Years

Indicator 4.E.	Of all children who attained permanece during the year (excluding placements of less than 8 days), what percentage remain with their families after five years?													
	1997		1998		1999		2000		2001		2001		2003	
	Illinois													
Attained Permanence	6,747		10,414		13,430		11,301		8,391		7,421		6,423	
Stable Placements (five years)	5,552		9,081		12,004		10,094		7,452		6,497		5,580	
Percent	82%		87%		89%		89%		89%		88%		87%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	5,552	82%	9,081	87%	12,004	89%	10,094	89%	7,452	89%	6,497	88%	5,580	87%
Central	1,023	73%	1,169	75%	1,342	81%	1,372	83%	1,306	83%	1,296	82%	1,127	81%
Cook	3,001	88%	6,041	92%	8,437	92%	6,854	93%	4,493	92%	3,680	92%	2,921	91%
Northern	675	76%	880	81%	1,017	83%	928	83%	834	84%	799	84%	756	85%
Southern	434	74%	497	80%	603	82%	483	78%	460	82%	404	78%	469	80%
Female	2,790	83%	4,622	88%	6,079	90%	5,097	90%	3,636	89%	3,155	89%	2,667	87%
Male	2,761	82%	4,454	87%	5,923	89%	4,988	89%	3,815	89%	3,342	87%	2,911	87%
Under 3	636	75%	911	82%	1,039	84%	937	84%	833	86%	931	86%	845	86%
3 to 5	1,351	84%	2,287	90%	2,953	92%	2,491	92%	1,744	91%	1,436	91%	1,311	90%
6 to 8	1,249	88%	2,188	90%	2,930	92%	2,424	92%	1,587	90%	1,255	90%	1,083	89%
9 to 11	913	86%	1,757	89%	2,420	89%	2,054	90%	1,480	90%	1,242	88%	994	87%
12 to 14	699	77%	1,137	80%	1,624	85%	1,373	85%	1,088	85%	944	82%	797	81%
15 to 17	704	78%	801	85%	1,038	88%	815	88%	720	86%	689	86%	550	85%
African-American	3,510	85%	6,607	89%	9,055	91%	7,553	91%	5,253	90%	4,308	89%	3,533	89%
Hispanic	323	88%	516	92%	587	91%	528	93%	383	94%	391	92%	332	87%
Other	86	74%	125	80%	150	81%	153	81%	165	86%	179	88%	153	84%
White	1,633	76%	1,833	80%	2,212	83%	1,860	83%	1,651	83%	1,619	83%	1,562	83%

Stability of Permanence at Ten Years

Indicator 4.F.	Of all children who attained permanece during the year (excluding placements of less than 8 days), what percentage remain with their families after ten years?										
	1993		**1994**		**1995**		**1996**		**1997**		**1998**
					Illinois						
Attained Permanence	5,016		4,493		5,773		6,075		6,747		10,414
Stable Placements (ten years)	3,496		3,196		4,331		4,646		5,291		8,801
Percent	70%		71%		75%		76%		78%		85%
	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	3,496	70%	3,196	71%	4,331	75%	4,646	76%	5,291	78%	8,801	85%
Central	960	65%	929	67%	992	66%	961	66%	956	68%	1,106	71%
Cook	1,101	70%	1,043	75%	1,801	81%	2,200	84%	2,869	84%	5,888	90%
Northern	576	68%	513	70%	614	74%	624	70%	638	72%	849	78%
Southern	349	68%	334	65%	429	70%	432	70%	418	71%	468	75%
Female	1,775	71%	1,593	72%	2,179	76%	2,350	77%	2,666	79%	4,471	85%
Male	1,721	69%	1,602	70%	2,149	74%	2,294	76%	2,624	78%	4,325	84%
Under 3	657	69%	579	67%	718	72%	630	71%	612	72%	860	77%
3 to 5	789	71%	808	76%	968	79%	1,123	79%	1,280	80%	2,192	86%
6 to 8	670	75%	584	74%	840	78%	964	78%	1,159	81%	2,071	86%
9 to 11	489	69%	421	72%	675	79%	688	76%	846	80%	1,696	86%
12 to 14	409	62%	380	62%	521	66%	600	74%	692	76%	1,171	82%
15 to 17	482	70%	424	73%	608	75%	641	79%	702	78%	811	86%
African-American	1,652	67%	1,525	70%	2,365	77%	2,781	79%	3,348	81%	6,414	87%
Hispanic	208	78%	209	80%	229	82%	269	82%	312	85%	500	89%
Other	65	77%	52	70%	75	76%	74	73%	83	72%	120	76%
White	1,571	71%	1,410	71%	1,662	72%	1,522	71%	1,548	72%	1,767	77%



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