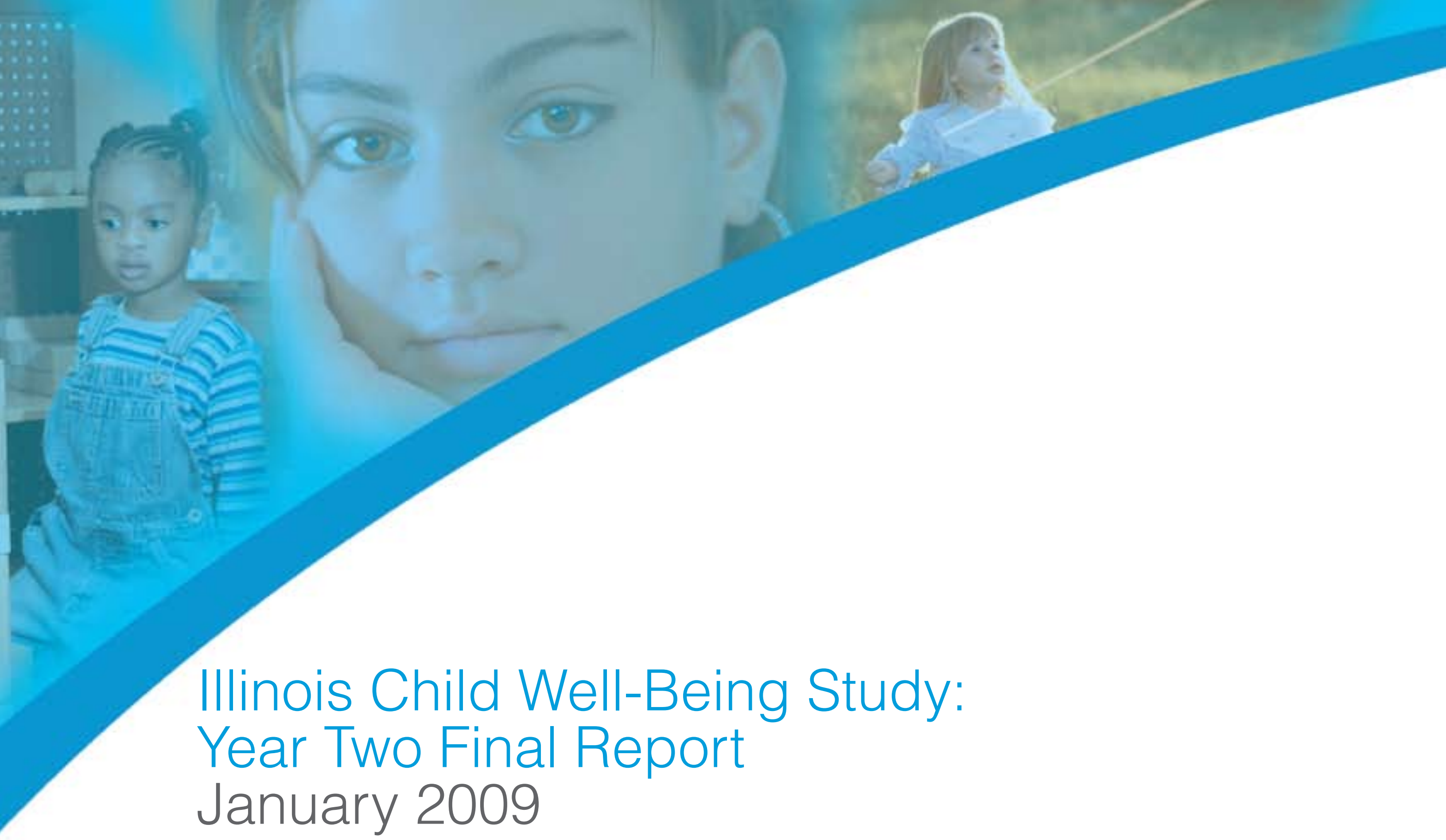
Illinois Child Well-Being Study: Year Two Final Report.

January 2009



Illinois Child Well-Being Study: Year Two Final Report

January 2009

Mary Ann Hartnett, Ph.D.

Christina Bruhn, Ph.D.

Jesse Helton, M.A.

Tamara Fuller, Ph.D.

Lynn Steiner, MSW

Children And Family Research Center
School Of Social Work

University Of Illinois at Urbana-Champaign
1203 West Oregon Street
Urbana, Illinois 61801

This project was supported by the Children and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign, which is funded in part by the Illinois Department of Children and Family Services.

Acknowledgements

We thank Bryan Samuels, former Director of the Illinois Department of Children and Family Services (DCFS), for his support of Rounds 2 and 3 of the study. We also thank Director Erwin McEwen for his continued support of the project and for his interest in and commitment to ensuring that the findings of the study are used to the advantage of children and families.

We thank Ben Wolf of the ACLU for his continuing dedication to the well-being of children in foster care in Illinois.

We thank several colleagues at DCFS for their direct work with this project. We are indebted to Jim Gregory for his invaluable assistance in updating information pertaining to samples of children, caregivers, and caseworkers. The office of D. Jean Ortega-Piron has demonstrated patience and perseverance in ensuring that the work of research is able to continue. We also thank the DCFS IRB, particularly Jessica Pantoja, for her work with CFRC on this and other projects. Mary Sue Morsch was instrumental in overseeing contract issues.

Ricki Horowitz was extremely generous with her time and expertise in helping to manage the collection of medical information from children's files. We express our gratitude to each DCFS nurse who, in addition to their other, pressing work, conducted the medical information abstraction of the records. They attended training meetings and traveled far and wide thorough the state to gather this important information for the study.

We are very grateful to Dr. Sharon Freagon, former Director (now retired) of the Center for Child Welfare and Education (CCWE) at Northern Illinois University for the work of CCWE in designing the educational record review component of the study as well as gathering, entering, cleaning, analyzing, and presenting data concerning educational status of children in DCFS custody. The work of Dr. Freagon influenced the nature of the investigation of educational status of children in care carried out in this study, as her theoretical contributions to the field guided instrument development not only for school record abstractions but for interviews as well. The work of Angela Baron-Jeffrey, current co-Director of CCWE along with Toni Tollerud, was also essential to this project as was that of Mark Cole, Assistant to the Director at CCWE. We are also particularly grateful to Dr. Lee Shumow for her analytic and writing work, for her assistance in reading and providing feedback for the entire report, and for her work in ensuring consistency between the work of CCWE and CFRC. We especially thank Joan Anderson for her diligent work and the Education Advisors at CCWE who interviewed, selected, and supervised reviewers to gather educational information from the children's school records. We also thank the reviewers themselves and the Assistant Advisors who helped coordinate collection of the data. Finally, we are grateful to all of the school district superintendents, school principals and other school staff for their time and willingness to support this work.

Special thanks go to Dr. John Rogers, sampling statistician at Westat, Inc., for his assistance in drawing the sample for Round 2. Thank you to Linda Owens at the Survey Research Laboratory at the University of Illinois at Urbana-Champaign for her assistance with evaluation of adjustment of survey weights for non-response.

Thank you very much to our partners at the Survey Research Laboratory (SRL) at the University of Illinois at Chicago, particularly Ingrid Graf and her indefatigable colleague, Liz Clary. The number of instrument revisions for Rounds 2 and 3 of this study were enormous, and the programming of the instrumentation was considerable in its difficulty. Our SRL colleagues bore our incessant pestering with grace and good humor, and without that relationship, this study could not have been carried out. We are also grateful to members of the Young Researchers' program formerly hosted at the Children and Family Research Center (CFRC), who are foster youth and former foster youth, for their testing of our instrumentation and for their feedback.

A number of staff members at or affiliates of CFRC also made important contributions to this work. Nancy Rolock, Wendy Haight, and Teresa Ostler all gave freely of their time to review and comment on early drafts of this report, which is better for their thoughtful input. We are grateful for the assistance of a Michelle True, student intern, with this study in a number of its particulars. The assistance of Kim Silver in completing copyright management work was also a key component to our ability to carry out the study. Lynn Steiner was diligent and thorough in her reviewing of literature, and Kathy Watnik provided much assistance with early edits of the report.

We owe a great debt of gratitude to Mark Testa, Director of the Children and Family Research Center for his constant work in ensuring that this study could go forward and opportunities for the analysis of this rich data set were taken the greatest advantage of possible. We thank him for his advice regarding design, instrumentation, sampling, analysis, and presentation and for his belief in the importance of the work and the abilities of the numerous contributors of the work to carry it out.

The core groups of people to whom we are most grateful are the children, caregivers, and caseworkers who participated in the study. All of them took time out of their busy schedules to contribute important information on the well-being of children in DCFS care. We appreciate, in particular, the voices of children and youth who answered numerous questions about themselves, their lives, and their experiences.

Table of Contents

Chapter 1: Purpose of the Study 1-1
The Importance of Studying Well-Being 1-1
The BH Consent Decree 1-2
Overview of the Illinois Child Well-Being Studies 1-2
Illinois – National Comparisons:
The National Survey of Child and Adolescent Well-Being 1-3
Theoretical Framework 1-3

Chapter 2: Methodology 2-1
Sample Selection 2-1
Sample Weights 2-2
Sample Characteristics 2-2
Child Characteristics 2-2
Caregiver Characteristics 2-2
The Consent Process 2-2
Instrumentation and Data Sources 2-5
Child Interviews 2-5
Caregiver Interviews 2-6
Caseworker Interviews 2-7
DCFS Case Record Abstraction 2-7
School Record Abstraction 2-7
DCFS Integrated Database 2-8
Instrument Response Rates and Completion Patterns 2-8
Imputation of Missing Data 2-8

Chapter 3: Children's Mental Health 3-1
Introduction 3-1
Literature Review 3-1
Introduction to Results 3-4
Children Identified as Having a Mental Health Condition - Measurement 3-4

- Caregiver Reports of Children’s Mental Health 3-4
- Caseworker Reports of Children’s Mental Health 3-4
- Children’s Reports of Their Mental Health 3-5

Identification of Mental and Behavioral Health Concerns – Results 3-5

- Caregiver Reports of Children’s Mental Health 3-5
- Caseworker Reports of Children’s Mental Health 3-6
- Children’s Reports of Their Mental Health 3-6
- Multivariate Analyses 3-10
- Summary of Mental Health Conditions 3-11

Mental Health Service Receipt 3-12

Mental Health Conditions and Services: National Comparisons 3-14

Relationship Between Mental Health Conditions and Service Receipt 3-16

Summary and Conclusions 3-18

Chapter 4: Children’s Physical Health 4-1

Literature Review 4-1

Introduction to Results 4-2

Children Identified with Physical Health Problems 4-2

- Caregiver Reports of Children’s Physical Health 4-2
- Children’s Reports of Their Physical Health 4-4
- Caseworker Reports of Children’s Physical Health 4-5
- Identification of Physical Health Conditions: Summary 4-6

Physical Health Diagnoses 4-6

Health Services 4-8

Illinois and National Comparison 4-8

- Injuries 4-9
- Other Physical Health Indicators 4-9

Summary and Conclusions 4-11

Chapter 5: Home and Community Factors 5-1

Introduction 5-1

Literature Review 5-1

- Parental Monitoring and Discipline 5-1
- Exposure to Violence 5-2
- Social Capital 5-3

Introduction to Results 5-4

Caregiver Monitoring 5-4

- Illinois Sample 5-4
- Illinois/NSCAW Comparison 5-5

Forms of Discipline in the Foster Home 5-5

- Illinois Sample 5-5
- Illinois/NSCAW Comparison 5-6

Violence Exposure 5-6

- Illinois Sample 5-6
- Illinois/NSCAW Comparison 5-9

Children’s Strengths and Connectedness to Community 5-11

Future Expectations 5-12
Attachment to Placement and Access to Biological Family 5-12
Sexual Experiences, Pregnancy, and Parenting 5-13
    Sexual Experiences – Illinois Data 5-13
    Pregnancy and Parenting – Illinois Data 5-14
    Sexual Experiences – Illinois/NSCAW Comparison 5-15
    Pregnancy and Parenting – Illinois/NSCAW Comparison 5-15
Summary and Conclusions 5-16

Chapter 6: Education and School Engagement 6-1
Introduction 6-1
Introduction to Results 6-1
Academic Performance from Report Cards 6-3
    Reading Report Card Marks 6-3
    Mathematics Report Card Marks 6-4
Grade Relative to Chronological Age 6-4
Achievement Test Scores 6-6
Behavior at School 6-6
Special Education 6-8
    Proportion of Children in Special Education 6-8
    Special Education Categories 6-9
Factors Contributing to Educational Problems of Children in Foster Care 6-11
    School Mobility 6-11
    Attendance 6-11
Summary and Conclusions 6-14

Chapter 7: Placement Stability and Exits to Permanence 7-1
Introduction to Results 7-1
Placement Stability 7-1
    Defining Placement Stability 7-1
    Number of Placement Moves 7-3
    Number of Placement Steps-Up and Steps-Down 7-5
    Impact of Placement Steps-Up and Steps-Down 7-5
Permanence 7-5
Mental Health and Placement Stability 7-6
Mental Health and Permanence 7-8
Summary and Conclusions 7-10

Chapter 8: Implications and Future Directions 8-1
Implications 8-1
    Delivery of Physical Health Services 8-1
    Delivery of Mental Health Services 8-1
    Outcomes for Children in Group and Residential Care 8-2
Future Directions 8-2

References R-1

Appendix A: Revised Weights and Supplemental Sample for BH Round 2 Study (Memo) A-1

Appendix B: Participant Consent Forms B-1

Appendix C: Overview of NSCAW Child, Caseworker, and Caregiver Instruments C-1

Appendix D: Additional Results Tables D-1

Appendix E: Education and School Engagement: Caregiver Reports E-1

Executive Summary

Introduction

The BH Consent Decree requires the Department to conform to the following standards to support well-being:

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

In 2001, the judge overseeing the BH Consent Decree called for a comprehensive study of the well-being of children in foster care in Illinois to determine whether the Department of Children and Family Services was meeting these minimal standards. The Children and Family Research Center (CFRC or the Center) undertook the Illinois Child Well-Being Study (IL-CWB) to measure children's functioning in the domains of safety, permanence, health, mental health, and education.

The IL-CWB Study Round 2 data were drawn from a sample of 655 children in care in Illinois on March 31, 2003. Significant changes were made to the methodology and data collection instruments used in Round 2. Interviews with caregivers, caseworkers, and children were modified to follow the interview instruments used in the National Survey of Child and Adolescent Well-Being (NSCAW). The NSCAW data collection instruments include several standardized child assessment instruments to assess behavior, depression, trauma, and other indices of well-being. This approach allows for direct comparisons with foster children nationwide and provides a standardized assessment of foster children in Illinois. In addition to the well-being domains of physical health, mental health, educational performance, placement stability, and permanence studied in Round 1, Round 2 of the IL-CWB Study includes sections on children's strengths and their connections to community.

Mental Health

Children in foster care in Illinois and those nationally are remarkably similar in terms of both caregiver-reported and self-reported symptomatology indicative of potential mental health concerns. In Illinois, 41% of children in foster care (ages 1.5 to 18 years) were rated by caregivers as having serious behavior problems, with children in kinship care rated lower than children in all other types of care. When children assessed their own behavior, 33% rated themselves as having serious behavior problems, with children in traditional foster care less likely to rate themselves in this fashion. Children are more likely to self-report behavioral problems than they are to report other forms of mental or behavioral health concerns, and children are, in all instances, less likely to report such concerns than caregivers. Overall, few children report either depression or trauma symptoms. In fact, a smaller portion of foster children in the sample scored in the clinical range of a depression instrument (3.7%) than in the normative (general) child population (7%), and 5.8% of the children in the sample scored in the clinical range on a measure of post-traumatic stress symptoms, compared to approximately 8% of the normative sample. The low levels of self-reported mental health symptoms among the youth in the sample run counter to previous findings on the mental health of foster children and suggest a need for additional investigation.

While foster children in Illinois and the nation have similar rates of mental health symptoms, the data on mental health service delivery suggest that foster children in Illinois appear less likely than foster children nationally to receive mental health services from less restrictive settings (such as a community mental health center or family physician) and more likely to receive mental health services from more restrictive settings (such as a medical hospital inpatient unit).

Physical Health

Of children living in DCFS care, the exact percentage of children identified as having serious and/or chronic health conditions varies by reporter. Caregivers indicated that 64.3% of children in their care had health that was fair or poor, had health problems that lasted a long time, or needed specialized care or medical devices. Of children interviewed, 23.1% indicated that they had illnesses, disabilities, handicaps, or recurring health problems. About 23% percent of caseworkers indicated that either the child needed services for a health problem within the past twelve months or that the child had a specific health condition. Nurse audits revealed that 29.3% of children have non-acute medical diagnoses recorded in their case records. While the questions asked of different reporters were not the same and are therefore not strictly comparable, one must note that caregivers were over twice as likely to report health conditions as caseworkers or children. Regardless of informant, the data consistently indicate that greater numbers of children with serious and/or chronic physical health conditions are living in more restrictive levels of care, and these relationships remain statistically significant regardless of which informant is considered.

Multiple considerations of health care services delivery indicate that there are few major problems with ensuring that children's physical health needs are met. A total of 89.6% of children were identified by caregivers as having received routine dental care; caseworkers identified a similar percentage. These figures are an improvement from IL-CWB Round 1 report. Obtaining specialized medical equipment continues to be a challenge for some families, as only 78.7% of caregivers reported that they were able to obtain this equipment when it is needed; however, discussions with early childhood service providers suggest that this problem is pervasive for all publicly insured children. The comparisons with national data are encouraging, as they suggest that children in Illinois are less likely than those nationally to stay in a hospital overnight or to visit an emergency room or urgent care facility. These findings may indicate that Illinois is doing a better job than other states in ensuring that children obtain primary care, thus addressing in a preventative fashion those health needs that could become critical if left unattended.

Home and Community Factors

Based on children's reports of the degree to which they are monitored, caregivers appear to be active in tracking and placing limitations upon children's whereabouts. Caregivers in Illinois closely parallel caregivers nationally with regard to the degree of monitoring they provide for children in their care. Children were also likely to report that their caregivers implemented a variety of disciplinary strategies.

The children and youth interviewed were very likely to report that they had strong resources in terms of adults (a parent, other relatives, or non-relatives) they could go to with problems. There were no differences in adult support by placement type, and there were no differences between foster children in Illinois and those nationwide. Children and youth in Illinois generally reported fairly low levels of loneliness and social dissatisfaction (an overall mean of 28.7 on a scale from 16 to 80 with 16 being least lonely). Children reported high degrees of connectedness with their caregivers (an overall mean of 39.4 on a scale from 12 to 48 with 48 being most connected), and there were no differences by placement type (these questions were not asked of children living in group care). There were no differences between children in foster care in Illinois and children in foster care nationally with regard to relationships with caregivers.

A noteworthy finding pertains to exposure to violence and the way in which history of exposure to violence varies across placement types. Children in group or residential care witnessed both mild and severe violence significantly more often than children in other types of placement, and were 2 to 17 times more likely to report that they had witnessed severe violence in all its forms: 86% have seen an adult steal from a person, 76% have seen an adult get arrested, 40% have seen an adult deal drugs, 39% have seen an adult point a weapon at a person, 33% have seen an adult stab a person, and 7% have seen an adult shoot a person. Children in group or residential care also experienced both mild and severe violence more often than children in other types of care: 61% were pushed by an adult, 46% were beaten up by an adult, and 24% had a gun or knife pointed at them by an adult.

Nearly a quarter of the children in foster care in Illinois who were interviewed indicated that their first sexual intercourse experience was forced. While more females reported this outcome (34%), a significant proportion of males also did so (14%). For Illinois youth ages 16 and 17, 71% of females and 89% of males reported having had sexual intercourse. Of these, 18% of females report having been pregnant, and all of these report having had children. Fourteen percent of males reported getting someone pregnant, and of these, all report having children. These findings raise the issue of whether girls in foster care have access to pregnancy termination choices and resources. Somewhat fewer females nationally than in Illinois reported having had sexual intercourse (25% versus 37%), whereas somewhat more males reported having done so (48% versus 29%). Reporting also varies by age, with children 12 to 13 reporting lower rates of sexual intercourse (17% in Illinois, 22% nationally) than children 14 to 15 (52% in Illinois and 53% nationally).

Education and School Engagement

The data indicate that, while about two third of the students in the sample received satisfactory or better marks in reading and math, they tended to perform poorly on achievement tests. The youth in foster care in this sample who were most at risk academically are those who were overage in grade, frequently absent, 14 and over, and/or African American. A substantially disproportionate number of students were receiving special education services; predominant classifications were emotional disturbance and specific learning disabilities. Students 14 or older were much more likely to be in special education than younger students. Students in special education or 14 years and over were twice as likely to be overage in grade. Youth who were overage in grade were more likely to attain unsatisfactory marks in reading and math than their peers who were in the age appropriate grades, and they scored in the lower ranges on achievement tests. Older students were also more likely to miss school than younger students. White students were almost three times more likely than African American students to perform satisfactorily in reading. Seventy-five percent of African American students scored in the lower half of the distribution in reading achievement tests.

Placement Stability and Exits to Permanence

The placement stability of the current (at time of sampling) placement spell was examined for the children in the sample. The number of placement moves ranged from zero to 23, with the most common number of moves (mode) at one move per child. Placement stability was associated with several factors: children in kinship foster care and residential or group care experienced fewer moves than children in traditional or specialized foster care, younger children experienced fewer moves than older children, children in care longer experienced more moves, children with higher levels of caregiver-reported behavior problems experienced more placement moves, and children who reported depression experienced more moves. When these variables were entered into a regression analysis (depression scores were not included due to low variability), three variables remained predictive of placement stability: kinship placement, younger age, and shorter length of time in care.

Three years after they were selected into the study, 37% of the children had been adopted, 11% were taken into legal guardianship, 11% were reunified, 35% were still in care, and 6% had “exited” to impermanent living arrangements (runaway, aged out, missing, unknown, or other). Children in group or residential care were significantly less likely to experience reunification or adoption/guardianship (none of these children had been adopted or taken into guardianship three years later), White children were more likely to be reunified and less likely to remain in care than African American children, children who were adopted entered care at younger ages, and children who exited to impermanence entered care at older ages than children with other permanency outcomes. There was no relationship between behavior problems and permanency outcomes, and children who exited to impermanence were less likely to report depressive or traumatic symptoms than children who exited to other permanency outcomes. Multivariate analysis of permanency outcomes suggests that placement type remains a strong predictor, with children in group or residential care least likely to experience positive permanency outcomes.

CHAPTER 1
Purpose of the Study

The Importance of Studying Well-Being

The well-being of children in out-of-home care is best assured by restoring them to their families through safe and stable reunification or, when this is not possible, by finding alternative permanent homes with relatives, adoptive parents, or legal guardians. A half-century of research demonstrates that children's emotional well-being, educational success, and capacity for leading healthy and productive lives build first upon meeting basic human needs for safety, trust, and connection with loving and caring adults. When primary family relationships are disrupted, it is incumbent upon the state to ensure that a child's developmental opportunities for health, education, emotional, and economic well-being are not unduly compromised by out-of-home placement (Rolock & Testa, 2006).

Safety has been the primary mandate of the child welfare system since its inception, with permanence increasingly recognized as a second but also critically important outcome. Only in recent times has some consensus emerged with regard to the idea that child welfare systems can and should also be held accountable for the well-being of children entrusted to their care. However, exactly what well-being is, how it is to be measured, and what the responsibilities of the child welfare system are with regard to well-being remain the subjects of some dispute.

A number of issues increase the complexity of well-being as a measurable outcome. For one, children enter out-of-home care with an existing state of well-being, often one that has been adversely affected by their experiences. The child welfare system is not responsible for children's exposure to disadvantaged economic and social conditions, violence, abuse, or neglect before the children come to the attention of the system. However, the child welfare system may be accountable for ensuring that the needs of children as they enter the system are recognized and addressed. Even this seemingly simpler mandate, however, involves issues of measurement and standards. A report on court accountability concludes that it is premature for juvenile and family courts to adopt measures of well-being, particularly when consensus does not exist on the measures for which the courts have direct responsibility, such as safety, appropriate removal from the home, continuity of care, and timely achievement of permanence (American Bar Association, 2004).

A second issue relates to the role of child welfare agencies relative to the role of other social institutions. Child welfare agencies and juvenile courts have a responsibility for assuring child well-being; however, this responsibility is typically shared with other institutions, such as schools, medical providers, and community mental health providers. Furthermore, child welfare systems may have different levels of accountability to different children based on their individual situations. For example, to what standards of well-being should agencies and the courts be held accountable while working toward reunification or an alternative permanency plan? What are the agencies' obligations when the goal of family permanence cannot be achieved? Do child welfare systems retain some level of obligation to former wards? Should foster children be given special assistance and scholarships for which children moved into permanent living arrangements are ineligible?

The need to assure the well-being of children in out-of-home care provokes questions that are not easily answerable. Nevertheless, while many areas of uncertainty remain, agreement about the need to advocate for and act on behalf of the well-being of each child while he or she remains under state custody demands attention to this topic (Rolock & Testa, 2006).

The BH Consent Decree

As the number of children entering foster care skyrocketed during the 1980s, the ability of the Illinois Department of Children and Family Services (DCFS or the Department) to care for children's safety, to arrange permanent homes, and to minister to their basic needs in order to support well-being came into serious question. The BH Consent Decree, which was the result of the BH v. Johnson class action suit filed in 1988 on behalf of 20,000 foster children in Illinois, mandated that the Department achieve minimum standards of adequacy in meeting the safety, permanency, and well-being needs of children in placement. The BH Consent Decree requires the Department to conform to the following standards to support well-being:

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

In 2001, the judge overseeing the BH Consent Decree called for a comprehensive study of the well-being of children in foster care in Illinois to determine whether the Department of Children and Family Services was meeting these minimal standards. The Children and Family Research Center (CFRC or the Center) undertook the Illinois Child Well-Being Study (IL-CWB) to measure children's functioning in the domains of safety, permanence, health, mental health, and education.

Overview of the Illinois Child Well-Being Studies

Researchers at the Children and Family Research Center began work on the first of three IL-CWB studies in 2001. An advisory board was convened to assist with developing the scope of the study. This group consisted of representatives from the Department, the American Civil Liberties Union, and the attorneys involved in the BH Consent Decree. Although the merits of a multi-wave longitudinal study of children in substitute care were considerable, resource and budget restrictions limited the study design to a series of cross-sectional studies spanning the course of several years.

The first of the IL-CWB studies (referred to in this report as Round 1) covered the following topics: mental health, physical health, educational performance, placement stability, and permanence. In Round 1 of the IL-CWB Study, 450 children were selected as a cross-sectional sample of children in care on March 31, 2001. Data were compiled from surveys with foster children, their caregivers, and caseworkers. In addition, DCFS nurse auditors conducted case record abstractions of DCFS records to obtain medical data, and Education Advisors working with the Education Access Project at the Center for Child Welfare and Education (Northern Illinois University) and substitute teachers hired specifically for the study collected educational data from school records. Data from DCFS administrative records were also analyzed. The Center oversaw all aspects of the consent process and the data collection and conducted the interviews with children. The results of the Round 1 study were published in a CFRC report in July 2005 and then updated in June 2006.[1]

---

[1] Copies of The Illinois Child Well-Being Study: Year One Final Report can be downloaded from the Center's website at: http://cfrcwww.social.uiuc.edu

Round 2 data were collected based on a sample of 655 children in care in Illinois on September 30, 2003. Significant changes were made to the methodology and data collection instruments used in Round 2. Interviews with caregivers, caseworkers, and children were modified to follow the interview instruments used in the National Survey of Child and Adolescent Well-Being (NSCAW). The NSCAW data collection instruments include several standardized child instruments to assess behavior, depression, trauma, and other indices of well-being. This approach allows for direct comparisons of foster children in Illinois with foster children nationwide (see following section) and provides for standardized assessments. In addition to the well-being domains of physical health, mental health, educational performance, placement stability, and permanence studied in Round 1, Round 2 of the IL-CWB Study includes sections on children's social relationships and their connections to community.

Data collection for the final segment of the IL-CWB study (Round 3) was completed in July 2005. The Round 3 sample consisted of children in out-of-home care on December 31, 2004. The data collection methodology and instruments used in Round 3 essentially replicate those used in Round 2.

Illinois – National Comparisons: The National Survey of Child and Adolescent Well-Being

NSCAW data represent the population of children and families involved with child welfare systems nationally. The core (Child Protective Services or CPS) sample for NSCAW includes foster children from 92 child welfare agencies nationwide.[2] Some of the children in the core sample had substantiated allegations of abuse or neglect, and some did not. Similarly, some entered foster care, and some did not. The NSCAW sampling plan also called for an ancillary sample of children who had been in foster care for at least 1 year, termed the Long-Term Foster Care (LTFC) sample. For purposes of the comparisons reported in this paper, the LTFC sample was chosen. This sample includes 797 children nationally who had been in foster care for at least 1 year at the time of study initiation (fall 1999). The children in this sample were felt to more closely resemble children in foster care in Illinois than the core NSCAW sample, as many children in foster care in Illinois have been in out-of-home settings for a year or more. Data were collected for the entire NSCAW sample (CPS and LTFC) in four waves.

The Illinois-national comparisons presented in this report utilize the first wave of NSCAW data. While a subsequent wave might have matched the Round 2 IL-CWB sample more closely in terms of when data were collected, the first wave was selected for several reasons. First, all the children in the LTFC sample were in out-of-home care at the time when the first wave of the study was fielded, and this was not the case later on. Given the relatively smaller sample size of the LTFC component of the NSCAW, the loss of cases due to children having exited child welfare systems has an important impact on the ability to analyze differences across categories. Similarly, completion rates for each instrument are lower in subsequent waves than in Wave 1. In addition, not all instruments were fielded at every wave; the interview schedule implemented in Wave 2 was more restricted than that implemented in other waves. Finally, the instrument utilized in the IL-CWB study was modeled after the first-wave instrument used in the NSCAW.

Theoretical Framework

What is at the core of this report is an appreciation for theory relevant to an understanding of children who have been placed in the care of others after the removal from a biological parent. The authors postulate that it is not enough to examine the physiological and psychological well-being of a child when such profound environmental changes have occurred. When maltreatment and subsequent removal from the care of a biological parent occurs, children are forced into different caregiver relationships, family environments, peer groups, communities, and possibly cultural lifestyles. These children are also part of a child welfare system that became active the moment an investigation began. Therefore, it is important for those researching children in out-of-home care to interpret findings in light of a person-in-context ontology.

[2] http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/reports/wellbeing_local_child/wellbeing_local_intro.html

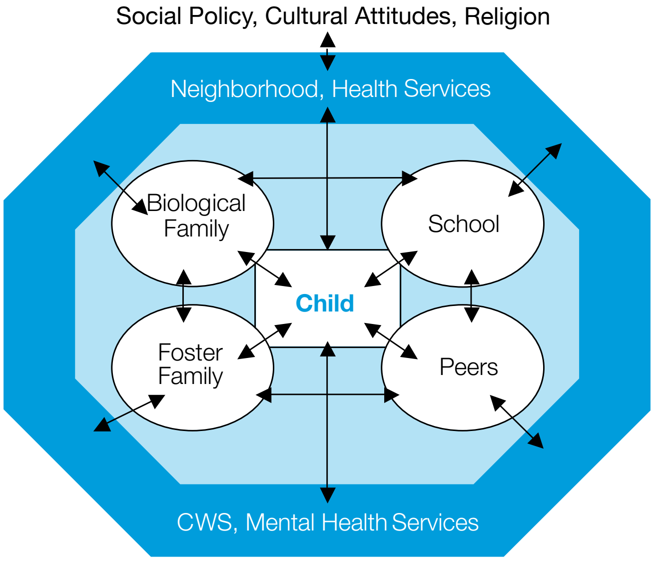
A person-in-context ontology posits that social and physical environments exert layers of influence on a child. Because the purpose of this report is to capture the dynamic and complex physical, emotional, behavioral, educational, and social well-being of Illinois foster youth and their interactions with various caregivers, peers, and service organizations, we have selected Bronfenbrenner's (1998) ecological systems theory as our theoretical framework. This will allow the authors to ground the findings within a rigorous and durable developmental theory that takes into account various levels of interactions within various types of environments.

Figure 1.1 summarizes the interrelatedness among the four ecological systems that are proposed to affect a foster child's development. The ecological systems theory posits that child development and child well-being are affected by various structures of the social environment nested within each other (like nested Russian wooden dolls). These structures range from the immediate face-to-face interaction with a caregiver (the inner-most half of Figure 1.1) to very general cultural belief systems (outer-most circle of Figure 1.1).

The ecological systems theory has four levels of interaction: (1) microsystem: the immediate setting in which the child lives (e.g. foster family); (2) mesosystem: the connection between two or more microsystems (e.g. a child's biological and foster family); (3) exosystem: the settings not experienced directly by the child but that influence the microsystem (e.g. services provided to foster parents); and (4) macrosystem: the wider attitudes, beliefs, and mores of the culture that envelops all other systems (e.g. the acceptance of corporal punishment as a valid disciplinary tactic).

As seen in Figure 1.1, interactions in the microsystem and mesosystem levels are personal and direct, while interactions on the exosystem and macrosystem levels are distant and often implicit. Within this approach, there are many different levels of influence at work on a child's current development, as well as opportunities to examine the transactions across nested systems. It is the position of the authors that using this approach will aid in the examination of well-being indicators across multiple domains and thus expand hypothesis testing beyond child-specific realms into the environment in which he or she is embedded.

Figure 1.1
The Interconnectedness of the Ecological Systems Theory for Children in Foster Care



CHAPTER 2
Methodology

Sample Selection

A sample of 554 children was drawn from the population of children who were in open placement cases as of September 30, 2003 (see Table 2.1). The sample was partitioned into children who had been in care less than three years as of September 30, 2003 (half of the sample) and children who had been in care 3 years or more (half of the sample). All children were in placements other than adoptive, guardianship, or intact family and must have been in placement a minimum of 3 months to be eligible. This was done to ensure that caregivers and caseworkers would have adequate knowledge about the child and that there would be information in the case file. Siblings of selected children were ineligible for sample selection, and only one child per caregiver was eligible for selection. This was done to reduce the survey burden on caregivers. This restriction was not imposed on children living in group or residential care.

The sample was also restricted such that children who were in detention of any type were excluded. This action was taken in response to Institutional Review Board restrictions. Children who were included in the sample of the IL-CWB Round 1 were not eligible to be included in Round 2. Children who were pregnant at the time of sampling could not be identified via the use of administrative data; however, caseworkers were asked about the pregnancy/parenting status of female children, and data collection did not proceed when it was learned that a child was pregnant. This action was also taken in response to Institutional Review Board restrictions. While no data collection occurred for these children, they were still considered part of the sample.

A supplementary sample of 101 cases was drawn to make up for sample loss due to greater than expected attrition (caused by children leaving care to reunification, adoption, and guardianship). This sample was selected in July of

Table 2.1
Sampling Strategy for the IL-CWB Round 2 Sample

Years in care, current spell	Current age	Target percent of sample	Original sample	Supplemental Sample	Total sample
3 months to < 3 years	3 mos. to < 3 yrs.	10%	54	56	54
	3 yrs. to < 5 yrs.	10%	57	57	57
	5 yrs. to < 9 yrs.	10%	56	164	73
	9 yrs. to < 17 yrs.	20%	110	33	143
3 years plus	3 yrs. to < 5 yrs.	10%	41.1 (34.7 – 47.8)	0	56
	5 yrs. to < 9 yrs.	10%	49.1 (42.6 – 55.6)	13	70
	9 yrs. to < 17 yrs.	30%	9.8 (7.5 – 12.9)	38	202
Total		100%	554	101	655

2004 from the population of children who were in care as of September 30, 2003 and who remained in care as of December 31, 2003 (the last date for which case data were available). Additional children were not selected in the younger age ranges because the purpose of the supplemental sample was to increase completion of child interviews, and only children seven years of age and older were interviewed.

Sample Weights

The total sample was weighted for both the design effect and non-response by professional survey organizations. Appendix A includes a detailed discussion of the computation of sample weights for Round 2 of the IL-CWB Study.

Sample Characteristics

Child characteristics

Table 2.2 provides a comparison of the child demographic characteristics of the IL-CWB Round 2 sample and the NSCAW Long-Term Foster Care (LTFC) sample. The first column presents information on the entire sample of children in the IL-CWB sample, ranging in age from three months to 17 years at the time of sample selection. The second column restricts the IL-CWB sample to children three months to 15 years, which is the age range for children included in the NSCAW sample (third column). A comparison of the second and third columns reveals several differences between the Illinois and NSCAW child samples:

- Race: Children in the Illinois sample are more likely to be African-American and less likely to be Hispanic.

- Placement type: There was no designation in NSCAW for "specialized foster care," which constitutes about 21% of the placement among children 0 – 15 in Illinois. However, if these specialized placements are combined with traditional foster care placements in Illinois (60%), the percentages in the IL-CWB sample and NSCAW look very similar.

- Number of years in care: NSCAW Long-Term Foster Care (LTFC) Wave 1 data used for comparison purposes in this report. All children in this dataset had been in foster care at least one year, but at the time of the first wave of data collection, none of them had been in care longer than two years. In contrast, children in the Illinois sample were purposely selected to provide wide variability with regard to length of time in care. Thus, while 100% of the NSCAW sample had been in care less than 2 years, only 45% of the IL-CWB Round 2 sample fell in this category; an additional 32% had been in care 2-5 years, and 23% had been in care 5 years or more.

Caregiver Characteristics

Table 2.3 displays the demographic characteristics of the caregivers in the IL-CWB Round 2 sample, and compares them to those in the NSCAW LTFC sample. Caregivers in both samples were predominantly female (93-94%). A comparison of the two samples reveals several differences:

- Race: Caregivers in Illinois are more likely to be African American and less likely to be Hispanic.

- Kinship: Caregivers in Illinois are more likely to be related to the child by blood.

The Consent Process

The methodology and instrumentation used in Round 2 of the IL-CWB study were reviewed and approved by the Institutional Review Boards (IRB) of the University of Illinois at Urbana-Champaign, Northern Illinois University, the University of Illinois at Chicago, and the Illinois Department of Children and Family Services. The Survey Research Laboratory (SRL) at the University of Illinois at Chicago administered the consent process for all interviews. Adult participants were informed via advance letters that participation was voluntary, that the information given would remain confidential, and that they could refuse to participate in the survey or refuse to answer any questions without penalty. Prior to the telephone interviews with caregivers and caseworkers, information about voluntary participation, confidentiality, and the right to refuse participation was read to the respondent. The interviewer did not proceed with the interview unless the respondent formally agreed to participate (see Appendix B for copies of all consent materials).

Table 2.2
Child Characteristics: Comparison Between Illinois and National Samples

	IL-CWB Round 2 Full Sample	IL-CWB Round 2 Children Ages 0 -15	NSCAW
Age at case opening			
0-5	57.8 (51.6-63.7)	61.6 (55.1-67.7)	Not available
6-13	38.2 (32.5-44.3)	37.5 (31.5-44.0)	
14 and older	4.1 (2.5-6.7)	0.9 (0.3-2.9)	
Age at time of study			
0-5	32.1 (25.7-39.1)	35.8 (28.9-43.3)	41.1 (34.7 – 47.8)
6-13	44.3 (38.2-50.5)	49.4 (42.6-56.2)	49.1 (42.6 – 55.6)
14 and older	23.7 (19.1-29.0)	14.8 (11.0-19.7)	9.8 (7.5 – 12.9)
# years in sub. care			
< 2 years	42.5 (36.1-49.1)	45.0 (38.2-52.0)	100%
2-5 years	31.1 (25.7-37.0)	32.4 (26.6-38.8)	
5 years or more	26.4 (21.5-32.0)	22.6 (17.8-28.3)	
# years in current placement			
< 6 months	12.5 (8.9-17.4)	12.3 (8.4-17.6)	Not available
1 year	11.5 (7.8-16.4)	11.5 (7.7-16.9)	
2 years	21.7 (16.8-27.6)	22.6 (17.3-29.1)	
3 years	19.0 (14.3-24.7)	20.8 (15.7-27.1)	
4 years or more	35.3 (29.7-41.5)	32.8 (16.9-39.3)	
Gender			
Female	46.5 (40.2-52.9)	47.8 (40.9-54.7)	50.6 (44.8 – 56.4)
Male	53.5 (47.1-59.8)	52.2 (45.4-59.0)	49.4 (43.6 – 55.2)
Ethnicity			
African American	71.4 (65.2-76.8)	71.7 (65.0-77.5)	48.6 (39.7 – 57.6)
White	22.9 (18.0-28.6)	22.3 (17.2-28.4)	32.9 (26.1 – 40.4)
Hispanic	5.7 (3.3-9.9)	6.0 (3.3-10.7)	18.5 (14.3 – 23.6)
Placement type			
Home of relative	35.9 (29.9-42.5)	36.4 (29.9-43.5)	32.3 (26.2 – 39.0)
Traditional foster care	37.0 (31.0-43.3)	38.9 (32.4-45.7)	58.3 (32.3 – 64.0)
Specialized foster care	22.3 (17.7-27.7)	21.1 (16.4-26.8)	---
Group home or residential care	4.8 (2.7-8.2)	3.6 (1.8-7.3)	8.2 (4.8 – 13.8)
Other	---	---	1.2 (0.3 – 4.1)

Table 2.3
Caregiver Characteristics: Comparison Between Illinois and National Samples

	Illinois	NSCAW
Gender		
Female	93.7 (90.2–96.0)	93.0 (89.9–95.2)
Male	6.3 (4.0–9.8)	7.0 (4.8–10.1)
Ethnicity		
African American	64.5 (58.3–70.4)	42.5 (34.0–51.4)
White	27.2 (21.9–33.2)	35.8 (28.5–43.8)
Hispanic	3.6 (1.7–7.3)	14.6 (10.5–20.0)
Other ethnicity	4.7 (2.5–7.5)	7.2 (4.6–11.1)
Related by blood to the child	38.5 (32.0–45.4)	24.2 (19.3–30.0)[1]
Currently employed outside the home	54.3 (47.4–61.1)	56.8 (52.2–61.4)
Of those employed		
Employed full-time	76.9 (68.1–83.9)	72.8 (67.2–77.8)
Employed part-time	23.1 (16.1–31.9)	27.2 (22.2–32.8)
Of those not working		
Unemployed	7.8 (3.4–16.8)	4.6 (2.1–9.7)
Retired	26.4 (18.0–37.0)	
Can't work due to illness or injury	16.1 (9.7–25.4)	Does not work 83.2 (73.1–90.1)
A homemaker	37.3 (28.1–47.5)	
Student or other reason	12.4 (5.8–16.6)	Other 12.2 (7.0–20.3)
Highest level of education		
Elementary school	12.9 (8.7–18.8)	Less than HS 20.1 (15.3–26.7)
High school GED	8.3 (5.0–13.4)	
High school diploma	45.5 (38.5–52.7)	HS or equivalent 39.0 (33.1–45.3)
Associate's degree	11.3 (7.7–16.1)	
RN degree	0.4 (0.1–2.7)	Greater than HS 40.6 (35.5–45.8)
Bachelor's degree	14.9 (10.9–20.6)	
Master's degree	6.8 (4.1–11.2)	
Household composition		
Average number of children under 18	3.2 (2.9–3.4)	2.7 (2.5–2.9)
Average number of adults (including self)	1.8 (1.7–2.0)	1.2 (1.0–1.4)

---

[1] Some, but not all, of these caregivers are related to the child. In the IL-CWB study, caregivers were asked if they are related by blood. The National Survey of Child and Adolescent Well-Being (NSCAW) does not have this question, just a type of care designation. Some of the children identified as being in kinship care are also identified as not being cared for by immediate relatives.

The DCFS Guardian Administrator (legal guardianship of most of the sampled minors) gave consent for the participation of sampled minors who were under State Guardianship after the child's caseworker had been contacted to verify the capacity of the child to be interviewed. DCFS Guardian consents for participation of sampled minors were not obtained in some cases for two reasons: either the Guardian denied consent or the caseworker did not complete the one-page evaluation form indicating the child's fitness to participate in the survey. Because the caseworker evaluation form is required by the DCFS Guardian, the latter group of cases was not able to be submitted to the Guardian for consent. In addition, consent could not be obtained for those children who were in temporary custody rather than Guardianship.

All minors 12 years of age and older were asked to give written assent prior to the interview. The assent form explained to the child that he/she had the right to refuse to participate and to refuse to answer any questions without any penalty. The assent form further explained that there were certain conditions under which we would report one or more of the child's answers to DCFS. It was stated that information would be reported if it indicated that there was an immediate safety issue and/or the child was an immediate danger to himself or others. If the minor refused to give assent, he/she was not interviewed. The assent form was written in clear, age-appropriate language. All materials were translated into Spanish.

Instrumentation and Data Sources

Information on each of the major well-being domains (mental health, physical health, education, development, placement stability, and family permanency) was obtained from at least two distinct data sources (see Table 2.4). The methodology and instrumentation used for each data source in Table 2.4 is described in the following sections.

Child Interviews

Youth were interviewed using a technology known as an Audio-CASI (Computer-Assisted Self-administered Interview), in which they used headphones and a touch-screen laptop computer to move from question to question (i.e., screen to screen) as they heard each question and all possible responses read aloud. They were able to go back and forth, change incorrect answers, and skip questions they did not wish to answer. All of their answers remained confidential and out of the view of parents, caregivers, and data collectors. At this point, the A-CASI has been extensively tested on wards and non-wards in several states, and well-developed training materials are readily available. Feedback from children indicates that the A-CASI is easy to use and not too time-consuming and that questions are understandable and not overly intrusive.

Table 2.4
Well-Being Domains and Data Sources

Data source	Domain					
	Mental health	Physical health	Education	Development	Stability	Permanence
Child interviews (ages 7 and older)	x	x	x		x	x
Caregiver interviews	x	x	x	x		
Caseworker interviews	x	x	x	x		
Case record abstraction	x	x		x		
School records abstraction			x	x		
DCFS integrated database					x	x

The child interview developed by Research Triangle Institute and currently in use for the NSCAW was adapted for use in the Round 2 data collection for the IL-CWB Study. Appendix C provides an overview of the modules contained in the NSCAW child instrument and whether or not each module was included in the IL-CWB Round 2 data collection.

The instrument asked children to self-report on the following domains of well-being:

- School engagement
- Relationship with peers (Loneliness and Social Dissatisfaction Questionnaire for Young Children; Asher & Wheeler, 1985)
- Protective factors (Resiliency Scale, Longscan, Runyan et al., 1998)
- Parental monitoring (Parental Monitoring; Dishion, Patterson, Stoolmiller, & Skinner, 1991)
- Out-of-home care (University of California at Berkeley Foster Care Study, Fox, Fransch, & Berrick, 2000)
- Satisfaction with caseworker services
- Future expectations (Adapted from Expectations about Education, Employmnet, and Life Span section from the Adolescent Health Survey)
- Depression (Children's Depression Inventory (CDI); Kovacs, 2003)
- Trauma (Trauma Symptom Checklist for Children (TSCC); Briere, 1996)
- Youth activities (Youth Self Report (YSR), Social Competence Scale; Achenbach, 1991a)
- Youth behavior (Youth Self Report (YSR), Total Problems Scale; Achenbach, 1991a)
- Relationship with caregivers (Rochester Assessment Package for Schools; Lynch & Cicchetti, 1991)
- Exposure to violence (Violence Exposure Scale, Revised; Fox & Leavitt, 1995)
- Services received
- Substance abuse (Drug Free Community Act Outcome Study Questions)
- Sexual activity (Longscan; Runyan et al., 1998)
- Delinquency (Modified Self-Report of Delinquency; Elliott & Ageton, 1980)
- Injuries (Child Health and Illness Profile – Adolescent Edition; Starfield et al., 1995)
- Child discipline (questions based on Parent-Child Conflict Tactics Scale; Straus, Hamby, Finklehor, Moore, & Runyan, 1998)
- Independent living (Ansell-Casey Life Skill Assessment (ACLSA); Nollan, Horn, Downs, Pecora, & Bressani, 2001).

The total length of the child interview varied by child age, with an average interview time of 76 minutes. Youth who participated received a McDonald's gift certificate.

Caregiver Interviews

The caregiver interview used in Round 2 of the IL-CWB study was adapted from NSCAW current caregiver instrument (see Appendix C). The caregiver interview included questions about the following topics:

- Child health problems, immunization, service needs and use
- Child dental, vision, and hearing services
- Developmental status (Brooks Publishing, 1999) of children aged 3 months to 5 years (Ages and Stages Questionnaire (ASQ) (Note, this instrument was not used in NSCAW)
- Special needs, testing and special education services, school attendance, grades, and discipline in schools
- Behavior and social competence (Child Behavior Checklist (CBCL); Achenbach, 1991b)
- Mental health service needs and use
- Delinquency

Caregiver interviews were administered over the telephone by interviewers from the Survey Research Laboratory, and took approximately 45 minutes to administer. Caregivers were given a $20 gift certificate upon completion of the interview.

Caseworker Interviews

The interviews with caseworkers were also conducted by trained interviewers at the Survey Research Laboratory. Several sections of the NSCAW caseworker interview were adapted for use in the IL-CWB Study caseworker interview (see Appendix C). Caseworker interviews took an average of 25 minutes to administer over the telephone. Topics covered were the following:

- Caseworker evaluation of child's capacity to be interviewed
- Services provided to the child
- Adoption and guardianship module
- Living environments
- Caseworker involvement

DCFS Case Record Abstraction

CFRC developed a Nurse Audit Record Abstraction Instrument used to gather information from DCFS case files regarding the health status and medical care provided to DCFS wards. DCFS nurses traveled to private agencies and DCFS field offices to collect the data from case files. All DCFS nurses received training on instrument administration and received feedback on the quality of their audits throughout the data collection period. Field retrieval efforts were conducted, as needed, to obtain any missing data. Information gathered from the case record reviews included

- Child enrollment in Healthworks
- Health Passport information
- Health care service receipt, such as immunizations, health screenings, and evaluations
- Information on child disability, referrals, services, medications, and equipment recommended and/or received
- ICD-09 diagnosis BAP break and DCFS disability codes

School Record Abstraction

The Center for Child Welfare and Education (CCWE) at Northern Illinois University (NIU) conducted reviews of children's educational records. Those children in the sample who were of school age during the 2003-2004 school year formed the sample for the educational record review.

The schools attended by these children were identified. In accordance with legal requirements, school district superintendents were notified about the impending record review by certified letter and, as a courtesy, superintendents were contacted by phone to resolve any questions they may have had. Reviewers, who were hired by NIU for this purpose, collected data in the spring of the school year by going to the schools of the children who had been selected for the sample. Educational advisors from the CCWE at NIU selected applicants, interviewed them, and subsequently trained those who were hired. The minimum qualification for a reviewer was a bachelor's degree and experience with schools. Following an established protocol, reviewers entered information from the child's educational record onto a standard form. In many instances they made copies of important documents, such as an Individualized Educational Plan, that were present in the file.

For school-age children, data were collected from administrative records on a number of indicators related to educational outcomes:

- Child age and grade level—if the child is placed at the expected grade level
- Educational programs (general education, special education)
- Individualized Education Plan (IEP) classification (learning disability, behavioral disability, etc.)
- For children receiving special education services and over a specified age, plans for transition to adult living
- Grades or other indicators of academic performance and standardized test scores
- Number of school transitions and number of placement changes
- Behavior in the schools—disciplinary action including detention, suspension, and expulsion

DCFS Integrated Database

The DCFS Integrated Database consists of administrative data collected by the Department and put into a longitudinal relational database by Chapin Hall Center for Children at the University of Chicago. For IL-CWB Round 2, data from the Integrated Database were used to analyze stability and permanency outcomes for the children in the study.

Instrument Response Rates and Completion Patterns

Table 2.5 presents the response rates for each of the data sources in the IL-CWB Round 2 study. The number of eligible children fluctuates between instruments because they were fielded over a period of several months; not all of the interviews were completed at the same time, and children continually left out-of-home care and changed guardianship status. For the child interviews, only 350 children of the 655 randomly selected into the study were eligible to complete the interview at the time data collection began. Of the 305 that were ineligible, 198 were under 7 years old (the bottom age-limit for the child interview) and 12 turned 18 years old during the data collection period, which is over the age-limit for the interview. Another 95 children either returned home (19) or were adopted (47), were placed in subsidized guardianship (178), moved out-of-state (8), or were incarcerated (4). Of the 192 children who were not interviewed, 24 refused, 64 did not have caseworker approval to be interviewed, 13 did not have guardian consent, and 91 were either not located or interviewed during the study period. A total of 158 child interviews were completed, for a completion rate of 45%.

For the caregiver interviews, 132 were ineligible for inclusion, either because the child had left their care, they were ill, incapacitated, or deceased, or they could not be located via telephone. Of the 523 caregivers who were eligible to participate, interviews were completed with 287 caregivers, for a completion rate of 55%. For the caseworker interviews, 116 were ineligible because the child was no longer a ward, leaving 539 potential caseworker interviews. Of these, 429 interviews were completed, for a response rate of 79.6%. DCFS nurses were able to audit 463 of the 605 open case files to collect medical information on the children in the study, for a completion rate of 76.5%.

Imputation of Missing Data

For all standardized instruments, instrument-specific methods were adhered to for data imputation. For non-standardized data that were missing, a mean value was substituted where existing Likert Scale data were available. For some items, data imputation was not possible and therefore certain cases were dropped from specific analyses.

Table 2.5
Total Eligible Participants, Completed Interviews/Reviews, and Response Rates

	Eligible participants	Completed interviews or reviews	Response rate
Child interviews	350	158	45.1%
Caregiver	523	287	54.9%
Caseworker	539	429	79.6%
Nurse audit/record review	605	463	76.5%
School record abstraction	305	241	79.0%

CHAPTER 3
Children's Mental Health

Introduction

The combination of maltreatment, subsequent removal from home, family and community, and the experience of foster care placement instability can create mental health issues for children in substitute care. Children need protection, affirmation, nurturing, and constancy in their relationship(s) with their parent(s). When these needs are thwarted, it is unlikely that children will be able to fully attend to the critically important developmental tasks of childhood. If left unaddressed, these altered developmental trajectories will continue to impact cognitive, educational, social, and occupational functioning.

The following section reviews the results of recent studies that have examined the prevalence of mental health concerns among children in out-of-home care and the related literature that explores the effects of trauma on child development. This is followed by presentation of a selection of results from the IL-CWB Study, Round 2, as they pertain to behavioral and mental health.

Literature Review

Many of the conditions that contribute to foster care placement also have a negative impact on children's emotional and behavioral development (specifically, physical or sexual abuse, neglect, parental substance use and parental mental illness). Burns et al. (2004), using the National Survey of Child and Adolescent Well-being, estimated that almost 48% of youth in out-of-home care scored in the clinical range on the Child Behavior Checklist (CBCL), demonstrating mental health needs. In Minnis, Everett, Pelosi, Dunn and Knapp's (2006) study, caregivers' and teachers' reports concerning children living in foster care in Scotland, along with child self-report, identified high rates of hyperactivity, emotional, conduct and peer problems in children ages 5-16. Attachment disorders may be a frequent underlying cause of children's emotional and behavioral problems and can result in such behaviors as aggression, avoidance, anger and social dysfunction (Vig, Chinitz v Shulman, 2005), although this assumption has been disputed (Barth, Crea, John, Thoburn, & Quinton, 2005). Children in foster care may have difficulty regulating their mood, attention, aggression, and eating and sleeping patterns.

Children often enter the child welfare system with existing mental health diagnoses. McMillan et al. (2005) reported that 61% of a sample of 17 year olds in foster care had a lifetime incidence of mental illness, with 60% of children having been diagnosed prior to entry into the child welfare system. Different diagnoses had different prevalence rates; in McMillan's sample, using the Diagnostic Interview Schedule for DSM-IV, 14% of the youth were diagnosed with PTSD, 20% with ADHD, 27% with major depression, and 47% with conduct disorder or oppositional defiant disorder (CD/ODD). Reported in the same study was the finding that externalizing disorders such as CD/ODD or ADHD were more likely to be diagnosed prior to entrance into the child welfare system, while internalizing disorders (e.g., depression and PTSD) were more likely to be diagnosed after entry into the system. Pilowsky and Wu (2006) found that adolescents in foster care had more psychiatric symptoms in every category compared to a control group of adolescents without a foster care history, including more symptoms of conduct disorder and anxiety; they also reported more suicide attempts and suicidal ideation. These youth were also slightly more likely to use alcohol and about twice as likely to use illegal drugs as the control group.

A range of mental health services exist for children in child welfare, including outpatient services (for example, counseling, case management, and day treatment) and psychiatric hospitalization. Utilization of these services varies by type. One study found the use of outpatient services to be most common, with about 15% of the sample reporting use of these services: a breakdown of these services included clinic or private practice (13%), in-home counseling (4%) and day treatment/therapeutic nursery (1%); psychiatric hospitalization was utilized by 3% (Burns et al., 2004). Becker, Jordan and Larsen (2006) described 59% of children in foster care as using outpatient services, which included 34% individual or family counseling and 22% case management services. In this study, 5% used psychiatric hospitalization. Rates of hospitalization in both studies were higher than the estimate for the general population (less than 1%). Becker, Jordan and Larsen (2006) also reported that more children utilized behavioral health services during placement than six months before (49% vs. 35%) and that rate of service use after placement dropped relative to the rate of services used during placement but remained higher than the rate of pre-placement service usage (41%). Frequently, the child welfare system becomes a gateway to access to mental health services for children entering it. Leslie, Hurlburt, James, Landsverk, Slymen and Zhang (2005) found that, regardless of placement type (e.g., child remained in home with no child welfare services, child remained in home with child welfare services, or child was placed out of home), mental health service use increased after contact with the child welfare system. However, it is clear that other factors play a role in mental health service use aside from mental health need. Mental health service need does predict mental health services receipt, but other factors do as well. Children placed in foster care are more likely to receive services than children placed in the homes of parents, and among those placed with parents, those whose families are receiving child welfare services are more likely to receive services than those whose families are not. Furthermore, older children and Caucasian children are more likely to receive services.

Some authors advocate for specific psychotherapeutic approaches to help address existing mental health problems and to prevent development of new problems. Vig, Chinitz, and Shulman (2005) recommended the prevention of multiple changes in caregivers when possible; including the relationship between the caregiver and the child in the therapeutic plan; providing counseling and support to the caregiver; providing psychotherapeutic services for trauma jointly to the child and caregiver; coaching biological parents on how to make visits a more positive experience; and expediting permanency planning. McMillan et al. (2005) suggested providing mental health services before placement outside the home in order to prevent unnecessary placements for some children, and for others, providing intensive mental health services to keep youth in family placement instead of moving them to congregate care.

Child welfare researchers have long had an interest in the concept of resilience. Resilience refers not to a trait but to a pattern of successful adaptation over time to adversity (e.g. Masten, 2001). The term resilience refers to a dynamic process – hence, theorists recognize that children may adapt more optimally at one point in time and less optimally at another, based on contextual circumstances. The concept of resilience is related to that of trauma insofar as children who have internal and external resources and are able to utilize those resources to promote adaptation may be less likely to experience psychological trauma as a consequence of events to which they are exposed. While some assume that every child entering the system has experienced traumatic events and can be expected to display symptoms of trauma, a great deal of variability is evident in children's experiences and adaptation. When children do demonstrate the effects of exposure to traumatic events, however, those effects may be global and can include problems with attachment, biological processes, affect regulation, disassociation, behavior regulation, cognition and self-concept (Cook et al., 2007). Exposure to traumatic events can disrupt children's ability to grow, think and learn as part of a healthy developmental process. Some behaviors and characteristics of the traumatized child could include hyperarousal, hypervigilance, aggression and destructiveness, difficulty concentrating, intrusive memories of traumatic events, sleep problems, withdrawal, diminished interests, dissociative behaviors, developmental regression, personality changes, onset of new fears and anxieties, depression, suicidal behaviors, other psychiatric disorders, and trauma play (Dyregrov and Yule, 2006; Vig, Chinitz and Shulman, 2005). In the past, it was generally believed that young children could not remember trauma and were thus not affected by it; research has shown this not to be true (NCTSN, 2001).

Only in recent years has the child welfare system identified and focused on understanding the experience and effects of trauma. Most children become involved with the system as a result of physical or sexual abuse or neglect by their caregivers. The experience of abuse or neglect, along with disproportionate likelihood of exposure to violence at home, in school or in the community has the potential to multiply the experience of trauma in the child's life; in addition, children can be further traumatized by their experience with the child welfare system (e.g., separation from families, repeating their stories in interviews, going to court) (Igelman, Conradi and Ryan, 2007). Finkelhor, Ormrod and Turner (2007) proposed that symptoms found in victimized children may be the result of an accumulation of victimizations rather than the result of one traumatic event.

Numerous evidence-based treatments for trauma in children have been found to be effective in addressing trauma symptoms. Trauma Focused Cognitive Behavior Therapy (TF-CBT) has been identified as a best practice treatment in the child welfare. TF-CBT is a short term treatment involving the parent and the child, and targets behavioral and emotional symptoms and negative thought patterns related to the trauma (Kauffman Best Practices Project to Help Children Heal from Child Abuse, 2004; Stambaugh, Burns, Landsverk and Reutz, 2007). The use of cognitive-behavioral therapy and stress inoculation can provide children with skills to reduce maladaptive behavioral and emotional responses and beliefs and their non-offending parents with supports and coping skills in order to respond positively to their traumatized children (American Academy of Child and Adolescent Psychiatry, 1998).

Other identified best practice treatments that may be appropriate for children involved with child welfare systems include Abuse-Focused Cognitive Behavioral Therapy (AF-CBT) and Parent-Child Interaction Therapy (PCIT). AF-CBT targets both the individual characteristics related to the abuse (including child, parent and family) and the family context in which the abuse occurs, and is based on learning theory and behavioral principles (Kauffman Best Practices Project, 2004). AF-CBT has been found to increase positive parenting skills and to decrease coercive or aggressive discipline. Parent-Child Interaction Therapy (PCIT) has been found to be very effective in work with maltreated children, especially physically abused children and their parents (Chaffin et al., 2004). The Kauffman Best Practices Project (2004) reported positive outcomes of PCIT to include improved parenting skills, decreased child behavior problems, and improvement in the quality of the parent-child relationship. Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) and the Trauma/Grief-Focused Group Psychotherapy Program are school-based programs; studies have shown that children receiving these treatments are less likely to drop out of school (NCTSN, 2001).

Dyregrov and Yule (2006) described additional effective treatments for PTSD, including groups for children that allow them to express their experiences and teach them how to cope with the trauma's effects; eye movement desensitization and reprocessing; massage; and therapeutic writing. The authors also proposed early intervention with families in order to prevent trauma. Finally, Lieberman and colleagues have developed a relationship- based intervention for young children exposed to family violence, and there is strong evidence to promote the efficacy of this approach (Lieberman & Van Horn, 2005).

One subgroup especially at risk are children with developmental disabilities, whose traumatic stress may not be diagnosed or treated due to assumptions about the extent to which children are affected and clinicians' feelings of unpreparedness to treat them (NCTSN, 2001). Children with hearing difficulties, including deaf children, are also underserved.

Introduction to Results

The results section will be presented in several parts. The first section will relate to prevalence of mental health conditions or needs among children in out-of-home care. For each standardized instrument, scores were compared among children with different demographic and placement characteristics to determine whether any differences were evident. The characteristics examined were gender, race or ethnic group, age of the child at entry into care, time in care, and type of placement at the time of the interview. A table containing results of all these analyses is available for review in Appendix D. Only those comparisons that demonstrated any statistically significant differences between groups are presented in this section.

The second section of results pertains to mental health services receipt. This section will examine the type of services received by children in care as well as the characteristics that differentiate children who receive services from those who do not. The final section provides a comparison between indicators of mental health need and mental health services receipt between children in foster care in Illinois and those in foster care nationally.

Children Identified as Having a Mental Health Condition - Measurement

Caregiver Reports of Children's Mental Health

The Achenbach Children Behavior Checklist (CBCL)[4] was completed by caregivers to measure the extent of serious child emotional or behavioral problems. In addition to this standardized instrument, a series of non-standardized questions was administered to caregivers regarding their observations of the child's mental health status. Specifically, caregivers were asked whether the child had any of the conditions listed. They were then asked if a doctor had diagnosed the condition and, where appropriate, whether the child received any medication for the condition. In cases where children were reported as receiving medication, caregivers were asked if the medication was helping. In cases where children were reported as not receiving medication, caregivers were asked if they felt the children needed medication, and if so, why they were not getting it. They were also asked whether children were receiving all, some, or none of the services needed for each condition.

Conditions caregivers were asked about included:

- Attention Deficit/Hyperactivity Disorder (ADHD)
- Depression
- Bipolar disorder or extreme mood swings
- Serious conduct or behavior problems
- Oppositional or defiant behavior disorder
- Serious problems with attachment to caregivers
- Eating disorders
- Sexually aggressive behavior
- Alcohol/substance abuse problems
- Other emotional/mental health problems

Caseworker Reports of Children's Mental Health

Caseworkers were asked whether: 1) a formal assessment had been completed for behavioral problems; 2) the child had an emotional/behavioral disturbance; 3) the child needed a mental health diagnosis; 4) the child needed services for behavioral problems, 5) the child needed medication for a behavioral problem; and 6) the child was currently in a psychiatric hospital.

---

[4] Child Behavior Checklist, Copyright (2006). T. M. Achenbach, Burlington, VT. University of Vermont.

[5] Youth Self Report, Copyright (2006). T. M. Achenbach, Burlington, VT. University of Vermont.

Children’s Reports of Their Mental Health

Children in the sample were administered a series of standardized instruments to assess the presence of mental health symptomatology and behavior problems. The Youth Self Report (YSR)[5] , an instrument complementary to the CBCL but that represents the youth’s perspective, was completed by youth ages 11 and older. The Children’s Depression Inventory (CDI)[6] was completed by children 7 and older to assess the extent of clinical level depression among children in the sample. Finally, the Trauma Symptom Checklist for Children (TSCC)[7], Post-traumatic Stress subscale (PTS) was completed by children 8 and older to assess post-traumatic distress.

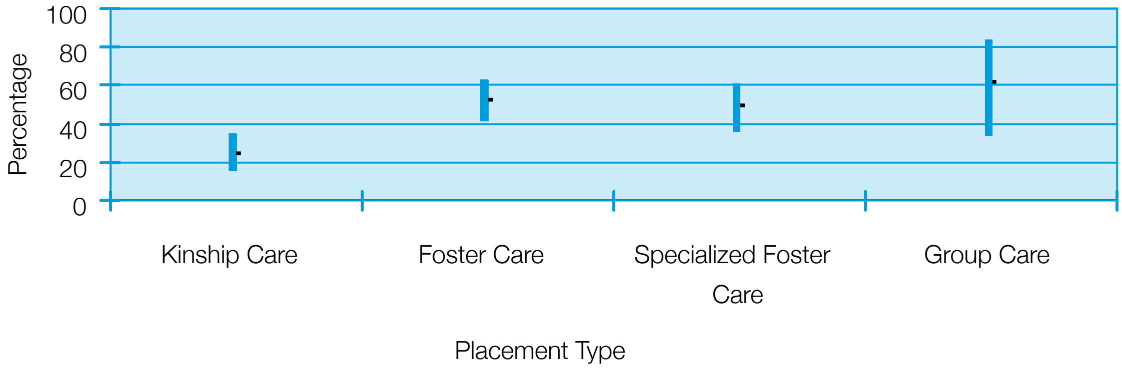
Identification of Mental and Behavioral Health Concerns - Results

Caregiver Reports of Children’s Mental Health

The Achenbach Child Behavior Checklist (CBCL)[4] scales for young children (ages 1 ½ to 5 years) and for school-age children (ages 6 to 18 years) are normed for national and international samples of boys and girls. The instrument produces a total scale score as well as internalizing and externalizing subscale scores. For the total, internalizing, and externalizing scales, 17% percent of children in the general population score within the combined clinical and borderline ranges.[8]

Based on caregiver reports, 41.4% (std. err. 3.1, 95% C.I. 35.4 – 47.7) of all children in DCFS care (1½ to 18 years of age) score within the combined clinical and borderline range on the CBCL (see Appendix Table D.1). A total of 32.7% score in the clinical range only (std. err. 2.9, 95% C.I. 27.3 – 38.5). A total of 36.7% (std. err. 3.0, 95% C.I. 31.0 – 42.8) score in the borderline or clinical range on the externalizing subscale, suggesting problems such as aggression and rule-breaking behavior. A total of 28.6% (std. err. 2.9, 95% C.I. 23.2 – 34.6) score in the borderline or clinical range on the internalizing subscale, suggesting problems such as feeling anxious, withdrawn or depressed or experiencing somatic complaints (e.g., nausea, stomach problems). There were no statistically significant differences in CBCL scores when children were compared by gender or age (Appendix Tables D.1 and D.3). Scores did vary in a statistically significant manner between children in different placement types and children of different racial/ethnic backgrounds (Figures 3.1 and 3.2). In Figures 3.1 and 3.2, the 95% confidence interval is represented. Within that interval, the point estimate is identified. Figure 3.1 indicates that children living in kinship care are significantly less likely to be rated by caregivers as having borderline or clinical levels of behavior problems

Figure 3.1: Percentage of Children with Borderline or Clinical CBCL Scores by Placement type



---

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

[7] Trauma Symptom Checklist for Children by John Briere, Ph.D., copyright 1989, 1995, by PAR, Inc., 16204 North Florida Avenue, Lutz, Florida, 33549.

[8] Scores in the clinical range are higher than those obtained by 91% of children in the national population. The “Borderline Clinical Range” spans the 84th to the 91st percentile.

than children in any other care type ($\chi 2$ = 19.50 (3, 273), *p* <.01). Children in other care types do not differ significantly. Figure 3.2 indicates that African-American children are less likely to be rated by caregivers as having borderline or clinical levels of behavior problems than White children ($\chi 2$ = 10.43 (3, 273), *p* = .02). In addition, children who had been in care longer were more likely to be identified by caregivers as having clinical levels of behavioral problems (Appendix Table D.3). Children identified as having clinical levels of behavior problems had been in care an average of 4.0 years (std. err. 0.3, 95% C.I. 3.4 – 4.7), whereas children not so rated had been in care an average of 2.9 years (std. err. 0.2, 95% C.I. 2.5 – 3.3, t (272) = 2.6, *p*< .01). Additional caregiver perspectives are presented in the service delivery section, as service delivery was discussed along with incidence of each condition.

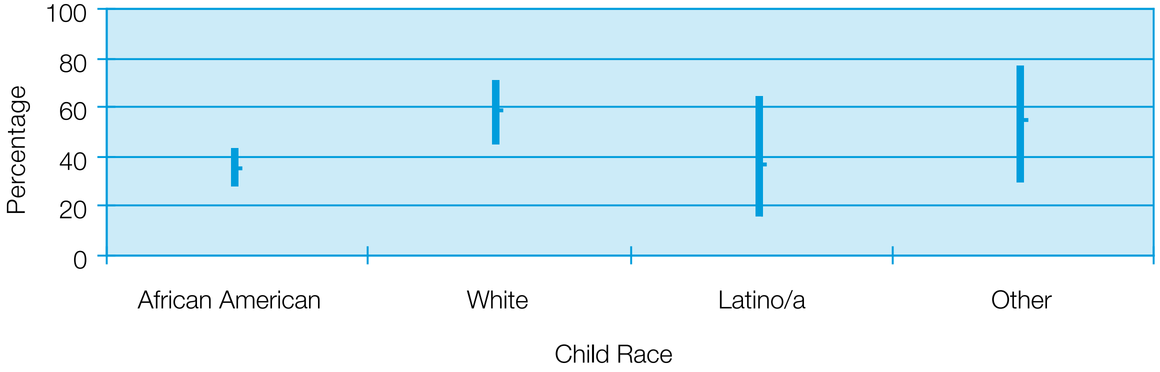
Caseworker Reports of Children's Mental Health

Caseworkers were asked a series of non-standardized questions about the child's mental and behavioral health. Caseworkers indicated that, at intake, 30.0% (std. err. 2.3, C.I 25.7 – 34.7) of children had some type of special need. This designation included special needs of any variety, including those that might not be considered mental health concerns, such as learning disabilities. Of the 30% of children identified as having special needs, 25.3% (std. err. 3.8, C.I. 17.4 – 32.5) were identified as having an emotional or behavioral disturbance. Hence, roughly one-fourth of one-third of children, or 7.5% of all children, were identified as having emotional or behavioral disturbances at intake. Table 3.1 represents caseworker responses concerning the needs of the children who were subjects of the interviews at the time of the interviews. Each of these questions was asked of every caseworker, so percentages are representative of all children, not, for example, only those children identified as having a mental health condition. The categories are not mutually exclusive, so a child identified as having a mental health condition could also be identified as needing services for an emotional, behavioral, or attention problem and vice versa. At the time of the interview, caseworkers identified about one-fourth of all children as needing mental health services, and close to one-half were identified as needing services for behavioral problems (Table 3.1). The contrast between the 7.5% of children identified as having emotional or behavioral disturbances at intake and the 47% identified as needing service for behavioral health conditions at the time of the interview suggests that need, identification of need, or both had increased since the time of intake.

Children's Reports of Their Mental Health

Children were asked to respond to questions comprising three separate standardized measures of mental health.

Figure 3.2: Percentage of Children with Borderline or Clinical CBCL Scores by Race or Ethnicity



These included the Youth Self Report, the Children's Depression Inventory, and the Trauma Symptoms Checklist for Children (Post-traumatic Stress Symptoms subscale). These instruments are described in greater detail below with results and interpretations.

The Youth Self Report (YSR)[9] is a self-report assessment of behavior problems that complements the Child Behavior Checklist and can be scored to reflect total, internalizing, and externalizing scores as well as scores for subscales. One-third (33.0%) (std. err. 4.5, 95% C.I. 24.7 – 42.4) of all children in who completed the survey (children 11 to 18 years of age) scored within the combined clinical and borderline range on the YSR (see Appendix Table D.1). A total of 16.4% (std. err. 3.6, 95% C.I. 10.6-24.7) respondents scored in the clinical range only. Bivariate analyses indicated that YSR scores have no statistically significant association with gender, age, race, or time in care (Tables D.1 and D.3). However, YSR scores are associated with placement type at the time of the interview (Figure 3.3); children in traditional foster homes were less likely to self-report borderline or clinical levels of behavior problems than children in other types of care ($\chi2 = 8.08$ (3, 109), $p = .04$).

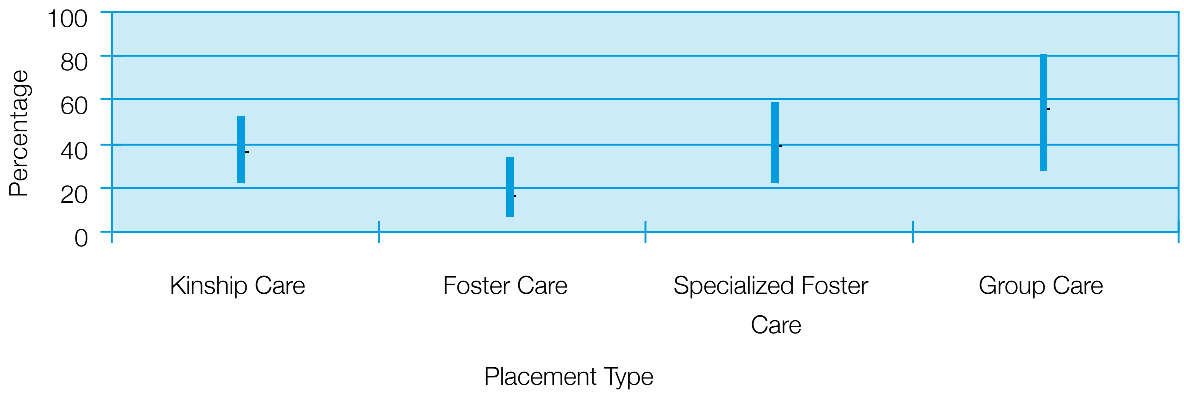
The Children's Depression Inventory (CDI)[11] measures the severity of depressive symptoms. A series of feeling and attitude items are presented to children, who then select one of three responses that best describes how they were feeling during the past two weeks. Responses indicate whether there is an absence of each symptom, a mild symptom or

Table 3.1
Caseworker Responses Concerning Identification of Behavioral or Mental Health Needs

	Point estimate (Standard error), 95% Confidence Interval
Child needs a mental health service[10]	27.4 (2.0), 23.6 – 31.6
Formal assessment for emotional, behavioral, or attention problems completed	47.4 (2.5), 42.6 – 52.2
Child needs services for an emotional, behavioral, or attention problem	45.6 (2.3), 41.1 – 50.2
Child needs medication for an emotional, behavioral, or attention problem	22.7 (2.0), 19.1 – 26.8

Note: each of these questions was asked of all caseworkers.

Figure 3.3: Percentage of Children with Clinical or Borderline YSR Scores by Placement Type



---

[9] Youth Self Report, Copyright (2006). T. M. Achenbach, Burlington, VT. University of Vermont.

[10] For example, for Attention Deficit Hyperactivity Disorder (ADHD), for Post-traumatic Stress Disorder (PTSD), for Oppositional Defiant Disorder, for Conduct Disorder, any type of depression, Bipolar Disorder, or any other mental health problem

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

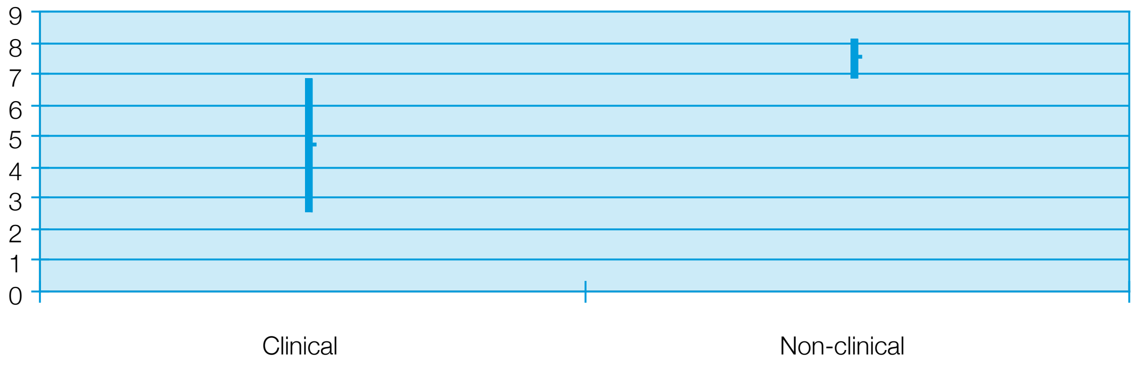
a definite symptom. All children in the IL-CWB Study who completed the child interview were age eligible to answer the CDI questions (158 children). Overall, 3.7% (std. err. 1.5, 95% C.I. 1.6 – 8.0) of the sample children scored in the clinical range on the CDI, compared to 7% of children in the normative sample (see Appendix Table D.2). The clinical range is defined as 1.5 standard deviations or more above the mean. An alternative interpretation of the CDI extends the clinical range to include a range of one standard deviation above the mean or higher. This range is designated by the instrument's authors as "above average" (Kovacs, 2003) and is referred to for purposes of this report as "clinical and subclinical." A total of 7.5% of children scored in the combined clinical/subclinical range. Approximately 16% of children would be expected to score more than one standard deviation above the mean in the general population.

The very low numbers of children that reported depressive symptoms caused bivariate analyses to produce inconclusive results. None of the bivariate analyses, including examinations of association between CDI scores and gender, age at entry, race, time in care, and placement type, demonstrated statistically significant results.

The Trauma Symptom Checklist for Children[12] (TSCC) measures post-traumatic distress. For the IL-CWB Study, the Post-traumatic Stress (PTS) subscale was administered to children ages 8 and above. The PTS subscale questions ask about intrusive thoughts, sensations and memories of painful past events, as well as nightmares, fears, and cognitive avoidance of painful feelings. Questions are intended to capture the child's current experience of previous traumatizing events.[13] Overall, 5.8% of sample children scored in the clinical range[14] on the Post-traumatic Stress subscale, compared to approximately 8% of children in the normative sample (Appendix Table D.2). As was the case with the CDI, an expanded range including a designation of clinical or "subclinical" can be defined as including any score one or more standard deviations above the mean. A total of 12.5% of children in the study scored in the combined clinical and sub-clinical ranges. Over 15% of children would be expected to score one or more standard deviations above the mean on a standardized scale.

Examination of bivariate associations indicated that while likelihood of reporting trauma did not vary by gender, race, or placement type (Appendix Table D.2), there were significant associations with age at entry and time in care (Figures 3.4 and 3.5; Appendix Table D.4). The results in Figures 3.4 and 3.5 indicate that children who entered care at a younger age and children who have been in care for a shorter period of time are more likely to report traumatic symptoms.

Figure 3.4: Age at Entry Among Children with Clinically Significant Trauma Scores



---

[12] Trauma Symptom Checklist for Children by John Briere, Ph.D., copyright 1989, 1995, by PAR, Inc., 16204 North Florida Avenue, Lutz, Florida, 33549.

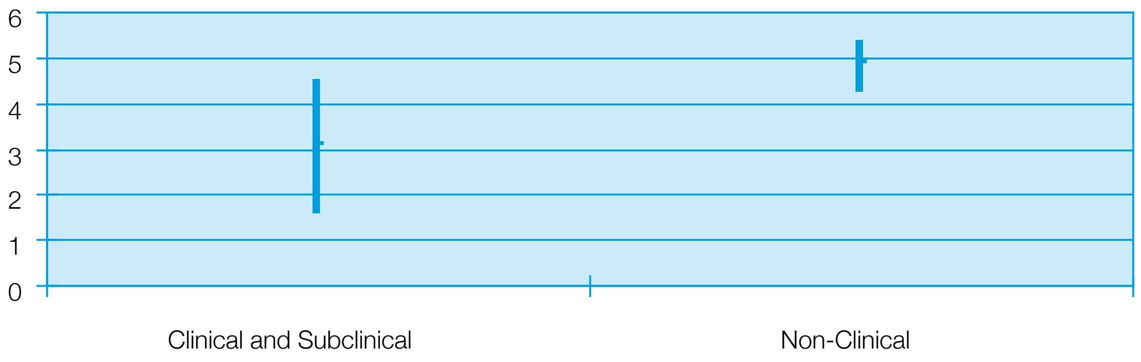
[13] These include natural disasters, such as earthquakes; witnessing domestic violence; experiencing physical or sexual abuse from parents, other adults or peers; divorce, and; hospitalization of a parent.

[14] The clinical range contains T score values that equal or exceed the scores of 94% of the children in the national standardization sample. Children scoring in the clinical range have significant trauma symptomatology.

In general, children in foster care are less likely to report themselves as depressed or traumatized than children in the general population. Clearly these findings run counter to intuition; one might expect that children who had experienced abuse or neglect severe enough to necessitate placement in out-of-home care would be more likely to report themselves as depressed or traumatized than children in the general population. A number of possibilities could account for the unexpectedly low numbers of children reporting depressive or traumatic symptoms. The first possibility is that the measurements are appropriate and sensitive, that children in foster care are, in general, insightful with regards to their feelings, and that they are truthful in the reporting of those feelings and that the results reported are, thus, accurate. The second possibility is that any one of the assumptions delineated is false and that the results reported are, thus, inaccurate.

Under-reporting of mental health concerns by children in foster care relative to population means has been noted in other studies as well. For example, in a study by Folman (2002), children in foster care were also found to significantly under-report depression relative to population norms. Dr. Folman provides some compelling arguments based on qualitative data and clinical literature that, in fact, foster children do experience feelings of separation, loss, grief, and stigmatization that impact self concept or self esteem and depression but that they learn to hide those feelings due to lack of validation of the feelings or outright rejection of them. Ostler, Haight, Choi, Kingery, and Sheridan (in press) also found under-reporting of trauma symptoms among children who had significant problems, and this under-reporting was due to family patterns of secrecy and having been told “not to talk” (personal communication).

Figure 3.5: Time in Care Among Children with Clinically Significant Trauma Scores



Results pertaining to trauma can also be thought to relate to the nature of the questions asked about trauma. Van der Kolk, Roth, Pelcovitz, Sunday, and Spinazzola (2005) stated that “Children and adults exposed to chronic interpersonal trauma consistently demonstrate psychological disturbances that are not captured in the posttraumatic stress disorder (PTSD) diagnosis. The DSM-IV (American Psychiatric Association, 1994) Field Trial …found that victims of prolonged interpersonal trauma, particularly trauma early in the life cycle, had a high incidence of problems with (a) regulation of affect and impulses, (b) memory and attention, (c) self-perception, (d) interpersonal relations, (e) somatization, and (f) systems of meaning” (p. 1). The questions included in the PTS are directly linked to the diagnostic criteria for Post-Traumatic Stress Disorder. The criteria for diagnosis of PTSD, for example, require that the subject experience “intrusive recollection” of the event or events (American Psychiatric Association, 2000). In essence, every question included in the PTS subscale measures some aspect of intrusive recollection. However, intrusive recollection becomes a muddled issue for children who have experienced chronic or complex trauma. For such children, one might suppose that the experience of and response to trauma might become habituated, reducing the likelihood of intrusive recall of any one of multiple traumatic incidents. Thus, the means of measuring trauma selected for the NSCAW may not capture the spectrum of traumatic stress responses experienced by children in foster care.

Multivariate Analyses

Multivariate analyses modeling borderline/clinical scores on the Child Behavior Checklist and Youth Self Report were conducted using age at entry, time in care, race, gender, and type of placement at the time of the interview as predictor variables. The results are presented in Table 3.2. Modeling of scores on the Trauma Symptom Checklist/Post-traumatic Stress subscale and the Children’s Depression Inventory was not attempted due to low numbers of children and youth self-reporting trauma and depression, which makes accurate modeling infeasible.

The results presented in Table 3.2 indicate that, once additional covariates are taken into consideration, only two variables are significantly related to caregiver ratings of

Table 3.2
Logistic Regression Predicting Borderline and Clinical Level Scores on the CBCL and YSR

	Model 1 (CBCL)			Model 2 (YSR)		
Predictor	B	SE B	eB	B	SE B	eB
Sex (Female)	.01	.28	1.01	.55	.46	1.74
Race						
White	.32	.43	1.38	.97	.65	2.65
Other	1.05	.34	2.87*	.62	.54	1.85
African American	Ref	Ref	Ref	Ref	Ref	Ref
Age at entry	-.00	.04	1.00	-.19	.12	.83
Time in care	.07	.05	1.08	-.18	.12	.83
Type of care						
Traditional foster care	1.15	.35	3.17**	-1.26	.60	.28*
Specialized foster care	.82	.38	2.26*	.09	.56	1.10
Group/residential care	1.42	.65	4.14*	1.94	.71	2.83
Kinship care	Ref	Ref	Ref	Ref	Ref	Ref
χ^2	2.93**			2.40*		
Df	9			9		

Note: eB = exponentiated B.
* p < .05
* *p < .01

child behavior problems: child race and placement type. Children with a racial or ethnic background “other than African American or White” are about 3 times more likely than the comparison group (African-American children) to be reported by caregiver as having behavior problems. The practical implications of this finding are minimal because the meanings of the “other” category are indistinct. Caregivers of children in kinship care are less likely to rate the children in their care as having behavior problems than caregivers of children in any other type of care, even after controlling for the effects of the other predictor variables. Caregivers of children in traditional foster care are 3.17 times more likely to rate the children in their care as having behavior problems than caregivers of children in kinship care. Results for the YSR run counter to those for the CBCL in that children in traditional foster care are 3.57 times less likely to rate themselves as having borderline or clinical levels of behavior problems than children in kinship care are.[15] No other variable predicted borderline/clinical scores on the YSR.

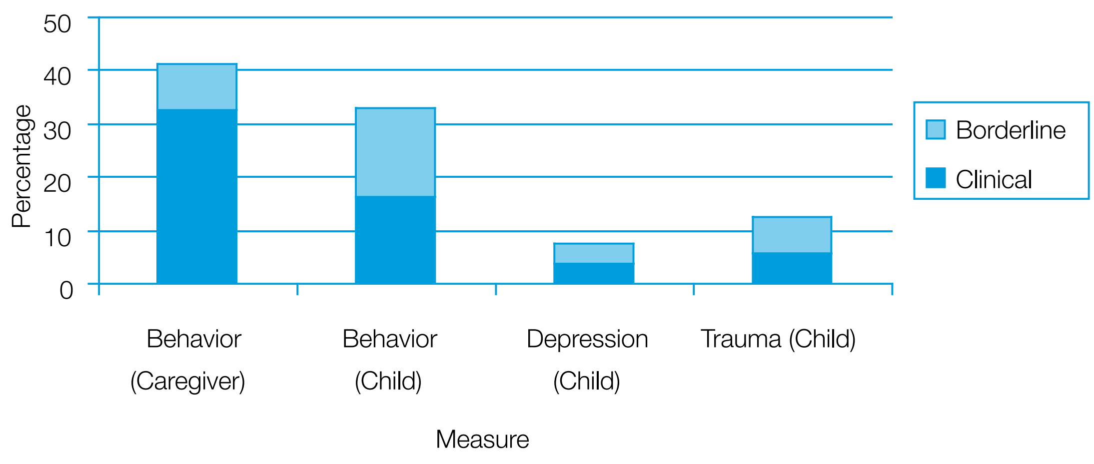
The disparity of the regression results for caregiver ratings of behavior (CBCL scores) and children’s ratings of their own behavior (YSR scores) prompted further examination of the correspondence between caregiver and child reports of behavior problems. When caregivers indicate that children do have behavior problems, approximately 66% of children indicate that they do not have behavior problems. In cases where the caregivers indicate that the children do not have behavior problems, approximately 25% of children indicate that they do have behavior problems. These ratios vary somewhat by placement type; however, due to the low numbers of children for whom both caregiver and child data are available in any given placement type, the significance of this variation cannot be determined.

Summary of Mental Health Conditions

Figure 3.6 represents the point estimates for each of the standardized measures described above for both clinical cut-offs and clinical/borderline or clinical/sub-clinical cut-offs. The figure demonstrates that children are less likely than caregivers to identify themselves as having behavior problems but are more likely to identify themselves as having behavior problems than they are to identify themselves as having symptoms of depression or trauma.

Both the bivariate and multivariate analyses revealed significant associations between placement type and clinical/borderline scores for behavior problems. There is some suggestion that depression would be found to vary by placement type as well, if more data were available. Children living in group homes and institutional care report the highest rates of depression (24.6%). These findings are presented in Figure 3.7, which depicts clinical/borderline or clinical/sub-clinical levels of mental health measures based on standardized instruments by placement type. While

Figure 3.6: Prevalence of Mental Health Conditions



---

[15] Regression results for the YSR pertain to children 7 years and older.

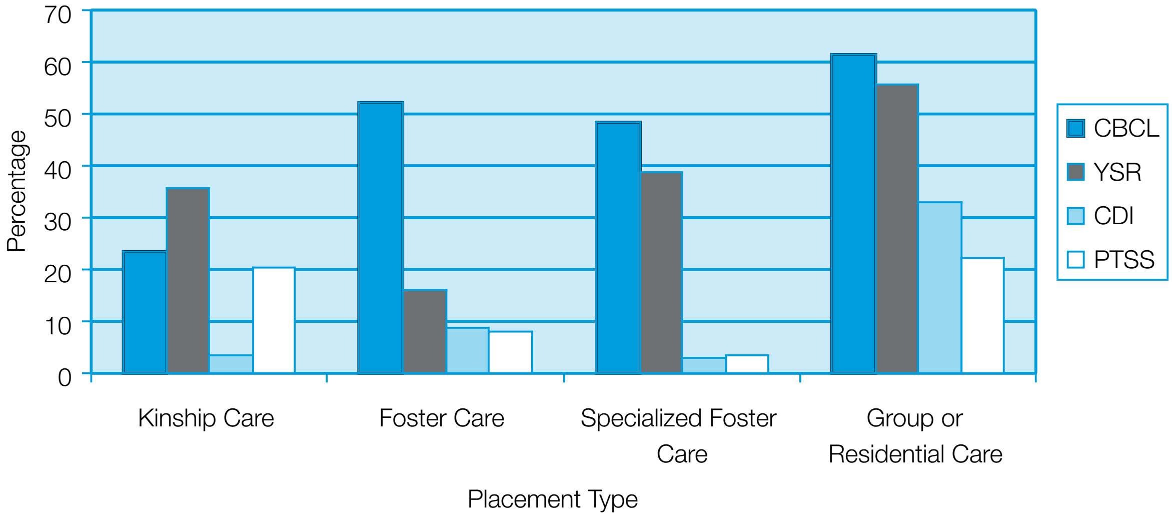
the data show that children in kinship care are reported by caregivers to having lower rates of behavior problems than children in traditional foster care (CBCL), it shows that children report themselves as having both higher rates of behavior problems (YSR) and higher rates of trauma symptoms (PTSS) than children in traditional foster care. Conversely, while traditional foster care providers are more likely to rate the children in their care as having behavior problems than kinship care providers are, the children themselves report lower rates of both behavior problems and trauma. The implication regarding kinship care is that caregivers may not be recognizing all of the mental health needs of children in their care and that, accordingly, these children may not be receiving treatment that could help to ameliorate their symptoms. Conversely, traditional foster care providers may be more attuned to potential mental health needs of children in their care than parents in the general population are.

Mental Health Service Receipt

Mental health services receipt was evaluated in three different ways. First, when caregivers were asked a series of questions about their perceptions of children's mental health diagnoses or conditions associated with possible diagnosis, they were also asked whether children had been diagnosed by a doctor as having the condition in question, whether they were receiving medication for the condition, and whether they were receiving none, some, or all recommended services. Caregivers were also asked about the helpfulness of the services children in their care were receiving. Finally, questions that were incorporated in the NSCAW were replicated in the Illinois Study of Child Well-being as closely as possible. These questions focused on whether children had ever received a range of mental health services, reasons for service receipt, when treatment started, when it stopped, the reasons why it stopped, and, to some extent, services that were needed but not received, and reasons for non-receipt of services. In addition, caregivers were asked, for a selection of services not addressed in the NSCAW, if the child was currently receiving the service, if the service was helping, unmet service needs, and reasons for unmet service needs.

Only a selection of the data gathered were analyzed and reported here, for several reasons. First, the number of responses in each category for many questions was extremely limited, which seriously impacts the possibility of a meaningful analysis, especially when comparing responses categorically (for example, by gender or race). In addition, it was anticipated that these analyses would be modeled after those conducted with the national data set. However, to date (eight years after the study was implemented), not

Figure 3.7: Comparisons of Mental Health Conditions by Placement Type



one single researcher nationally has published results on the range of mental health data available (specifically, dosage, reasons for service termination, reasons for non-receipt of services). This observation speaks to the complexity of analyzing and interpreting these data. Consequently, the approach taken thus far with the national data – that being to simply calculate whether or not a child has ever received a service in question (or, in fact, any service at all) – is also taken here. Results describing the identification of specific mental health conditions are presented first, along with information about formal diagnosis and receipt of services for those conditions. Next, additional information about mental health services not addressed by the NSCAW is presented, including information about service helpfulness. Finally, a comparison between Illinois data and national data concerning mental health service usage among children in foster care is presented.

Table 3.3 represents questions asked of caregivers about 1) whether a child has a specific mental health condition 2) whether this condition has been diagnosed by a doctor 3) how much service the child is receiving for the condition (none, some, or all), and 4) whether the child is taking prescription medication for the condition (where appropriate). The last three questions (diagnosed by a doctor, receipt of services, and receipt of medication) were only asked in cases where the caregiver indicated that the child had the mental health condition in question. This series did not include questions about whether a doctor had been told of the concerns of the caregiver or whether child had been otherwise formally assessed for the conditions of concern.

The data in Table 3.3 reveal that the disorders most frequently identified by caregivers are ADHD (37%) and Oppositional/Defiant Disorders (36%). These were also two of the mental

Table 3.3
Caregiver Identification of Mental Health Concerns, Rates of Formal Identification, and Rates of Service Delivery

	Identified by Caregiver as Having	Of those identified by the caregiver as having each specific condition		
		Diagnosed by a Doctor	Received NO Services for the Condition	Received Medication for the Condition
ADHD	36.9%	57.2%	19.0%	51.8%
Depression	24.2%	58.3%	20.4%	32.2%
Bipolar Disorder or extreme mood swings	29.7%	36.1%	31.1%	25.2%
Oppositional or Defiant	35.9%	34.3%	21.0%	---
Extreme Stress from Abuse/Neglect*	22.7%	50.4%	13.7%	---
Problems with Attachment**	23.5%	34.1%	30.9%	---
Eating Disorder	12.4%	20.4%	47.4%	---
Sexually Aggressive	10.5%	35.6%	42.9%	---
Alcohol or Substance Abuse	2.7%	59.8%	13.3%	---

* This may reflect presence of symptoms that map to diagnostic criteria for Acute Stress Disorder (symptoms enduring for less than one month), Post-traumatic Stress Disorder (symptoms enduring for a greater length of time), or Adjustment Disorder.

** This may reflect presence of symptoms that map to diagnostic criteria for Reactive Attachment Disorder of Infancy or Early Childhood health conditions that children were most likely to be receiving services for, along with alcohol or other substance abuse. Although eating disorders and sexual aggression are less frequently identified by caregivers, they also report that children are much less likely to receive services for these conditions. In both cases, over 40% of caregiver-identified children are not receiving services of any kind.

A second set of questions asked caregivers about services children were currently receiving (Table 3.4). These questions were asked of all caregivers regardless of whether or not a child was identified as having any of the conditions listed above. Clearly, counseling is the most common modality for service delivery, followed by services delivered in school settings and outpatient psychiatry.

Table 3.4 also indicates that, for the most part, caregivers are expressing a fairly high degree of satisfaction with the services they are receiving. The ratings of service helpfulness do not vary significantly from service to service with the exception of outpatient psychiatry, which is rated as more helpful than counseling or self esteem/anger management classes. The implications could be that children are being referred to the services most appropriate to meet their needs, that all services are equally helpful, or that caregivers are unwilling to express dissatisfaction with services.

Mental Health Conditions and Services: National Comparison

Table 3.5 provides a summary comparison of mental health indicators for children in placement in Illinois and children in placement nationally. Please note that, in some cases, the numbers reported in this section do not match those reported earlier in this chapter. The reason for this is that a subset of the IL-CWB sample was taken in order to match the NSCAW sample. Specifically, the NSCAW sampled children only to the age of 15, so only those children 15 and under in the IL-CWB sample were included in the comparison analysis (see section 1.4 for additional information).

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

Table 3.4
Caregiver Identification of Mental Health Service Receipt and Helpfulness

Service	Percentage of children receiving the service Point estimate (standard error) and 95% C.I.	Average helpfulness rating[16] Point estimate (standard error) and 95% C.I.
Counseling	42.9 (3.1) 37.0 – 49.0	2.0 (0.1) 1.8 – 2.2
Outpatient psychiatry	18.8 (2.3) 14.6 – 23.8	1.6 (0.2) 1.4 – 1.8
Inpatient psychiatry	1.9 (0.8) 0.8 – 4.2	2.3 (0.8) 0.7 – 3.9
Group therapy	14.2 (2.1) 10.6 – 18.8	1.9 (0.2) 1.6 – 2.2
In school therapy	20.7 (2.6) 16.2 – 26.2	1.8 (0.1) 1.6 – 2.1
Self esteem or anger management classes	9.0 (1.7) 6.2 – 13.0	2.2 (0.2) 1.8 – 2.6
Mentoring	12.8 (2.0) 9.4 – 17.2	1.6 (0.1) 1.3 – 1.8
Crisis intervention	4.7 (1.2) 2.8 – 7.8	1.5 (0.2) 1.0 – 2.0
SACY program/services	1.3 (0.7) 0.5 – 3.5	2.3 (0.6) 1.2 – 3.4
Therapeutic day program	4.2 (1.2) 2.4 – 7.3	1.5 (0.3) 1.0 – 2.1

[16] 1 = quite a bit, 2 = somewhat, 3 = just a little, 4 = not at all

Table 3.5
Mental Health Indicators and Services

Indicators	Estimated percentage within a 95% confidence interval			
	estimate	NSCAW	estimate	ILLINOIS
Trauma * (Clinical Range)	Ages 8-15 N=281		Ages 8-15 N=118	
Combined Clinical Sub-Clinical Range	7.5 13.2	3.8 – 14.4 8.6 – 19.7	5.8 12.5	2.9 – 11.1 8.1 – 18.9
Depression* (Clinical Range)	Ages 7-15 N=328		Ages 7-15 N=128	
	6.2	3.7 – 10.0	3.7	1.5 – 8.9
Youth Self Report of Behavior* (Clinical/Borderline)	Ages 11 – 15 N = 187		Ages 11 – 15 N = 74	
	17.3	10.7 - 26.7	34.6	24.9 – 45.8
Caregiver Reported Behavior (CBCL)** (Clinical/Borderline)	Ages 7-15 N=338		Ages 6-15 N=179	
	47.5	41.0 – 53.4	50.8	43.4 – 58.2
SERVICES*** (asked if child EVER received these services for emotional, behavioral, learning, attentional or substance abuse problems; ages of children noted in parentheses)	Estimated percentage within a 95% confidence interval			
	Ages 2-15 N=727		Ages 2-15 N=221	
Psychiatric hospital (2+)	9.0	5.5 – 14.4	10.5	7.3 – 14.7
A detox unit of inpatient drug or alcohol unit (10+)	1.5	0.4 – 4.7	0.0	none
A hospital medical inpatient unit (2+)	1.2	0.6 – 2.4	4.7	2.7 – 8.0
A residential treatment center or group home (2+)	11.3	7.2 – 17.2	5.5	3.3 – 9.0
Day treatment (6+)	12.2	6.8 – 20.6	5.3	2.4 – 11.6
An outpatient drug or alcohol clinic (10+)	1.9	.07 – 5.3	0.8	0.1 – 5.5
A mental health or community mental health center (2+)	15.5	10.9 – 21.6	5.2	3.1 – 8.8
Received in-home counseling or crisis services (2+)	17.9	13.3 - 23.7	16.5	12.5 – 21.6
Seen your family doctor or another medical doctor (2+)	17.9	13.8 – 22.9	9.7	6.6 – 14.2
Seen a school guidance counselor, school psychologist, or school social worker (6+)	36.3	29.9 – 43.3	35.9	29.1 – 43.4

* Standardized Scales from the Child Survey

** Standardized Scale (CBCL) from Caregiver Interview

*** Questions from Caregiver Interview

Patterns of mental health service usage for children in foster care in Illinois closely parallel those observed nationally in several regards. However, there were also several important differences observed (Figure 3.8):

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

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

Relationship Between Mental Health Conditions and Service Receipt

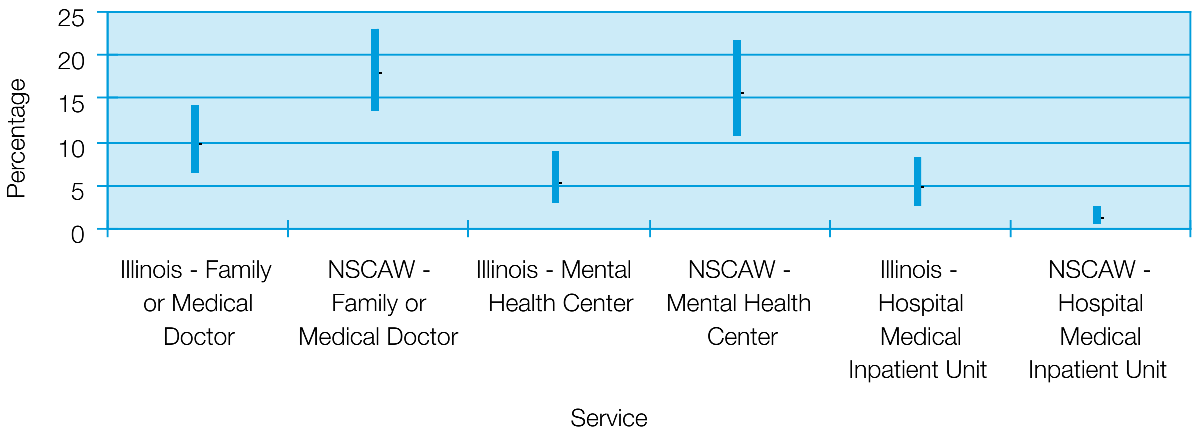
A special analysis was undertaken in order to determine, based on the data available, what percentage of children have a mental or behavioral health condition of any type, what percentage are receiving services, the correspondence between service need and service delivery, and factors associated with service delivery for children with identified needs. In order to evaluate the presence of any mental health condition, a variable was constructed based on the following criteria:

- Clinical/borderline or clinical/subclinical score on the Child Behavior Checklist, Youth Self Report, Children's Depression Inventory, or Post-traumatic Stress subscale

OR

- Caregiver's indication that the child has been diagnosed by a doctor as having ADHD, Depression, Bipolar Disorder, Conduct Disorder, or Oppositional Defiant Disorder

Figure 3.8: Comparison of Usage of Selected Mental Health Services between Illinois and the Nation



Based on these criteria, 47.3% (std. err. 2.8, 95% C.I. 41.8 – 52.9) of children have been identified as having some type of mental or behavioral health need. In order to evaluate service delivery for these children, the data were constrained to only those cases for which caregiver responses were present. The reason for this is that all information about service delivery used for this analysis is based on the caregiver interview – hence, if a child indicated that he or she was experiencing symptoms of some type, but the caregiver data were not present for that child, including that child's information would result in the appearance that the child was not receiving services, whereas in fact the service delivery status is unknown. Of children for whom caregiver data are available, 50.1% (std. err.3.2, 95% C.I. 43.9 – 56.3) are identified as having a mental or behavioral health condition.

Service delivery was identified as current receipt of any of the following services based on responses of caregivers: inpatient psychiatric services, day treatment, outpatient psychiatric services, counseling or services from a mental health center, group therapy, in-school therapy, self-esteem or anger management classes, mentoring, crisis intervention, SACY programs or services, therapeutic day program, outpatient alcohol or substance abuse clinic services, or services from a family or medical doctor (for emotional, behavioral, attention, learning, or substance abuse problems). Results indicate that 50.0% (std. err. 3.0, 95% C.I. 44.2 – 55.8) of children are receiving some form of mental health service. The similarity of this figure to the figure representing mental health need is encouraging; however, the correspondence between identified need and identified service delivery is not exact, as is reflected in Table 3.6.

Table 3.6
Relationship Between Identified Mental Health Need and Service Delivery

	Caregiver Identified Service Delivery	
Identified Mental or Behavioral Health Need	No Percentage, Standard Error, 95% Confidence Interval	Yes Percentage, Standard Error, 95% Confidence Interval
No	77.0 (3.7) 69.0 – 83.4	23.0 (3.7) 16.6 – 31.1
Yes	23.1 (4.0) 16.2 – 31.9	77.0 (4.0) 68.1 – 83.8

The relationship between service need and service delivery is statistically significant ($\chi^2 = 76.8$, (1, 276) $p < .01$), indicating that children without identified mental health needs are less likely to receive services and children with identified mental health needs are more likely to receive services. To complete the analysis, a model was developed to identify factors associated with non-delivery of services to children who have identified mental health needs. The results indicated that child's gender, race, and living arrangement have no relationship with the likelihood of service delivery. However, both the child's age at entry and the child's length of time in care in years were found to have relationships with the likelihood of service delivery. These results are presented in Table 3.7.

The results indicate that, for every year older children are when they enter care, they are 1.18 times more likely to receive mental health services. Furthermore, for every additional year they spend in care, they are 1.45 times more likely to receive services. Notably, the relationship between living arrangement and service receipt, while not found to be statistically significant, neared significance (the relationship was significant at the $\alpha = .10$ level)). This

Table 3.7
Logistic Regression Predicting Mental or Behavioral Health Service Delivery Among Children with Identified Needs

Predictor	B	SE B	e^B
Sex (Female)	-.20	-.20	.82
Race			
Whitev	1.38	1.01	3.99
Other	.58	.65	1.79
African American	Ref	Ref	Ref
Age at entry	.16	.07	1.18*
Time in care	.37	.15	1.45*
Type of care			
Traditional foster care	.92	.48	2.51
Specialized foster care	.15	.89	4.49
Kinship care	Ref	Ref	Ref
χ^2	3.47**		
Df	8		

Note: eB = exponentiated B.

* $p < .05$

* *$p < .01$

finding, in combination with findings previously reported in the literature, suggests that children in kinship care may be slightly less likely to receive services than children in foster care or specialized foster care.

Summary and Conclusions

The mental health section of this chapter focused on behavior problems, depression and trauma, all of which compromise a child's current well-being and, if unaddressed, their future well-being as well. Children in foster care in Illinois and those nationally are remarkably similar in terms of both caregiver-reported and self-reported symptomatology indicative of potential mental health concerns. Overall, few children report either depression or trauma. Children are more likely to self-report behavioral problems than they are to report other forms of mental or behavioral health concerns, and children are, in all instances, less likely to report such concerns than caregivers.

While foster children in Illinois and the nation have similar rates of mental health symptoms, the data on mental health service delivery suggest that foster children in Illinois appear less likely than foster children nationally to receive mental health services from less restrictive settings (such as a community mental health center or family physician) and more likely to receive mental health services from more restrictive settings (such as a medical hospital inpatient unit).

CHAPTER 4
Children's Physical Health

Literature Review

Children enter the child welfare system with significantly more health and chronic medical problems than children in the general population (Schneiderman, Brooks, Facher & Amis, 2007). Some medical conditions that have been identified as being over-represented in this population include in-utero exposure to alcohol and drugs, congenital infection, shaken baby syndrome, failure to thrive, lead toxicity, and common chronic medical conditions (asthma, short stature, anemia, microcephaly, vision and hearing problems, dermatological problems, dental caries (cavities), and underimmunization) (Vig, Chinitz & Shuman, 2005). In a sample of children in foster care, 65-69% of the children in all groups had at least one medical problem (Horwitz, Owens & Simms, 2000).

Flaherty et al. (2006) looked at the effect of early childhood adverse experiences on child health and found that children who were exposed to at least one adverse factor – psychological maltreatment, physical abuse, sexual abuse, caregiver problem drinking, caregiver depression, caregiver treated violently, or criminal behavior in the household – were almost twice as likely to have overall poor health as children not exposed. It is important to note that two thirds of their sample experienced at least one adverse experience, and 37% of the children experienced two or more. Hansen, Mawjee, Barton, Metcalf and Joye (2004), in their cross sectional study comparing low income children (those in foster care and those not in care), found high rates of problems and risk factors in children in foster care: 16% were born prematurely; 24% had been hospitalized; 12% had chronic health problems; almost 19% were currently taking medication; 11% had short stature; 27% had dental caries; and about 37% had skin abnormalities. Compared to the children not in foster care, a significantly greater proportion of those in foster care have problems identified in the physical exam (61% vs. 31% of children not in care) and dental exam (37% vs. 11%). Additionally, children in foster care had significantly more referrals for all services compared to the children not in care. In a child welfare sample of children under 6 years old, Leslie, Gordon, Meneken, Premji, Michelmore and Ganger (2005) reported almost 87% of children with physical problems noted in their records, and the majority had one (32%) or two (30%) problems, with an additional 25% having three or more problems.

Medical assessments are often the first and most consistently performed assessments, due perhaps to the fact that many children enter the child welfare system as a result of physical abuse and neglect. However, even when children's health is assessed, there is evidence that only the most serious health conditions are treated, while routine care remains unutilized. Hansen and colleagues (2004) found high rates of delayed immunizations, dental caries, and uncorrected vision in their sample of foster children, suggesting that these children were not currently receiving adequate routine medical care. Studies have documented unmet healthcare needs in foster children, including 12% of children having no routine healthcare, 34% receiving no immunizations, and 32% continuing to have at least one unmet medical need (Vig, Chinitz & Shulman, 2005). However, Horwitz, Owens and Simms (2000) reported that children with recognized medical needs were almost four times more likely to receive recommended services than other children.

Interventions recommended to ameliorate continuing systemic failures to address globally the health care need of children in custody include quickly obtaining previous medical records at entry into care or soon thereafter and a comprehensive treatment approach with a "medical home" that remains the same regardless of child placement (Vig, Chinitz & Shulman, 2005).

Introduction to Results

The findings on health of Illinois foster children are based on data collected from interviews with caregivers and caseworkers, the youth survey, and a medical audit of children's case records conducted by project-trained nurses at DCFS. The following sections describe the demographic and system characteristics of children who have serious health conditions from the perspectives of caregivers, the children, and caseworkers; the types of health conditions with which children have been diagnosed, co-morbidity issues, and the receipt of health care services both for routine health maintenance and health problems. The last section of the chapter provides a comparison of health indicators for Illinois foster children and the national (NSCAW) sample of children in foster care.

Children Identified with Physical Health Problems

Caregiver Reports of Children's Physical Health

While caregivers are not always knowledgeable about a lifetime diagnostic history for the children in their care, they do see the children in their care every day and are responsible for seeing that those children receive medical care for routine, acute, and chronic health needs. Caregivers' responses to the following series of interview questions about children's current health status were used to construct a variable indicating whether the child had a serious or chronic health condition:

- Child's health rated as fair or poor
- Child has health problems that last a long time
- Child currently needs health care from a specialist
- Child currently needs special medical equipment

When caregivers responded positively to any of these questions, the variable representing serious or chronic health condition was coded "yes." Based on this definition, caregivers indicated that 64.3% of children have serious and/or chronic physical health conditions. Caregivers also rated their children's health on a scale from 1 (poor) to 5 (excellent). The majority of children were rated in "excellent" (33%) or "very good" (32%) health, 25% were described as having "good" health, 9% were in "fair" health, and only 1% were described as having "poor" health.

The demographic characteristics of children identified by caregivers as having serious health conditions are presented in Appendix Table D.5. The only child characteristics significantly associated with caregiver-identified health conditions were race and living arrangement (see Figures 4.1 and 4.2). These figures indicate that children in specialized foster care are more likely to be identified as having health conditions than children in kinship care (Figure 4.1), and White children are more likely to be identified by caregivers as having health conditions than African American children (Figure 4.2). In general, the likelihood of being identified with a health condition is greater in more intensive levels of care, but statistical significance of this relationship is not noted due to imprecision of the point estimate (for children in group or residential care) due to lower numbers of children in this type of care. Neither age at entry nor time in care were significantly related to caregiver identification of serious health conditions (Appendix Table D.6).

Figure 4.1: Identification of Physical Health Conditions by Placement Type

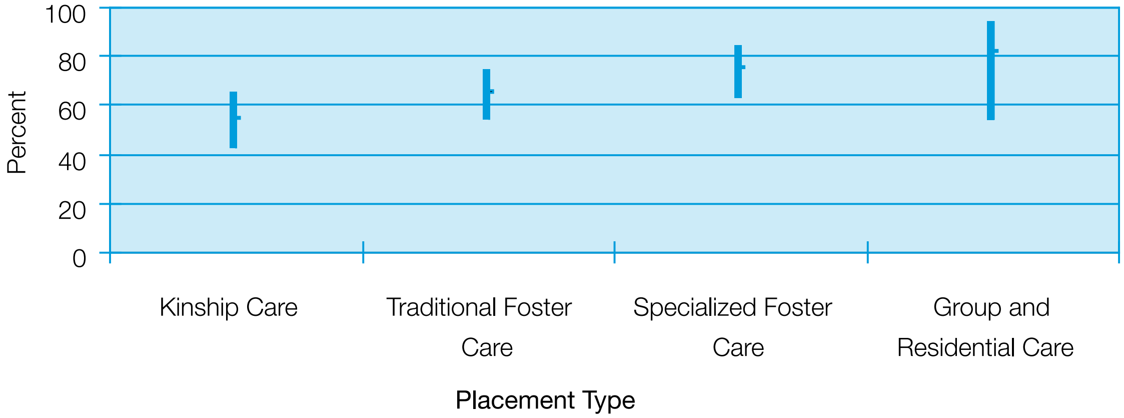
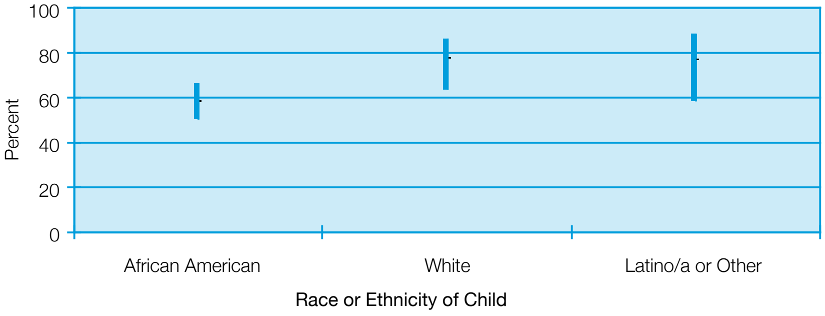


Figure 4.2: Identification of Physical Health Conditions by Race or Ethnicity of Child



Children's Reports of Their Physical Health

In the child interview, 158 children responded to the following two questions, for which a variable was constructed to indicate that the child had a serious and/or chronic health condition:

- Child indicated he/she has an illness, disability, or handicap
- Child indicated he/she has a recurring health problem

Based on this definition, 23.1% of the children interviewed indicated that they had a serious and/or chronic health problem. Appendix Table D.7 displays the association between demographic and placement characteristics of children and self-identified health conditions. Only child gender and living arrangement were significantly associated with self-identified health problems: females were more likely to identify themselves as having health conditions than males (Figure 4.3) and children in traditional foster care were less likely to identify themselves as having health conditions than children in group or residential care (Figure 4.4).

The association between age at entry and self-identification of a serious health condition was also significant; average age at entry for identified children was 8.7 years (0.6, 7.6 –

Figure 4.3: Self-identification of Physical Health Problems by Gender

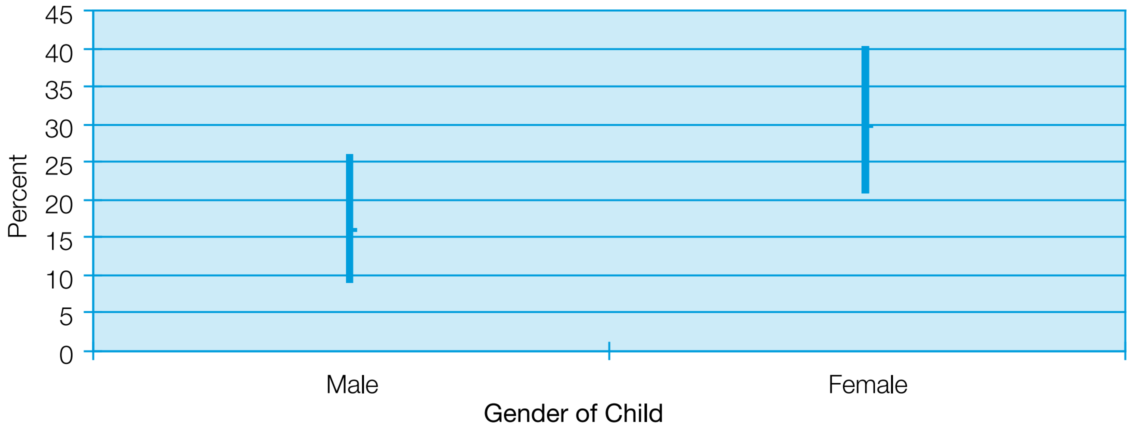
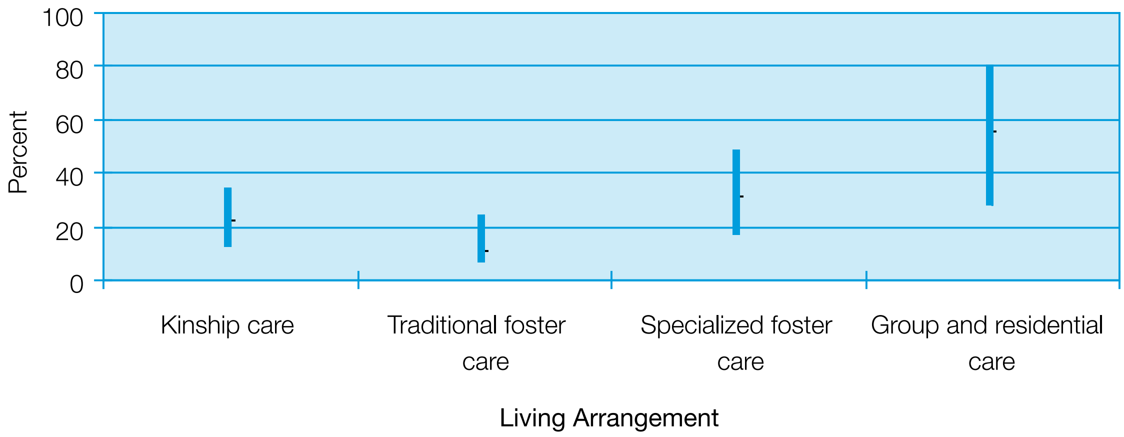


Figure 4.4: Self-identification of Physical Health Problems by Living Arrangement



9.9) compared to an average age at entry of 6.6 years (0.3, 6.0 – 7.2) for children who did not self-identify a serious health conditions. The relationship between time in care and likelihood of self-identifying a physical health condition was not statistically significant.

Caseworker Reports of Children's Physical Health

Caseworkers were asked very different questions about children's health than caregivers. If caseworkers answered yes to any of the health items, which are shown in Table 4.1, the child was coded as having a caseworker-identified health problem.[17] Overall, caseworkers reported that 22.9% of the children in the sample had physical health conditions.

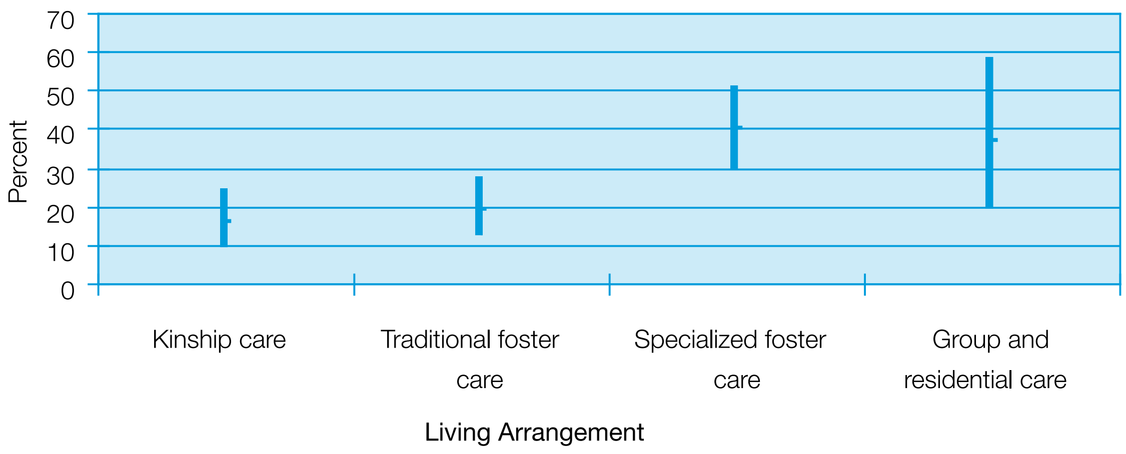
The likelihood of a caseworker identifying a physical health condition did not significantly vary according to child gender, race, age at entry or time in care (see Appendix Table D.8). However, caseworkers identified a significantly greater percentage of children in specialized foster care or group or residential care with physical health conditions than either children in kinship care or children in traditional foster care (Figure 4.5).

Table 4.1
Caseworker Ratings of Children's Health

Health condition	Point estimate (standard error) 95% Confidence Interval
Any health condition	22.9 (2.3) 18.7 – 27.8
Case worker indicates child needed services for health problem within last twelve months	20.4 (2.2) 16.4 – 25.2
Child is medically complex	2.2 (1.2) 0.7 – 6.5
Child has a hearing impairment or is deaf	1.1 (0.5) 0.4 – 2.6
Child has severe visual impairment or blindness	0.9 (0.5) 0.4 – 2.4
Child has traumatic brain injury	0.4 (0.3) 0.1 – 1.8
Child has severe cerebral palsy*	1.8 (0.8) 0.8 – 4.4
Child was too ill to participate in an interview*	3.2 (1.1) 1.6 – 6.4

* Of children 7 years and older

Figure 4.5: Caseworker Identification of Physical Health Conditions by Living Arrangement



---

[17] Caseworkers were also asked if children had orthopedic impairments; none of the caseworkers responded affirmatively to this question, so it is not included in Table 4.1.

Identification of Physical Health Conditions: Summary

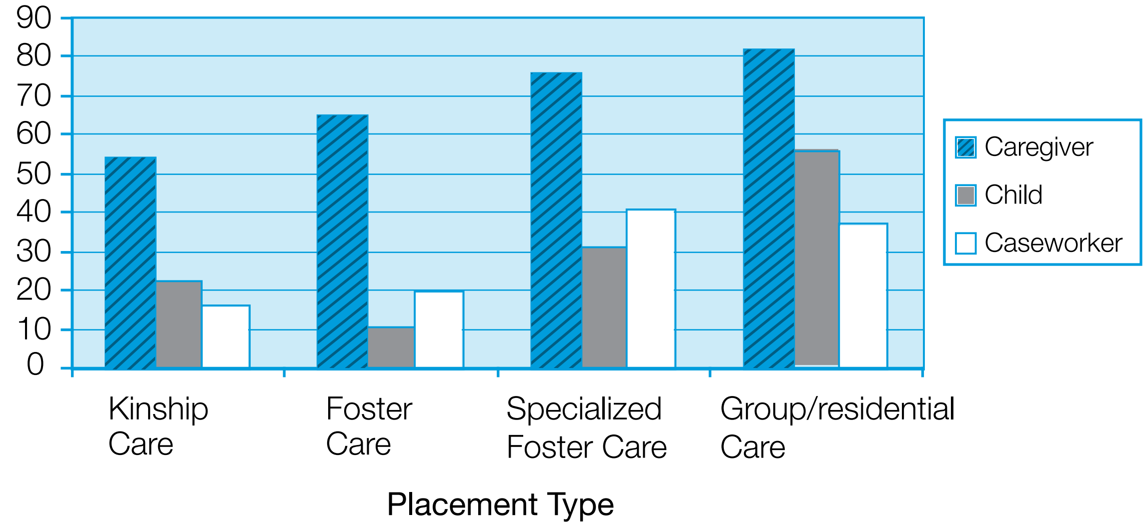
Figure 4.6 shows the relationship between physical health conditions, placement type, and reporter. Please note that the questions asked of caregivers, children, and caseworkers were different; the percentages of children with health concerns identified by each reporter are consequently not strictly comparable. However, given that each reporter will view health conditions through a slightly different lens, it is still possible to compare patterns of identification of health concerns among children in different types of placements. Figure 4.6 suggests that, as was the case with mental health (Chapter 3), significantly fewer children in traditional foster care identify themselves as having health conditions than children in kinship care, but a greater proportion of caregivers of children in traditional foster care identify the children in their care as having health conditions than caregivers of children in kinship care.

While the exact percentage of children identified as having health conditions varies by reporter as a result of differences in measurement, it is important to remember that a substantial proportion of children in out-of-home care do have serious or chronic health conditions and accordant health care needs. Serious and chronic health needs can place an extra burden upon caregivers to provide additional transportation to and from medical appointments, to administer medication and treatments in the home, and to monitor and report on the child's ongoing health condition to the agency. It is especially important to provide caregivers of children with health problems with adequate information on the child's needs, training on in-home procedures, support, and feedback.

Physical Health Diagnoses

The findings in this section are based on the DCFS nurse audit of children's case files (N = 359 completed cases). Medical health diagnoses made by an MD were abstracted from the record by the DCFS nurse and reported as ICD-09[18] diagnostic codes. According to the nurse audit data, 29.3% of children in DCFS foster care have non-acute physical health conditions documented in their case files.[19] This percentage is much lower than the 64.5% identified by caregivers because the nurse audits were restricted to reporting only medical conditions diagnosed by an MD and documented in children's case files.

Figure 4.6: Caseworker Identification of Physical Health Conditions by Placement Type



---

[18] International Classification of Diseases, Ninth Revision.

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

Table 4.2 shows the percentage of children in the sample diagnosed with specific categories of illnesses and conditions. The three most common health conditions are musculoskeletal system disorders (9.3%), disorders of the eye (9.0%), and respiratory disease (6.7%, predominantly asthma).

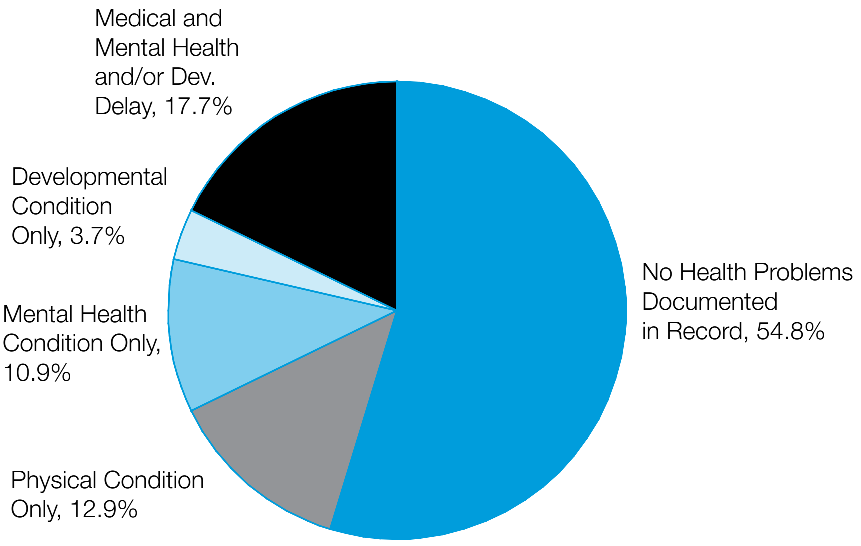
Table 4.2
Children with Physical Health Diagnoses

Diagnosis	%
Musculoskeletal system	9.3
Disorders of the eye	9.0
Respiratory disease	6.7
Congenital anomalies	5.6
Cerebral palsy and other paralytic syndromes	5.6
Diseases of the skin	4.3
Complications of pregnancy and childbirth	2.8
Diseases of the ear	2.6
Epilepsy and seizure disorders	1.8
Adverse effects of medical care	1.8
All other illnesses and conditions	1.7
Diseases of the blood	1.3
Infectious and parasitic diseases	1.2
Diseases of the circulatory system	1.0

Many of the children in the sample who were identified with diagnosed physical health conditions had more than one diagnosis: 37.7% had one diagnosis, 28.6% had two diagnoses, 15.3% had three diagnoses, and 18.4% had four to seven diagnoses.

Figure 4.7 shows co-morbidity among physical health, mental health, and developmental delay conditions based on information contained in case records only. Just over half of the children in the sample (54.8%) had no cognitive, physical, or emotional/behavioral conditions documented in their case file. Children who had a combination of cognitive, physical, and/or emotional conditions comprised 17.7% of the sample, 12.9% of children presented with solely physical health conditions, 10.9% had a mental health condition only, and 3.7% presented with solely developmental delay conditions.

Figure 4.7
Co-morbidity of Physical Health, Mental Health, and Developmental Delay



Health Services

This section presents information concerning the health services received by children. Data reflecting the perspectives of caregivers are presented in Table 4.3, which shows the percentage of children, as reported by caregivers, who needed specific health services and the percentage of those children who received the services. For children who did not receive the services, the reason are shown. The highest rates of physical health service delivery were for hearing problems (100%), vision problems (94.7%), dental problems (90.7%) and routine dental care (89.6%). The lowest rates of health service delivery occurred for special medical equipment (78.7%) and "other" medical services (63.2%). For those children who needed services but did not receive them, key barriers were Medicaid problems, referral issues, and waiting lists.

Caseworker perspectives on health care services delivery are presented in Table 4.4. Caseworkers indicated that most of the children who were identified as needing particular services received them. Contrary to expectations, caseworkers did not report that all children required routine examinations or immunizations, or that all children three and older needed routine dental care, hearing or vision screenings (only about half of children were identified as needing hearing or vision screenings).

Illinois and National Comparison

The measurement of physical health has proven somewhat more elusive than one might at first think that it would. The multitude of physical health diagnoses (see, for reference, the ICD-09) as well as the relative rarity of most of those diagnoses complicates matters when one considers the need to ask questions of respondents such as caseworkers, caregivers, and children in a way that is 1) easily understood and 2) brief. Moreover, the fact that some conditions are acute and some are chronic and that those that are chronic

Table 4.3
Caregiver Reports of Health Service Needs and Receipt

Health service needed	Percentages		
	Need the health service	Receiving the health service (of those who need it)	Reason not receiving needed health service
Needs medication	21.9 (2.7) 17.1 – 27.6	86.6 (4.8) 74.0 – 93.7	Referral problems Child refused to take
Needs care from a specialist	16.8 (2.2) 12.8 – 21.6	85.9 (4.7) 73.9 – 92.9	Medicaid problems Child on waiting list
Needs special medical equipment	9.8 (2.1) 6.3 – 14.8	78.7 (9.6) 54.6 – 91.9	Other reasons Appointment scheduling
Needs other medical services	8.2 (1.7) 5.4 – 12.1	63.2 (10.8) 40.8 – 81.1	Referral problems Child on waiting list No provider nearby
Has gone for a dental checkup in the past 12 months	(all children 3 and older are expected to need this service)	89.6 (3.2) 81.6 – 94.3	Medicaid payment problems Other
Has a dental problem requiring service	16.2 (2.3) 12.1 – 21.1	90.7 (4.5) 77.6 – 96.5	Medicaid payment problems
Ever had a vision test	(all children 3 and older are expected to need this service)	92.8 (2.6) 85.5 – 96.5	
Has a vision problem	10.5 (1.8) 7.5 – 14.6	94.7 (3.7) 81.0 – 98.7	Referral problems No provider nearby
Ever had a hearing test	(all children 3 and older are expected to need this service)	85.8 (3.7) 77.0 – 91.6	
Has a hearing problem	2.7 (0.9) 1.3 – 5.2	100.0	

may be continuous, sporadic, or periodic, that conditions range in severity, and that many existing conditions cause little or no discomfort or trouble to the sufferer clouds the issue of measurement of these conditions. These factors impacted the measurement of physical health in both the IL-CWB Study and the NSCAW. The result is that there are fewer overlapping, relevant measures in this domain available from both data sources than is the case for some other domains. This section reports findings concerning children's self-reports of physical injuries as well as some key indices from caregiver interviews.

Injuries

Children between 11 and 17 years of age in Illinois and between 11 and 15 nationally were asked about the types of injuries they had sustained in the past year and whether they saw a medical professional for those injuries. The children were not asked about the frequency of the different types of injuries, only whether they had sustained the injury at least once in the past year. They were also not asked about the severity of the injury or the cause of the injury. They were asked whether they had incurred such an injury and whether they had seen a doctor for it. Illinois figures and national figures based on NSCAW data are presented in Table 4.5.

Table 4.4
Caseworker Reports of Health Service Needs and Receipt

	Needed service	Caseworker made a referral (as a percentage of all children)	No referral because child was already receiving services (as a percentage of children needing service but not referred)	Child received the service after the referral (as a percentage of children needing service and referred for service)
Routine check-up or immunizations	92.8 (1.3) 89.7 – 95.0	78.5 (2.2) 73.8 – 82.6	85.8 (4.6) 74.3 – 92.6	96.2 (1.0) 93.7 – 97.8
Services for a health problem	20.4 (2.2) 16.4 – 25.2	9.8 (1.7) 6.9 – 13.7	45.3 (7.5) 31.4 – 60.0	94.6 (3.1) 84.2 – 98.3
Routine or preventative dental care (children 3 and older)	90.4 (1.8) 86.2 – 93.4	64.9 (2.5) 59.8 – 69.7	76.7 (5.3) 66.6 – 87.2	90.8 (1.7) 86.8 – 93.7
Services for a dental problem	9.8 (1.4) 7.3 – 13.0	5.6 (1.2) 3.7 – 8.5	51.6 (10.2) 32.3 – 70.5	83.5 (7.7) 62.7 – 93.8
Hearing screening or services (children 3 and older)	44.8 (2.56) 39.8 – 49.9	36.8 (2.5) 32.0 – 41.8	76.9 (5.1) 65.5 – 85.4	86.6 (2.8) 80.0 – 91.2
Vision screening or services (children 3 and older)	57.0 (2.6) 51.8 – 62.0	44.0 (2.6) 39.1 – 49.1	79.9 (4.4) 69.8 – 87.2	89.4 (2.4) 83.8 – 93.3

Table 4.5
Injuries as Reported by Children in Illinois and Nationally

	NSCAW total (N = 177)		Illinois total (N = 78)	
	Point estimate	Confidence interval	Point estimate	Confidence interval
Total injuries	55.9 (6.7)	42.4 – 68.5	65.1 (5.1)	53.7 – 75.0
Cut or sprain	50.0 (6.8)	36.7 – 63.3	47.1 (5.8)	36.2 – 58.4
Burn or bite wound	23.6 (4.3)	16.1 – 33.3	28.5 (5.7)	19.5 – 39.6
Broken bone	9.3 (2.7)	5.1 – 16.2	9.7 (4.5)	4.9 – 18.5
Stabbing or gunshot wound	4.3 (1.9)	1.8 – 10.1	2.3 (3.4)	0.6 – 8.9

The Illinois data were constrained to include only children ages 11 to 15 for purposes of comparability. These data indicate that there are no significant differences between children in foster care in Illinois and children in foster care nationally with regard to self-reported injury data.

For Illinois data only, the prevalence of injuries and of receiving care for the injuries was examined in association with demographic and placement variables. These comparisons were not carried out with NSCAW data due to non-comparability of placement type designations. Specifically, Illinois designates some children as being placed in specialized foster care, and NSCAW collapses specialized foster care and traditional foster care together into one category.

Some variations in treatment of injuries by placement types were observed. Of those children who reported experiencing an injury in the past year, only 48% of children living with kin and 49% of children living with traditional foster parents reported seeing a nurse or doctor because of the injury. These rates of receipt of medical care for injuries for children in these care types are significantly lower ($\chi 2=10.65$ (3, 70), $p = .02$) than those for children living in specialized foster (75%) or group care (100%). No significant relationships existed between indicators of injury, receipt of care, race, gender, years in care, or age at entry.

Other Physical Health Indicators

Table 4.6 presents a comparison of results from the IL-CWB sample and the NSCAW sample on key physical health indicators from caregiver interviews. Most of the indicators show close similarities between Illinois foster children and foster children nationally. Results in Illinois showed some indication of possible difference from national numbers in only two areas:

Table 4.6
Indicators of Physical Health
(for children ages 1–15)

Condition, episode, intervention	NSCAW total N = 727 cases		Illinois total N = 250 cases	
	Point estimate	Confidence interval	Point estimate	Confidence interval
Child's health is fair or poor	6.9	4.6–10.2	8.0	4.8–13.0
Child has persistent health problem(s)	26.1	21.8–30.8	31.6	25.5–38.5
Child is NOT up-to-date with immunizations	1.8	0.67–4.7	0.0	---
In the past 12 months…				
Child has NOT been to a dentist for cleaning/checkup	19.9	15.2–25.7	18.5*	13.6 – 24.7
Child has been admitted into hospital overnight	12.4	10.1–15.1	7.5	4.6–12.2
Child admitted to hospital overnight 3 or more times (of those admitted)	12.5	6.1–23.8	12.1	1.7–51.4
Child spent 5 or more days in hospital for illness or injury (of those admitted)	51.6	34.6–68.2	48.6	24.9–72.9
Child has gone to ER or UC	31.0	26.3–36.1	23.6	18.1–30.0
Went to ER or UC 3 times or more	27.0	19.7–37.3	27.2	5.8–69.2
Child has had a serious injury, accident, or poisoning that needed the care of an MD or nurse	7.9	5.6–11.1	7.1	4.4–11.3

* Note that the finding reported here is in contrast with the finding reported in Table 4.3. The reason for the difference is that, for the sake of comparability with NSCAW data, children as young as one year old were included in the analysis for Table 4.6. In most cases, dental checkups are not warranted for children as young as one or even two years old. The finding reported in Table 4.3 represents dental services delivered to children three years of age and older.

- Admitted to a hospital overnight: A somewhat smaller proportion of Illinois foster children have been admitted to a hospital for an overnight stay (between 5% and 12% in Illinois and between 10% and 15% nationally).
- Child has gone to ER or UC: A somewhat smaller proportion of Illinois children (between 18% and 30%) have gone to an emergency room or urgent care facility than children in foster care nationally (between 26% and 36%).

Summary and Conclusions

Of children living in DCFS care, the exact percentage of children identified as having serious and/or chronic health conditions varies somewhat by reporter. Caregivers indicated that 64.3% of children in their care had health that was fair or poor, had health problems that lasted a long time, or needed specialized care or medical devices. Of children interviewed, 23.1% indicated that they had illnesses, disabilities, handicaps, or recurring health problems. A total of 22.9% of caseworkers indicated that either the child needed services for a health problem within the past twelve months or that the child had a specific health condition. Nurse audits revealed that 29.3% of children have non-acute medical diagnoses recorded in their case records. While the questions asked of different reporters were not the same and are therefore not strictly comparable, one must note that caregivers were over twice as likely to report health conditions as caseworkers or children. Regardless of informant, the data consistently indicate that greater numbers of children with serious and/or chronic physical health conditions experience more restrictive levels of care, and these relationships remain statistically significant regardless of which informant is considered.

Multiple considerations of health care services delivery indicate that there are few major problems with ensuring that children’s physical health needs are met. Both caregiver and caseworker perspectives were considered, and a variety of questions was asked of each informant. A total of 89.6% of children were identified by caregivers as having received routine dental care; caseworkers identified a similar percentage. These figures are an improvement from IL-CWB Round 1 report. Obtaining specialized medical equipment continues to be a challenge for some families, as only 78.7% of caregivers reported that they were able to obtain this equipment when it is needed; however, discussions with early childhood service providers suggest that this problem is pervasive for all publicly insured children.

CHAPTER 5
Home and Community Factors

Introduction

Chapters 3 and 4 have addressed the emotional, behavioral, and physical well-being of Illinois foster youth. Chapter 6 addresses well-being indicators in the social environment of the classroom and examines indices of educational well-being. Chapter 7 will attend to permanence and stability. Thus, this chapter on home and community factors is situated between biology and environment, which is exactly where it needs to be. The emotional, physical, and educational well-being of children does not develop in a vacuum. There is now ample proof in the research literature that a reciprocal interaction exists between human physiology and the physical, social, and familial environment it is embedded in (Bronfenbrenner & Morris, 2006; Ceci, 1996). Other levels of interaction occur outside the child/caregiver dyad, extending into multiple systems of developmental instructions: extended family, possibly a new foster family, peer groups, and the community at large. Therefore, a developmental perspective of a foster child living in the state of Illinois could not be completed without full examination of all systems involved. These systems can best be characterized by analyzing the parenting characteristics of the substitute caregiver, the substitute familial environment, aspects of familial and environmental safety, and the influence of peer groups and supportive adults in the community.

Literature Review

Parental Monitoring and Discipline

The amount and kinds of parental supervision and discipline experienced by foster youth have major implications for their well-being and involvement in risk-taking. Parental monitoring will be defined in this review as a set of correlated parenting behaviors by a primary caregiver involving awareness and tracking of a child's whereabouts and activities (Crosby et al., 2002; Dishion & McMahon, 1998). Discipline, broadly defined, is a caregiver's use of instruction to develop and control a child's behavior. General studies of parental monitoring and discipline consistently show that greater amounts and intensity of monitoring and discipline result in lower rates of child injury (Garling & Garling, 1993), substance use and risky sexual behavior (Borawski, Ievers-Landis, Lovegreen, & Trapl, 2003; DiClemente, Wingood, & Crosbey, 2001; Stanton & Galbraith, 2000), and educational underachievement (Kurdek, Fine, & Sinclair, 1995). The various types of parental monitoring have also been found to have different effects on different children. For instance, a study by Borawski and colleagues (2003) found that males were less likely to use alcohol and more likely to use a condom when parental monitoring was high where females were not.

There is a shortage of information describing child-rearing behaviors of foster parents in general (DeRobertis & Litrownik, 2004). However, one study, a report by Smith (1994), observed the maternal child-rearing practices and beliefs of foster mothers in up-state New York. The author found that foster children were better able to focus and concentrate when there was established routine for discipline in the home. In a comparative study of biological parents and foster parents who have been reported for maltreatment and subsequently lost their child to out-of-home placement, Linares, Montalto, Rosbruch, and Li. (2006) found no significant difference between the two groups in overall reporting of positive discipline, appropriate discipline, clear expectations, and harsh parenting techniques. Likewise, Singer, Doornenbal, and Okma (2004) examined the difference between child consent to parental authority during disciplinary conflict among a sample of children living in foster care and children living with birthparents in the Netherlands. The authors found no significant differences between children living with foster parents and children living with birthparents—each avoided arguments and could cope without anxiety at the same rate. Children living with foster parents, however, were more likely to distance themselves during disciplinary conflicts, while children living with birthparents intensified their involvement in these conflicts.

Although the above research points to no significant differences between the types of discipline and parental monitoring used by biological parents and substitute caregivers, the issue of use of harsh discipline and corporal punishment among different types of out-of-home caregivers is complex. Some studies have asserted that kinship caregivers are more likely to have attitudes favorable towards corporal punishment (Gebel, 1996; Litrownik, 2003), more likely to report using harsh discipline (DeRobertis & Litrownik, Newton, Mitchell, & Richardson, 2004), and more likely to endorse problematic parenting behaviors (Harden, Clyman, Kriebel, & Lyons, 2004). However, other studies either refute or amend their findings due to the discovery of additional mediating and moderating factors. For instance, in a qualitative study, Coakley, Cuddeback, Buehler, and Cox. (2007) found that kinship caregivers reported certain skills and parenting beliefs, such as positive and consistent parenting, as necessary for effective fostering. Berrick (1997), using a number of measures relating to the home environment, found no difference in the disciplinary practices of kinship and non-kinship caregivers. Harden et al. (2004) initially found that kinship caregivers endorsed more problematic parental attitudes, less warmth towards the child, greater rate of anger and conflict, and increased rates of strictness. However, when controlling for caregiver age in multivariate analyses, the relationship dissolved. It seemed that the poor parenting skills reported by kinship caregivers had more to do with their increasing age and ambivalence concerning reprising a parenting role long since completed than it did with biological-relatedness.

Exposure to Violence

Children who become involved with the child welfare system because of physical abuse have clearly been exposed to violence. However, even children who have not been physically abused by caregivers may have been exposed to violence as a witness or a victim in their homes or communities. Although the construct of "abuse and neglect" in child welfare has customarily been reported as direct violence (abuse) or an immediate disregard for a child's basic needs (neglect), simply witnessing a violent act in the immediate environment may have some of the same injurious effects on a child as "direct" abuse and neglect (Rossman, Hughes, & Rosenberg, 2000). Whether witnessed or experienced, violence has a negative impact on children's development. The violence a child may witness comes from several sources, but we will focus on two here: within the home and outside the home. In terms of witnessing inter-adult violence within the home, a review of literature by Lehmann (2000) found that children exposed to these episodes have a variety of debilitating sleep disorders, post-traumatic repetitive play, a host of emotional instabilities, and an overall feeling of a foreshortened future. A recent meta-analysis (Kitzmann, Gaylord, Holt, & Kenny, 2003) showed that children exposed to domestic violence exhibited significantly worse problems than children not exposed, and that witnessing domestic violence may be more harmful than witnessing other forms of destructive conflict. Furthermore, children exposed to domestic violence were not found to be significantly different than physically abused children or those who were physically abused and exposed to violence when assessing psychological, emotional, social, and educational outcomes.

Due in part to the myriad detrimental effects witnessing violence has on children's development, it has been argued that children exposed to family violence should be seen as legally neglected due to a parent's failure to provide the child with a safe environment. Some states have adopted laws redefining neglect to include domestic violence in the presence of a child (Kantor & Little, 2003). However, this remains controversial for two reasons: clear boundaries cannot be legally defined as to what constitutes domestic violence, and victims of domestic violence are seen as being punished further by the possible removal of their children from the violent home. Policy makers are apprehensive about broadening neglect to include domestic violence as mothers may become fearful of authorities removing their children if they disclose spousal assault. Accordingly, Devoe and Smith (2003) found that a portion of battered women in their sample were less likely to seek help from Child Protective Service (CPS) out of fear of their children's removal.

Anywhere between 29% (Hazen, Connely, Kelleher, Landsverk, & Barth, 2004) and 64% (Beeman, Hagemeister, & Edelson, 2000) of caregivers reported to CPS because of allegations of abuse and neglect also reported being victims of spousal abuse. In 40% of cases investigated by CPS, domestic violence was identified as a risk factor to the child (English, Edelson, & Herrick, 2005), mirroring an earlier finding of 40% co-occurrence in Appen and Holden's (1998) sample. Using case files from a community-based child welfare agency in Washington State, Folsom, Christensen, Avery and Moorse (2003) found that, of the mothers involved in a CPS investigation, 49% reported experiencing domestic violence, compared to only 36% of mothers not currently involved with CPS. An investigation by Beeman et al. (2001), comparing a sample of dual domestic violence and child maltreatment reports with a control group indicating only a child maltreatment report found that CPS investigators identified dually reported families as being at greater risk for future reports. Furthermore, the study found that CPS investigators were more likely to open cases for services for dually reported families. Likewise, among all families with moderate to high risk assessments, those with an indication of domestic violence were significantly more likely to have at least one child placed in out-of-home care (English et al., 2005).

Other studies have found significant effects of exposure to community violence (outside the home) on the probability of traumatic symptomatology in young children. Raviv et al. (2001) compared children in second and fourth grades in two neighborhoods (low violence and high violence). The authors reported that both younger children and children in low-violence neighborhoods experienced less everyday violence than older children and children in high-violence neighborhoods. While this, in itself, is not surprising, the authors noted that children exposed to violence—even mild violence—reported more distress symptoms and were more likely to be rated by their mothers as having behavior problems. For this population, reports of severe violence were rare, but mild violence was frequently reported. One study (Stein, Jaycox, Kataoka, Rhodes, & Vestal, 2001) that focused solely on the rate of exposure to community violence experienced by children in foster care found that school-age children reported high levels of exposure to violence at home and in their schools. Eighty-five percent of these foster children reported being a witness and 51% a victim of violence in their lifetime. The authors noted three important points. First, being a victim of violence was significantly associated with high levels of trauma symptoms, while being a witness to violence was not. Second, 93% of children reported exposure to mild violence, and exposure to mild violence was strongly associated with developing distress symptoms. And third, violence exposure continued to be a common experience for children in child welfare even when they were in foster care.

Social Capital

Social capital is defined as "the connection among individuals - social networks and the norms of reciprocity and trustworthiness that arise from them" (Putnam, 2000, pg. 19). Social capital is not a new construct in the field of sociology. It has its roots as far back as Emile Durkheim's assertion that when interdependent people are connected sufficiently, the breakdown of societal norms cannot occur (Durkheim, 1947). To possess social capital, a child must be related to others. It is those others, not the child, who are the sources of advantage in the form of economic, cultural, and community opportunities. Social capital can be found when children have an ample and well connected network of peers and adults. Authors of one of the first longitudinal studies of the effect of social capital on child development (Furstenberg & Hughes, 1995) found that most measures of social capital were related to indications of socioeconomic success and proper development in early adulthood. Results of another study indicated that at-risk youth who have experienced family instability as children but became well-adjusted adults were more likely to have an important adult in their lives (Werner & Smith, 1982).

Social capital is not only seen as positive to academics and practitioners; youth also recognize it as having both current benefits and potential future benefit. Although this construct has never been examined among foster children, youth in the general population report that participation in organizations, such as after school programs, is valuable because it leads to activities such as learning about jobs, working with others, and being involved in community services (Quinn, 1995). Building the social capital of other social networks, such as peer groups, also has positive effects on youth development. Greenberger, Chen and Beam (1998) found that negative peer reactions to adolescent misconduct moderates the relationship between family risk factors and adolescent risk-taking.

Studies focusing on foster youth and social capital have produced two consistent findings: one, a substantial proportion of foster youth have some sort of support network despite frequent displacement, and two, that the foster youth believe that network is supportive. Eighty-six percent of emancipated foster youth interviewed as part of the Title IV-E evaluation (Cook, 1994) reported having at least one person in their lives providing them with a close relationship. Well over half of the emancipated youth (60%) also reported a strong social network, which included people who could be relied upon to provide help, advice, and closeness. Similarly, Mallon (1998), who interviewed youth after their discharge from an independent living program in New York City, found that 96% of his sample reported having a close relationship with at least one person in their lives. Furthermore, the youth also reported that they had regular contact with their former supervisors at the independent living program, and that those staff members were very helpful after their discharge.

A more recent study by Farruggia, Greenberger, Chen and Heckhausen (2006), comparing a group of pre-emancipated foster youth and a matched sample of youth, found that foster youth were significantly more likely to report a very important non-parental adult in their life than the matched group. The foster youth also reported receiving greater support from their non-parental adult than the matched group, although the matched group reported significantly more support from biological parents. One of the latest studies by the Children and Family Research Center (Ryan, Testa, & Zhia, in press) tested aspects of social control theory focusing on the both level of attachment with foster care providers and aspects of social capital. The study found that children reporting both a more positive relationship with their foster care provider and some involvement with a religious organization decreased their likelihood of delinquency. The authors emphasize the need for child welfare professionals to facilitate and maintain attachment between foster youth and foster parents, to facilitate and maintain youth involvement with important social institutions (such as schools), and to secure a stable home for all foster youth.

Introduction to Results

A number of measures were utilized to examine foster children's social experiences and behavior and their connectedness to the adults and peers in their lives. The results of the analyses are presented in several sections. The first describes caregiver monitoring of and limitations on children's whereabouts. This is followed by an examination of the disciplinary strategies used by caregivers of foster children. Next, children's exposure to violence (both witnessed and experienced) in the home and community are explored. Protective factors, in terms of availability of supportive adults, the importance of/connection to religiosity or spirituality, and relationships with peers and caregivers, are described next. The final section examines sexual behavior, pregnancy, and parenting. In each section, findings for Illinois are provided in total and by placement type, and each section is followed by a comparison between Illinois and national data.

Caregiver Monitoring

Illinois Sample

The Parental Monitoring Scale (Dishion, Patterson, Stoolmiller, & Skinner, 1991) is a short instrument measuring extent to which parents (in this case, caregivers) are aware of and place limits upon their children's whereabouts. In general, caregiver monitoring appears to be somewhat higher for children living in more restrictive settings (i.e., group or residential care). Although these differences are not statistically significant, there appears to be a trend of increased parental monitoring in more restrictive child settings, a trend that could become significant with greater statistical power (Table 5.1; see Appendix Table D.9 for item analyses).

Illinois/NSCAW Comparison

The Illinois/NSCAW comparison for caregiver monitoring is limited to children ages 10 to 15, as this is the age group for which both sets of data are available. Examination of Table 5.2 demonstrates that there are no differences between parental monitoring of children and youth in foster care in Illinois and parental monitoring of children and youth in foster care nationally. The average scores are remarkably similar between the two groups for each item and for summary scores.

Forms of Discipline in the Foster Home

Illinois Sample

The questions regarding discipline in the home are a very small subset of questions from the Conflict Tactics Scale (CTS; Straus, Hamby, Finkelhor, Moore, & Runyan, 1998), which were administered to children and youth ages 11 to 17.[23] When results are compared across placement types, the only difference found was that children in traditional foster care were more likely to have experienced “time out” as a disciplinary strategy at some point in the past 12 months than children in other placement types ($\chi2=18.7$ (3, 23), *p*=.03; see Appendix Table D.10). However, other child demographic characteristics interacted with different forms of discipline.

Table 5.1
Caregiver Monitoring Scale, Mean Scores[20] (as reported by the youth,[21] Illinois sample)

	All children	Kinship care	Traditional foster care	Specialized foster care	Group/ residential care
Mean for overall monitoring[23]	4.3 (0.1) (4.2-4.4)	4.2 (0.1) (4.0-4.5)	4.3 (0.1) (4.0-4.4)	4.4 (0.1) (4.2-4.7)	4.7 (0.1) (4.6-4.8)

[20] Mean estimates within a 95% confidence interval.

[21] All youth ages 7-17 in the IL-CWB study were administered this instrument

[22] On a 5-point Likert Scale with 1 = never and 5 = very often

Table 5.2
Caregiver Monitoring, Mean Scores: Comparison Between Illinois and National Samples (as reported by youth ages 10-15)

	Illinois	NSCAW
Mean for overall monitoring	3.7 (3.5–3.8)	3.6 (3.4–3.8)
Child does not leave the house without telling caregiver	1.6 (1.4–1.8)	1.8 (1.5–1.0)
Caregiver knows child’s whereabouts	4.5 (4.4–4.7)	4.2 (4.0–4.5)
Caregiver knows whom child is with	4.3 (4.1–4.5)	4.3 (4.1–4.5)
Caregiver gives child a curfew	4.4 (4.2–4.6)	4.1 (3.8–4.4)
Caregiver establishes a time for the child to return home	3.9 (3.6–4.2)	3.7 (3.2–4.1)

---

[23] The original scale included levels for 0, 1 time, 2 times, 3–5 times, 6–10 times, 11–20 times, and more than 20 times. The scale was recoded due to small numbers of responses in the lowest and highest categories. The resulting estimates remain imprecise because of relatively low numbers of available responses in each category; however, they are useful for demonstration of any major differences in disciplinary approach across placement type.

For example, a significantly greater percentage of White children reported being disciplined with a “time out” in the last 12 months compared to African American children ($\chi2$=20.6 (1, 22), *p* <.01). Likewise, a significantly greater percentage of White children reported being “grounded” compared to African American children ($\chi2$=11.8 (1, 23), *p* = .01). Differences can also be found with regards to gender. For instance, a greater percentage of females reported an adult explained why something was wrong in the last 12 months compared to males ($\chi2$=9.1 (1, 33), *p* = .03), although they also reported being “yelled at” within this time frame at a higher rate compared to male wards ($\chi2$=10.4 (1, 28), *p* = .01). It would seem that females are being engaged verbally at greater rates than males, although possibly with harsh and aggressive tones (see Appendix Table D.10).

Illinois/NSCAW Comparison

Table 5.3 provides data comparing child reports of disciplinary strategies used by caregivers between children in foster care in Illinois and those in foster care nationally. This analysis is limited to the set of children for whom data are available for both samples; thus, only the responses of children ages 11 to 15 are presented. Given the fact that this approach constrains the number of responses available for analysis, only two categories (experienced or did not experience) were calculated. The results suggest that children in Illinois are slightly more likley to report that adults explained why something was wrong, equally as likely to report having been put in “time out,” slightly more likely to report that they were yelled at, and significantly more likely to report having been grounded.

Violence Exposure

Illinois Sample

The Violence Exposure Scale, Revised (VEX-R; Fox & Leavitt, 1995) measures a number of constructs, including whether a child has witnessed violence, whether a child has personally experienced violence, and the severity of the violence to which children are exposed. The instrument can be used to create scores indicating whether a child has been exposed to mild/severe violence at all (yes or no), the number of types of violence a child has been exposed to, and the overall frequency of that exposure (which can be totaled separately for the mild and severe scales). Each item is scored on a scale of 1 to 4, with 1 being “never” and 4 being “lots of times.” Results for each item are reported individually, as they are not duplicative and are all of interest. In addition, a mean score is created for each scale (witnessed/experienced and mild/severe).

This instrument was administered to all children and youth in the study. However, the protocol for administering the questions to children under the age of 11 was different than that for administering the questions to children 11 and older. For the younger children, cards with pictures of a child named “Chris” (male for boys, female for girls) were used. The interviewer held the cards for the children participating in the interview. The children listened to questions on headphones, and then they pointed to their answers on the cards. The answers were in the form of thermometers, with 1 being an empty thermometer and 4 being a full thermometer. The interviewer entered the answers into the computer. Older children listened to the questions with headphones and saw them on the computer screen, then

Table 5.3
Forms of Discipline by Placement Type: Comparison Between Illinois and National Samples

In the past 12 months	Illinois	NSCAW
Adult explained why something was wrong	73.1 (63.7–80.8)	67.5 (56.2–77.0)
Child was put in a “time out”	54.7 (45.1–64.0)	67.7 (55.5–77.8)
Adult yelled at child	64.4 (54.8–72.9)	53.2 (39.8–66.1)
Child was grounded	75.6 (66.4–82.9)	61.2 (49.5–71.7)

entered their own answers using the touch screen. The interviewer emphasized that the events being asked about were things that Chris really saw or that really happened to Chris, not things that Chris saw on television or in a movie.

Figures 5.1 and 5.2 describe the mean frequency of witnessing mild violence (such as an adult yelling at a person, an adult pushing a person, or an adult slapping a person) or severe violence (such as an adult dealing drugs, beating a person up, or stabbing a person). Figure 5.1 showed no significant difference in mean frequencies by placement type, although the higher score reported by children in group care approached significance at the .05 level. All children in Illinois reported a mean score slightly below witnessing a mildly violent act once in a while (1.8). In Figure 5.2, children in group placements reported a significantly higher frequency of witnessing severe violence than children in all other placements (2.0 vs. 1.3). This is cause for much concern due to the implications regarding trauma and its effects on child development. Table 5.4 summarizes the responses of children and youth concerning violence they have witnessed, both mild and severe, by item. Overall, 84% of children witnessed at least one mildly violent act. However, children in group or residential care were 2 to 17 times more likely than children in any other type of care setting to report that they had witnessed severe violence in all its forms:

- 85.8% have seen an adult steal from a person
- 76.1% have seen an adult get arrested
- 40.1% have seen an adult deal drugs
- 38.6% have seen a adult point a weapon at a person
- 32.9% have seen an adult stab a person
- 7.3% have seen an adult shoot a person with a gun

Figures 5.3 and 5.4 describe the mean frequency of experiencing mild violence (such as being yelled at by an adult or being slapped by an adult) or severe violence (such as being beat up by an adult or having a gun or knife pointed in their direction). As with Figure 5.1, there were no significant differences in frequency of experienced mild violence. Children, overall, reported a slightly reduced frequency of experienced mild violence as compared to witnessed mild violence (1.6 vs. 1.8). As reported in Table 5.5, nearly three fourths (73%) of all children in the study

Figure 5.1: Mean Frequency of Witnessed Mild Violence in Placement Type.

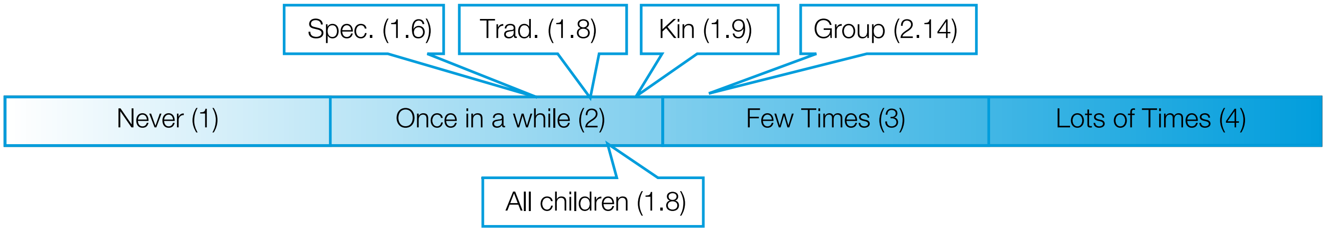


Figure 5.2: Mean frequency of Witnessed Severe Violence in Placement Type.

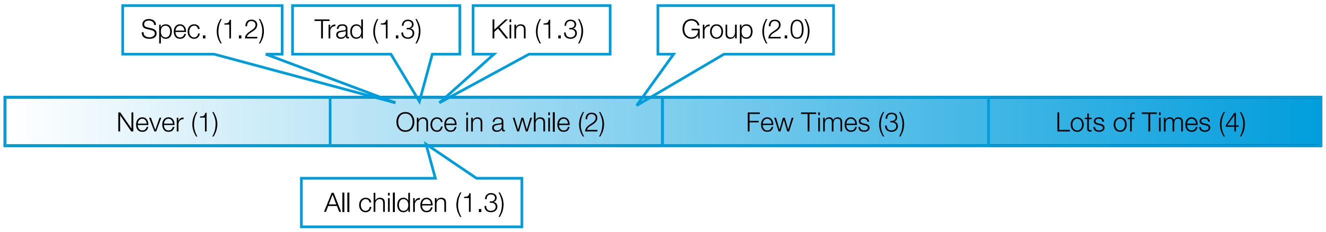


Table 5.4
Percentage[24] of Children Who Have Witnessed Violence in a Home They Have Lived In (Illinois sample)

	All children	Kinship foster care	Traditional foster care	Specialized foster care	Group/ residential care
Mild violence					
Adult yelled at a person	84.4 (0.1) (77.9-89.3)	82.4 (0.1) (70.1-90.4)	89.3 (0.1) (78.0-95.2)	76.7 (0.1) (59.5-88.1)	92.6 (0.1) (61.4-99.0)
Adult spanked a person	68.0 (0.1) (60.2-74.9)	70.5 (0.1) (57.3-80.9)	67.1 (0.1) (53.6-78.3)	68.9 (0.1) (51.1-82.5)	57.6 (0.1) (29.7-81.4)
Adult threw something at a person	29.3 (0.1) (22.6-37.0)	36.3 (0.1) (24.7-49.8)	29.2 (0.1) (18.6-42.6)	14.7 (0.1) (6.1-31.1)	38.7 (0.1) (16.4-67.0)
Adult pushed a person	32.5 (0.1) (25.6-40.3)	41.0 (0.1) (28.9-54.3)	26.2 (0.1) (16.3-39.3)	21.3 (0.1) (10.4-38.6)	55.7* (0.2) (28.0-80.2)
Adult slapped a person	27.5 (0.1) (21.0-35.1)	31.9 (0.1) (21.0-45.3)	28.2 (0.1) (17.9-41.5)	18.2 (.07) (8.3-35.4)	29.6 (0.1) (11.1-58.7)
Severe violence					
Adult beat up a person	19.1 (0.1) (13.7-26.1)	22.7 (0.1) (13.5-35.5)	15.9 (0.1) (8.4-28.1)	8.9 (0.1) (2.8-24.5)	47.6* (0.2) (22.3-74.3)
Saw adult steal from a person	39.4 (0.1) (.31.9-47.3)	38.9 (0.1) (27.0-52.3)	37.7 (0.1) (25.9-51.2)	27.1 (0.1) (14.6-44.7)	85.3* (0.1) (55.5-96.4)
Saw adult get arrested	37.1 (0.1) (29.8-45.0)	36.1 (0.1) (24.4-49.6)	30.1 (0.1) (19.4-43.4)	37.1 (0.1) (22.3-54.8)	76.1* (0.1) (45.7-92.3)
Saw adult deal drugs	18.0 (0.1) (12.6-24.9)	20.1 (0.1) (11.4-32.9)	14.6 (0.1) (7.4-26.8)	12.5 (0.1) (4.7-29.1)	40.1 (0.1) (17.2-68.3)
Adult pointed a weapon at a person	8.5 (0.1) (5.1-14.0)	8.6 (.0.1) (3.6-19.3)	1.9 (0.1) (0.3-12.5)	9.1 (0.1) (2.9-25.0)	38.6* (0.1) (16.4-66.9)
Adult stabbed a person	3.8 (0.1) (1.7-8.3)	--	1.9 (0.1) (0.3-12.8)	3.2 (0.1) (0.4-19.6)	32.9* (0.1) (12.6-62.5)
Adult shot a person with a gun	1.2 (0.1) (0.3-4.7)	--	1.8 (0.1) (0.3-11.9)	--	7.3 (0.1) (1.0-38.6)

* Significant at the *p* < .05 level.

[24] Point estimate within a 95% confidence interval.

Figure 5.3: Mean Frequency of Experienced Mild Violence in Placement Type

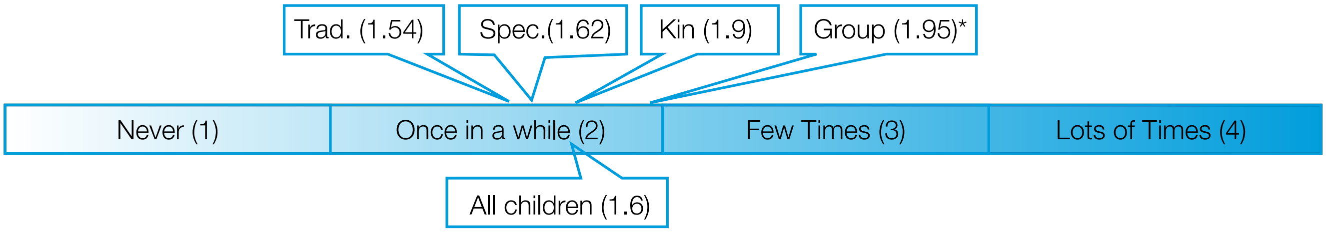
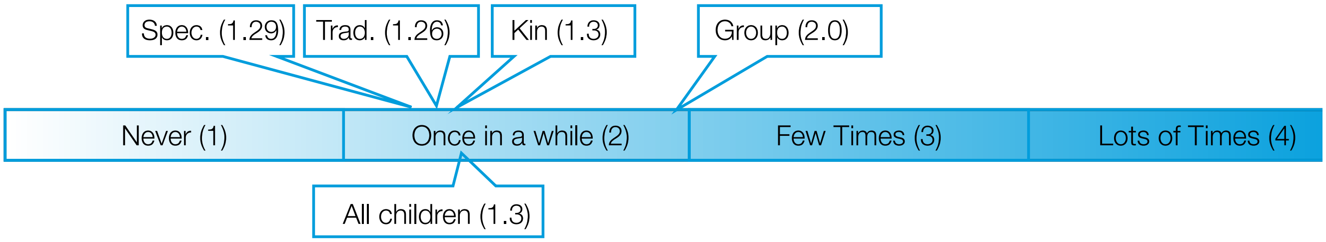


Figure 5.4: Mean Frequency of Experienced Severe Violence in Placement Type



reported having experienced violence. Children in group care reported significantly higher frequencies of having experienced both mild and severe violence than children in other types of care. The differences on an item-by-item level for the severe violence scale are profound. For instance, nearly half (46%) of children living in group and residential care reported having been beaten up by an adult while one fourth (26%) indicated that an adult has pointed a knife or a gun at them.

Children were further asked about whether these events had taken place in the homes in which they were living at the times of the interviews. Children very infrequently indicated that they had experienced violence in the homes in which they were currently living. For example, no children indicated that they had been slapped hard in the home in which they were currently living. Seven children indicated that they had something thrown at them, although when questioned later, five indicated that the events occurred in other placements. There were no variations by type of care in reporting of violence in the home in which the child currently lived—all of the noted differences relate to previous experiences being reported by children.

Illinois/NSCAW Comparison

Figure 5.5 indicates that children in foster care in Illinois profile similarly to children in foster care nationally with regard to having witnessed violence (95% confidence

Table 5.5
Percentage[26] of Children Who Have Experienced Violence in a Home They Have Lived In (Illinois sample)

	All children	Kinship foster care	Traditional foster care	Specialized foster care	Group/ residential care
Mild violence					
Yelled at by an adult	72.7 (0.1) (65.1-79.1)	75.7 (0.1) (62.7-85.2)	70.8 (0.1) (57.4-81.4)	73.7 (0.1) (56.3-85.9)	64.4 (0.1) (34.6-86.1)
Spanked by an adult	50.3 (0.1) (42.3-57.9)	51.8 (0.1) (38.8-64.5)	48.2 (0.1) (35.4-61.3)	55.2 (0.1) (38.1-71.2)	36.9 (0.1) (15.5-65.3)
Pushed by an adult	18.0 (0.1) (12.7-24.8)	16.4 (0.1) (8.7-28.9)	14.2 (0.1) (7.2-26.2)	11.9 (0.1) (4.5-28.0)	61.3* (0.2) (31.9-84.3)
Adult threw something at child	16.1 (0.1) (11.1-22.9)	20.5 (0.1) (11.7-33.4)	11.2 (0.1) (5.1-22.9)	15.0 (0.1) (6.3-31.6)	22.3 (0.1) (7.1-51.9)
Slapped "really hard" by an adult	22.2 (0.1) (16.3-29.5)	30.8 (0.1) (20.0-44.2)	14.7 (0.1) (7.5-26.9)	18.1 (0.1) (8.3-35.1)	29.4 (0.1) (11.0-58.5)
Severe violence					
Beat up by an adult	17.8 (0.1) (12.6-24.6)	19.8 (0.1) (11.2-32.5)	13.7 (0.1) (6.9-25.4)	11.8 (0.1) (4.5-27.9)	46.0* (0.1) (21.2-72.9)
Gun or knife was pointed at child by an adult	3.1 (0.1) (1.3-7.4)	1.9 (0.1) (0.3-12.3)	--	3.1 (0.1) (0.4-19.5)	23.7 (0.1) (7.6-54.1)

[26] Point estimate within a 95% confidence interval.

*p<.05

Figure 5.5: Mean Frequency of Witnessed Violence: Comparison between Illinois and Nation

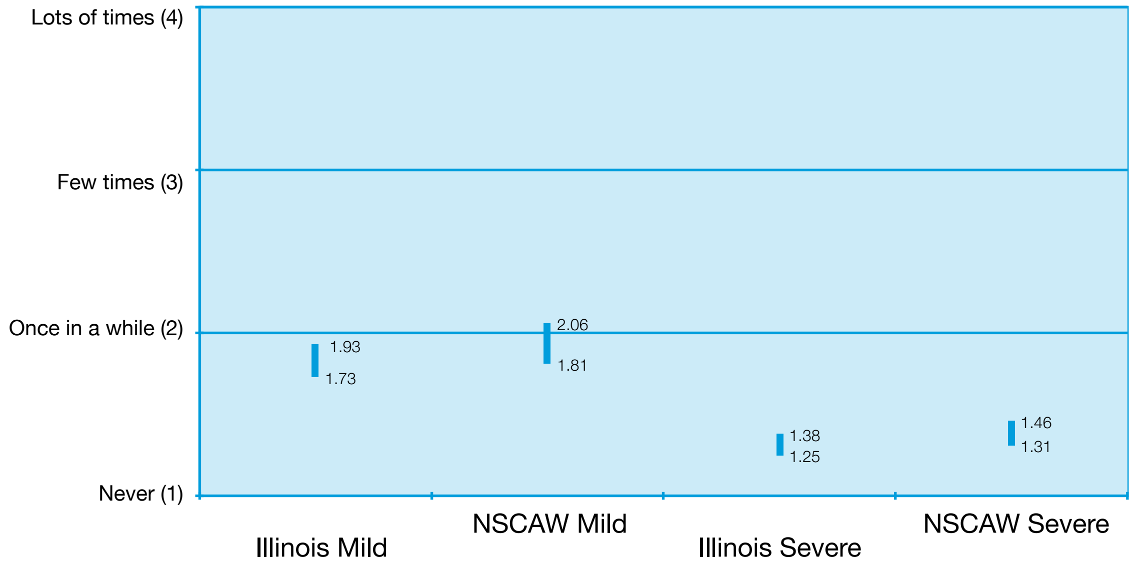
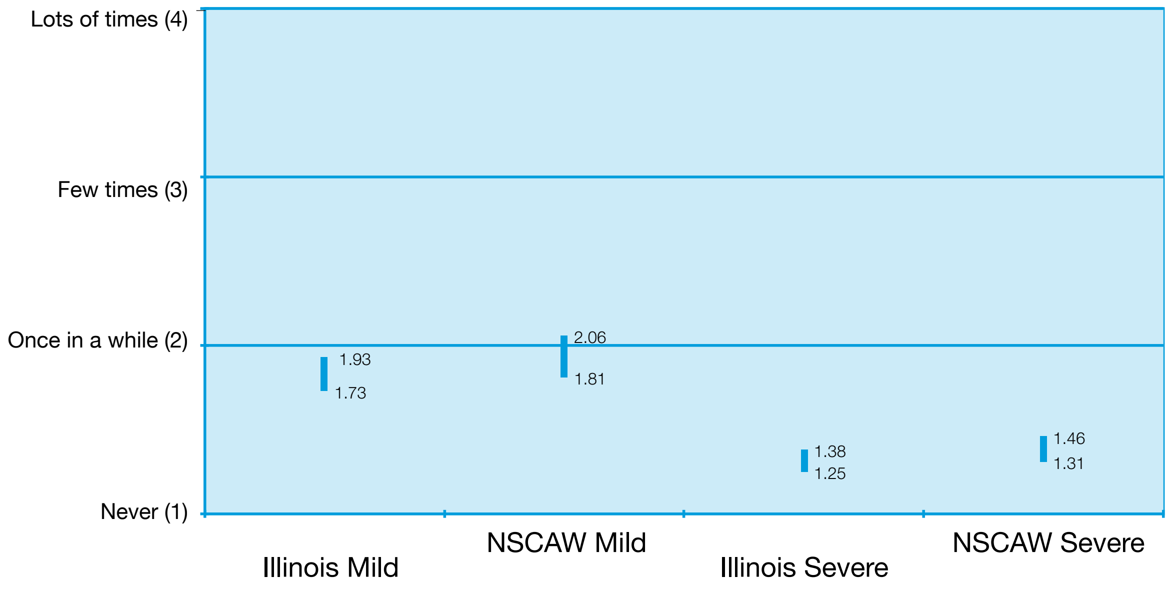


Figure 5.6: Mean Frequency of Experienced Violence: Comparison between Illinois and Nation



intervals are graphed). This is true with regard to presence or absence of witnessed exposure to each individual type of violence and to overall frequency of witnessed violence. No significant differences are noted between the two samples (see Appendix Table D.11). This analysis was limited to children in the 7- to 15-year-old age group; the questions in Illinois were administered to children ages 7 to 17, and nationally they were administered to children ages 5 to 15.

Figure 5.6 indicates that children in foster care in Illinois also profile similarly to children in foster care nationally with regard to having experienced violence. This is true with regard to the experience of each individual type of violence and to the overall frequency of experienced violence (see Appendix Table D.12).

Overall, while it should be noted that while witnessing or experiencing any form of violence can be detrimental to the child's physical, psychological ,and emotional well-being, the actual frequencies for witnessing these acts (as described in the Figure 5.5 and 5.6) are relatively low. Both nationally and in Illinois adolescent and early adolescent children in out-of-home placements reported these violent acts as occurring between never and once in a while.

Children's Strengths and Connectedness to Community

Three instruments were used to assess the children's strengths and their connectedness to their communities. Each of these instruments was also utilized for the first NSCAW cohort. The questions concerning protective factors (strengths) are based on the Resiliency Scale that was first used in the Longscan study (Runyan et al., 1998). In the IL-CWB study, these questions were administered for children ages 7 to 17, while only children ages 10 to 15 in the NSCAW received these questions. Examination of the responses for the full Illinois sample (see Appendix Table D.13 for item analyses) indicates that almost all of the children (94%) have an adult they can go to for help.

When the Illinois sample is constrained to children ages 10-15 so that comparisons can be made to the national sample, there are only minor statistically significant differences between the two groups (Table 5.6). Both groups report strong resources in terms of adult support, including parents or parental figures, relatives, and non-relatives. Both are likely to say that they have resources in terms of non-relative support, although this is less so in Illinois than nationally. However, these resources are not guaranteed to be helpful.

The Loneliness and Social Dissatisfaction Scale is used to measure peer relationships among children (Asher & Wheeler, 1985). For both the IL-CWB study and NSCAW, the questions were administered in two separate modules, one for children ages 5 to 7 (only age 7 in Illinois), and one for children ages 8 to 15. Results for the Illinois sample indicate that, although the differences were not significant, children in group/residential care reported higher levels of loneliness and social dissatisfaction than children in other

Table 5.6
Protective Factors: Comparison Between Illinois and National Samples

	Illinois	NSCAW
Child has an adult they can turn to for support		
There are adults I can go to for help	94.2 (87.5–97.4)	95.0 (87.9–98.0)
I can go to a parent or someone like a parent with a problem	94.1 (87.4–97.4)	91.1 (83.9–95.2)
I can go to another relative with a problem	83.7 (75.1–89.7)	81.5 (70.4–89.1)
I can go to a non-relative adult with a problem	71.6 (62.1–79.8)	94.3 (88.1–97.4)
This person has made a difference in my life	81.9 (73.2–88.3)	86.6 (76.0–92.9)
Scale score (sum of above items)	4.4 (4.2–4.5)	4.3 (4.0–4.6)
Religion/Spirituality		
Importance of religion/spirituality to me [24]	3.1 (3.0–3.3)	3.4 (3.2–2.6)
How many times I have gone to religious services within the past year [25]	3.3 (3.0–3.5)	3.0 (2.7–3.2)

[24] On a scale from 1 to 4 with 1 indicating "Not at all important" and 4 indicating "very important."

[25] 1= never, 2= rarely or occasionally, 3= once or twice a month 4= once a week or more

placement types (see Appendix Table D.12). Children in foster care in Illinois are very similar to children in foster care nationally with regard to self-reported loneliness and social dissatisfaction (Figure 5.7).

An additional scale was administered to assess the children's relationships with their caregivers. The Relationship with Caregivers Scale was originally developed as part of the Rochester Assessment Package for Schools (RAPS; Connell, 1990; Lynch & Cicchetti, 1991). This instrument contains 12 questions that can be used to produce four subscale scores. For this analysis, only the total score was calculated. In the IL-CWB study, these questions were administered for children ages 7 to 17, while the NSCAW administered the scale to children ages 10 to 15. Only scores for children ages 10 to 15 from both samples were used in the analyses reported here. Examination of Figure 5.8 reveals that children in foster care in Illinois bear an extremely strong resemblance to children in foster care nationally with regard to relatedness to caregivers.

Future Expectations

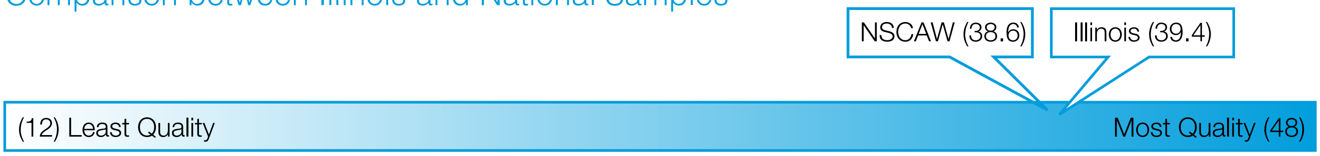
Children ages 9 to 17 were asked a series of questions about their future, the results of which are presented in Appendix Table D.15. The children answered each question on a likelihood scale that ranged from "no chance this will happen" to "it will happen." In general, all children seem to be optimistic about living to be 35, graduating from high school, and finding a good job by age 30. Although there were no statistically significant differences between types of placement, children in group/residential placements reported that there was "some chance" of having a child before age 18. These children were also less optimistic about living to be at least 35, graduating from high school, and finding a good job than all other children.

Attachment to Placement and Accessibility of Biological Family

Children between the ages of 7 and 17 reported on their current placement, friends, siblings, and availability of their biological parents. In Illinois, a small proportion of

Figure 5.7
Loneliness and Social Dissatisfaction with Peers: Comparison between Illinois and National Samples

Figure 5.8
Relationship with Caregiver:
Comparison between Illinois and National Samples



children in all placements reported that they disliked living with their current caregiver and had attempted to leave (see Appendix Table D.16). As shown in Table 5.7, a significantly smaller proportion of children living with kin reported having different friends because of the move than children in all other placement types ($\chi2=7.9$ (3, 39), $p < .05$). Furthermore, significantly fewer children living with kin reported that their current neighborhoods were worse than the neighborhoods they lived in previously ($\chi2=21.9$ (3, 4), $p < .01$). Although not significant, only 12% of children living with kin reported never having seen their biological mothers in the last year, compared with 40% of children living with traditional foster caregivers (Appendix Table D.16).

Sexual Experiences, Pregnancy, and Parenting

Sexual Experiences—Illinois Data

Several questions were asked of Illinois children ages 12 and older at the time of interview regarding their sexual experiences, pregnancy, and parenting. Questions addressed whether the youth had ever had sexual intercourse, age at first intercourse, whether first intercourse was forced or consensual, and pregnancy and parenting history. All questions were included in both the Illinois study and the national study. For the sake of brevity, only Illinois data are presented for several questions here, and a short comparison between Illinois and national data is presented at the end of this section.

Table 5.7
Attachment to Current Placement: Illinois sample (as reported by the youth ages 7 to 17)

	All children	Kinship foster care	Traditional foster care	Specialized foster care	Group/ residential care
Have different friends because of the move*	80.3 (0.1) (73.3-85.9)	68.7 (0.1) (55.5-79.5)	87.4 (0.1) (75.5-93.9)	88.5 (0.1) (72.7-95.7)	79.3* (0.1) (44.9-94.7)
The neighborhood of current home worse than the previous neighborhood*	15.9 (0.1) (10.5-23.4)	9.4 (0.1) (3.5-22.9)	17.2 (0.1) (8.7-31.2)	7.0 (0.1) (1.7-24.5)	56.6* (0.2) (28.7-80.9)

* $p < .05$

Table 5.8:
Age at which Youth First had Sexual Intercourse (Percent of all Youth in Each Age Category)

Age at first experience	Youth current age			
	12-13	14-15	16-17	All 12-17 youth
Have had sexual intercourse	17.1	52.3	76.6	49.8[27]
Under 8 years old	6.5	8.4	7.3	7.5
8 or 9 years old	0.0	2.7	6.9	3.2
10 or 11 years old	0.0	11.0	3.6	5.4
12 or 13 years old	10.6	8.1	12.8	10.3
14 or 15 years old	NAE[28]	22.1	31.9	NV[29]
16 years or older	NAE	NAE	14.2	NV

[27] Total percentage includes youth of all ages 12-17

[28] NAE – Not age eligible

[29] NV – Not valid to sum age-eligible and non-age-eligible children for these outcomes

In Illinois, 49.8% of youth ages 12 to 17 reported they had experienced sexual intercourse.[30] Almost exactly half of males who responded and half of females who responded indicated that they had experienced sexual intercourse; however, older children were much more likely to indicate that they had experienced sexual intercourse. Seventeen percent of children 12 to 13 years old responded positively to the question, whereas almost 76% of children 16 to 17 years old did so.

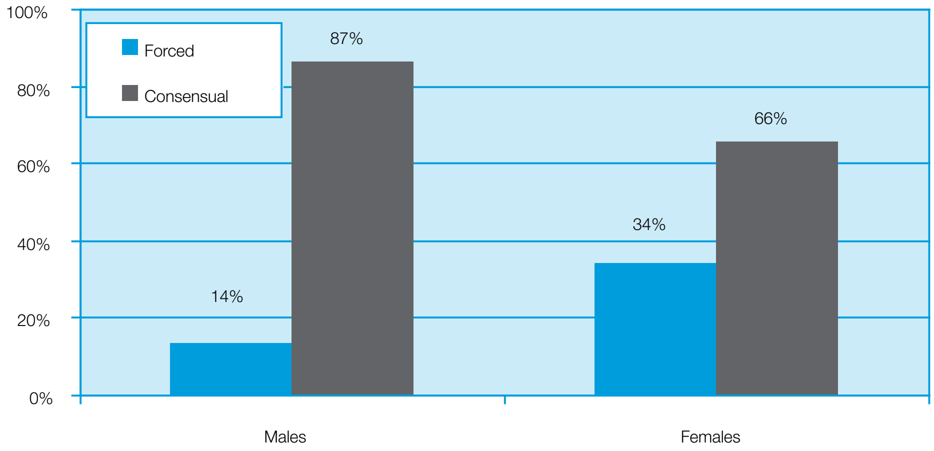
Youth were asked about the age at which they had first had sexual intercourse. These results are presented in Table 5.8. Confidence intervals are very wide given the low incidence of these responses and are not presented here – the numbers provide only a rough estimate of the extent of the situation. However, these results demonstrate that, in some cases, children are indicating that their first experiences of sexual intercourse were at very young ages.

Figure 5.9 shows the percentage of youth surveyed who indicated that they had experienced sexual intercourse, by gender and by whether the first sexual intercourse experience was forced or consensual. These data indicate that nearly a quarter of these youth perceive their first experience of sexual intercourse to have been non-consensual. This figure also demonstrates that, while females are more likely to indicate that their first experiences of sexual intercourse were non-consensual, 14% of males also indicate that this was the case for them. While the numbers presented are distressing in that they indicate the nature of victimization that a number of children have experienced at young ages, they likely constitute an under-report of the situation due to the probable reticence of some youth in divulging their experiences.

Pregnancy and Parenting—Illinois Data

The rates at which youth indicate that they have had sexual intercourse vary by age. Rates at which they indicate that they have been pregnant (for females) or that they have gotten someone pregnant (for males) also vary. For youth ages 12 to 15, 37% of females and 39% of males reported having had sexual intercourse. Of these, 9% of females report having been pregnant, and all report having had children. No males in this age group report having gotten someone pregnant. For youth ages 16 and 17, 71% of females and 89% of males reported having had sexual intercourse. Of these, 18% of females report having been pregnant, and all report having had children. Fourteen percent of males reported having gotten someone pregnant, and of these, all report

Figure 5.9
Status of First Sexual Intercourse Experience: Forced or Consensual



---

[30] 1.9% of the youth refused to answer this question.

having had children. Each youth who indicated that he or she had become a parent reported having only one child. The fact that every youth who reported having been pregnant or who reported having gotten someone pregnant also reported having a child suggests the need for some consideration. First, the probability is that not every youth who had become pregnant or had gotten someone pregnant reported the experience. Those young women who had become parents may have felt more obligated to report the experience given that it was likely to have been known by caregivers and caseworkers. However, these data do not indicate whether those young men and women who became parents did so by choice or due to a lack of resources to terminate unwanted pregnancies. This topic suggests a need for further research in this area.

Sexual Experiences—Illinois/ NSCAW Comparison

Questions regarding sexual experiences, pregnancy, and parenting were asked of children ages 12 to 17 in the IL-CWB sample and ages 11 and older in the NSCAW sample. At the point of data analysis, the maximum age of NSCAW respondents was 16 years; however, too few respondents had aged into the 16-year-old category to be included in the analysis. The analysis below was therefore limited to children ages 12 to 15 so that results would be comparable.

Illinois closely parallels the nation with regard to overall percentage of youth in care who indicate that they have had sexual intercourse. Overall, 38.0% of youth ages 12 to 15 in foster care in Illinois and 37.2% of youth in the same age range in foster care nationally indicate that they have had sexual intercourse. Somewhat fewer females nationally, however, reported having had sexual intercourse (25.2%), whereas somewhat more males reported having done so (48.9%). In Illinois, females (37.0%) and males (39.0%) report having had sexual intercourse at approximately equal rates.

Pregnancy and Parenting—Illinois/ NSCAW Comparison

Table 5.9 provides a comparison of rates of sexual intercourse, pregnancy (for females) or getting someone pregnant (for males), and parenthood. The table indicates that rates of self-reported pregnancy and parenthood among 12 to 15 year olds are higher nationally than in Illinois. The pregnancy rate among 12 to 15 year olds in the national sample (32% for females) is higher than that even among 16 to 17 year old youth in Illinois (18%). This pattern is true for

Table 5.9
Pregnancy and Parenting: Comparison of Illinois and National Data

	NSCAW (ages 12–15) N = 151	Illinois (ages 12–15) N = 63	Illinois (ages 16 & 17) N = 30
Males			
Have had sexual intercourse	48.1 (34.5–61.9)	39.0 (23.5–57.1)	89.3 (50.3–98.6)
Have gotten someone pregnant	19.6 (5.3–51.9)	-- --	13.5 (1.8–57.1)
Have had children	88.7 (49.3–98.5)	-- --	100 --
Females			
Have had sexual intercourse	25.2 (14.9–39.3)	37.3 (21.1–57.0)	71.0 (48.4–86.8)
Have been pregnant	31.7 (11.9–61.5)	8.6 (1.1–43.6)	18.0 (5.6–45.0)
Have had children	46.1 (18.1–76.8)	100 --	100 --

males as well: 20% of 12 to 15 year old males in the national sample reported having impregnated someone, compared to 14% of 16 to 17 year old males in the Illinois sample. About half of females who reported having become pregnant in the national sample, and almost 90% of the males who reported having impregnated someone, became parents. In Illinois, all youth who reported having become pregnant (or having impregnated someone) also reported having children. The confidence intervals presented are very wide, indicating that these figures are very rough estimates. The reason for the breadth of the confidence intervals is that the number of youth responding to each question was very small. Only children over the age of 12 were asked these questions, fewer than half indicated that they had experienced sexual intercourse, and fewer still indicated that they had been or gotten someone pregnant. Obtaining a bigger sample or repeating the survey would increase confidence in the reported findings.

Summary and Conclusions

Based on children's reports of the degree to which they are monitored, caregivers appear to be active in tracking and placing limitations upon children's whereabouts. Caregivers in Illinois closely parallel caregivers nationally with regard to the degree of monitoring they provide for children in their care. Children were also likely to report that their caregivers implemented a variety of disciplinary strategies. As a disciplinary strategy, "time out" was used less frequently than other strategies; however, given the age of children questioned, this finding could be expected. Caregivers in Illinois, based on children's reports, do not differ significantly from caregivers nationally in engaging in disciplinary strategies.

The children and youth interviewed were very likely to report that they had strong resources in terms of adults (a parent, other relatives, or non-relatives) they could go to with problems. There were only minor differences in adult support by placement type, and there were only minor differences between foster children in Illinois and those nationwide. Children and youth in Illinois generally reported fairly low levels of loneliness and social dissatisfaction (an overall mean of 28.7 on a scale from 16 to 80). Children reported high degrees of connectedness with their caregivers (an overall mean of 39.4 on a scale from 12 to 48), and there were no differences by placement type (these questions were not asked of children living in group care). There were no differences between children in foster care in Illinois and children in foster care nationally with regard to relationships with caregivers.

A noteworthy finding pertains to exposure to violence and the way in which history of exposure to violence varies across placement types. It is widely accepted that exposure to violence affects children's social and emotional development and that it may contribute to the emergence of maladaptive behaviors. The finding that children in more restrictive settings (who are often placed in those settings as a consequence of a need to master more adaptive behavioral responses and coping mechanisms) might have been exposed to greater violence is not, therefore, unexpected. However, the degree of difference between the self-reported exposure of children in group and residential care and that of children in other care settings is surprising. The fact that the differences are even greater for severe violence and that differences are present for both witnessed and experienced violence is an important finding and one that may have implications for how children are assessed upon intake. Several assumptions are implicit, one of which is that children who are eventually placed in group care are exposed to these types of violence in their homes of origin and that this exposure is one of the factors that affects their developmental trajectories. Given this assumption, however, specific attention to exposure to violence and type of exposure upon intake might allow assessors to identify children who are at risk for altered developmental trajectories and may be a marker for a need for early behavioral intervention. Such intervention might allow children to gain placement stability earlier, preventing later need for movement to more intensive settings. While recommendations are premature, this finding warrants additional exploration as a potential avenue by which to effect change.

Nearly a quarter of the Illinois children interviewed indicated that their first sexual intercourse experience was forced. While more females reported this outcome (34%), a significant proportion of males also did so (14%). It is possible that few of these children were placed in out-of-home care due to sexual abuse and that their experiences of early sexual victimization have never been addressed with them by competent helping professionals. For Illinois youth ages 16 and 17, 71% of females and 89% of males reported having had sexual intercourse. Of these, 18% of females report having been pregnant, and all report having had children. Fourteen percent of males reported getting someone pregnant, and of these, all report having children. These findings raise the issue of whether girls in foster care have access to pregnancy termination choices and resources.

CHAPTER 6
Education and School Engagement

Lee Shumow, Ph.D.
Angela Baron-Jeffrey. M.S.
Sharon Freagon, Ph.D.
Center for Child Welfare and Education
Northern Illinois University

Introduction

Education is central to the lives of children and adolescents in the United States. In fact, school is likely to be second only to the family as a context of importance to the development of young people. In essence, being a student is to children what being employed is to an adult – going to school takes up a considerable amount of waking hours, requires expenditure of much energy, and provides important information about one's present and future identity.

For those in foster care, education is especially important because they have experienced traumatic events and instability in their families. It is important, then, to determine how well children in DCFS custody are doing in school. Historically, policy and case workers within the child welfare system have not closely monitored this aspect of children's lives. Rather, the focus has been on the immediate and proximal need to protect children's bodily safety. Within the last decade, however, child advocates have called for more attention to the educational circumstances of children in state guardianship because the long term consequences of school adjustment are so important to the well-being of an individual.

Introduction to Results

Several indicators of educational well-being were collected from the student's educational records.[31] Those were ratings of academic performance from report cards, educational test scores, students' grade level placements relative to chronological age, and whether they were assigned to general education or special education programs. The goal of this data collection was to determine how well children in DCFS care were doing in school. Past studies, although limited in number, have documented serious school problems in this population of children culminating in the fact that far fewer children who have been in foster care graduate from school when compared to children who have not (Burley & Halpern, 2001; Smithgall, Gladden, Howard, George, & Courtney, 2004). The indicators of educational well-being examined here are important to educators and caregivers but perhaps most important because they provide students with feedback about themselves – how they fare and where they rank in the estimation of their teachers and compared to their peers. That feedback signals who they are in school and what they might expect of themselves and is associated, even for the youngest children, with their life course trajectory (Alexander, Entwisle, & Kabbani, 2001).

Selected characteristics of the children in the Round 2 education sample appear in Table 6.1. As can be seen in the table, most are African-American and between the ages of 6 and 13 years of age. Slightly more than half live in Cook County.

---

[31] Additional indicators of educational well-being were collected during the caregiver interviews. Caregiver perspectives on children's educational well-being are summarized in Appendix E.

Table 6.1
Population Estimates for Characteristics of the Children in the Education Sample

	Round 2* Population	Standard Error
Age at Time of Study	Mean = 11.6 years	0.1
6 – 13	59.0 %	3.0
14 and older	41.0 %	3.0
Race/Ethnicity		
African American	66.6 %	3.1
Hispanic	6.6 %	6.6
Non Hispanic White	22.8 %	4.1
Other	1.9 %	2.5
Grade at Time of Study		
First	6.6 %	1.6
Second	8.7 %	1.8
Third	8.7 %	1.7
Fourth	10.7 %	2.0
Fifth	10.1 %	1.9
Sixth	8.4 %	1.8
Seventh	8.1 %	1.7
Eighth	11.1 %	2.0
Ninth	12.6 %	2.1
Tenth	9.3 %	1.9
Eleventh	5.0 %	1.4
Twelfth	1.5 %	0.9
Gender		
Male	53. 7 %	3.2
Female	46.3 %	3.2
Region		
Cook County	60.6 %	3.2
Remainder of IL	39.4 %	3.2
Age at Case Opening	Mean = 6.9 years	0.2
0 – 5	42.2 %	
6 -13	55.3 %	
14 and older	2.5 %	
Years in Substitute Care	Mean = 4.7 years	0.1
Placement Type		
Kinship Care	37.0 %	2.0
Traditional Foster Care	41.0 %	2.1
Specialized Foster Care	16.9 %	1.4
Group or Residential Care	5.2 %	0.8

*Note: Round 2 data are weighted to reflect the stratified nature of the sample. The SPSS Complex Samples package was used to compute the percentages; that program provides population estimates.

Academic Performance from Report Cards

Report cards are a common method throughout the United States for informing parents and guardians about a child's school progress. Although policy makers have recently pushed for standardized testing as the central method of determining student progress, parents consider report card grades to be more informative about how their child is performing in school than standardized tests (Shepard & Bleim, 1995; Shumow, 1997). Thus, data on academic grades were collected from student report cards.

The format and grading system of each report card is selected by local school districts. As a result, some students receive letter grades on their report cards and others receive progress reports (e.g. excellent, good, satisfactory, needs improvement, unsatisfactory). For the purposes of this study, student who received C or better grades and those who received satisfactory or better marks are considered to have satisfactory performance whereas those who received lower grades or marks are considered to have unsatisfactory performance.

Reading report card marks

Table 6.2 displays estimates of percentages in the population of children in Illinois foster care who attain satisfactory and unsatisfactory marks in reading. As can be seen in the table, about two thirds have satisfactory marks in reading. Also shown in the table are the estimated percentages of children by age, school placement, gender, race, state, location and grade relative to age. Pearson's chi square test of proportions was used to test to see whether there were statistically significant differences in these estimates. Race was associated with reading performance in this population such that African American children were less likely to attain satisfactory reading marks than White children were. Being in a grade commensurate with their chronological age was related to reading marks such that students who were in the grade for their age had better reading marks than older students in their same grade. Student age, school program placement, gender and location in the state were not related to reading grades among this population.

Calculation of an odds ratio indicates how much more likely students in a given category are to have satisfactory marks in reading compared to students in the comparable category.

Table 6.2
Classroom Marks in Reading by Student Characteristics

	Unsatisfactory Reading Performance	Satisfactory Reading Performance	Significance Test χ^2
Full Sample	33.3 % (3.2)	66.7 % (3.2)	
Age			NS
Less than 14 yrs.	32.6 % (4.1)	67.4 % (4.1)	
14 years or older	34.3 % (5.0)	65.7 % (5.0)	
School Placement			NS
Special Education	33 % (4.8)	67 % (4.8)	
General Education	32.9 % (4.3)	67.1 % (4.3)	
Gender			NS
Male	38.2 % (4.5)	61.8 % (4.5)	
Female	27.7 % (4.4)	72.3 % (4.4)	
Race[32]			6.54**
African-American	38.6 % (4.0)	61.4 % (4.0)	
White	18.8 % (5.4)	81.2 % (5.4)	
Location in State			NS
Cook County	32.9 % (4.1)	67.1 % (4.1)	
Remainder of IL	34.9 % (5.1)	65.1 % (5.1)	
Grade Relative to Age			5.09*
Overage in Grade	43.2 % (5.7)	56.8% (5.7)	
At Age for Grade	28.1 % (3.8)	71.9 % (3.8)	

[32] Hispanic and other ethnic groups not included due to sample size.

Note: Standard errors for the estimates are shown in parentheses

**p* <.05, ***p*<.01

The odds ratio of 2.7 associated with race indicates that White students are 2.7 times more likely to attain satisfactory marks in reading than African American students. The inverse of the odds ratio of 0.5 shows that those at age for grade were about twice as likely as older classmates to attain satisfactory grades in reading.

Mathematics report card marks

Similar to the results for reading, nearly two-thirds of the students are attaining satisfactory marks in mathematics class. The only characteristic associated with mathematics marks was being overage in grade (Table 6.3). The odds ratio indicated that students who were at the grade level corresponding to their age were approximately three times more likely than their older classmates to have satisfactory marks in mathematics.

Grade Relative to Chronological Age

The educational well-being study determined whether the children were at the grade level commensurate with their age because being retained in school is one of the most powerful predictors of which students will leave (drop out of) school (Jimerson, Anderson, & Whipple, 2002). Retention communicates a strong message that a child is not competent and undermines a sense of camaraderie/fitting in with peers. Findings from a large longitudinal study (Alexander, Entwisle, & Kabbani, 2001) revealed that students retained in first grade were three times more likely to drop out of school than those students who had not been retained; young adolescents who were retained in middle school were dramatically more likely to drop out of high school than those who were not (odds ratio of 23).

Because students enter school based on their chronological age, being overage in grade is a strong indicator that they have been retained and is often used as a proxy variable for retention. The data indicate that two thirds (66.2%, s.e. = 3.0) of the students were attending a grade that corresponded to their age. Conversely, approximately 1/3 (33.8 %, s.e. = 3.0) were overage for their grade. Almost all (89 %) of those students are one year overage in grade with relatively few (11 %) two years overage in grade.

As can be seen in Table 6.4, being overage in grade was associated with age of child such that students who are

Table 6.3
Classroom Marks in Math by Student Characteristics

	Unsatisfactory Math Performance	Satisfactory Math Performance	Significance Test χ^2
Full Sample	35.3 % (3.2)	64.7 % (3.2)	
Age			NS
Less than 14 yrs.	32.9 % (4.2)	67.1 % (4.2)	
14 years or older	38.8 % (5.2)	61.2 % (5.2)	
School Placement			NS
Special Education	35.7 % (4.9)	64.3 % (4.9)	
General Education	34.4 % (4.3)	65.6 % (4.3)	
Gender			NS
Male	39.8 % (4.6)	60.2 % (4.6)	
Female	39.8 % (4.6)	69.8 % (4.5)	
Race[33]			NS
African-American	38.2 % (4.1)	61.8 % (4.1)	
White	24.7 % (6.0)	75.3 % (6.0)	
Location in State			NS
Cook County	37.2 % (4.3)	62.8 % (4.3)	
Remainder of IL	33.6 % (5.1)	66.4 % (5.1)	
Grade Relative to Age			15.21**
Overage in Grade	52.7 % (5.7)	47.3 % (5.7)	
At Age for Grade	26.2 % (3.7)	73.8 % (3.7)	

[33] Hispanic and other ethnic groups not included due to sample size.

*p<.01

fourteen and older are more likely to be overage in grade than students younger than fourteen. Educational placement is also associated with being overage in grade; students placed in special education programs are more likely to be overage in grade than students in general education programs. Gender, race/ethnicity, and location in state were not associated with being overage in grade.

The odds ratio of 1.8 reveals that a child fourteen years of age of older is nearly twice as likely as a child younger than fourteen to be overage in grade. It is somewhat surprising that more students over fourteen are overage in grade because teachers (with approval of administrators) are more likely to favor retaining students in the primary grades (grade three and lower) but more reluctant to retain students in fourth grade or older, (Tomchin & Impara, 1992). However, there are several reasons that an older youth would be more likely to be overage in grade. Most basically, older students have attended school longer and have thus had more opportunities to be retained. Academic and behavioral expectations become more stringent as students grow older, and those challenges might unveil latent educational problems. A prior investigation of eighth grader wards who were significantly overage in grade eight (15 and 16 years old) indicated that slightly more than one-quarter had failed a grade; slightly less than one-quarter had missed a year of school because they had run away and a similar proportion had initially started school later than normal (Freagon, Baron-Jeffrey, & Cole, 2004).

The odds ratio of 2.1 indicates that students placed in special education are slightly more than twice as likely to be overage in grade as their peers in general education programs. This may be the case because schools may retain students who are struggling in school before referring them to special education, or students may start school late or miss a great deal of school due to their disabilities. Some children are not deemed eligible for special education services until after they have been retained after performing poorly for years or evincing severe behaviors that led to suspension or expulsion. Others have been referred for special education but have experienced delays in provision of services.

Students are overage in grade for different reasons. Some have been retained because the school determines that they are not able to move on to the next grade level for academic, behavioral, or social reasons. Others did not start school on time or were kept out of school for a time because the

Table 6.4
Overage in Grade Status by Student Characteristics

	Overage in Grade	At Grade for Age	Significance Test χ^2
Age			4.1*
Less than 14 yrs.	28.6 % (3.8)	71.4 % (3.8)	
14 years or older	41.2 % (4.9)	58.8 % (4.9)	
School Placement			7.9**
Special Education	43.1 % (4.9)	56.9 % (4.9)	
General Education	25.8 % (3.8)	74/2 % (3.8)	
Gender			NS
Male	36.0 % (4.3)	64 % (4.3)	
Female	31.2 % (4.4)	68.8 % (4.4)	
Race[34]			NS
African-American	34.0 % (3.8)	66.0 % (3.8)	
White	29.9 % (6.0)	70.1 % (6.0)	
Location in State			NS
Cook County	33.6 % (3.9)	66.4 % (3.9)	
Remainder of IL	35.0 % (4.9)	65.0 % (4.9)	

---

[34] Hispanic and other ethnic groups not included due to sample size.

Note: * *p* < .05, ** *p* < .01

caregiver or parent, before children were taken into care, determined the child was not ready or able to attend school. Yet others encountered registration problems and got behind in their school work. In the case of older students, some leave school and then return later. Further explanation for why each student was overage in grade in this sample was sought in their school records. It is important to understand why a student is overage in grade in order to determine whether intervention is necessary to address particular problems that are common or systemic. There were no or very vague reasons (e.g. "retention") for about one-quarter of the students who were overage in grade. For those students with more extensive information in the file, a disability of some sort (including mental health issues) was cited as the reason for being retained or overage in grade more often than any other. The next most frequent reason noted in the files of students who were overage in grade was poor attendance. Being initially enrolled in school a year later than eligible because their birthdate fell toward the end of the admissible age range was the third most frequent reason provided. Medical problems, mobility, and involvement with the juvenile justice system were noted in a few cases.

Achievement Test Scores

There have been few studies that have examined the achievement test scores of students in foster care. A study of children in foster care conducted in the state of Washington found that, even controlling for demographic characteristics associated with academic achievement, foster care status alone accounted for a 7-8 percentile decrement in achievement test scores (Burley & Halpern, 2001). Bruhn and Hartnett (2003) found that 71% of wards of the state in Illinois were below grade level on state tests of mathematics and 67% were below grade level in reading. Available evidence suggests that children enter foster care below grade level and scores continue to decline over time after entering care (Courtney, Roderick, Smithgall, Gladden & Nagaoka, 2004; Smithgall, Gladden, Howard, Goerge, & Courtney, 2004).

Although records were collected for students between Kindergarten and twelfth grade, achievement test scores were examined for students between third and eighth grade only for two reasons. First, professional organizations (e.g. NAEYC) have policies against using standardized test scores to assess the educational achievement of students before third grade. Second, in Illinois, achievement tests are given in tenth grade and the results are returned the following year to the school attended in tenth grade. Thus, current data is not available for freshman and sophomores in high school, who make up the preponderance of the high school sample.

Table 6.5 displays the percent of students in grades 3 through 8 who fall into the first, second, third, and fourth quarters of the distribution on reading achievement tests. As can be seen in the table, slightly more than two-thirds of the students who were wards of the state fall into the bottom half of the distributions. Only a tenth are represented among students scoring in the top fourth. Not surprisingly, educational program and being overage in grade were both associated with reading achievement. More students in special education programs were estimated to fall in lower ranges than were students in general education. A similar pattern was observed with those overage in grade, who did not score as well as those who were not. Although race is not statistically significant, probably because of the large standard errors, it is worth mentioning that nearly 75% of the African American students have reading scores in the lower half of the distribution.

Nearly three-fourths of students fall into the lower half of the distributions on the math achievement tests (Table 6.6). School placement and being overage in grade are associated with mathematics achievement test scores in similar ways as for reading achievement. Mathematics achievement also is associated with location in the state.

Behavior at School

Studies have consistently shown that children in foster care have many behavior problems in school whether reports were collected from teachers, foster parents, or the children themselves (Advocates for Children, 2000; Kortenkamp & Macomber, 2002; Shore, Sim, LeProhn, & Keller, 2002; Zima, Bussing, Freeman, Yang, Belin, & Forness, 2000).

Whether and how often students have been suspended or expelled serves as an indicator of serious behavioral

Table 6.5
Reading Achievement of 3rd to 8th Graders by Student Characteristics

	Lowest Quarter	2nd Quarter	3rd Quarter	Highest Quarter	Significance Test χ^2
3rd to 8th Graders	36.2 (4.8)	33.4 (4.8)	20.3 (4.1)	10.1 (3.)	
School Placement					11.2*
Special Education	59.3 (8.7)	22.8 (7.6)	9.2 (5.1)	8.6 (4.8)	
General Education	25.5 (5.4)	39.2 (6.1)	24.4 (5.4)	11 (3.9)	
Gender					NS
Male	44.5 (7.1)	33.6 (6.9)	16.1 (5.3)	5.7 (3.2)	
Female	28.1 (6.4)	33.2 (6.7)	24.3 (6.2)	14.4 (5.0)	
Race[35]					NS
African-American	41.0 (6.0)	33.7 (5.8)	16.3 (4.6)	8.9 (3.5)	
White	22.6 (8.9)	27.8 (9.7)	36 (10.3)	13.6 (7.3)	
Location in State					NS
Cook County	44.7 (6.3)	28.7 (5.7)	15.2 (4.5)	11.4 (4.1)	
Remainder of IL	20.2 (6.9)	44.0 (8.6)	27.5 (7.9)	8.3 (4.6)	
Grade Relative to Age					9.3*
Overage	54.5 (8.2)	27.1 (7.4)	10.4 (5.0)	8.1 (4.5)	
At Age	25.3 (5.5)	37.2 (6.2)	26.2 (5.7)	11.3 (4.0)	

[35] Hispanic and other ethnic groups not included due to sample size.

*$p<.05$

Table 6.6
Mathematics Achievement of 3rd to 8th Graders by Student Characteristics

	Lowest Quarter	2nd Quarter	3rd Quarter	Highest Quarter	Significance Test χ^2
3rd to 8th Graders	41.0 (5.0)	30.9 (4.7)	19.5 (4.0)	8.6 (2.8)	
School Placement					19.1**
Special Education	72.1 (8.0)	15.4 (6.4)	6.4 (4.4)	6.1 (4.2)	
General Education	26.4 (5.4)	37.4 (6.1)	26.3 (5.5)	10 (3.6)	
Gender					NS
Male	44.7 (7.1)	28.4 (6.5)	21.2 (5.9)	5.8 (3.3)	
Female	37.4 (6.9)	33.4 (6.8)	17.8 (5.4)	11.4 (4.4)	
Race[36]					NS
African-American	43.3 (6.1)	30.7 (5.7)	16.5 (4.5)	9.6 (3.5)	
White	31.4 (9.9)	35.4 (10.2)	28.2 (9.7)	4.9 (4.8)	
Location in State					9.7*
Cook County	45.7 (6.3)	22.4 (5.3)	26 (5.6)	5.9 (2.9)	
Remainder of IL	32.1 (8.0)	45.1 (8.7)	8.8 (4.9)	14.0 (5.9)	
Grade Relative to Age					10.5*
Overage	57.2 (8.2)	32.4 (7.7)	7.5 (4.2)	2.9 (2.8)	
At Age	31.3 (5.9)	30.0 (5.9)	26.7 (5.7)	12.0 (4.0)	

[36] Hispanic and other ethnic groups not included due to sample size.

*$p <.05$ **$p<.01$

adjustment problems at school. Data collected for the first educational record review showed that 9.8 % of the students had in-school suspensions, 12.8 % had out-of-school suspensions (5.6 % state suspension average), and 1.6 % (0.11 % state average) had been expelled (Freagon, Shumow, Baron-Jeffrey, & Cole, 2005). A three-state (including Illinois) study of adolescents aging out of foster care found that approximately 17 % reported having been expelled from school and the majority reported having been suspended from school at least once during their tenure in school (Courtney, Tarao, & Bost, 2004). Notably, children aging out of foster care will differ in important ways from the population of children in foster care at any given time.

For the Round 2 record review, data was collected pertaining to behavioral indicators including whether the student was sent home (without being officially suspended) and for both in and out of school suspensions for the 2003-2004 school year. Evidence of whether the student had ever been expelled also was recorded. Table 6.7 shows the estimates for the percent of the sample for whom there was evidence in the file that they had been sent home from school or suspended (in school, out of school, and either in or out of school). The percent of students who had been expelled or who had behavior plans in their files also is provided. A behavior plan indicates that educators at the school had identified behavioral concerns about the student, met about those, and formulated strategies for addressing the behavioral issues.

Table 6.7
Population Estimates for School Behavior Indicators

Behavioral Indicators	Population Estimate
Sent Home	16.8 % (2.4)
In School Suspensions	15.7 % (2.3)
Out of School Suspension	22.2 % (2.7)
Any Suspensions	28.0 % (2.9)
Any Expulsion	0.8 % (.6 %)
Behavior Plan in File	25.1% (2.8)

Note: Standard errors for the estimates are shown in parentheses.

Table 6.8 displays associations between student characteristics and suspensions. As can be seen in the table, older students are more likely to be suspended than younger students. The odds ratio of 2.2 associated with that difference indicates that older students are more than twice as likely to be suspended. As might be expected, students who had been suspended were 3.5 times more likely to have behavior plans than students who had not been suspended. It is important to note, however, that 52.7 % of the students with behavior plans had not been suspended which may indicate that the behavioral plans were having some success. On the other hand, 20.6 % of the students who are wards who had been suspended did not have a behavioral plan in their file. Educational advisors might encourage schools to develop behavioral plans for students whose behavior is so severe as to result in suspension from school. Other student characteristics shown were not statistically significant. Interestingly, there was not an association between satisfactory grades and suspensions.

Special Education

Proportion of Children in Special Education

A number of researchers have noted that a substantial and disproportionate number of children in foster care are placed in special education programs (Freagon, Shumow, Baron-Jeffrey, & Cole, 2005; Hanley, 2002; Smithgall, Gladden, Howard, & Courtney, 2004; Zima, Bussing, Yand, & Belin, 2000). The first round of the educational record review estimated that almost half of State of Illinois wards were in special education programs (Freagon, Shumow, Baron-Jeffrey, & Cole, 2005; Bruhn & Hartnett, 2003). Other studies substantiate that estimate. Zima and colleagues (2000), for example, randomly selected 302 school-aged (6 – 12 year old) children in foster care and found that 52% of them had been in special education programs. Another study (Courtney, Terao & Bost, 2004) reported that nearly half of older adolescents who were aging out of the foster care system had been in special education at some time. Yet another study found that middle school students in foster care attending the Chicago

Public Schools were placed in special education three times more often than students not in foster care (Smithgall, Gladden, Howard, & Courtney, 2004).

The current record review estimates that 42.9 % (s.e. = 3.2) of students in foster care were receiving special education services in the 2003/2004 school year. The proportion in special education programs was associated with age but did not vary by gender, race, or geographic location (Table 6.9). The odds ratio of 2.2 suggests that students fourteen or older are much more likely to be in special education than those younger. Within the general population, males are far more likely than females to be placed in special education (Coutinho & Oswald, 2005), so the fact that there is not a significant difference within this population is particularly noteworthy.

Special Education Categories

Students placed in special education are labeled with particular disabilities. The previous educational record review of State wards found that 28.6 % of wards were classified as emotionally disturbed, 20.9 % as having specific learning disabilities, and 7.6 % as cognitively disabled (Freagon et al. 2005; Bruhn & Hartnett, 2003). Estimates were calculated for common categories (Table 6.10). Low-incidence disabilities like visual impairment are not included in the table.

There has been some discussion about whether or not children in foster care are over or under identified for special education (Goerge, Van Voorhis, Grant, & Casey, 1992; Shumow & Perry, 2006). One position is that more

Table 6.8
Suspensions by Student Characteristics

	No Suspensions	One or More Suspensions	Significance Test χ^2
Age			7.2*
Less than 14 yrs.	78.5% (3.4)	21.5% (3.4)	
14 years or older	62.7 % (4.9)	37.3% (4.9)	
School Placement			NS
Special Education	67.7 % (4.6)	32.3 % (4.6)	
General Education	76.3 % (3.6)	23.7% (3.6)	
Gender			NS
Male	68.6 % (4.1)	31.4 % (4.1)	
Female	76.1 % (4.0)	23.9 % (4.0)	
Race[37]			NS
African-American	68.3 % (3.7)	31.7 % (3.7)	
White	77.1 % (5.6)	22.9 % (5.6)	
Location in State			NS
Cook County	69.0 % (3.9)	31.0 % (3.9)	
Remainder of IL	75.9 % (4.4)	24.1 % (4.4)	
Reading Marks			NS
Not Satisfactory	68.9 % (5.4)	31.1 % (5.4)	
Satisfactory	73.0 % (3.6)	27.0 (3.6)	
Mathematics Marks			NS
Not Satisfactory	70.9 % (5.2)	29.1 % (5.2)	
Satisfactory	71.9 % (3.8)	28.1 % (3.8)	

[37] Hispanic and Other ethnic groups not included due to sample size.

*$p < .05$

children need than receive special education services because many more children in foster care are diagnosed with psychological disorders than are identified as emotionally disturbed in school. It should be noted, however, that children may have been diagnosed with and treated for psychological disorders outside of school. The medication and therapy they receive may be effective such that their educational performance is unimpaired. Another position is that if children in foster care received treatment for post traumatic stress and commensurate accommodations within general education then fewer would be labeled emotionally disturbed. This is a serious matter because once children are labeled as emotionally disturbed (usually before age 10) they tended to retain that label throughout their entire education (Smithgall, Gladen, Yang, & Goerge, 2005).

Alternatives to special education placement include creation of 504 Plans that specify accommodations and services provided within general education to meet students' needs. Records were searched for 504 plans, and very few were located. In fact, the population estimate was that only .1 % of students in foster care have 504 plans. It appears that this may be an underutilized mechanism for addressing students' educational needs.

Table 6.9
Characteristics of Children in Special and General Education Programs

		Special Education	General Education Only	Significance Test χ^2
Age				9.1**
	Less than 14 yrs.	34.9 % (4.0)	65.1 % (4.0)	
	14 years or older	54.6 % (5.1)	45.4 % (5.1)	
Gender				NS
	Male	47.0 % (4.5)	53.0 % (4.5)	
	Female	38.2 % (4.5)	61.8 % (4.5)	
Race[38]				NS
	African-American	39.5 % (3.9)	60.5 % (3.9)	
	White	50.9 % (6.8)	49.1 % (6.8)	
Location in State				NS
	Cook County	41.1 % (4.1)	58.9 % (4.1)	
	Remainder of IL	46.0 % (5.1)	54.0 % (5.1)	

[38] Hispanic and other ethnic groups not included due to sample size.

Note Standard errors are shown in parentheses

** $p < .01$

Table 6.10
Percent of Children Classified with Specific Disabilities

Special Education Category	Percent of All Students in Sample	Percent of Students Placed in Special Education[39]
Emotional Disturbance	26.7 %	62.3 %
Specific Learning Disability	19.2 %	44.8 %
Speech & Language Disability	8.3 %	19.3 %
Mental Retardation	1.2 %	2.7 %

[39] Column total exceeds 100 % because some children have more than one label.

Factors Contributing to Educational Problems of Children in Foster Care

The educational problems of foster children have been explained in several ways. Most obviously, children who are state wards have experienced extreme adverse circumstances which are highly likely to disrupt their learning and adjustment in school. However, "systemic" or organizational factors in schools and in the child welfare system can exacerbate or mitigate the risk attendant to the basic circumstances. Students in foster care may have school problems in part because of school mobility and attendance problems. Absences, school changes, placement changes, and other disruptions take a toll on academic adjustment. Children need consistency and routine in order to concentrate on normative developmental tasks. It is important to monitor absences and mobility because policies and practices of school and child welfare institutions are amenable to changes that might mitigate disruptions to the educational process.

School Mobility

Children placed in foster care typically experience greater school mobility than children who remain with their families (Burley & Halpern, 2001; Conger & Finkelstein, 2003; Hartman, 2002). When children are moved to a foster home or between foster placements they must often move to a new school because school assignment is usually geographically determined. Researchers have compared the educational adjustment of students who move schools with those who stay in the same school. Controlling for demographic background factors related to school adjustment, research consistently finds that school mobility predicts adverse educational adjustment for students (Hofferth, 1998). When students are moved they must expend considerable energy adjusting to a new home and school rather than on learning. In addition, curriculum is rarely aligned across schools. In New York City, 45 % of the caseworkers reported more than two school transfers per year among their clients (Advocates for Children, 2000). The first Illinois educational record review of children in foster care found that 39.7% of the DCFS wards had experienced one school transition and 21.2% had experienced two or more (Freagon, Shumow, Baron-Jeffrey, & Cole, 2005).

Students also might be moved between schools for educational reasons that are normative or typical. For example, they might be moved because they were promoted to the next level. For this educational record review, the number of nonpromotional transfers in the past two years was examined because children in foster care can experience nonpromotional moves as a result of being in foster care. Some of those might be avoided by careful decision making.

Population estimates for the number of nonpromotional transfers can be seen for entire sample and by groups in Table 6.11. Overall, 35.4% of the State wards are estimated to have moved once or more for reasons other than being promoted to a new grade housed in a different school in the two year time span considered. Some (12.7%) moved twice or more (Range 2 – 6 times). None of the characteristics considered were associated with nonpromotional transfers, however. It could be that our nominal measure of grades is not sufficient to pick up variation in grades. It also could be that the well established negative associations of grades with mobility is suppressed by including promotional transfers, which are stressful, in the "none" category.

Attendance

Attendance at school is, not surprisingly, related to success in school (Advocates for Children, 2000; Conger & Finkelstein, 2003). According to a number of reports, children in the foster care system have tended to be absent frequently. Thus, the number and reason for students' school absences were recorded from their records. Children in foster care were estimated to be absent from school an average of 9.4 (s.e. = 0.8) days during the 2003/2004 school year. Nearly ten percent (9.9 %) of the students were estimated to have never been absent, yet 32.2 % were absent more than ten days.

Table 6.12 displays mean absences by characteristics of students who are wards of the State and F statistics testing associations between those characteristics and days absent. As expected, children who obtain both better reading and mathematics grades are present more often in school than children who obtain unsatisfactory grades. Older students are absent more frequently than younger students. Students in special education programs miss significantly more school than their peers in general education programs. Attendance did not differ by student gender, race, location in the state, or overage in grade status.

Any reasons for absences provided in the records were noted. Because multiple reasons were provided for many students and reasons were missing from the files of approximately 15% of the students, statistical analyses were not conducted to associate reasons for absences with school performance or with other characteristics of students. However, overall, it can be said that the most frequent reasons provided pertained to illness and medical appointments. The high stress attendant to being in foster care is known to compromise health and often results in numerous physical illnesses during childhood and adolescence including headaches, gastrointestinal disorders, and dysregulation of the respiratory system (Anda et al., 2006; Perry & Pollard, 1998; Perry & Azad, 1999). Anecdotal reports from educational advisors and data from earlier waves of data collection identify asthma as the medical condition most often associated with absences among wards.

The second most common reason for absences was related to behavioral problems including skipping class, tardiness, and removal from class for disciplinary reasons. Among those students who were absent for very many days, hospitalization, running away, and/or other behavioral indicators (truancy, court appearances, suspension) were usually recorded as the explanations for absence. Until recent policy changes resulting from advocates' spotlight on

Table 6.11
Non-promotional Transfers and Student Characteristics

	None	One	Two	Significance Test χ^2
Entire Sample	64.7 % (3.2)	23.2 % (2.9)	12.0% (2.1)	
Age				NS
Less than 14 yrs.	66.4 % (4.2)	22.7 % (3.7)	10.9 % (2.7)	
14 years or older	62.2 % (5.2)	24.1 % (4.6)	13.8 % (3.6)	
School Placement				NS
Special Education	67.6 % (4.8)	21.3 % (4.3)	11.1 % (3.2)	
General Education	62.8 % (4.4)	24.3 % (4.0)	13.0 % (3.0)	
Gender				NS
Male	67.3 % (4.4)	23.7 % (4.0)	8.9 % (2.6)	
Female	61.7 (4.8)	22.7 % (4.2)	15.6 % (3.5)	
Race[40]				NS
African-American	66.6 (3.9)	21.6 % (3.5)	11.8 % (2.6)	
White	64.4 % (6.6)	21.1 % (5.7)	14.5 % (4.8)	
Location in State				NS
Cook County	65.8 % (4.1)	23.6 % (3.7)	10.6 % (2.6)	
Remainder of IL	62.9 % (5.4)	23.5 % (4.8)	13.6 % (3.7)	
Grade Relative to Age				NS
Overage	61.8 % (5.6)	19.1 % (4.7)	19.1 % (4.5)	
At Age	66.2 % (4.0)	25.3 % (3.7)	8.5 % (2.3)	
Reading Marks				NS
Not Satisfactory	59.9 % (6.1)	27.5 % (5.7)	12.5 % (3.9)	
Satisfactory	66.9 % (4.0)	22.0 % (3.5)	11.1 % (2.6)	
Mathematics Marks				NS
Not Satisfactory	61.8 % (5.8)	25.6 % (5.4)	12.6 % (3.7)	
Satisfactory	66.6 % (4.1)	22.3 % (3.6)	11.1 % (2.7)	
Suspensions				NS
None	68.0 % (3.7)	20.9 % (3.3)	11.1 % (2.4)	
One or more	56.0 % (6.4)	29.6 % (6.0)	14.4 % (4.5)	

[40] Hispanic and other ethnic groups not included due to sample size.

Note: Standard errors for the estimates are shown in parentheses.

the problem, a large contributing factor to the high number of school absences was long delays (up to five months) in getting children registered in school following removal from the home and placement in foster care (Advocates for Children, 2000; Conger & Finkelstein, 2003). In no case in this review were absences attributed to such delays in school registration. When the Educational Advisor project was established, the primary reason for absences among wards was long delays (up to months) in enrollment. As a result, DCFS implemented policies (Educational Procedures 314) recommended by the Center for Child Welfare and Education requiring that DCFS wards be enrolled in schools within two to five days of placement changes. The CCWE also intervened in individual cases, established collaborations with schools districts and threatened injunctions in some cases.

Table 6.12
Absences and Student Characteristics

	Mean Days Absent	Standard error	Significance Test Ward F
Entire Sample			
Age			9.54**
Less than 14 yrs.	7.3	0.8	
14 years or older	13.6	1.9	
School Placement			8.63**
Special Education	11.6	1.4	
General Education	6.9	0.7	
Gender			NS
Male	10.2	1.3	
Female	8.4	0.9	
Race[41]			NS
African-American	9.6	1.1	
White	8.7	1.2	
Location in State			NS
Cook County	9.1	1.1	
Remainder of IL	9.8	1.4	
Grade Relative to Age			NS
Overage	10.7	1.8	
At Age	8.7	0.8	
Reading Marks			4.2*
Not Satisfactory	12.7	2.1	
Satisfactory	8.1	0.8	
Mathematics Marks			6.1*
Not Satisfactory	12.7	1.9	
Satisfactory	7.6	0.8	
Suspensions			10.85***
None	7.5	0.9	
One or more	14.0	1.8	

[41] Hispanic and other ethnic groups not included due to sample size.

**p*<.05 ***p*<.01

Summary and Conclusions

Because these records are drawn from a random sample, this study is an important means of monitoring the educational situation of the children in foster care in Illinois. The data indicate that, while about two third of the students in the sample received satisfactory or better marks in reading and math, they tended to perform poorly on achievement tests.

As we examine which segments of youth in foster care in this sample are most at risk academically, we find those who are in special education programs, overage in grade, frequently absent, 14 and over, and/or African American are struggling. A substantially disproportionate number of students were receiving special education services; predominant classifications were emotional disturbance and specific learning disabilities. Students 14 or older are much more likely to be in special education than younger students. Students in special education or 14 years and over were twice as likely to be overage in grade. Youth who are overage in grade are more likely to attain unsatisfactory marks in reading and math than their peers who are in the age appropriate grades, and they score in the lower ranges on achievement tests. Older students were also more likely to miss school than younger students. White students were almost three times more likely than African American students to perform satisfactorily in reading. Seventy-five percent of African American students scored in the lower half of the distribution in reading achievement tests.

Future studies can ascertain the effectiveness of interventions targeted at addressing the problems that were identified. For example, it is important to establish if there is a relationship between the effects of undiagnosed and unaddressed trauma symptoms and the high representation of youth in foster care in special education programs. Trauma sensitive educational practices might result in fewer behavior problems, improved learning, fewer absences, and overall better adjustment. Ensuring that school records follow children when they change placement is likely to reduce the incidence of grade retention due to unattained high school credits and inappropriate grade placements. Culturally competent approaches for improving outcomes should be explored because African Americans are both disproportionately represented in foster care and in poor academic performance.

Collaborations developed with schools may assist with smooth transitions for students who must change schools upon relocation. DCFS has an early childhood initiative that requires all DCFS youth three to five to be enrolled in educational programs. Whether this helps with reading readiness needs to be tested. Additional services that target improved reading and math also are important to investigate as means to improve educational outcomes. As one would expect, youth who obtain both better reading and mathematics grades are present more often in school than children who obtain unsatisfactory grades. As was noted earlier, while other states are still struggling with serious delays in school enrollment, Illinois has moved beyond that with the implementation of an educational referral resource for workers and caregivers, the establishment of policy, and the provision of training. The high absence rate for some wards warrants additional strategies for improving attendance. This may be realized in part through DCFS' implementation of performance based contract protocols that hold agencies accountable for educational outcomes.

Education is a significant component of well-being. Children and youth in care, like all others, thrive better educationally when adults responsible for their welfare and education partner to accomplish this goal. Overall academic improvement and behavioral adjustment would be accomplished for every ward if ideally, DCFS and the schools worked together to coordinate appropriate educational planning and to intervene early when problems arise.

CHAPTER 7
Placement Stability and Exits to Permanence

Introduction to Results

DCFS administrative data were used to examine placement stability and permanency outcomes for the children in the IL-CWB Round 2 sample. These children were selected into the sample from the population of children in care as of September 30, 2002, which allows an observation period of approximately three years. Placement stability and permanency outcomes were examined for all children in the sample, regardless of whether or not the children remained in care. The analyses reported in this chapter represent the outcomes for all children in the sample through June 30, 2006, approximately three years post-selection.

This chapter is presented in four sections. The first two sections describe the placement stability and permanency outcomes for children in the IL-CWB Round 2 study. The last two sections describe the associations between child mental health, placement stability, and permanency outcomes. Child mental health was chosen as the construct for focus in this chapter because previous research has documented a consistent association between mental health, placement stability, and permanence. This is not the case for other elements of well-being, such as health and education. Moreover, the mental health data collected in Round 2 contain several standardized measures, which have greater reliability and validity than the physical health and education variables included in the study. In this chapter, mental health is evaluated as a potential predictor of both stability and permanence, although past research has suggested that placement stability and permanence may also predict the mental health outcomes of children in foster care. The bi-directional nature of this relationship will be explored at greater length in future work.

Placement Stability

Defining Placement Stability

Placement stability can be defined and measured in a number of different ways. There are many dimensions to stability, and no single measure seems likely to capture all the elements of stability completely. Several measures have been used in previous research, each with their own advantages and limitations. A selection of measures that have not yet been reported in the academic literature may characterize the placement experiences of children in out-of-home care in meaningful ways as well. Both types of measures are discussed here.

- Number of total moves. Even this seemingly simple metric requires several important decisions about what constitutes a placement "move." For example, children may move to respite care, a hospital setting, or a detention setting and then return to a prior provider; the decision as to whether these constitute "moves" must be made. Similarly, an initial placement in emergency care or a setting intended for evaluation purposes may not be considered a placement. Placements that endure for a very short period of time, such as eight days or less, may not be considered placements. Runaway from care and then return to a prior placement might not be considered a placement move. Remaining with the same provider but moving to a different residence may or may not be considered a placement move.

- Number of total moves controlling for time in care. This measures takes into consideration that 10 moves means something different for a child who has been in care 10 years than it does for a child who has been in care one year. Measurement of this kind could be done in many ways, such as average moves per year, moves in the past year, or moves in the past two or three years. The federal measure is two or fewer placement settings for all children in a fiscal year, and this measure is broken out by children who remained in care less than 12 months, those who remained in care less than 24 months, and those who remained in care for 24 months or more.
- Number of school moves or number of school moves controlling for time in each school.
- Geographic distance between placements, possibly controlling for time in placement. This measure takes into consideration that moving 10 miles from a placement that endured for a year might have a different impact than moving 50 miles from a placement that endured for 5 days. A related issue is geographic distance from home of origin or from the present home of the family of origin.
- "Quality" of placement moves. Measurements of placement move quality could take into consideration that some moves are made in order to allow children to live with relatives, with siblings, or closer to their families of origin. These moves might be considered "good" moves. Similarly, moves that are planned to allow a child to access needed services that might not be available in a placement setting might be considered more desirable than unplanned moves. Moves that are made because of unavoidable family circumstances, such as the death of a foster parent, may be considered more innocuous than those instigated by foster parents in response to children's behavior. A measure of quality would be challenging to construct, and data concerning move quality are generally not available in administrative databases.
- Restrictiveness of the placement. Placement with relatives is considered desirable because it is associated with greater contact with birth parents and siblings and is not associated with reduced likelihood of permanency outcomes. Placement with non-relatives who act in the role of a parent is preferred to congregate care because it offers a more home-like setting and a greater likelihood of exit to a permanent living arrangement. The issues of placement stability and placement setting are intertwined, and a variety of approaches can be taken to capture these constructs numerically. For example, time in care can be disaggregated into a percentage of time spent in each major care type (home of relative, foster care, specialized or treatment foster care, and congregate care). Alternately, measurement of "step up" or "step down" can be applied to stability analyses by assigning numerical values to placement types, based on increasing levels of restrictiveness. For example, consider the following ordinal scale, based on increasing levels of restrictiveness:
- Home of relative = 1
- Traditional foster care = 2
- Specialized/treatment foster care = 3
- Group or residential care = 4

Using this scale, a movement from home of relative to group or residential care would equal "+3." A move from group or residential care to home of relative would equal "-3."

These calculations are represented in tabular format in Table 7.1. A cumulative "step up" indicator and a cumulative "step down" indicator can be calculated for each child using this table. This approach allows for the fact that not all moves are equal in impact, and that a simple sum of individual moves is not the most nuanced indicator available. This approach was taken to develop variables representing "impact" that were employed in analyses described later in this section.

- Patterns of placement stability. Four categories, including early stability, later stability, variable pattern, and unstable pattern, were identified by James, Landsverk, and Slymen (2004) to take into consideration that the rate of placement movement (or the number of movements over a given period of time and how this rate changes over time) may impact children's experiences of movement.

The analyses in this chapter utilized several measures of placement stability. These were selected based on the availability of information contained in the administrative database. First, a description of total number of moves and average moves per child will be presented. Next, the number of steps-up and steps-down per child will be described. Finally, the "impact" of steps up and down will be described. This term is utilized to indicate the number of steps up or down a child takes on the continuum of restrictiveness of placement and the accumulation of those steps over time. The impact variable was calculated as described above and in Table 7.1. Each move that represented a step "up" (from less to more restrictive) and the degree of that move (+1 to +3) was tallied, as was each move "down" (from more to less restrictive). Steps-up and steps-down are calculated separately, for moves to more restrictive placements and moves to less restrictive placements could feasibly cancel each other out if calculated on the same scale (for example, a +3 and a -3 on the same scale would results in an impact of 0). This was not felt to accurately capture the construct of interest.

Placement moves were considered to include any move that met the following criteria:

- The placement endured for longer than 7 days
- Did not constitute a move to respite and back to the same provider
- Did not constitute a move to a hospital or detention setting and back to the same provider
- Did not constitute an unauthorized absence from placement and return to the same provider
- Remained with the same provider regardless of whether or not the provider changed residences

Number of Placement Moves

The 655 children who were part of the sample experienced 2,892 placement moves over the course of their time in out-of-home care before June 30, 2006. Limiting the set to the current spell (the spell of care active as of the date of sampling, that being September 30, 2002) in out-of-home care reduced the figure to 2,693 moves. The number of placement moves recorded (excluding respite moves) ranged

Table 7.1
Creation of "Impact" Variable Representing Degree of Movement Between Placements

	Placement moved to			
Placement moved from	Kinship care	Traditional foster care	Specialized foster care	Group or residential care
Kinship care	0	+1	+2	+3
Traditional foster care	-1	0	+1	+2
Specialized foster care	-2	-1	0	+1
Group or residential care	-3	-2	-2	0

from 0 to 23, with an average of 2.9 (0.12) moves per child, and a mode of one move (n = 150; Figure 7.1). For the most part, the likelihood of experiencing an increased number of moves drops at a predictable rate (the spike at 6 moves is likely to be an anomaly). While the length of the current spell varies from child to child, this figure serves to graphically represent the assertion that relatively few children are experiencing high numbers of moves.

The association between total number of moves and placement type at the time of sample selection was examined (Table 7.2). There was a statistically significant relationship between placement type (as of September, 2002) and total number of placement moves experienced as of June 30, 2006 (F(3, 643) = 26.5, *p* <.01). As suggested by non-overlapping confidence intervals, children in kinship care experienced the fewest moves. They were followed by children in group or residential care, children in traditional foster care, and children in specialized foster care. The number of moves associated with first placement in the current spell in out-of-home care was also examined, but it was not statistically significant. Given that a period of time had elapsed for most children between their entry into care and their selection for participation in the study, the relationship between placement type and placement stability appears to be one that emerges over time.

Total number of moves also varied significantly by child gender (Table 7.3). The relationship between age at entry and number of moves is significant and positive – as age at entry increases, so does the number of placement moves. The value of the coefficient is 0.2 (*p*=.01, 95% C.I 0.1- 0.3), and the intercept is 2.0, suggesting that a child entering the system at the age of five would be expected to experience 3 moves, whereas a child entering the system at 10 would experience 4 moves, and a child entering the system at 15 would experience 5 moves (t (648) = 6.9, p <.01). Years in care was similarly associated with number of moves – the intercept is 1.2, and the coefficient is 0.5 (*p*=.05, 95% C.I 0.4 - 0.6), so children would be expected to experience one additional move for each two years they spend in care (t (649) = 9.4, *p* <.01). Number of moves did not differ significantly by child race (Appendix Table D.17).

Table 7.2
Number of Placement Moves by Placement Type on September 30, 2002

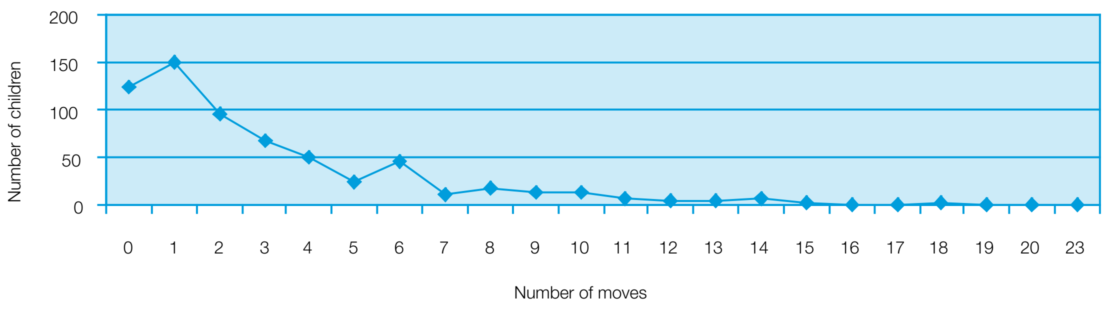
Type of placement	Number of moves (std. err), 95% C.I.
Kinship care	1.7 (0.1), 1.4 – 2.0
Traditional foster care	4.6 (0.4), 3.8 – 5.5
Specialized foster care	6.8 (0.9), 5.0 – 8.5
Group or residential care	2.8 (0.2), 2.4 – 3.1

Table 7.3
Child Gender and Number of Placement Moves

Gender	Number of moves (std. err) 95% C.I.
Male	3.2 (0.2) 2.8 – 3.6
Female	2.6 (0.2) 2.3 – 3.0

(t (639) = -2.00, *p* = .04)

Figure 7.1
Number of Moves Experienced During Most Recent Spell



---

[33] As of June 30, 2006

Number of Placement Steps-Up and Steps-Down

The number of steps-up ranged from 0 to 7 (mean 1.5, s.e. 0.1). Steps-up are considered any movement from a less to a more restrictive setting with kinship care considered to be the least restrictive setting, followed by traditional foster care, specialized foster care, and group or residential care. The number of steps down ranged from 0 to 5 (mean 1.4, s.e. 0.1), and the number of lateral moves ranged from 0 to 13 (mean 1.5, s.e. 0.1). The number of upward moves, downward moves, and lateral moves were not significantly different from each other.

Impact of Placement Steps-Up and Steps-Down

The "impact" of steps up and down was also analyzed, with impact being quantified using the structure displayed in Table 7.1. Thus, a move from a level 1 placement (home of relative) to a level 4 placement (congregate care) would be equal to +3. The impact from each step-up move was totaled, as was the impact from each step-down move. Step-up impact ranged from 0 to 20 with a mean of 1.5 (0.1). Step-down impact ranged from 0 to 11 with a mean of 1.0 (0.1). The impact of upward moves was significantly higher than the impact of downward moves. This suggests that children may tend to move up more than one level at a time, whereas downward moves are more likely to be one level at a time.

Permanence

Three years after they were selected into the study sample, 37% of the children in the IL-CWB sample had been adopted, 11% were taken into legal guardianships, 11% were reunified, and 35% were still in care (Table 7.4). The outcome "impermanence" was defined as aged out (at 18th birthday did not have a permanent family), runaway, missing, unknown, or other.

The occurrence of each type of outcome varied according to the last placement type experienced (Table 7.5). This table is constructed such that the columns sum downward to approximately 100%; thus, of children in homes of relatives, 13.3% exited to reunification, 56.4% exited to

Table 7.4
Legal Permanence Outcomes at June 30, 2006

Permanency outcome	Percent (std. err.), 95% C.I.
Reunification	11.1 (1.3), 8.8-14.0
Adoption or subsidized guardianship	48.0 (2.1), 44.0 – 52.0
Still in care	35.3 (2.0), 31.5 – 39.2
Impermanence (runaway, aged out, missing, unknown, other)	5.6 (0.8), 4.2 – 7.4

Table 7.5
Legal Permanence by Living Arrangement

Outcome	Kinship care	Traditional foster care	Specialized foster care	Group/residential care
Reunification	13.3 (2.4) 9.2 – 18.8	10.9 (2.1) 7.4 – 15.9	12.4 (3.8) 6.7 – 21.8	2.5 (2.5) 0.4 – 15.8
Adoption/guardianship	56.4 (3.4) 49.6 – 62.9	53.5 (3.4) 46.8 – 60.1	32.2 (5.5) 22.5 – 43.8	0
Still in care	28.4 (3.1) 22.7 – 34.9	33.0 (3.2) 27.0 – 39.7	49.8 (5.8) 38.6 – 60.9	65.6 (6.6) 51.8 – 77.2
Impermanence	2.0 (0.8) 0.9 – 4.3	2.5 (0.9) 1.3 – 5.0	5.6 (2.5) 2.3 – 13.1	5.6 (2.5) 2.3 – 13.1

adoption or guardianship, 28.4% did not exit, and 2.0% exited to impermanent living arrangements. The failure of numbers in these columns to add to exactly 100% results from weighting issues. Examination of Table 7.5 reveals that children in group or residential care were less likely to experience desirable outcomes than those in any other type of care ($\chi 2$ (9, 625) = 83.5, $p < .01$). In addition, children with specialized foster care as their last recorded living arrangement prior to June 30, 2006 were less likely to experience guardianship or adoption and more likely to remain in care than children living in homes of relatives or traditional foster care. Notably, not one child who was placed in group care in 2003 had experienced an adoption outcome by 2006, and only one child had been reunified with his or her family of origin.

Analysis of the associations between child race and permanency outcomes reveals that White children are less likely than both African American children and those of other races or ethnicities to remain in care, and are more likely than African American children to be reunified ($\chi 2$ (6, 652) = 17.1, $p = .01$; Table 7.6). Males and females were equally likely to experience the permanency outcomes analyzed (see Appendix Table D.18).

Permanency outcomes also differed significantly by child age at entry into foster care and length of time in care (Table 7.7). Children who were adopted entered care at younger ages than children with all other permanency outcomes, and children who exited to impermanent living arrangements entered care at older ages than children with all other permanency outcomes. In terms of time in care, children who were reunified spent the least time in care, followed by children who were adopted, children who remained in care, and children who exited to impermanence.

These findings are relevant to the consideration of whether children who are still in care are qualitatively the same as children who have exited the system to impermanence. One might consider that children who remain in care are fundamentally children who will exit to impermanence but simply have not yet because they are younger and have not been in care as long. An examination of time in care suggests that this might be the case – if the children who were still in care when this analysis was conducted were to remain in care, they would eventually age out, and their total time in care statistics would probably appear more similar to those of children who have already aged out. However, children who were still in care and those who exited to impermanence appear differently in terms of their age at entry, race, and last recorded placement, suggesting that this is not a monolithic group of children, and that some may yet experience positive permanency outcomes.

Mental Health and Placement Stability

Several mental health measures were examined for association with indicators of placement stability, including caregiver-reported behavior problems (Child Behavior Checklist [CBCL] score, clinical/borderline or otherwise), child self-reported behavior problems (Youth Self-Report [YSR] score, clinical/borderline or otherwise), child self-reported depression (Children's Depression Inventory [CDI], clinical/sub-clinical or otherwise), and child self-reported trauma (Trauma Symptom Checklist for Children [TSCC], Post-traumatic Stress subscale, clinical/sub-clinical or otherwise). These measures were chosen because they are present for sufficient numbers of children and demonstrate some degree of variability. Tests of bivariate association

Table 7.6
Permanency Outcomes by Race or Ethnicity

	African American	White	Latino/a or Other
Reunification	8.8 (1.4) 6.3 – 12.0	16.4 (3.5) 10.6 – 24.5	15.4 (4.6) 8.4 – 26.8
Guardianship/Adoption	48.4 (2.5) 43.5 – 53.3	51.6 (4.5) 42.9 – 60.3	37.4 (6.6) 25.6 – 50.9
Still in Care	37.4 (2.5) 32.7 – 42.3	24.7 (3.7) 18.2 – 32.6	44.6 (6.6) 32.4 – 57.6
Impermanence	5.5 (1.0) 3.8 – 7.8	7.3 (2.0) 4.2 – 12.2	2.5 (1.8) 0.6 – 9.6

(Table 7.8) reveal that children whose caregivers reported clinical/borderline child behavior problems (CBCL scores) experienced a higher number of total placement moves and more lateral moves than children without serious behavior problems. Placement stability was not associated with self-identified behavioral problems (YSR).

Table 7.9 indicates that number of placement moves is significantly associated with self-report of depression such that children who identified themselves as depressed experienced higher numbers of total and lateral moves. As with all tests of bivariate association, the directional nature of this relationship cannot be assumed. Specifically, depression could clearly be a consequence of multiple moves, as multiple moves create disruptions in ties to biological families, communities, peers, and caregivers. However, one may also suspect that depression contributes to the likelihood of movement, as it may impede the abilities of children to form meaningful attachments to the people with whom they live. The failure to form attachments may be interpreted by caregivers and foster families as rejection, and this perception may cause them to reduce their efforts to reach out to children. Early identification of and proper treatment for depression could have an impact on placement stability, if this is the case.

Table 7.10 reflects results of a multivariate model of placement moves as predicted by CBCL scores, living arrangement at the time of the study, age at entry, and years in care at the time of the study. Scores for the YSR were not included because those scores are only available for children 11 and older. Scores for the CDI and TSCC were

Table 7.7
Permanency Outcomes by Age at Entry and Time in Care

Permanency outcome	Age at entry	Time in care
Reunification	5.8 (0.5), 4.8 – 6.7	1.9 (0.2), 1.5 – 2.3
Adoption	3.5 (0.2), 3.1 – 3.8	3.6 (0.1), 3.3 – 3.3
Still in care	5.2 (0.2), 4.7 – 5.7	4.0 (0.2), 3.6 – 4.4
Impermanence	9.9 (0.6), 8.6 – 11.1	5.7 (0.6), 4.5 – 6.8

Notes: Age at entry, F (3, 652) = 35.5, *p* <.01; time in care, F (3, 652) = 23.9, *p* <.01.

Table 7.8
Behavior Problems and Placement Stability

	CBCL		YSR	
	Not clinical or borderline	Clinical/ borderline	Not clinical or borderline	Clinical/ subclinical
Number of moves	2.6 (0.3) 2.1 – 3.2	3.5* (0.3) 2.8 – 4.1	4.6 (0.4) 3.8 – 5.4	4.9 (0.6) 3.6 – 6.2
Number of step-up moves	0.9 (0.1) 0.6 – 1.1	1.1 (0.1) 0.9 – 1.4	1.6 (0.2) 1.2 – 1.9	1.9 (0.3) 1.4 – 2.5
Number of step-down moves	1.5 (0.1) 1.4 – 1.7	1.5 (0.1) 1.3 – 1.8	1.7 (0.1) 1.5 – 2.0	1.4 (0.3) 1.0 – 1.8**
Number of lateral moves	1.2 (0.1) 1.0 – 1.5	1.8** (0.2) 1.4 – 2.1	2.3 (0.2) 1.8 – 2.8	2.6 (0.4) 1.7 – 3.5

Notes: Moves, t (265) = -1.03, *p* = .05
Lateral moves: t (265) = -2.19, *p* <.01

not included due to the minimal variability in those scores and unavailability of scores for children under the age of 7 (CDI) or 8 (TSCC). The model indicates that three variables have significant predictive value with regard to placement stability: kinship care predicts increased placement stability, increased age at entry predicts decreased placement stability, and increased time in care predicts decreased placement stability. These findings are supportive of similar findings that have been reported in other studies. The multiple R2 value for the model is only .30, suggesting that the model is incompletely specified.

Mental Health and Permanence

A similar set of bivariate tests examined the relationships between child mental health measures and permanency outcomes (reunification, adoption/subsidized guardianship, remaining in foster care, and impermanence). There was no statistically significant association between behavior measures and permanency outcomes, whether behavior is reported by caregivers or children (Table 7.11). Both depression and trauma were significantly related to permanency outcomes. Specifically, children who exited

Table 7.9
Child Depression, Trauma, and Placement Stability

	CDI		TSCC	
	Not clinical or subclinical	Clinical/ subclinical	Not clinical or borderline	Clinical/ subclinical
Number of moves	3.8 (0.3) 3.2 – 4.3	6.8* (1.4) 4.1 – 9.4	4.2 (0.3) 3.6 – 4.8	3.6 (0.8) 2.0 – 5.3
Number of step-up moves	1.3 (0.1) 1.1 – 1.5	1.9 (0.5) 0.8 – 2.9	1.4 (0.1) 1.2 – 1.7	1.2 (0.3) 0.5 – 1.8
Number of step-down moves	1.6 (0.1) 1.5 – 2.2	1.9 (0.4) 1.0 – 2.8	1.6 (0.1) 1.4 – 1.8	1.7 (0.3) 1.1 – 2.3
Number of lateral moves	1.9 (0.2) 1.5 – 2.2	4.0* (0.9) 2.3 – 5.7	2.2 (0.2) 1.8 – 2.6	1.8 (0.5) 0.7 – 2.8

Notes: Moves, t (152) = -2.18, *p* = .03
Lateral moves, t (152) = -2.40, *p* = .02

Table 7.10
Multivariate Modeling of Placement Stability

Covariate	B	S.E. Beta	95% C.I.	t	*p*
Borderline or Clinical CBCL score	0.15	0.38	-0.60-0.90	0.39	0.69
Living arrangement					
Kinship care	-0.78	0.34	-1.46-0.10	-2.26	0.02
Specialized foster care	0.90	0.56	-0.21-2.00	1.58	0.11
Group/res.	0.82	0.99	-1.13-2.77	0.83	0.41
Traditional foster care (ref)	Ref	Ref	Ref	Ref	Ref
Age at entry	0.21	0.05	0.12-0.30	4.59	<0.01
Time in care	0.42	0.06	0.29-0.55	6.50	<0.01

to impermanent living arrangements were less likely than children with all other permanency outcomes to rate themselves depressed or traumatized. These findings should be considered suggestive rather then conclusive, particularly in the case of depression scores, due to low overall numbers of children rating themselves as having symptoms of depression or trauma.

Unfortunately, multivariate analyses using depression and trauma to predict permanency outcomes could not be conducted. Depression and trauma measures were collected only for children ages 7 to 8 (respecitively) and over, and the permanency outcomes being modeled were strongly associated with age such that many children experiencing the outcomes of interest (particularly impermanence) were over the age of 8. The fact that so many of the cases that were lost (because of the unavailability of these measures for younger children) were those for which the outcome being modeled had been realized created some instability in the models. These measures were therefore excluded from further multivariate modeling attempts.

The results of a multivariate analysis predicting permanency outcomes using child behavior problems, placement type, placement stability, and child age at entry into care as predictor variables is presented in Table 7.12. Time

Table 7.11
Permanency Outcomes and Mental Health Measures

Outcome	CBCL Clinical/ borderline	YSR Clinical/ borderline	CDI Clinical/ subclinical	TSCC/PTSS Clinical/ subclinical
Reunification	38.2 (11.6) 19.2 – 61.8	33.6 (15.6) 11.1 – 67.2	6.3 (6.1) 0.9 – 34.0	7.4 (7.2) 1.0 – 38.4
Adoption/ subsidized guardianship	34.4 (4.7) 25.9 – 44.0	48.3 (10.6) 23.7 – 63.3	4.5 (3.2) 1.1 – 16.4	15.0 (5.7) 6.8 – 29.8
Still in care	50.1 (4.9) 40.6 – 59.6	32.4 (5.9) 22.0 – 44.7	10.6 (3.3) 5.6 – 19.1	14.1 (3.8) 8.1 – 23.2
Impermanence	33.4 (11.2) 15.7 – 57.3	20.8 (10.8) 6.8 – 48.8	0	0

Notes: Children’s Depression Inventory, (χ2 (3, 157) = 7.76, *p* = .05)
Trauma Symptoms Checklist for Children, (χ2 (3, 148) = 9.93, *p* = .02)

Table 7.12
Multivariate Modeling of Permanency Outcomes

Covariate	Reunification		Adoption/SG		Still in care		Impermanence	
	Hazard	C.I.	Hazard	C.I.	Hazard	C.I.	Hazard	C.I.
CBCL score clinical or borderline	0.88	0.46 – 2.74	0.69	0.95–2.21	1.32	.50 – 1.15	0.58	0.34-8.69
Placement Type Kinship Specialized Group/res. Foster	 1.42 1.09 0.00** Ref	 0.48 – 4.22 0.37 – 3.21 0.00 Ref	 1.10 0.70 0.00** Ref	 0.67–1.80 0.43–1.13 0.00 Ref	 1.52 0.52* 1.00 Ref	 0.90-2.56 0.32–0.87 0.56–1.80 Ref	 1.04 0.48 1.820 Ref	 0.27–3.91 0.18–1.31 0.42–7.79 Ref
Age at entry	1.05	.93 – 1.19	1.01	0.95-1.07	1.13**	1.06–1.20	2.10**	1.48–2.96
Number of placement moves	0.90	0.75 – 1.08	0.81**	0.73–0.89	0.98**	0.97-0.98	1.28**	1.12–1.47

Notes: Reunification, Group or residential care, t (265) = -15.25, *p* <.01
Adoption, Group or residential care, t (265) = -17.43, *p* <.01
Adoption, Number of placement moves, t (265) = -4.20, *p* <.01
Still in Care, Specialized foster care, t (265) = -2.50, *p* <.01
Still in Care, Age at entry, t (265) = 3.72, *p* <.01
Still in Care, Number of placement moves, t (265) = -2.63, *p* <.01
Impermanence, Age at entry, t (265) = 4.19, *p* <.01
Impermanence, Number of placement moves, t (265) = 3.56, *p* <.01

in care is controlled for in the modeling process, as the dependent variable is time to an event. The event, in this case, is the permanency outcome—reunification, adoption/guardianship, remaining in care, or impermanence. Each outcome is modeled as present or absent at the end of the time period observed (through June 30, 2006), and the duration modeled is either the time to the event, the time to the point at which the event could no longer take place, or the time to the end of the period of observation. The approach taken is survival analysis, which allows for study of the occurrence and timing of events and accommodates the inclusion of cases for which the event of interest does not occur in the time period studied (Allison, 1995). In the "hazard" column, a number of less than 1 indicates that a person with that characteristic has a likelihood of the event occurring at any given time that is lower than the likelihood if he or she did not have that characteristic. Hence, given that the hazard for adoption for a person with a clinically significant CBCL score is 0.88, that person has 88% of the likelihood of adoption that he or she would have without a clinically significant score (controlling for the other factors in the model). A number greater than 1 would indicate an increased likelihood of the event occurring at any given time for a person with that characteristic.

The results indicate that child behavior problems were not significantly predictive of any of the four permanency outcomes when other factors are controlled for (Table 7.12). The likelihood of reunification with family of origin was predicted only by placement type; children in group or residential care experienced a reduced likelihood of reunification. In fact, not a single child who was in group or residential care and for whom data were included in the model at the time of sampling for this study was reunified during the follow-up observation period. The likelihood of being adopted or taken into guardianship was also predicted by placement type, with children in group or residential care significantly less likely to achieve these outcomes. Children with more placement moves were also less likely to experience adoption and guardianship. Children who remained in foster care through the follow-up period were older at entry into care, had experienced fewer placement moves, and were less likely to live in specialized foster care than those who did not remain in care. Finally, youth who exited the foster care system to impermanence were older at entry and had experienced more placement moves than those who did not exit to impermanence. The model for impermanent outcomes was subpopulated to children who were at or over the age of 18 by June 30, 2006, as these were the children who would most likely have experienced the outcomes of interest. However, the results of the model changed little as a result of this adjustment, so the results for the full model are reported here.

Summary and Conclusions

While mental health status of children in foster care is commonly assumed to be a principal determinant of their outcomes, in terms of both placement stability and permanence, this analysis suggests that mental health status should not be treated as a monolithic construct but rather examined in greater specificity to more fully understand its relationship to these outcomes. Caregiver-reported behavior problems were not strongly associated with either placement stability or permanence when studied at either the bivariate or multivariate level. However, self-reported depression was associated with placement stability at the bivariate level such that children who reported themselves as depressed experienced more moves.

Unfortunately, depression symptomatology could not be incorporated in multivariate modeling, which would allow further exploration of the nature its relationship to placement stability. While depression may certainly be the result of multiple moves, it may also be the case that depression impacts the likelihood of this outcome. Children who are depressed are unlikely to be perceived as responsive to caregivers' efforts to connect with them and may be considered unfriendly, negative, or difficult, and this dynamic could contribute to placement instability. Assessment for depression and appropriate treatment when necessary may allow some children to attain a more optimal level of social functioning and may contribute to closer relationships with caregivers and more opportunities for lasting connection.

Self-reported trauma symptoms and depression were both associated with permanency outcomes (at the bivariate level) such that fewer children who identified themselves as experiencing trauma symptoms or depression later aged out of care or otherwise exited to impermanent living arrangement. This finding suggests some cause for concern with data validity. The children who exited to impermanent living arrangements might have been expected to be more likely to experience symptoms of trauma and depression than children who experienced permanency outcomes. One possibility is that these children are functioning less optimally than children who have established lasting connections with adults and are consequently not able to recognize and respond to their own affective states or have more completely disassociated themselves from those states. Another possibility is that, given that children who exited care to impermanent living arrangements were more likely to come into care when they were older, they may actually have come from families that were more functional, producing more optimal mental health. Further study to determine whether either of these possibilities or others as yet unconsidered are at work in driving these findings is needed.

The fact that mental health indices did not demonstrate strong or consistent associations with placement stability or permanence is meaningful in itself. The ability of researchers to effectively predict outcomes such as reunification, adoption, and placement stability, has long been hampered by challenges in matching data measuring child-specific characteristics with valid administrative data that can be used to calculate outcomes. The National Survey of Child and Adolescent Well-being (NSCAW) constitutes a major attempt to address these challenges; however, even in this ground-breaking, national study, data representing outcomes are considered, in some cases, incomplete. Administrative data representing outcomes are not available to the research community. Hence, the study reported here is one of few representing a match of at least one standardized measure of mental health with valid administrative data representing outcomes. If these findings are to be replicated in future studies, strong implications for the understanding of what drives the outcomes under study could emerge.

CHAPTER 8
Implications and Future Directions

Implications

The results from Round 2 of the IL-CWB study provide a wealth of information that adds considerably to the existing knowledge base about the state of well-being among foster children in Illinois. The study confirms the results from Round 1 in several important ways, suggests some trends toward improvement in some areas, adds information about dimensions of well-being that have not previously been considered, and provides an introductory basis for comparison with national data concerning well-being. This section reviews a very limited selection of some of the most noteworthy findings and their potential implications for policy, practice, and planning. The next section discusses some of the limitations of the existing study and ways in which this work could be advanced to the benefit of children and families whose lives have been touched by the child welfare system in Illinois.

Delivery of Physical Health Services

The findings concerning physical health care, presented in Chapter 4, suggest that delivery of physical health care services to children identified as needing them is a strength for the child welfare system in Illinois. Most of children identified by caregivers as needing health care services were reported as receiving them. In fact, service receipt in certain critical areas, such as dental care, has improved compared to findings from Round 1: current results reveal that 90% of children are receiving routine dental care, compared to only 79% in the previous study. Moreover, comparison of data from Illinois with national data suggest that children in foster care Illinois are less likely to make use of emergency or urgent care services or to stay overnight in a hospital than children in foster care nationally. The implication is that efforts to ensure early identification of medical needs and to improve communication about medical needs and services among caregivers, caseworkers, and providers appear to have been successful and that these and other efforts to promote access to health care should be recognized and maintained.

Delivery of Mental Health Services

The difficulties with identifying and appropriately responding to the mental health needs of children in foster care before unmet needs contribute to the development of crises that affect children and their caregivers and threaten placement stability is endemic to child welfare systems, and in fact, are faced by many families without child welfare system involvement. Data on mental health services delivery, presented in Chapter 3, suggest substantial efforts on the part of the administration, supervisors, and caseworkers who are working to promote the well-being of children in foster care, as a total of 50% of children in care were reported as receiving mental health services. The findings from this round of the IL-CWB study suggest that placement may have a less pronounced association with the delivery of mental health services than was evident based on Round 1 data; however, the findings continue to suggest that children in kinship care and traditional foster care who have identified mental health needs are somewhat less likely to receive services than children in specialized or group/residential care placements. The findings furthermore suggest that, among children with identified needs, those who are older when they enter care and those who remain in care longer are more likely to receive mental health services. The implication is that perseverance in attempts to identify mental health needs among children in foster care early and to ensure rapid access to services is crucial.

Findings emerging from the comparison of Illinois data to national data are also instructive in this matter. Children in foster care in Illinois were reported as less likely to receive mental health services from a family or medical health doctor or a community mental health center than children nationally and more likely to receive mental health services from medical inpatient unit. This finding suggests several possibilities. One is that medical doctors in Illinois are not encouraged to screen for mental health needs among the children they are serving. Another possibility is that there is a shortage of community mental health service providers, at least in some areas of the state. Recent work by other university/agency partnerships in Illinois suggests this is likely to be the case. If these more preventative services are not available, the likelihood of unmet mental health needs escalating to the point where a crisis necessitates inpatient hospitalization is likely to be greater. The implication is that efforts to identify those areas where community mental health providers are in the shortest supply and to promote resource development in those areas are well-advised and should continue.

Outcomes for Children in Group and Residential Care

The finding that children living in group and residential settings are less likely to exit care to permanent homes is not surprising. Children in these settings have the highest reported rates of physical health needs, the highest reported rates of mental health needs, and the highest rates of special education usage. An additional, noteworthy finding emerging from this study is that children in group and residential care have the highest reported exposure to violence, both witnessed and experienced, prior to entry into foster care. The intense and enduring nature of the needs of these children makes them more difficult to provide care for, and the impact of their experiences has often produced developmental differences that make building relationships with those around them more difficult. However, the finding that, even controlling for child behavior, group and residential care is associated with less desirable permanency outcomes gives pause. Children in group and residential care settings may come from families with fewer resources to provide for their care, and they may have less contact with their birth families, limiting reunification opportunities. Moreover, the nature of these settings is such that it limits contact with adults who are likely to become permanent care providers by way of adoption or guardianship in ways that kinship care, foster care, and specialized foster care do not. The implication of this finding is that further study of the specific needs of children who enter group or residential care, the exact nature of the services provided, the outcomes of these services, and how these factors relate to permanency outcomes is warranted. Pilot programs to increase contact with potential adoptive or guardianship resources for children in group or residential care could provide valuable insight into appropriate interventions to support improved permanency outcomes for this population.

Future Directions

To make the best decisions to promote children's physical, emotional, and educational well-being, policy makers and caseworkers must have up-to-date, methodical, and empirically-sound information. The B.H. Consent Decree monitoring process has established a structure to evaluate child well-being indicators and how they relate to safety, stability, permanence, and continuity. This report was shaped by two major goals: 1) to report on standardized and participant-reported (i.e. caregiver, caseworker, and child) indicators of well-being for Illinois foster youth, and 2) to compare Illinois foster youth with foster youth nationally. The results presented in this report provide a snapshot of several key well-being indicators for children in the Illinois foster care system, and comparisons to national data indicate that the well-being of foster children in Illinois generally mirrors that of foster children across the nation, with a few important exceptions.

The cross-sectional, or “snapshot,” nature of the current Illinois Child Well-Being studies provides us with a “report card” of how children are faring at a single point in time. This information should be used to uncover findings with potential implications for practice and policy, raise additional questions about key areas of interest, and lay the foundation for future research that can examine the issues in more depth. However, these types of data are limited in several ways. First, the existing data employ a limited selection of standardized instruments. This restricts the ability of researchers to compare findings with normative populations or with national data representing children in foster care. Second, the existing data over-represent children who have remained in care for longer periods of time. This feature of the sample may exaggerate the extent of measured needs among children in foster care as a whole, as those who remain in care for extended periods of time are likely to profile as having greater needs than those who enter and exit quickly. Third, the data do not support strong conclusions about changes over time in important dynamics such as service delivery. Finally, these data do not allow us to measure improvement or deterioration in the functioning of individual children as related to their abuse or neglect, placement, and service experiences. The importance of the types of information that could be obtained using a larger sample, a longitudinal approach, and more extensive employment of standardized instruments is such that these methods are strongly recommended for future work.

References

Advocates for Children of New York, Inc. (2000). *Educational neglect: Delivery of educational services to children in New York City's foster care system*. New York: Author. Retrieved 12/31/08 from www.advocatesforchildren.org.

Achenbach, T.M. (1991a). *Manual for the Youth Self-Report and 1991 profiles*. Burlington, VT: University of Vermont Department of Psychiatry.

Achenbach, T.M. (1991b). *Manual for the Child Behavior Checklist 4-18 and 1991 profile*. Burlington, VT: University of Vermont Department of Psychiatry.

Alexander, K., Entwisle, D., & Kabbani, N. (2001). The dropout process in life course perspective: Early risk factors at home and school. *Teachers College Record, 103*, 760 - 822.

Allison, P.D. (1995). *Survival analysis using the SAS System*: *A practical guide*. Cary, NC: SAS Institute, Inc.

American Academy of Child and Adolescent Psychiatry (1998). *Practice parameters for the assessment and treatment of children and adolescents with posttraumatic stress disorder*. Washington, DC: Author. Retrieved 12/31/08 from http://www.aacap.org/galleries/PracticeParameters/PTSDT.pdf .

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

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.

Anda, R.F., Felitti, R.F., Walker, J., Whitfield, C., Bremner, D.J., Perry, B.D., Dube, S.R., & Giles, W.G. (2006). The enduring effects of childhood abuse and related experiences: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatric and Clinical Neuroscience, 256*, 174 – 186.

Appel, A.E., & Holden, G.W. (1998). The co-occurrence of spouse and physical child abuse: A review and appraisal. *Journal of Family Psychology, 12*, 578-599.

Asher, S. R., & Wheeler, V. A. (1985). Children's loneliness: A comparison of rejected and neglected peer status. *Journal of Counseling and Clinical Psychology, 53*, 500–505.

Barth, R.P., Crea, T.M., John, K., Thoburn, J., & Quinton, D. (2005). Beyond attachment theory and therapy: Towards sensitive and evidence-based interventions with foster and adoptive families in distress. *Child and Family Social Work, 10*, 255-268.

Becker, M., Jordan, N., & Larsen, R. (2006). Behavioral health service use and costs among children in foster care. *Child Welfare, 85,* 633-647.

Beeman, S.K., Hagemeister, A.K., & Edleson, J.L. (2001). Case assessment and service receipt in families experiencing both child maltreatment and woman battering. *Journal of Interpersonal Violence, 16*, 437-458.

Berrick, J.D. (1997). Assessing the quality of care in kinship and foster family care. *Family Relations, 46*, 273-280.

Borawski, E.A., Ievers-Landis, C.E., Lovegreen,L.D., & Trapl, E.S. (2003). Parental monitoring, negotiated unsupervised time, and parental trust: The role of perceived parenting practices in adolescent health risk behavior. *Journal of Adolescent Health, 33*, 60-70.

Briere, J. (1996). *Trauma symptom checklist for children: Professional manual.* Lutz, FL: Psychological Assessment Resources Inc.

Bronfenbrenner, U., & Morris, P.A. (2006). The bioecological model of human development. In L.M. Lerner (Ed.), *Handbook of child psychology: Vol. 1, theoretical models of human development (6th ed.).* New York: Wiley.

Brookes Publishing (1999). *Technical report on ASQ.* Retrieved October 25, 2008 from http://www.brookespublishing.com/store/books/bricker-asq/asq-technical.pdf.

Burley, M. & Halpern, M. (2001). *Educational attainment of foster youth: Achievement and graduation outcomes for children in state care.* Olympia, WA: Washington State Institute for Public Policy. Retrieved 12/31/08 from http://www.wsipp.wa.gov.

Burns, B.J., Phillips, S.D., Wagner, H.R., Barth, R.P., Kolko, D.J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry*, *43,* 960-970.

Ceci, S.J. (1996). On Intelligence: *A bio-ecological treatise on intellectual development.* Cambridge, MA: Harvard University Press.

Chaffin, M., Silovsky, J.F., Funderbunk, B., Valle, L.A., Brestan, E.V., Balachova, T., Jackson, S., Lensgraf, J., & Bonner, B.L. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, *72*, 300-510.

Coakley, T.M., Cuddeback, G., Buehler, C., & Cox, M.E. (2007). Kinship foster parents' perceptions of factors that promote or inhibit successful fostering. *Children and Youth Services Review*, *29*, 92-109.

Conger, D. & Finkelstein, M. (2003). Foster care and school mobility. *Journal of Negro Education*, *72*, 97-103.

Connell, J. P. (1990). Context, self, and action: A motivational analysis of self-system processes across the life span. In D. Cicchetti & M. Beeghly (Eds.), *The self in transition* (pp. 61–97). Chicago: University of Chicago Press.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Sprague, C., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E. & van der Kolk, B. (2007). Complex trauma in children and adolescents. *Focal Point*, *2*, 4-8.

Cook, R.J. (1994). Are we helping foster care youth prepare for their future? *Children and Youth Services Review, 16*, 213-229.

Courtney, M., Terao, S., & Bost, N. (2004). *Midwest evaluation of the adult functioning of former foster youth: Conditions of youth preparing to leave state care.* Chicago: Chapin Hall Center for Children.

Courtney, M., Roderick, M., Smithgall, S., Gladden, R., & Nagaoka, J. (2004). *Educational status of foster children* (Issue Brief 102). Chicago: Chapin Hall Center for Children.

Coutinho, M. & Oswald, D. (2005). State variation in gender disproportionality in special education: Findings and recommendations. *Remedial and Special Education, 26*, 7-15.

Crosby, R.A., DiClemente, R.J., Wingood, G.M., Harrington, K., Davies, S., Hook , E.W., & Oh, M.K. (2002). Low parental monitoring predicts subsequent pregnancy among African-American adolescent females. *Journal of Pediatric and Adolescent Gynecology, 15*, 43-46.

DeRobertis, M.T., & Litrownik, A.J. (2004). The experience of foster care: Relationship between foster parent disciplinary approaches and aggression in a sample of young foster children. *Child Maltreatment, 9,* 92-102.

Devoe, E.R., & Smith, E.L. (2003). Don't take my kids: Barriers to service delivery for battered mothers and their young children. *Journal of Emotional Abuse, 3,* 277-294.

DiClemente, R.J., Wingood, G.M., & Crosbey, R. (2001). Parental monitoring with adolescents risk behaviors. *Pediatrics, 107,* 1363-1368.

Dishion, T. J., Patterson, G. R., Stoolmiller, M., & Skinner, M . S. (1991). Family, school, and behavioral antecedents to early adolescent involvement with antisocial peers. *Developmental Psychology, 27,* 72–180.

Dishion, T.J., & McMahon, R.J. (1998). Parental monitoring and the prevention of child and adolescent problem behavior: A conceptual and empirical formation. *Clinical Child and Family Psychology Review, 1*, 61-75.

Durkheim, E. (1947). *The division of labor in society*. G.Simpson (Trans.). Glencoe, IL: Free Press. (Originally published in 1893).

Dyregrov, A., & Yule, W. (2006). A review of PTSD in children. *Child and Adolescent Mental Health, 11*, 176-184.

Elliot, D., & Ageton, S. (1980). Reconciling race and class differences in self-reported and official estimates of delinquency. *American Sociological Review, 45,* 95–110.

English, D.J., Edleson, J.L., & Herrick, M.E. (2005). Domestic violence in one state's child protective caseload: A study of differential case dispositions and outcomes. *Children and Youth Services Review, 27*, 1183-1201.

Evans, L.D., Scott, S.S., & Schulz, E.G. (2004). The need for educational assessment of children entering foster care. *Child Welfare, 83*, 565-580.

Farruggia, S.P., Greenberger, E., Chen, C., & Heckhausen, J. (2006). Perceived social environment and adolescents' well-being and adjustment: Comparing a foster care sample with a matched sample. *Journal of Youth and Adolescence, 35,* 349-358.

Finkelhor, D., Ormrod, R.K., & Turner, H.A. (2007). Polyvictimization and trauma in a national longitudinal cohort. *Development and Psychopathology, 19*, 149-166.

Finn. J.D. (1993). *School engagement and students at risk*. Washington, DC: National Center for Education Statistics.

Flaherty, E.G., Thompson, R., Litrownik, A.J., Theodore, A., English, D.J., Black, M.M., Wike, T., Whimper, L., Runyan, D.K., & Dubowitz, H. (2006). Effect of early childhood adversity on child health. *Archives of Pediatric and Adolescent Medicine, 160,* 1232-1238.

Folman, R. (2002, September). *Assessing well being among traumatized children in foster care: the reality behind the numbers*. Paper presented at the Research Symposium on Child Well-being, Institute on Government and PublicAffairs, University of Illinois at Urbana-Champaign.

Folsom, W.S., Christensen, M.L., Avery, L., & Moore, C. (2003). The co-occurrence of child abuse and domestic violence: An issue of service delivery for social service professionals. *Child and Adolescent Social Work Journal, 20*, 375-387.

Fox, N.A., & Leavitt, L.A. (1995). *The Violence Exposure Scale for Children (VEX)*. College Park, MD: University of Maryland.

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

Freagon, S., Shumow, L, Baron-Jeffrey, A., & Cole, M. (2005, April). *Educational outcomes for Illinois children in foster care: A comprehensive record review*. Paper presented at the annual meeting of the American Educational Research Association, Montreal, CA.

Freagon, S., Baron-Jeffrey, A., & Cole, M. (2004, February). *Educational status of oldest CPS DCFS eighth graders during the 2002 – 03 school year*. Presentation at the annual meeting of the NIU Center for Child Welfare and Education Advisory Board Meeting, Chicago, Illinois.

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

Garling, A. & Garling, T. (1993). Mothers' supervision and perception of young children's risk of unintentional injury in the home. *Journal of Pediatric Psychology, 18*, 104-114.

Gebel, T.J. (1996). Kinship care and nonrelative family foster care: A comparison of caregiver attributes and attitudes. *Child Welfare, 75*, 5-18.

Geenen, S., & Powers, L.E. (2006). Are we ignoring youths with disabilities in foster care? An examination of their school performance. *Social Work, 51*, 233-241.

Goerge, R., Van Voorhis, J., Grant, S., & Casey, K. (1992). Special-education experiences of foster children: An empirical study. *Child Welfare, 71*, 419 – 437.

Greenberger, E., Chen, C., & Beam, M.R. (1998.) The role of "very important" nonparental adults in adolescent development. *Journal of Youth and Adolescence, 27*, 321-343.

Hanley, B., (2002). Intersections of the fields of child welfare and developmental disabilities, *Mental Retardation, 40*, 213-215.

Hansen, R.L., Mawjee, F.L., Barton, K., Metcalf, M.B., & Joye, M.R. (2004). Comparing the health status of low-income children in and out of foster care. *Child Welfare, 83*, 367-380.

Harden, B.J., Clyman, R.B., Kriebel, D.K., & Lyons, M.E. (2004). Kith and kin care: Parental attitudes and resources of foster and relative caregivers. *Children & Youth Services Review, 26*, 657-671.

Hartman, C. (2002). *High classroom turnover: How children get left behind*. Washington, DC: Citizen's Commission on Civil Rights. (ERIC Document Reproduction Service No. ED 466506).

Hazen. A.L., Connelly, C.D., Kelleher, K., Landsverk, J., & Barth, R. (2004). Intimate partner violence among female caregivers of children reported for maltreatment. *Child Abuse & Neglect, 28 (3)*, 301-319.

Hofferth, S. (1998). *Healthy Environments: Healthy children: Children in families*. A report on the 1997 Panel Study of Income Dynamics. Unpublished manuscript, Ann Arbor, MI: Institute for Social Research.

Horwitz, S.M., Owens, P., & Simms, M.D. (2000). Specialized assessments for children in foster care. *Pediatrics, 106*, 59-66.

Igelman, R., Conradi, L., & Ryan, B. (2007). Creating a trauma-informed child welfare system. *Focal Point, 21*, 23-26.

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

Jimerson, S., Anderson, G., & Whipple, A. (2002). Wining the battle and losing the war: Examining the relation between grade retention and dropping out of high school. *Psychology in the Schools, 39*, 441–457

Kantor, G.K., & Little, L. (2003). Defining the boundaries of child neglect: When does domestic violence equate with parental failure to protect? *Journal of Interpersonal Violence, 18*, 338-355.

Kauffman Best Practices Project to Help Children Heal from Child Abuse. (2004). *Closing the quality chasm in child abuse treatment: Identifying and disseminating best practices*. National Child Traumatic Stress Network. Retrieved 1/2/09 from http://www.nctsnet.org/nctsn_assets/pdfs/reports/kauffmanfinal.pdf.

Kitzmann, K.M., Gaylord, N.K., Holt, A.R., & Kenny, E.D. (2003). *Child witnesses to domestic violence: A meta-analytic review*. Journal of Consulting and Clinical Psychology, *71*, 339-352.

Kortenkamp, K., & Macomber, J.E. (2002). *The well-being of children involved with the child welfare system: A national overview* (Series B, No B-43). Washington, DC: The Urban Institute.

Kovacs, M. (2003). *Children's Depression Inventory manual*. Minneapolis, MN: Pearson Assessments, Inc.

Kurdek, L.A., Fine, M.A., & Sinclair, R.J. (1995). School adjustment in sixth graders: Parenting transitions, family climate, and peer norm effects. *Child Development, 66*, 430-445.

Lehmann, P. (2000). Posttraumatic stress disorder (PTS) and child witnesses to mother assault: A summary and review. *Children and Youth Services Review, 22*, 275-306.

Leslie, L.K., Gordon, J.N., Meneken, L., Premji, K., Michelmore, K.L., & Ganger, W. (2005). The physical, developmental, and mental health needs of young children in child welfare by initial placement type. *Developmental and Behavioral Pediatrics, 26*, 177-185.

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.

Lieberman, A.F. & Van Horn, P. (2005). *Don't hit my mommy! A manual for child-parent psychotherapy with young witnesses of family violence*. Washington, DC: Zero to Three Press.

Linares, L.O., Montalto, D., Rosbruch, N., & Li, M.M. (2006). Discipline practices among biological and foster parents. *Child Maltreatment, 11*, 157-167.

Litrownik, A.J., Newton, R., Mitchell, B.E., & Richardson, K.K. (2003). Long-term follow-up of young children placed in foster care: Subsequent placements and exposure to domestic violence. *Journal of Family Violence, 18,* 19-28.

Lynch, M., & Cicchetti, D. (1991). Patterns of relatedness in maltreated and nonmaltreated children: Connections among multiple representational models. *Development and Psychopathology, 3*, 207–226.

Mallon, G. (1998). After care, then where? Outcomes of an independent living program. *Child Welfare, 77*, 61-78.

Mann, D. (1987). Can we help dropouts? Thinking about the undoable. In G. Natriello (Ed.), *School dropouts: Patterns and policies* (pp. 3 – 19). New York: Teachers College Press.

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist, 56*, 227-238.

McMillan, J.C., Zima, B.J., Scott, L.D., Auslander, W.F., Munson, M.R., Ollie, M.T., & Spitznagel, E.L. (2005). Prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child and Adolescent Psychiatry, 44* , 88-95.

Minnis, H., Everett, K., Pelosi, A.J., Dunn, J., & Knapp, M. (2006). Children in foster care: Mental health, service use and costs. *European Child and Adolescent Psychiatry, 15*, 63-70.

National Child Traumatic Stress Network. (2004). Children and trauma in America: A progress report of the National Child Traumatic Stress Network. Author. Retrieved 1/3/09 from http://nctsn.org/nctsn_assets/pdfs/reports/NCTSNProgressReport2004.pdf.

Nollan, K.A., Horn, M., Downs, A.C., Pecora, P.J., & Bressani, R.V. (2001). *Ansell Casey Life Skills Assessment (ACLSA) and life skills guidebook manual.* Seattle, WA: Casey Family Programs.

Ostler, T., Haight, W., Black, J., Choi, G.Y., Kingery, L., & Sheridan, K. (2007). Mental health outcomes and perspectives of rural children reared by parents who abuse methamphetamine. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*, 500-507.

Perry, B., & Azad, I. (1999.) Posttraumatic stress disorders in children and adolescents. *Current Opinion in Pediatrics, 11,* 310-316.

Perry, B.D. & Pollard, R. (1998.) Homeostasis, stress, trauma, and adaptation: A neurodevelopmental view of childhood trauma. *Child and Adolescent Psychiatric Clinics of North America, 7*, 33-51.

Pilowsky, D.J., & Wu, L. (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.

Putnam, R.D. (2000). Bowling alone: The collapse and revival of American community. New York: Simon & Schuster.

Quinn, J. (1995). Positive effects of participation in youth organizations. In M. Rutter (Ed.), *Psychosocial disturbances in young people: Challenges for prevention*. New York: Cambridge University Press.

Raviv, A., Erel, O., Fox, N., Leavitt, L., Raviv, A., Dar, I., Shahinfar, A., & Greenberg, C.W. (2001). Individual measurement of exposure to everyday violence among elementary schoolchildren across various settings. *Journal of Community Psychology, 29*, 117-140.

Rolock, N., & Testa, M.F. (2006). *Conditions of children in or at risk of foster care in Illinois: An assessment of their safety, stability, continuity, permanence, and well-being*. University of Illinois at Urbana-Champaign, Children and Family Research Center.

Rossman, B.B.R., Hughes, H.M., & Rosenberg, M.S. (2000). *Children and interpersonal violence: The impact of exposure*. Philadelphia: Taylor and Francis.

Runyan, D. K., Curtis, P., Hunter, W. M., Black, M. M., Kotch, J. B., & Bangdiwala, S. (1998). LONGSCAN: A consortium for longitudinal studies of maltreatment and the life course of children. *Aggression and Violent Behavior: A Review Journal, 3*, 275–285.

Ryan, J.P., Testa, M.F., & Zhia, F. (in press). African American males in foster care and the risk of delinquency: The value of social bonds and permanence. *Child Welfare*.

Schneiderman, J.U., Brooks, D., Facher, B., & Amis, J. (2007). Improving health services for foster youth: Multidisciplinary and multistakeholder perspectives and recommendations. *Children and Youth Services Review, 29*, 313-328.

Shepard, L. A. & Bleim, C. (1995). An analysis of parent opinions and changes in opinions regarding standardized tests, teacher’s information, and performance assessments. Los Angeles: National Center for Research on Evaluation, Standards, and Student Testing. (ERIC Document Reproduction Service No. ED389734).

Shore, N., Sim, K., LeProhn, N., & Keller, T. (2002.) Foster parent and teacher assessments of youth in kinship and non-kinship foster care placements: Are behaviors perceived differently across settings? *Children and Youth Services Review, 24*, 109-134.

Shumow, L. (1997). Parent's educational beliefs: Implications for parent participation in school reforms. *The School Community Journal, 7*, 37-49.

Shumow, L., & Perry, B. (2006). *Literature review on trauma, stress and its implications for the education of children in foster care*. Paper presented at the Symposium on Trauma, Stress and the Education of Children and Youth in Foster Care, Northern Illinois University Center for Child Welfare and Education, DeKalb, IL.

Singer, E., Doornenbal, J., & Okma, K. (2004). Why do children resist or obey their foster parents? The inner logic of children's behavior during discipline. *Child Welfare, 83*, 581-610.

Smith, M.C. (1994). Child-rearing practices associated with better developmental outcomes in preschool-age foster children. *Child Study Journal, 24*, 299-327.

Smithgall, C., Gladden, R., Howard, E., Goerge, R, & Courtney, M. (2004). *Educational experiences of children in out-of-home care in Chicago*. Chicago: Chapin Hall Center for Children.

Smithgall, C., Gladden, R., Yang, D., & Goerge, R. (2005). *Behavior problems and educational disruptions among children in out-of-home care*. Chicago: Chapin Hall Center for Children.

Stambaugh, L., Burns, B.J., Landsverk, J., & Reutz, J.R. (2007). Evidence-based treatment for children in child welfare. *Focal Point, 21*, 12-15.

Stanton, B., Li, X., & Galbraith, J. (2000). Parental underestimates of adolescent risk behavior: A randomized, controlled trial of a parental monitoring intervention. *Journal of Adolescent Health, 26*, 18-26.

Starfield, B., Riley, A.W., Green, B.F., Ensminger, M.E., Ryan, S.A., Kelleher, K. et al. (1995). The Adolescent Child Health and Illness Profile: A population-based measure of health. *Medical Care, 33*, 553-566.

Stein, B.D., Jaycox, L.H., Kataoka, S., Rhodes, H.J., & Vestal, K.D. (2003). Prevalence of child and adolescent exposure to community violence. *Clinical Child and Family Psychology Review, 6*, 247-264.

Straus, M., Hamby, S., Finkelhor, D., Moore, D., & Runyan, D. (1998). Identification of child maltreatment with the Parent-Child Conflict Tactics Scales: Development and psychometric data for a national sample of American parents. *Child Abuse & Neglect, 22*, 249–270.

Tomchin, E., & Impara, J. (1992). Unraveling teachers' beliefs about grade retention. *American Educational Research Journal, 29*, 199-223.

Van der Kolk, B.A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress, 18*, 389 – 399.

Vig, S., Chinitz, S., & Shulman, L. (2005). Young children in foster care: Multiple vulnerabilities and complex service needs. *Infants & Young Children, 18*, 147-160.

Werner, E.E., & Smith, R.S. (1982). *Vulnerable but invincible*. New York: McGraw-Hill.

Zetlin, A. (2006). The experiences of foster children and youth in special education. *Journal of Intellectual & Developmental Disability, 31*, 161-165.

Zetlin, A., Weinberg, L., & Kimm, C. (2004). Improving education outcomes for children in foster care: Intervention by an education liaison. *Journal of Education for Students Placed At Risk, 9*, 421-429.

Zima, B., Bussing, R, Yang, X., Belin, T., & Forness, S. (2000). Behavior problems, academic skill delays and school failure among school-aged children in foster care: Their relationship to placement characteristics. *Journal of Child and Family Studies, 9*, 87-103.

APPENDIX A:
SAMPLE SELECTION AND WEIGHTING DOCUMENTATION

July 20, 2004

To: Christina Bruhn
From: John Rogers

SUBJECT: Revised weights and supplemental sample for the BH Round 2 study

REVISED July 20, 2004: Documents redraw of supplemental sample restricted to children 7 years or older as of 7/1/2004

In May of 2003, Westat selected a sample of children for the BH Round 2 study. The data files with the sample included sampling weights and additional variables relevant to the sampled children. The additional variables were obtained from the March 2003 version of the Chapin Hall foster care files. Due to lower than planned completion rates, Westat was asked to select a supplemental sample of children in order to increase the final number of respondents. At the same time, Westat realized there was a minor problem with the sampling weights and recommended calculation of revised sampling weights.

This memo documents the revision of the sampling weights for the original sample and the selection of the supplemental sample of children. A supplemental sample was selected in the beginning of July 2004. However, that sample did not restrict the frame to children 7 years and older. The supplemental sample was reselected after restricting the frame to children 7 and older.

Enclosed is a CD with files with the revised weights and revised supplemental sample. All files are provided in both SAS and Excel formats. The CD also has a copy of this memo.

Revision of the Sample Weights

The original sample weights reflected the probabilities of selection at each sampling phase as if those probabilities were independent across sampling phases. However, they were not independent. As a result of the lack of independence, it is difficult to calculate the correct probability of selection for each child. Approximate probabilities were therefore used to calculate the revised weights.

The sample design required randomly selecting children and then subsampling to select no more than one child from the same family and one child from the same non-group provider. Thus, the probability of selection depended on whether there were multiple children associated with a family or a provider. The more children with the same family (or provider), the higher the probability that multiple children from the same family would be sampled and thus that subsampling would be needed.

Consider the case where a family has N children in the files. If the probability of selection for each child is p, then the probability that the first child is selected for the study is the sum of

1) The probability that the first child is selected and no other children in the family are selected, $P(1-p)^{N-1}$, and

2) The probability that the first child is selected, one of the remaining N–1 children is selected, and the first child is selected in the subsample,

$$. \quad \frac{(N-1)p^2(1-p)^{N-2}}{2}$$

3) The probability that the first child and two other children are selected and the first child is selected in the subsample,

$$\frac{(N-1)(N-2)p^3(1-p)^{N-3}}{3}$$

4) Et cetera, until all N children are selected, and the first child is selected in the subsample.

Since the probabilities of selection were relatively small and the number of families with many children is relatively small, terms for the probability of selecting more than two children can be reasonably ignored. To approximate the probabilities of independent selection, the following formula was used:

$$(1-p)^{N-1} + \frac{(N-1)p^2(1-p)^{N-2}}{2} = p + \left((1-p)^{N-1} + \frac{(N-1)p(1-p)^{N-2}}{2} - p \right)$$

where N is the number of children in a family.

The formulas above apply if the children are selected independently. However, children were paired and pairs to children were selected to create a paired primary and clone sample, distorting the probabilities. In addition, a child might be subsampled if there were multiple children in a family or if there were multiple children with the same provider. A scaling factor (F) was added to adjust for the effect of subsampling by both family and provider and for the effect of pairing children before sampling. The final formula for the probability of selection becomes

$$p + \left((1-p)^{N-1} + \frac{(N-1)p(1-p)^{N-2}}{2} - p \right) F$$

F was determined empirically so that the sum of weights for the sample approximated the population size. Due to the random effects of subsampling and the stratified design (different children from the same family [or provider] might be in different strata with different probabilities of selection), the sum of weights for the sampled children is a random variable that is only approximately equal to the population size. For applying the approximation above, p is the probability of selection in the strata for the child being considered and N is, $N = N_f + N_p - 1$, where Nf is the number of children in the child's family and Np is the number of children with the child's provider (Np = 1 for group providers). Based on experimentation, F was set to 0.5.

The weights based on the formula above are approximate.

However, because the basic probability of selection (before subsampling) is small, the ultimate effect of the subsampling is relatively small. As a result, the approximations make relatively little difference for most children. In the original weights, children that were selected by subsampling had a much smaller weight. In the revised weights, all children in a stratum have more similar weights.

The revised sample weights are in the following files:

PrimarySampleRev- with revised weights for the primary sample

CloneSampleRev- with revised weights for the clone sample

Each of these files has the original weight SAMPWGT and the revised weight SAMPWGT1, as well as all the other variables in the original sampling files.

Selection of the Supplemental Sample

The frame for selection of the supplemental sample includes those children that 1) meet the sample criteria, 2) are in both the March 2003 data files and the December 2003 version of the Chapin Hall foster care files, 3) were not selected in the original sample, and 4) were 7 years or older as of July 1, 2004. To determine which children met the sampling criteria, the program that was used to process the March 2003 data was applied to the December 2003 data file.

The original sample was selected from seven strata. The supplemental sample of 100 children was selected from four of the original strata (the strata with the older children). Otherwise, the supplemental sample was selected with the same procedures as was the original sample. Sample weights for just the supplemental sample were calculated as above. Because some children had left the system and children were selected from four instead of seven strata, the frame for sample selection was smaller for the supplemental sample than for the original sample (7,096 versus 15,777 children).

When the original and supplemental samples are combined, the sample weights must be adjusted to reflect the probabilities of selection in both samples. Children selected in the original sample that were not in the December 2003 data file could only be selected in the original sample. Thus their probability of selection and sampling weight are the same as in the original sample.

Children that were eligible and in both data files had two changes of selection. Since the probability of selection is the inverse of the sample weight, the probability of selection for children in both frames is

$$q = \frac{1}{\text{Original sampleweight}} + \frac{1}{\text{Supplemental sampleweight}}$$

Therefore the sample weight for the combined sample is

$$W = \frac{1}{q}$$

Note that, before the sample was selected all children that were in both frames had two chances to be selected, once in the original sample and once in the supplemental sample. The fact that children selected in the original sample were excluded from the frame for the supplemental sample does not change the fact that these children had two chances to be selected. As a result, selecting a supplemental sample changes the weights for the original sample (at least for those children in both data files). The files for the supplemental sample have data and weights for all sampled children. The weights for the combined original and supplemental sample are in the SAMPWGT2 variable.

The files with the supplemental samples are the following:

PrimarySuppSample2 with weights and data for the original and supplemental sample

CloneSuppSample2 with weights and data for the original and supplemental sample

For the children selected in the original sample, these files have associated data from the March 2003 foster care files. For children selected in the supplemental sample, these files have associated data from the December 2003 foster care files. The SAMPLE variable can be used to select the children in just the supplemental sample.

To summarize the weights:

- Although SAMPWGT is in the attached data files, I do not recommend using the SAMPWGT weights. The results using these weights will be close to those with the SAMPWGT1 weights.
- For analyzing data from just the original sample (before the supplemental sample results are available), I recommend using the SAMPWGT1 weights.
- For analyzing data from both the original and supplemental samples, use the SAMPWGT2 weights.
- Before any analysis, these weights should be adjusted for non-response.
- Due to the subsampling, the number of children in the supplemental sample is a random variable. The sampling process was adjusted to obtain a final sample size close to the desired number. Due to the random nature of the sampling and subsampling, the primary and clone supplemental samples have different numbers of children. The primary sample has 101 children and the clone supplemental sample has 99 children.

In case they are needed for anything, the data CD includes the programs used to select the supplemental sample and adjust the weights. The programs use Westat's proprietary sampling macro WESSAMP.

May 1, 2003
Memo 2.2
To: Christina Bruhn, Illinois DCFS
Mark Testa, Illinois DCFS
From: John Rogers
CC: Ronna Cook, Westat
Mike Cross, Westat
SUBJECT: Selection of the Year 2
Well-Being Sample

Changes from the prior memo: Update description of the sample based on the new data

This memo summarizes the procedures used to select the Round 2 Well-Being primary sample and clone sample. The primary sample and clone sample are selected from the sample frame. Memo 1.4 describes the construction of the sample frame. The frame has 15,777 children.

The sample selection uses stratified random sampling, subject to some constraints. The primary sample and clone samples were selected to maximize the similarity between the two samples.

The sample was a stratified sample with target sample sizes for each stratum. The constraints for the sample include the following:

1) For non-group providers, no more than one child per provider is selected. Non-group providers are those with typecode of FHA, FHB, FHI, FHP, FHS, FOS, HMR, HRA, and HRL exclusively. Provider ID = 000000 was assumed to be a group provider since most of the typecodes associated with this ID were for group providers.

2) No more than one child per family (defined by the caseid variable) is selected.

The basic approach to selecting the primary and clone samples within each stratum is to create pairs of similar children, randomly select child-pairs, and then randomly assign one child from each pair to the primary sample and the other to the clone sample. Where possible, the children were paired such that both children in a pair had the same provider and the same or similar ages. If a provider had only one child on the frame, it was not possible to pair children within the provider. These children were grouped together, sorted by age, and paired to create pairs of children with similar ages but different providers.

The basic approach above was modified to fit the frame and to provide a sample with more constant weights within strata. As a general rule, a sample with constant weights (i.e., all the weights are identical) will provide estimates with less sampling error than a sample with non-constant weights. The basic approach above was modified as follows:

1) If there were an odd number of children associated with a provider or in a stratum, one “pair” of children would have three children. I will continue to use the term “pair” to refer to a small group of children even though a few “pairs” have more that two children.

2) For non-group providers with more than one child, all children with the provider were placed into one “pair.” Usually the “pairs” had only two children, however the largest such “pair” had six children.

3) Pairs of children were sampled with probability proportional to the number of children in the pair.

4) One child within the pair was sampled for the primary sample and another was sampled for the clone sample. In pairs that had more than three children, subgroups with either two or three children were defined such that children in a subgroup had similar ages. The children selected for the primary and clone sample came from the same subgroup. In the sampling files, the SubGrp variable identifies the pairs. Thus, a child from the primary sample and a child from the clone sample that have the same value for SubGrp are from the same pair.

The constraints on the sample selection were achieved by 1) selecting a stratified sample without any constraints; 2) for multiple children associated with the same non-group provider, subsampling to select one child; and 3) for multiple children associated with the same family, subsampling to select one child. As a result of the random selection of children and the subsequent subsampling to remove multiple children per provider or family, the number of sampled children is random, varying slightly around the target sample sizes for each stratum. The subsampling was performed separately for the primary and clone samples. As a result, a few children in the clone sample may not have a corresponding child in the primary sample and vice versa.

The sample weights are the inverse of the probability of selection. For many sample designs, the sum of the sample weights is equal to the number of records in the frame. This is true for the preliminary sample, before subsampling to remove multiple children per family or provider. However, the sum of the weights for the final sample is not exactly equal to the number of records in the frame. This does not indicate a problem with the sample. If it is important to have the sum of the weights equal the number of records in the frame, the weights can be adjusted. If performed, this adjustment is usually made when the weights are adjusted for non-response or for children that are not eligible for the survey.

The sample files have all the variables in the frame plus the following variables, added as part of the sample selection:

Variable	Definition
SampWgt	Sample weight, the number of similar children represented by the sampled child
YICStrat	Years in care strata (1 = less than 3, 2 = greater than or equal to 3 years)
AgeStrat	Current Age stratum (1 = less than 3, 2 = 3 to less than 5, 3 = 5 to less than 9, 4 = 9 to less than 17)
Strata	Strata, defined as YICStrat*10 + AgeStrat
SubGrp	Identifier of the pair from which the child was sampled

The strata are defined by years in care in the current spell and by current age. Table A.1 shows the number of children in the frame, the target number of cases to be selected, and the number of cases actually selected, by stratum. The target

Table A.1
Number of Children in the Frame and Sample, by Stratum

Strata			Number of children			
Years In Care, current spell	Current Age	Target percent of sample	In the frame	Target sample size	Primary sample	Clone sample
3 months to < 3 years	3 mo. to < 3 yr.	10%	2,933	55	54	56
	3 yr. to 5 yr.	10%	1,325	55	57	52
	5 yr. to < 9 yr.	10%	1,811	55	56	55
	9 yr. to < 17 yr.	20%	2,665	109	110	110
3 years or more	3 yr. to 5 yr.	10%	847	55	56	57
	5 yr. to < 9 yr.	10%	1,678	55	57	52
	9 yr. to < 17 yr.	30%	4,518	164	164	164
Total		100%	15,777	548	554	546

sample size is 547 children. The sample size was allocated to different strata based on a percentage allocation provided by DCFS. The target sample size for each strata was entered into the sampling program. Where necessary the target sample sizes were increased or modified, to account for subsampling, until the number of children in each stratum was close to the desired target.

Using the Weights

The sampling weights can be interpreted as the number children in the frame represented by each sampled child. The children in each strata were essentially randomly selected, however, not all with the same probability of selection. Proper analysis of the data requires a program that uses information on how the sample was selected, such as WesVar or SUDAAN. WesVar uses replicate weights to calculate variances. Replicate weights have not been created and generally are not created until any adjustment for non-response is made.

Because of how the sample was selected, using SAS (or another statistical program that assumes the data are from a random sample) for preliminary analysis of the survey results within a stratum will provide a reasonable approximation to the more correct results from WesVar. However, the results will not be correct when data from multiple strata are used in an analysis. Results across multiple strata might be obtained by calculating results for each stratum and manually combining the stratum results.

APPENDIX B:
PERMISSION ,CONSENT, AND RELEASE FORMS

PERMISSION FORM FOR MINOR

WELL BEING STUDY

As legal guardian of ____________________________, date of birth, _________________, C #____________________, (referred to hence as "the minor"), I hereby give my consent for her/him to parti in the "Well Being Study" being conducted by Professor Mark Testa of the Children and Family Research University of Illinois Urbana-Champaign for the Illinois Department of Children and Family Services (DCFS). giving this consent subject to the following conditions and understandings:

The study of 800 children will determine current levels of child well being in the areas of safety, permanency, physical and mental health, education, social functioning and transition to adulthood.

- The participation of the minor will involve completing a 30 to 60-minute, <u>interviewer-administered, survey with some self-administered computerized questions</u>. Most of the interview will be taken by a trained interviewer using a laptop computer. During the self-administered portion of the interview the minor will wear headphones and those questions will be collected privately. The interviewer will be nearby to provid any help the minor might need. The interview questions cover different areas of the minor's life, including school functioning, favorite activities, and physical and mental health. There are also questions are about topics such as skipping school, smoking, drinking, vandalism, using drugs, sexual activities, and other risk or illegal behaviors. In total the survey will take about 30 to 60 minutes to complete.

- I understand that the primary risk of this study is that the minor may experience some emotional upset or discomfort as a result of answering questions for this survey. To minimize this risk, the minor may skip an questions that cause discomfort. If the minor reports any distress, the interviewer will, with the minor's permission, contact the minor's foster parent or the minor's other care provider.

- The minor's participation will be completely voluntary. The interview will not be conducted unless the researcher has obtained an assent form from the minor. Also, the minor will be advised prior to the interview that she/he may decline to answer any or all questions asked and that no one will be told of that decision not to answer questions. If the minor refuses to participate in this project, it will not affect any services or benefits his or her family is entitled to from DCFS or any other government agencies.

- There are no direct benefits to the minor as a result of participating in this study. The primary benefit to the minor will be that he/she is contributing to knowledge about child welfare services which will be helpful to better understanding the strengths and needs of families and children in Illinois.

- Information provided by the minor in the interview will be confidential. Only designated project staff will have access to this information. DCFS staff will only have access to reports of the information. All information will be reported as grouped data, with no identifying information. The only exception to this guarantee of confidentiality will be the child's disclosure of information that she/he is currently being abused or neglected, or is currently being put at serious risk of abuse or neglect, or intent to harm him/her self. Such information will be reported to the DCFS Child Abuse Hotline, or emergency services as required by law. The minor will be advised of this requirement prior to being asked to give assent to be interviewed.

- The minor will be given a $15.00 gift certificate for participation in the interview. And the minor may keep the gift certificate even if he/she does not complete all of the interview questions.

- If any minor has questions regarding this study and/or his/her rights as a research participant they will be advised to call Ingrid Graf of the Survey Research Laboratory at 1-800–688-0582 or Professor Mark Testa, the Primary Investigator, at the Children and Family Research Center at 1-800-638-3877 or the Institutional Review Board of the University of Illinois Urbana Champaign by dialing collect (1-217-333-2670) or on-line at irb@uiuc.edu.

- A signed copy of this form has been given to me.

____ ______/_____/_____

SIGNATURE OF DCFS GUARDIAN DATE

UNIVERSITY OF ILLINOIS
APPROVED CONSENT
VALID UNTIL

SEP 1 6 2005

MINOR ASSENT FORM, CHILDREN 7-10 YEARS OF AGE
WELL BEING STUDY

READ TO MINOR:

Hello, (MINOR'S NAME). It's nice to meet you. My name is (INTERVIEWER). I'm from the Survey Research Laboratory at the University of Illinois-Chicago. My job is to talk to children and teenagers all over Illinois about what it's like living in different kinds of families. I am collecting information for a research study called the Well Being Study being conducted by Professor Mark Testa of the Children and Family Research Center. In all, we are going to follow over 800 kids. Today I'm here to talk to you about what it's like living with (CAREGIVER NAME). Your (DCFS Guardian or parent) has given me permission to talk to you. We're trying to determine how you are doing where you live now so we can help DCFS learn how to give kids the things they need. We were hoping that you could help with that.

The study will involve a computerized interview. I will be asking you questions about favorite activities, any problems at home or in school, your health, and your family and community. I will also ask about how you behave at home and at school, how you feel about your family, your friends, school, and about people who may help you. I will be entering your answers into a computer. There will be a portion of the interview that you will complete on my computer. You have to listen to those questions using headphones on your ears. The interview lasts about 30 minutes. You will be given a $15.00 gift certificate at the end of the interview as 'a thank you' for your time.

During the course of this interview, you may become emotionally upset or uncomfortable. If any of the questions upset you, you do not have to answer them. If you want to talk about any of the questions let me know and, if you tell me it is okay with you, I will tell your family or caseworker.

You can decide whether or not you want to do the interview. It's up to you. You may decide to stop at any time, or skip questions. If you should choose not finish the whole interview, you will still receive the $15.00 gift certificate. Whatever you decide, you or your family will not get into any trouble or be punished in any way.

Everything you say today is confidential. That means that no one will know where this information came from, not even (CAREGIVER NAME). There is one exception. If you give us information about any incident of abuse or neglect that occurred after you entered DCFS care or about any risk of harm to yourself or if you state your intention to harm someone else, I am required by law to report this to your caseworker, his or her supervisor, or emergency services, to make sure you are safe.

After we are all done interviewing, we're going to put together the information you give me today with the information from all the other kids we will be talking to, and make a report about kids and their different experiences living in different kinds of families.

Do you have any questions for me?

If you have any questions later, you can call Ingrid Graf at the Survey Research Laboratory at 1-800-688-0582 or you can call Professor Mark Testa, the Primary Investigator for this study, at 1-800-638-3877, or you can call the Institutional Review Board at the University of Illinois Urbana Champaign by dialing collect 217-333-2670 or on the internet at irb@uiuc.edu.

If it is OK with you to do the interview, **I need you to sign the statement below**. I'll read it to you, let me know if you don't understand and I'll explain it to you.

Subject Statement:
I agree to participate in the study, and in the interview that will include questions about services I have received, my health, my favorite activities, any problems at home or school and my family and community. I understand what my participation in the study involves and that I am free to stop the interview at any time. I will answer truthfully to the best of my ability. This consent will be valid for the duration of the study, through September 16, 2005. A signed copy of this assent agreement has been given to me.

....	............/........../...........
SIGNATURE OF MINOR	DATE
....	............/........../...........
SIGNATURE OF WITNESS	DATE

UNIVERSITY OF ILLINOIS
APPROVED CONSENT
VALID UNTIL

SEP 1 6 2005

MINOR ASSENT FORM, CHILDREN 11-17 YEARS OF AGE
WELL BEING STUDY

READ TO MINOR:

Hello, (MINOR'S NAME). It's nice to meet you. My name is (INTERVIEWER). I'm from the Survey Research Laboratory at the University of Illinois-Chicago. My job is to talk to children and teenagers all over Illinois about what it's like living in different kinds of families. I am collecting information for a research study called the Well Being Study being conducted by Professor Mark Testa of the Children and Family Research Center. In all, we are going to follow over 800 kids. Today I'm here to talk to you about what it's like living with (CAREGIVER NAME). Your (DCFS GUARDIAN or PARENT) has given me permission to talk to you. We're trying to determine the needs of children who don't live with their parents so we can help DCFS learn how to give them the kinds of things they need. We were hoping that you could help with that.

The study will involve a computerized interview. I will be asking you questions about the kinds of things you do, any problems at home or in school, your health, your family and community. I will be entering most of your answers into a computer. There will be a portion of the interview that you will complete on my computer. You have to listen to those questions using headphones on your ears. These questions are about things you may do that your parents don't know about or don't like for you to do, such as skipping school, smoking, drinking, vandalism, using drugs, sexual activities, and other risky or illegal behaviors. There are also some questions about things that may have happened in your home that scared or hurt you. You may also find that some of these questions bring back sad or frightening memories. Only you will hear those questions and know how you answered them.

During the course of this interview, you may become emotionally upset or uncomfortable. If any of the questions upset you, you do not have to answer them. If you want to talk about any of the questions let me know and, if you tell me it is okay with you, I will tell your family or caseworker.

The interview lasts about 60 minutes. You will be given a $15.00 gift certificate at the end of the interview, as a 'thank you' for your time. You can decide whether or not you want to do the interview. It's up to you. You may decide to stop at any time, or skip questions. If you should choose not finish the whole interview, you will still receive the $15.00 gift certificate. Whatever you decide, you or your family will not get into any trouble or be punished in any way.

Everything you say today is confidential. That means that no one will know where this information came from, not even (CAREGIVER NAME). There is one exception. If you give us information about any incident of abuse or neglect that occurred after you entered DCFS care or about any risk of harm to yourself or if you state your intention to harm someone else, I am required by law to report this to your caseworker, his or her supervisor, or emergency services, to make sure you are safe.

After we are all done interviewing, we're going to put together the information you give me today with the information from all the other kids we will be talking to, and make a report about kids and their different experiences living in different kinds of families.

Do you have any questions for me?

If you have any questions later, you can call Ingrid Graf at the Survey Research Laboratory at 1-800-688-0582 or you can call Professor Mark Testa, the Primary Investigator for this study, at 1-800-638-3877, or you can call the Institutional Review Board at the University of Illinois Urbana Champaign by dialing collect 217-333-2670 or on the internet at irb@uiuc.edu.

If it is OK with you to do the interview, **I need you to sign the statement below**. I'll read it to you, let me know if you don't understand and I'll explain it to you.

Subject Statement:
I agree to participate in the study, and in the interview that will include questions about services I have received, my health, the kinds of things I do, any problems at home or school and my family and community. I understand what my participation in the study involves and that I am free to stop the interview at any time. I will answer truthfully to the best of my ability. This consent will be valid for the duration of the study, through September 16, 2005. A of signed copy of this assent agreement has been given to me.

....	............/........../...........
SIGNATURE OF MINOR	DATE
....	............/........../...........
SIGNATURE OF WITNESS	DATE

UNIVERSITY OF ILLINOIS
APPROVED CONSENT
VALID UNTIL

SEP 1 6 2005

CONSENT FOR RELEASE OF INFORMATION
Well Being Study

I, D. Jean Ortega-Peron, DCFS Guardian Administrator, as legal guardian for «Childs_name», date of birth «Clds_DOB», cycis# «CYCIS», hereby give consent to caseworkers for the Illinois Department of Children and Family Services and POS agencies and to schools attended by DCFS wards permission to release information about this child to Dr. Mark Testa of the Children and Family Research Center at the University of Illinois at Urbana-Champaign. Dr. Testa will direct the data collection activities of the Children and Family Research Center at the University of Illinois at Urbana-Champaign and the Center for Child Welfare and Education at Northern Illinois University.

Types of Information

1. **Child Welfare**: All DCFS records including health information and developmental assessments.
2. **Education:** School records including ISAT OR PSAE scores or other test scores, grades, school attendance, disciplinary action, special education records and other permanent and temporary records.

Purpose for Requesting Information

The purpose for requesting information is for research purposes only. Record reviewers will examine records on site. No removal will be necessary. Whether or not the subject is included in this research study will not affect the services received as a DCFS ward in any way.

It is understood that the person authorizing release of this information has the right to inspect and copy the information to be disclosed and that that information will not be re-disclosed without the proper authorization.

This consent for any and all information is valid until September 15, 2005, when the research should be completed.

Date: ____________________

Signature: ____

Witness: ____

UNIVERSITY OF ILLINOIS
APPROVED CONSENT
VALID UNTIL

SEP 16 2005

The expiration date for this protocol, UIUC number 02243, is 9/15/2005.
The risk designation applied to your project is no more than minimal risk.

Draft, 8/30/02

Confidentiality Procedure for Caseworker Telephone Interview

- The caseworker will be mailed a letter in advance of the interview that will outline confidentiality procedures. (See attached on next page)

- The following script will be read to the caseworker prior to the telephone interview:

Hello, my name is NAME. I'm calling from the University of Illinois at Chicago. I am calling because a foster child, NAME, who is or used to be in your case load, has been selected for a research study, being conducted by Professor Mark Testa of the Children and Family Research Center at the University of Illinois Urbana-Champaign for the Illinois Department of Children and Family Services.

1. ARE YOU [fill CASEWORKER NAME]?
1 = YES
2 = NO [collect current caseworker name]

2. [SKIP IF R IS CURRENT CASEWORKER]
Who is the child's current caseworker?
(THE CASEWORKER WHO HAS WORKED ON THE CASE WITHIN THE LAST THREE MONTHS)?

Case Manager: [fill CASE MANAGER NAME] [fill CASE MANAGERPHONE#]

[fill AGENCY NAME]

The study is called the Well Being Study. The purpose of the study is to determine current levels of child well being in the areas of permanency, physical and mental health, education, well being social functioning and transition to adulthood. The survey is **completely confidential. D. Jean Ortega-Peron, DCFS Guardian Administrator, the child's legal guardian, has given approval for the release of information you will be asked to provide for this study.** Did you receive a letter from us about the study?

DID NOT RECEIVE LETTER: Well, let me tell you a little bit about the study….
RECEIVED LETTER: Great, let me tell you a little bit more about the study…

EVERYONE: In this study we are following 400 children currently in DCFS care. We will be collecting information from caseworkers, caregivers and the kids themselves. In addition we will be looking at school records and case records.

Our telephone interview with you will take less than 30 minutes to complete. We will be asking you some questions about the child's placement and the services the child receives. All information you give us is confidential. Your name and that of the child will not be reported with any of the information you provide. Your answers will be combined with the answers of others in the study and reported in a summary form. The only time we would tell anyone your name or the child's name is if you tell me the child is at risk of harm due to abuse or neglect, or at risk of harm to him or herself, or if the child states intent to harm someone else, we are required by law to report this to emergency services, to make sure the child is safe.

Your participation in this study is completely voluntary. You can refuse to answer any question or stop the interview at any time. Your decision about participation will not affect you, your job or any services the child might be receiving in any way.

This study involves minimal risks to you. The most important risk is that you may become emotionally upset or uncomfortable during the interview. If any of the questions upset you, you do not have to answer them.

However, we hope you will agree to be interviewed about this child. Your participation will help us evaluate the well being of children in foster care. It is important that we have information about every child in our study.

Do you have any questions you would like me to answer?

If you have questions later, about the study or about your rights as a participant, you can contact Ingrid Graf at the Survey Research Laboratory. Her number is 1-800-688-0582 or Dr. Mark Testa, the primary investigator, at 1-800-638-3877 or you can call the Institutional Review Board at the University of Illinois Urbana Champaign by calling collect 217-333-2670 or on the internet at irb@uiuc.edu.

Is now a good time to do the interview? Before we start I need your formal consent to do the interview. Is it okay with you to do the interview?

CIRCLE ONE: YES, OKAY TO DO. NO, FIRM REFUSAL

[IF CONSENT YES GOTO CASEWORKER EVALUATION]

CARE-GIVER TELEPHONE INTERVIEW INTRODUCTORY SCRI[illegible]

- The caregiver will be mailed a letter in advance of the interview that will outline confidentiality procedures. (See attached on the next page.)
- The following script will be read to the caregiver prior to the telephone interview.

Hello, my name is INTERVIEWER. I'm calling from the Survey Research Laboratory at the University of Illinois-Chicago. I am calling because a foster child, NAME, who lives with you, or has recently lived with you, has been included in a research study. The study is being conducted by Professor Mark Testa of the Children and Family Research Center at the University of Illinois Urbana-Champaign for the Illinois Department of Children and Family Services. The study is called the Well Being Study. The purpose of the study is to determine current levels of child well being in the areas of permanency, physical and mental health, education, well being social functioning and transition to adulthood. The survey is completely confidential. Did you receive a letter from us about the study?

DID NOT RECEIVE LETTER: Well, let me tell you a little bit about the study….
RECEIVED LETTER: Great, let me tell you a little bit more about the study…

EVERYONE: In this study we are following 400 children currently in DCFS care. We will be collecting information from caseworkers and caregivers. We will also be talking to children between 7 and 17 years old. In addition, we will be looking at school and case records.

Our telephone interview with you will take only about 40 minutes to complete. I will be asking you questions about the child's health, school performance and any academic, behavioral, or developmental problems you might have observed. All information you give us is confidential. Your name and that of the child will not be reported with any of the information you provide. Your answers will be combined with the answers of others in the study and reported in a summary form. The only time we would tell anyone your name or your child's name is if you tell us the child is at risk of harm due to abuse or neglect, or at risk of harm to him or herself, or your child states intent to harm someone else, we are required by law to report this to your child's caseworker, his or her supervisor, or to emergency services, to make sure your child is safe.

This study involves only minimal risks; you may experience some emotional upset or discomfort while discussing these issues. If any of the questions upset you, you do not have to answer them.

Your participation in this study is completely voluntary. You can refuse to answer any question. Your decision about participation will not positively or negatively affect any benefits that you or your foster child may be receiving. You can ask to stop the interview at any time.

However, we hope you will agree to be interviewed. Your participation will help us understand more about placing children in the homes that work best for them and what kinds of service they need. It is important that we have information about every child in our study. As a token of our appreciation you will receive a $20 gift certificate for completing the interview. Even if you do not complete all of the questions you will receive the gift certificate.

Do you have any questions you would like me to answer? If you have questions later about the study or about your rights as a respondent, you can contact Ingrid Graf at the Children and Family Research Center. Her number is 1-800-688-0582 or Professor Mark Testa, the Primary Investigator, at 1-800-638-3877 or the Institutional Review Board at the University of Illinois Urbana Champaign by calling collect

217-333-2670 or on the internet at irb@uiuc.edu.

Is now a good time to do the interview? Before we start I need your formal consent to do the interview. Is it okay with you to do the interview?

CIRCLE ONE: YES, OKAY TO DO NO, FIRM REFUSAL

APPENDIX C: INSTRUMENTATION SPECIFICATIONS

Overview of NSCAW Child Instrument

Module	Illinois Study	CAPI Section	Construct	Measure	Author / Publisher	Child Age	Waves	Information Gathered
Child Household	Modified	CH	Child characteristics	Project-developed questions	N/A	All	1, 3, 4, 5	Child's demographic information, and height, weight, and head circumference for children < 4
Cognitive Status	No	KB	Developmental / Cognitive status	Kaufman Brief Intelligence Test (K-BIT): Expressive Vocabulary, Definitions, and Matrices	Kaufman & Kaufman, American Guidance Service, Inc. (1990)	>4	1, 3, 4, 5	Standardized assessment tool comprised of two subsets: Vocabulary (expressive vocabulary and definitions) & Matrices (ability to perceive relationships & complete analogies). Not administered for Spanish-language interviews.
Cognitive Status	No	BD	Developmental / Cognitive status	Battelle Developmental Inventory (BDI) & Screening Test: Cognitive Skills section	Newborg, Stock, Wnek, Guidubaldi, & Svinicki, Riverside Publishing (1984)	<4	1, 3, 4	Cognitive skills; administered to age 4 and older if K-BIT score = 0
Neuro-Developmental Impairment	No	NI	Developmental / Cognitive status	Bayley Infant Neurodevelopmental Screener (BINS)	Aylward (1995)	<2	1, 3	Basic brain function, ability to comprehend and express, and intellectual processes

Communication	No	CO	Communication skills	Preschool Language Scales-3 (PLS-3)	Zimmerman, Steiner, & Pond, The Psychological Corporation (1992)	<6	1, 3, 4, 5	Standardized assessment tool comprised of two scales: expressive communication and auditory comprehension; total language score computed
School Achievement	No	AH	Academic achievement	Mini Battery of Achievement (MBA)	Woodcock, McGrew, & Werder, Riverside Publishing (1994)	>6	1, 3, 4	Standardized test of academic achievement; two subtests used: reading, which measures sight identification, vocabulary, and comprehension, and mathematics, which includes calculation, reasoning, and concepts. Not administered for Spanish-language interviews.
School Achievement	No	WJ	Academic achievement	Woodcock-Johnson III Tests of Achievement (WJ-III)	Richard W. Woodcock, Kevin McGrew and Nancy Mather, Riverside Publishing (2004)	>5	5	Standardized test of academic achievement; four subtests used: Letter-Word Comprehension, Passage Comprehension, Calculation, and Applied Problems. Not administered for Spanish-language interviews.
Community Environment	No	CN	Neighborhood factors	Adapted from APhiladelphia Family Management Study@ Parent Interview Schedule	Furstenburg, F. (1990)	EY	4, 5	Behavior of emancipated youth in terms of the environment of their community; items mirror Community Environment module in Current Caregiver Instrument

School Engagement	Yes	SE	School engagement	Drug Free Schools (DFSCA) Outcome Study Questions	U.S. Department of Education: Office of the Under Secretary	>6	1, 3, 4, 5	School achievement; student's disposition toward learning and school; administered only to children in school (excludes home schooled situations)
Relationship with Peers	Yes	RP	Peer relationships, including social rejection	Loneliness and Social Dissatisfaction Questionnaire for Young Children	Asher, S. and Wheeler, V. (1985)	5-7	1, 3, 4, 5	Success in making and keeping friendships; school adjustment; administered only to children in school (excludes home schooled situations)
Relationship with Peers	Yes	RR	Peer relationships, including social rejection	Loneliness and Social Dissatisfaction Questionnaire for Young Children	Asher, S. and Wheeler, V. (1985)	>8	1, 3, 4, 5	Success in making and keeping friendships; school adjustment; administered only to children in school (excludes home schooled situations)
Protective Factors	Yes	PF	Protective factors	Resiliency Scale - LongSCAN	Runyan, Curtis, Hunter, Black, Kotch, Bangdiwala, Dubowitz, English, Everson, Landsverk (1997)	>11	1, 3, 4, 5	Resources that a child has that facilitate resiliency
Parental Monitoring	Yes	PM	Behavioral Monitoring	Parental Monitoring	Dishion, Patterson, Stoolmiller, and Skinner (1991)	>10	1, 3, 4, 5	Extent to which the caregiver monitors the child's activities
Independent Living	No – used Ansell Casey Life Skills	IP	Independent living	Project-developed questions	N/A	>14	4, 5	Life skills the youth may have developed and where he/she learned the skill

Questions for Children in Out-of-Home	Yes	OH	Child in out-of-home care; Perceptions of Permanency, Disruptions, Contact with Family	University of California at Berkeley Foster Care Study	Fox, Frasch, & Berrick (2000)	>6	1, 3, 4, 5	Adjustment of children in out-of-home placement, including concerns about how well they fit in with their foster family and how permanent they view the placement
Family Contact for Adopted and Emancipated Youth	No	AO	Perceptions of Permanency, Disruptions, Contact with Family	University of California at Berkeley Foster Care Study	Fox, Frasch, & Berrick (2000)	>6	4, 5	Adjustment of adopted and emancipated youth, including concerns about how well they fit in with their adoptive family (if applicable) and contact with biological family
Satisfaction with Caseworker Services	Yes	SW	Satisfaction with Caseworker services	Project developed satisfaction questions	N/A	>11	1, 3, 4, 5	Degree of satisfaction with caseworker services
Future Expectations	Yes	FE	Future expectations	Adapted from Expectations About Employment, Education, and Life Span Section from Adolescent Health Survey	Bearman, Jones, and Udry (1997) Carolina Population Center, University of NC-Chapel Hill (1998)	>10	1, 3, 4, 5	Expectations related to children's life experiences
Social Support	No	SU	Social support and other family resources, including assistance with child-rearing	Adapted from Duke-UNC Functional Social Support Scale and Sarason Social Support Questionnaire-3	Broadhead, Gehlbach, deGruy, and Kaplan (1998) Sarasan, Levine, Basham, & Sarason (1983); Sarason, Sarason, Shearin & Pierce (1987)	EY	4, 5	Perceived social support for emancipated youth; items mirror Social Support module in Current Caregiver Instrument
Physical Health	No	PE	Physical health	Short-Form Health Survey (SF-12)	Ware, Kosinski & Keller (1998)	EY	4, 5	Physical health status of emancipated youth; items mirror Physical Health module in Current Caregiver Instrument

Depression	Yes	CD	Mental health	Children's Depression Inventory	Kovacs, Multi-Health Systems, Inc. (1992)	>7	1, 3, 4, 5	All aspects of well-being, including behavior problems. Not administered for Spanish-language interviews.
Trauma	Yes	TR	Mental health	Adapted from Trauma Symptom Checklist for Children - PTSD Section	Briere (1996)	>8	1, 3, 4, 5	Indicators of Post-traumatic Stress Disorder
Youth Activities	Yes	YA	Participation in activities	Youth Self Report - Social Competence Scale	Achenbach, University Associates in Psychiatry; Burlington, VT (1991)	>11	1, 3, 4, 5	Involvement in activities which may promote social skills or cognitive development
Youth Behavior	Yes	YB	Behavior problems	Youth Self Report - Syndrome and Total Problems Scale	Achenbach, University Associates in Psychiatry; Burlington, VT (1991)	>11	1, 3, 4, 5	Magnitude of aggressive behavior and impulse control
ACASI Introduction		AC	AC	Project-developed practice questions	N/A	>11	1, 3, 4, 5	N/A
Relationship with Caregiver(s) (ACASI)	Yes	RC	Relationship with parents and other significant adults	Rochester Assessment Package for Schools (RAPS)	James P. Connell (1990) Lynch, M & Cicchetti D. 1991	>11	>11	Degree of supportive relationships between child and adult
Closeness to Caregiver(s) (ACASI)	Yes	CL	Relationship with parents and other significant adults	National Longitudinal Study of Adolescent Health, In-Home questionnaire	Carolina Population Center, University of North Carolina at Chapel Hill (2002)	>11	1, 3, 4, 5	Degree of supportive relationships between child and adult
Exposure to Violence (ACASI)	Yes	EV	Loss, violence and other stressors in and out of the home	Violence Exposure Scale (VEX-R) - Home Set	Fox & Leavitt (1995)	>5	1, 3, 4, 5	Violence observed and experienced in the home
Services Received (ACASI)	Yes	SV	Services received	Project-developed questions	N/A	>11	1, 3, 4, 5	Factors that affect the service provision process; includes items administered only at Wave 4 for emancipated youth
Substance Abuse (ACASI)	Yes	SA	Substance abuse	Drug Free School Community Act Outcome Study Questions	U.S. Department of Education: Office of the Under Secretary	>11	1, 3, 4, 5	Misuse of controlled substances as associated with depression and maltreatment

Sexual Activity (ACASI)	Yes	SX	Sexual behavior	LongSCAN	Runyan, Curtis, Hunter, Black, Kotch, Bangdiwala, Dubowitz, English, Everson, Landsverk (1997)	>11	1, 3, 4, 5	Early sexual activity
Delinquency (ACASI)	Yes	DE	Delinquency	Modified Self Report of Delinquency	Elliott and Ageton (1980)	>11	1, 3, 4, 5	Participation in delinquent or criminal activities; includes items added at Wave 4 on reasons for recent arrests
Injuries (ACASI)	Yes	IJ	Maltreatment	Injury Questions from Child Health and Illness Profile-Adolescent Edition	Starfield, Riley, Green Ensminger, Ryan, Kelleher, Kim-Harris, Johnson Crawford (1995)	>11	1, 3, 4, 5	Nature and extent of injuries in the past 12 months
Victimization (ACASI)	No	VC	Victimization	Incidence and Prevalence of Drug Abuse Among Runaway and Homeless Youth Study - Shelter Sample Questionnaire	Research Triangle Institute (2002)	EY	4, 5	Emancipated youth=s victimization, including things that may have happened to the youth since he/she started living on own (e.g., robbery sexual assault)
Child Maltreatment (ACASI)	Modified	CM	Maltreatment	Adaption of Parent-Child Conflict Tactics Scale	Straus, M.A., Hamby, S.L., Finkelhor, D., Moore, D.W., & Runyan, D (1998)	>11	1, 3, 4, 5	Additional maltreatment information in order to better understand the effects of the severity and specific type of abuse
ACASI Finish		AF	N/A	Project-developed script to close ACASI module	N/A	>11	1, 3, 4, 5	N/A
Teacher Authorization		AU	N/A	Project-developed questions to collection contact information for the teacher survey	N/A	EY	4, 5	Teacher contact information collected from emancipated youth, including school name, address, and phone number

Overview of NSCAW Services Caseworker Instrument

Module	Illinois Study	CAPI Section	Construct	Measure	Author / Publisher	Waves	Information Gathered
Questionnaire Introduction	Modified	QC	N/A	Project-developed introduction script	N/A	All	N/A
Up-Front Module	Modified	UP	N/A	Project-developed questions to drive instrument wording/ flow and ensure data linkage	N/A	All	Caseworker name and employee ID (to link child interviews to caseworker interviews); employer, date of birth, and name and relationship of child's current caregiver
History Since Case Report	No	HR	Project-developed questions	N/A	N/A	2, 3, 4, 5	Child's history with the child welfare system since the case report that resulted in the child's selection for NSCAW
Services to Parents	No	SP	Services to parents	Project-developed questions	N/A	All	Service needs, regardless of availability; asked for longer-term foster care (LTFC) cases only at Wave 1
Services to Child	Yes	SC	Services to child	Project-developed questions	N/A	All	Services the child may have received; asked for longer-term foster care (LTFC) cases only at Wave 1
Independent living	No	IP	Independent living skills	Project-developed questions	N/A	4, 5	Independent living skills the child may have developed and where each skill was learned
Adoption Module	Yes	AM	Adoption possibilities for child	Project-developed questions	N/A	2, 3	Adoption possibilities for children in out-of-home care; also factors that encouraged or discouraged the caregiver's decision about adoption

Permanency Planning	No	PO	Permanency planning possibilities for child	Project-developed questions	N/A	4, 5	Permanency planning possibilities for children in out-of-home care, including adoption, legal guardianship, and long-term foster care; also factors that encouraged or discouraged the caregiver's permanency planning decision. PO module replaced the AM module from prior waves.
History Before Case Report	No	HB	Prior reports of abuse/neglect	Project-developed questions	N/A	2	Child's history with the child welfare system before the case report that resulted in the child's selection for NSCAW; administered at Wave 3 if the Wave 2 caseworker interview was not obtained
Court Hearings	No	CT	Involvement with juvenile justice/ court system	Project-developed questions	N/A	2, 3, 4, 5	History of court hearings related to the case, including type of hearing, recommendations made by the child welfare agency, and outcome of the hearing
Living Environments	Yes	LN	Child's placement history/parental living situations	Project-developed questions	N/A	2, 3, 4, 5	History of child's living situations since investigation, including type of living arrangement and child's contact with biological parents
Caseworker Involvement	Yes	IV	Caseworker involvement with child/family	Project-developed questions	N/A	2, 3, 4, 5	Caseworker's individual involvement with case, including referrals made for family members, caseworker contact with siblings, number of contacts with service providers and family, attitudes about service to family
Family Compliance and Progress	No	CP	Family's compliance and progress towards case plan	Project-developed questions	N/A	2, 3, 4, 5	Family's progress with and adherence to case plan
Caseworker Background	No	CB at Wave 2BG at Waves 3 and 4	Caseworker demographic characteristics	Project-developed questions	N/A	2, 3, 4, 5	Demographic information about the caseworker, including employment and educational history, and attitudinal questions about work as a caseworker; completed as a self-administered paper-and-pencil questionnaire or as a module of the CAPI interview. Brief subset of items administered in subsequent waves.

Overview of NSCAW Current Caregiver Instrument

Module	Illinois Study	CAPI Section	Construct	Measure	Author / Publisher	Perm/ Non-Perm	Waves	Information Gathered
Questionnaire Introduction	Modified	QP	N/A	Project-developed introduction script	N/A	P/NP	All	N/A
Up-Front Verification Module	Modified	NP	N/A	Project-developed verification questions to drive instrument wording/flow	N/A	P/NP	All	Verification of respondent contact information, relationship to child, out-of-home placement status, and legal guardianship
Household Roster	No	HH	Family composition and demographics	Project-developed questions	N/A	P/NP	All	Family composition and demographic information necessary for classification and description of subjects.
Group Home Household Roster	No	GH	Group home classification and composition	Project-developed questions	N/A	P/NP	4, 5	Composition of group home facility, including number of children in home and relationship to child, and demographics of group home caregiver
Child's Living Environment	No	LE for base¬line wave LV for post-baseline waves	Disruption in living environment	Project-developed questions	N/A	P/NP	1, 3, 4, 5	Variations/ Changes of mother and father figures

Community Environment	No	CE	Neighborhood factors	Adapted from "Philadelphia Family Management Study" Parent Interview Schedule		P/NP	1, 3, 4, 5	Behavior of individuals and families in terms of the environment of their community
Child Health & Services	Modified	HS for permanent caregivers CS for non-permanent caregivers	Health and disabilities Services received by child	Child and Adolescent Services Assessment (CASA); Child Health Questionnaire from National Evaluation of Family Support Programs; Brief Global Health Inventory; and project developed questions on services	Burns, Angold, Magruder-Habib, Costello, & Patrick (1996)	P/NP	All	History of health, injury, and disability status of child; services received by the child
Independent Living Module for Caregivers of Emancipated Youth	No	LP	Child's readiness to live on own	Project-developed questions	Eisen, Donald, Ware, and Brook (1980)	P/NP	4, 5	Most recent caregiver's perception of emancipated youth's readiness to live independently
Adaptive Behavior	No	VI for Children 0-2 VN for Children 3-5 VE for Children 6-10	Adaptive Skills	Vineland Adaptive Behavior Scale (VABS) Screener - Daily Living Skills	Sparrow, Carter, & Cicchetti (1993)	P/NP	1, 3, 4, 5	Regular behaviors the child exhibits
Prosocial Skills	No	PS for Children 3-5 PT for Children 6-10 PU for Children 11+	Global Social Competence	Social Skills Rating System -- Social Skills Scale	Gresham and Elliot, American Guidance Service (1990)	P/NP	1, 3, 4, 5	Level of development of social skills possessed by the child
Emotional Regulation - Temperament (Child Ages 3)	No	TE	Emotional regulation / Temperament	How My Infant/Toddler/Child Usually Acts from National Longitudinal Survey of Youth Infant Behavior Questionnaire (IBQ)	Baker, Keck, Mott, Quinlan (1993) Rothbart, 1981 Worobey & Blajda (1989)	P/NP	All	Child's demonstration of ability to express emotions and cope with highly charged emotional situations
Behavior Problem Index	No	BX for Children 2-3 BI for Children 4 BP for Children 5+	Behavior problems	Behavior Problem Index, with addition of items from Social Skills Rating System -- Social Skills Scale	Baker, Keck, Mott, & Quinlan (1993) Peterson & Zill (1986)	P/NP	2	Added at Wave 2 to collect child well-being measure from current caregiver

Income	No	IN	Income	Project-developed questions	N/A	P/N	1, 3, 4, 5	Financial resources available to the child's household
Services Received by Caregivers	No	SH for baseline wave SR for post-baseline waves	Services received by caregiver	Project-developed questions	N/A	P	All	Frequency and duration that services were received
Social Support	No	SS	Social Support and other family resources, including assistance with child-rearing	Adapted from Duke-UNC Functional Social Support Scale and Sarason Social Support Questionnaire-3	Broadhead, Gehlbach, deGruy, and Kaplan (1998) Sarason, Levine, Basham, & Sarason, 1983; Sarason, Sarason, Shearin & Pierce (1987)	P	1, 3, 4, 5	Perceived social support for child and family
Physical Health - SF-12	Physical Health - SF-12	PH	Physical Health	Short-Form Health Survey (SF-12)	Ware, Kosinski & Keller (1996)	P/NP	1, 3, 4, 5	Caregiver's physical health status
Services Received by Foster Caregivers	No	FC	Services received by foster caregivers	Project-developed questions	N/A	NP	All	Frequency and duration that services were received
Adoption Module for Foster Parents	No	AP	Adoption possibilities for child	Project-developed questions	N/A	NP	2, 3	Adoption possibilities for child, including factors that encouraged or discouraged adoption decision
Permanency Planning	No	PP	Permanency planning possibilities for child	Project-developed questions	N/A	NP	4, 5	Permanency planning options for child, including adoption, legal guardianship, and long-term foster care
Depression	No	DP	Mental Health - Depression	Composite International Diagnostic Interview Short-Form (CIDI-SF) - module for depression	Kessler, Andrews, Mroczek, Ustun, & Wittchen (1998)	P	1, 3, 4, 5	Caregiver experiences that indicate symptoms of depression
ACASI Introduction	No	AZ	N/A	Project-developed ACASI practice questions	N/A	P	1, 3, 4, 5	N/A
Alcohol Dependence (ACASI)	No	AD	Mental Health - Substance Abuse	Composite International Diagnostic Interview Short-Form (CIDI-SF) - module for alcohol dependence	Kessler, Andrews, Mroczek, Ustun, & Wittchen (1998)	P	1, 3, 4, 5	Caregiver experiences that indicate symptoms of alcohol dependence

Drug Dependence (ACASI)	No	DD	Mental Health - Substance Abuse	Composite International Diagnostic Interview Short-Form (CIDI-SF) - module for drug dependence	Kessler, Andrews, Mroczek, Ustun, & Wittchen (1998)	P	1, 3, 4, 5	Caregiver experiences that indicate symptoms of drug dependence
Involvement with the Law (ACASI)	No	IL	Criminal Involvement of Parents	Project-developed questions	N/A	P	1, 3, 4, 5	Caregiver criminal history and involvement with the criminal justice system
Discipline & Child Maltreatment (ACASI)	No	DS	Behavioral Monitoring and Discipline	Parent-Child Conflict Tactics Scale (CTSPC) with Neglect and Substance Abuse questions added	Straus, Hamby, Finkelhor, Moore, & Runyon (1998)	P	1, 3, 4, 5	Methods and frequency of discipline measures used by the caregiver with the child during the last 12 months
Domestic Violence (ACASI)	No	DV	Domestic Violence in the Home	Conflict Tactics Scale (CTS1)	Straus, M.A. (1990)	P	1, 3, 4, 5	Type and frequency of violence occurring in the home and directed toward female caregiver in the last 12 months, and subsequent use of services
Satisfaction with Caseworker	No	S	Satisfaction with Caseworker	Project-developed questions	N/A	P	All	Satisfaction level with services received from caseworker
HOME Scales - Scripted Items (Child Age < 10)	No	HO	Emotional Nurturing, Cognitive/Verbal Responsiveness and Stimulation	Home Observation for Measurement of the Environment-Short Form (HOME-SF) National Longitudinal Survey of Youth 1979 Cohort Center for Human Resource Research (2000)	Baker, Keck, Mott, & Quinlan (1993)	P/NP	P/NP	Scripted items about the child's home environment
Locator Form	No	LF	N/A	Project-developed questions to track respondent for future interview waves	N/A	P/NP	All	Locator information for caregiver and up to 3 contact persons
Verifications, Change of Address, & Payment	No	VF	N/A	Project-developed script informing respondent of potential recontact for interview QC purposes	N/A	P/NP	All	N/A
Teacher Authorization	No	TA	N/A	Project-developed questions to collect contact information for teacher survey	N/A	P/NP	1, 3, 4, 5	Teacher contact information, including school name, address, and phone number
Permission for Data Linkage	No	LK	N/A	Project-developed script requesting permission for researchers to link NSCAW data to data from other sources	N/A	P/NP	3,4, 5	N/A
HOME Scales - Observational Items (Child Age < 10)	No	OB	Emotional Nurturing, Cognitive/Verbal Responsiveness and Stimulation	Home Observation for Measurement of the Environment-Short Form (HOME-SF)	Baker, Keck, Mott, & Quinlan (1993)	P/NP	1, 3, 4, 5	Field Representative observations of the child's home environment

APPENDIX D: SUPPLEMENTAL DESCRIPTIVE AND BIVARIATE ANALYSES

Table D.1
Rates of Behavior Problems Among Children in Care by Demographic and Placement Variables

	Child Behavior Checklist N = 273		Youth Self Report N = 109	
	Clinical N = 96	Clinical/borderline N = 118	Clinical N = 18	Clinical/borderline N = 36
Total	32.7 (2.9) 27.3 – 38.5	41.4 (3.1) 35.4–47.7	16.4 (3.6) 10.6–24.7	33.0 (4.5) 24.7–42.4
Sex				
Male	35.8 (4.3) 27.8–44.6	43.8 (4.7) 35.0–53.1	12.3 (4.8) 5.6–25.0	29.9 (6.7) 18.5–44.4
Female	29.8 (3.9) 22.8–38.0	39.3 (4.3) 31.3–48.0	19.6 (5.1) 11.4–31.5	35.3 (6.1) 24.4–48.0
Race				
White	46.7 (6.4) 34.5–59.3	58.8 (6.4) 45.9–70.6	23.3 (8.4) 10.8–43.3	38.7 (9.6) 22.2–58.4
African American	27.2 (3.4) 21.0 – 34.4	35.1 (3.7) 28.2–42.8	11.4 (3.8) 5.8–21.3	27.0 (5.3) 17.9–38.6
Latino/a	24.1 (11.1) 8.8–51.2	36.9 (13.3) 16.0–64.1	Insufficient data	Insufficient data
Other	54.6 (12.8) 30.3–76.8	54.6 (12.8) 30.3–76.8	Insufficient data	Insufficient data
Living arrangement				
Kinship care	14.8 (3.8) 8.7–24.0	23.5 (4.8) 15.5–34.1	14.8 (5.6) 6.8–29.5	35.9 (7.8) 22.5–52.1
Foster care	40.9 (5.1) 31.4–51.1	52.4 (5.3) 42.0–62.6	9.1 (5.0) 2.9–24.8	16.0 (6.6) 6.8–33.2
Specialized foster care	45.6 (6.2) 33.9–57.7	48.5 (6.2) 36.6–60.6	20.1 (8.0) 8.7–40.2	38.9 (9.6) 22.4–58.6
Group/ residential care	45.1 (13.9) 21.4–71.1	61.6 (13.6) 34.2–83.2	32.9 (13.7) 12.7–62.3	55.6 (14.6) 28.1–80.0

Notes: Youth Self Report, Borderline and Clinical and living arrangement: χ2 = 8.08 (df = 3, n = 109, *p* = .04)

Child Behavior Checklist, Borderline and Clinical and race: χ2 = 10.43 (df = 3, n = 273, *p* = .02)

Child Behavior Checklist, Borderline and Clinical and living arrangement: χ2 = 19.50 (df = 3, n = 273, *p* = .01)

Child Behavior Checklist, Clinical and race: χ2 = 10.15 (df = 3, n = 273, *p* = .02)

Child Behavior Checklist, Clinical and living arrangement: χ2 = 24.15 (df = 3, n = 273, *p* = .01)

Table D.2
Rates of Self-Reported Depression and Trauma Among Children in Care by Demographic and Placement Variables

	Children's Depression Inventory N = 158		Trauma Symptom Checklist for Children—Post-traumatic Stress Symptoms N = 148	
	Clinical N = 6	Clinical/subclinical N = 12	Clinical N = 8	Clinical/subclinical N = 19
Total	3.7 (1.5) 1.6–8.0	7.5 (2.1) 4.3–12.8	5.8 (2.0) 2.9–11.1	12.5 (2.7) 8.1–18.8
Sex				
Male	1.2 (1.2) 0.2–8.0	5.6 (2.7) 2.1–13.9	4.5 (2.5) 1.4–13.1	7.1 (3.1) 3.0–16.0
Female	5.9 (2.6) 2.4–13.5	9.3 (5.2) 4.7–17.6	6.9 (2.9) 2.9–15.4	17.1 (4.2) 10.4–27.0
Race				
White	7.2 (4.0) 2.3–20.2	12.1 (5.1) 5.1–26.2	11.4 (5.3) 4.4–26.6	13.8 (5.7) 5.8–29.1
African American	1.2 (1.1) 0.2–7.6	2.3 (1.6) 0.6–8.8	3.8 (2.1) 1.2–11.0	11.0 (3.3) 6.0–19.3
Latino/a	Insufficient data	Insufficient data	Insufficient data	Insufficient data
Other	Insufficient data	Insufficient data	Insufficient data	Insufficient data
Living arrangement				
Kinship care	3.5 (2.4) 0.9–13.1	3.5 (2.4) 0.9–13.1	6.3 (3.5) 2.1–17.8	20.4 (5.6) 11.6–33.4
Specialized foster care	1.5 (1.5) 0.2–10.1	8.9 (3.8) 3.7–19.7	6.4 (3.60) 2.1–18.0	8.2 (3.9) 3.1–19.8
Specialized foster care	0	3.2 (3.1) 0.4–19.4	3.3 (3.2) 0.4–19.9	3.3 (3.2) 0.4–19.9
Group/ residential care	25.5 (12.8) 8.4–56.2	32.9 (13.7) 12.7–62.3	7.5 (7.3) 1.0–39.0	22.3 (11.7) 7.2–51.5

Notes: Findings for the Children's Depression Inventory and the Trauma Symptom Checklist for Children, Post-traumatic Stress subscale are presented only to indicate the results of the current study. Given the very low number of positive responses, as reflected in large standard error terms and wide confidence intervals, total percentages may be considered representative of the population being studied, but individual bivariate comparisons are not valid due to insufficient variation.

Table D.3
Rates of Behavior Problems Among Children in Care by Age at Entry and Time in Care.

	Child Behavior Checklist N = 273				Youth Self Report N = 109			
	Clinical N = 96		Clinical/borderline N = 118		Clinical N = 18		Clinical/borderline N = 36	
	Yes	No	Yes	No	Yes	No	Yes	No
Age at entry (mean, st. dev.)	4.6 (0.4) 3.9 – 5.4	4.3 (0.3) 3.8 – 4.9	4.6 (0.3) 3.9 – 5.2	4.3 (0.3) 3.7 – 4.9	7.4 (0.9) 5.6 – 9.3	8.4 (0.4) 7.6 – 9.1	8.1 (0.7) 6.8 – 9.4	8.2 (0.4) 7.5 – 9.1
Time in care (mean, st. dev.)	4.0 (0.3) 3.4 – 4.7	2.9 (0.2) 2.5 – 3.3	3.7 (0.3) 3.1 – 4.3	3.0 (0.2) 2.5 – 3.4	5.1 (0.8) 3.5 – 6.7	5.1 – 0.4) 4.4 – 5.8	4.9 (0.6) 3.8 – 6.0	5.2 (0.4) 4.4 – 6.0

Notes: Child Behavior Checklist, Clinical and time in care t (272) = 2.6, $p < .05$

Table D.4
Rates of Self-Reported Depression and Trauma Among Children in Care by Age at Entry and Time in Care

	Children's Depression Inventory				Trauma Symptom Checklist for Children – Post-traumatic Stress Symptoms			
	Clinical N = 6		Clinical/borderline N = 12		Clinical N = 8		Clinical/borderline N = 19	
	Yes	No	Yes	No	Yes	No	Yes	No
Age at entry (mean, st. dev.)	7.1 (0.3) 6.5 – 7.6	8.3 (1.4) 5.5 – 11.0	7.2 (1.0) 5.2 – 9.2	7.1 (0.3) 6.6 – 7.7	4.7 (1.1) 2.6 – 6.8	7.5 (0.3) 6.9 – 8.1	7.6 (0.9) 5.8 – 9.3	7.3 (0.3) 6.7 – 7.9
Time in care (mean, st. dev.)	3.7 (1.4) 1.0 – 6.4	4.5 (0.2) 4.0 – 5.0	3.5 (1.0) 1.5 – 5.4	4.5 (0.3) 4.0 – 5.1	4.6 (1.4) 1.8 – 7.5	4.6 (0.3) 4.1 – 5.2	3.1 (0.8) 1.6 – 4.5	4.9 (0.3) 4.3 – 5.4

Notes: Trauma Symptom Checklist for Children, Clinical and age at entry t (147) = -2.52, $p = .01$
Trauma Symptom Checklist for Children, Clinical/subclinical and time in care t (147) = -2.17, $p = .03$

Table D.5
Caregiver-Identified Serious Physical Conditions by Child Demographic and Placement Characteristics

	Point estimate (s.e.), 95% Confidence Interval
Sex	
Male	58.8 (4.4) 50.1 – 67.0
Female	70.6 (4.4) 61.2 – 78.5
Race	
White	58.3 (4.0) 50.4 – 65.9
African American	77.1 (5.6) 64.3 – 86.2
Latino/a or Other	76.6 (7.7) 58.5 – 88.3
Living arrangement	
Kinship care	54.2 (5.7) 43.0 – 65.1
Foster care	65.0 (5.1) 54.5 – 74.2
Specialized foster care	75.6 (5.2) 64.0 – 84.4
Group/ residential care	81.9 (9.9) 54.9 – 94.4

Notes: Race/ethnicity: $\chi2 = 9.06$ (2, n = 276), $p = .01$
Living arrangement: $\chi2 = 9.18$ (2, n = 276), $p = .02$

Table D.6
Caregiver-Identified Health Conditions by Age at Entry and Time in Care

	Identified as having a health condition	Not identified as having a health condition
Average age at entry	4.1 (0.3) 3.5 – 4.6	4.8 (0.4) 4.0 – 5.6
Average time in care	3.1 (0.2) 2.7 – 3.6	3.3 (0.3) 2.7 - 4.0

Table D.7
Self-Identified Physical Health Conditions by Demographic and Placement Characteristics

Sex	
Male	29.7 (4.9) 21.0 – 40.2
Female	15.8 (4.2) 9.2 – 25.8
Race	
African American	21.7 (4.2) 14.6 – 31.1
White	35.8 (7.5) 22.8 – 51.4
Living arrangement	
Kinship care	22.0 (5.4) 13.1 – 34.
Foster care	10.3 (4.3) 6.6 – 24.1
Specialized foster care	30.8 (8.1) 17.4 – 48.
Group/ residential care	55.6 (14.6) 28.1 – 80.2

Notes: Gender: $\chi2$ = 4.50 (1, n = 158), p = .03
Living arrangement: $\chi2$ = 8.71 (3, n = 158), p = .03

Table D.8
Caseworker-Identified Physical Health Conditions by Child Demographic and Placement Characteristics

Sex	
Male	22.6 (3.2) 16.9 – 29.6
Female	23.5 (3.4) 17.5 – 30.7
Race	
African American	23.7 (3.0) 18.4 – 30.1
White	24.0 (6.3) 13.8 – 38.3
Latino/a or Other	20.5 (4.4) 13.2 – 30.3
Living arrangement	
Kinship care	16.0 (3.7) 10.0 – 24.7
Foster care	19.5 (3.7) 13.3 - 27.7
Specialized foster care	40.4 (5.5) 30.2 – 51.4
Group/ residential care	37.1 (10.3) 19.8 – 58.5

Notes: Living arrangement: $\chi2$ = 15.44 (3, n = 413), p = .01

Table D.9
Caregiver Monitoring Scale,[35] Mean Scores[36] (as reported by the youth, Illinois sample)

	All children	Kinship care	Traditional foster care	Specialized foster care	Group/ residential care
Mean for overall monitoring[37]	4.3 (0.1) (4.2-4.4)	4.2 (0.1) (4.0-4.5)	4.2 (0.1) (4.0-4.4)	4.4 (0.1) (4.2-4.7)	4.7 (0.1) (4.6-4.8)
Child does not leave the house without telling caregiver	4.3 (0.1) (4.1-4.5)	4.3 (0.2) (3.9-4.6)	4.3 (0.2) (4.0-4.6)	4.2 (0.2) (4.2-4.9)	4.0 (0.7) (2.5-5.4)
Caregiver knows child's whereabouts	4.5 (0.1) (4.4-4.7)	4.4 (0.1) (4.2-4.7)	4.6 (0.1) (4.4-4.8)	4.5 (0.2) (4.01-4.9)	5.0
Caregiver knows whom child is with	4.3 (0.1) (4.1-4.5)	4.3 (0.2) (3.9-4.6)	4.2 (0.2) (3.8-4.6)	4.3 (0.1) (4.0-4.6)	5.0
Caregiver gives child a curfew	4.4 (0.1) (4.2-4.6)	4.4 (0.2) (4.1-4.8)	4.4 (0.2) (4.0-4.8)	4.4 (0.2) (4.0-4.8)	5.0
Caregiver establishes a time for the child to return home	4.0 (0.1) (3.7-4.3)	3.8 (0.2) (3.4-4.3)	3.8 (0.3) (3.3-4.3)	4.4 (0.2) (4.0-4.9)	4.5 (0.4) (3.8-5.2)
Child is not left home without an adult or sitter (ages 7–11 only)	4.1 (0.2) (3.7-4.6)	4.0 (0.3) (3.4-4.7)	4.1 (0.4) (3.2-4.8)	4.4 (0.4) (3.5-5.2)	--

[35] Dishion, Patterson, Stoolmiller, & Skinner. (1991).

[36] Mean estimates within a 95% confidence interval.

[37] On a 5-point Likert Scale with 1 = never and 5 = very often.

Table D.10
Forms of Discipline by Placement Type (Illinois sample)

In the past 12 months	Total	Kinship foster care	Traditional foster care	Specialized foster care	Group/ residential care
Times adult explained why something was wrong					
Never	26.9 (0.1) (19.2-36.2)	34.4 (.08) (20.9-50.9)	19.6 (.07) (8.9-37.6)	26.3 (.09) (12.9-46.4)	3.8 (.12) (7.6-54.2)
1–2 times	30.2 (0.1) (22.1-39.7)	28.4 (.07) (16.2-44.7)	22.8 (.08) (11.1-41.1)	38.6 (.10) (22.0-58.5)	35.6 (.14) (13.8-65.6)
3–5 times	14.2 (0.1) (8.7-22.4)	13.3 (.06) (5.6-28.7)	13.5 (.06) (5.1-31.3)	12.0 (.06) (3.8-31.6)	23.7 (.12) (7.5-54.2)
6 times or more	28.8 (0.1) (20.9-38.2)	23.9 (.07) (12.8-40.3)	44.1 (.09) (27.7-61.9)	23.1 (.08) (10.6-43.2)	17.0 (.11) (4.2-49.0)
Times child was put in a "time out"					
Never	45.2 (0.1) (36.0-54.9)	58.6 (.08) (42.3-73.2)	26.9 (.08) (14.4-44.7)	56.5 (.10) (37.0-74.1)	28.0* (.14) (9.2-60.0)
1–2 times	25.8 (0.1) (18.3-35.0)	18.2 (.06) (8.8-33.9)	38.1 (.09) (22.9-56.1)	19.7 (.08) (8.3-39.8)	30.2 (.13) (11.3-59.5)
3–5 times	12.4 (0.1) (7.2-20.3)	7.8 (.04) (2.5-21.9)	22.7 (.08) (11.1-40.8)	11.9 (.06) (3.8-31.4)	0
6 times or more	16.6 (0.1) (10.6-25.0)	15.5 (.06) (7.0-30.9)	12.3 (.06) (4.6-29.0)	12.0 (.07) (3.9-31.6)	41.8 (.14) (18.1-70.0)
Times adult yelled at child					
Never	35.6 (0.1) (27.0-45.3)	34.1 (.08) (20.7-50.6)	30.7 (.08) (17.1-48.7)	33.1 (.09) (17.8-52.9)	59.4 (.14) (31.1-82.6)
1–2 times	29.0 (0.1) (21.0-38.4)	24.1 (.07) (12.9-40.6)	31.6 (.08) (17.8-49.7)	35.2 (.09) (19.3-55.3)	22.6 (.12) (7.2-52.6)
3–5 times	17.0 (0.1) (10.9-25.6)	20.9 (.07) (10.7-37.0)	16.5 (.07) (6.9-34.2)	15.9 (.07) (6.0-35.9)	9.0 (.09) (1.2-44.2)
6 times or more	18.4 (0.1) (12.1-27.0)	20.9 (.07) (10.6-36.9)	21.3 (.07) (10.3-38.9)	15.8 (.07) (6.0-35.7)	9.0 (.09) (1.2-44.2)
Times child was grounded					
Never	24.4 (0.1) (17.0-33.6)	28.7 (.07) (16.4-45.1)	16.0 (.07) (6.7-33.6)	27.6 (.09) (13.5-48.1)	26.6 (.13) (8.6-58.4)
1–2 times	34.5 (0.1) (25.9-44.1)	31.3 (.08) (18.5-47.8)	40.0 (.09) (24.5-57.8)	36.0 (.10) (19.7-56.4)	25.9 (.13) (8.5-57.1)
3–5 times	19.6 (0.1) (13.0-28.3)	22.0 (.07) (11.3-38.5)	24.9 (.08) (12.8-42.9)	7.5 (.05) (1.8-26.2)	23.7 (.12) (7.5-54.2)
6 times or more	21.6 (0.1) (14.7-30.6)	18.0 (.06) (8.7-33.7)	19.0 (.07) (8.7-36.8)	28.9 (.09) (14.4-49.8)	23.7 (.12) (7.6-54.3)

*$p<.05$

Table D.11

Percentage[38] of Children Who Have Witnessed Violence in a Home They Have Lived In: Comparison Between Illinois and National Samples

	Illinois	NSCAW
Mild violence		
Adult yelled at a person	84.4 (77.9–89.3)	71.7 (65.5–79.1)
Adult spanked a person	68.0 (60.2 –74.9)	60.3 (51.2–68.6)
Adult threw something at a person	29.3 (24.2–39.1)	31.4 (24.4–39.4)
Adult pushed a person	32.5 (25.6–40.3)	29.0 (24.4–39.4)
Adult slapped a person	27.5 (21.0–35.1)	25.0 (17.8–33.8)
Severe violence		
Adult beat up a person	19.1 (13.7–26.1)	26.0 (19.2–34.3)
Saw adult steal from a person	39.4 (31.9–47.3)	33.0 (25.6–41.2)
Saw adult get arrested	37.1 (29.8–45.0)	39.5 (32.8–46.7)
Saw adult deal drugs	18.0 (12.6–24.9)	18.7 (12.9–26.2)
Adult pointed a weapon at a person	8.5 (5.1–14.0)	17.3 (12.4–23.5)
Adult stabbed a person	3.8 (1.7–8.3)	4.2 (2.1– 8.0)
Adult shot a person with a gun	1.2 (0.3–4.7)	6.3 (3.0–12.9)

[38] Point estimate within a 95% confidence interval.

Table D.12

Percentage[39] of Children Who Have Experienced Violence in a Home They Have Lived In: Comparison Between Illinois and National Samples

	Illinois	NSCAW
Mild violence		
Mean frequency for mild violence[40]	1.6 (1.5–1.7)	1.8 (1.6–2.0)
Yelled at by an adult	72.7 (65.1–79.1)	68.4 (61.1–74.9)
Spanked by an adult	50.3 (42.3–57.9)	48.3 (37.4–59.4)
Pushed by an adult	18.0 (12.7–24.8)	24.5 (18.1–32.4)
Adult threw something at child	16.1 (11.1–22.9)	27.7 (19.0–38.4)
Slapped "really hard" by an adult	22.2 (16.3–29.5)	21.7 (14.1–31.8)
Severe violence		
Mean frequency for severe violence	1.3 (1.2–1.4)	1.2 (1.1–1.4)
Beat up by an adult	17.8 (12.6–24.6)	17.2 (11.0–25.9)
Gun or knife was pointed at child by an adult	3.1 (1.3–7.4)	9.3 (4.7–17.6)

[39] Point estimate within a 95% confidence interval.

[40] On a 4-point Likert Scale where 1 = never, 2 = one time, 3 = a few times, and 4 = lots of times.

Table D.13
Protective Factors: Children Responded Positively to These Items (Illinois sample)

Item	All children	Kinship foster care	Traditional foster care	Specialized foster care	Group/ residential care
Child has an adult they can turn to for support					
There are adults I can go to for help	94.2 (.02) (87.5-97.4)	97.1 (.03) (81.9-99.6)	96.6 (.03) (78.9-99.5)	88.6 (.06) (69.5-96.4)	91.0 (.09) (55.8-98.8)
I can go to a parent or someone like a parent with a problem	94.1 (.03) (87.4-97.4)	94.4 (.04) (79.8-98.6)	96.5 (.03) (78.6-99.5)	91.6 (.06) (71.3-97.9)	91.9 (.08) (58.2-98.9)
I can go to another relative with a problem	83.7 (.04) (75.1-89.7)	84.3 (.06) (68.9-92.9)	81.4 (.07) (63.8-91.6)	82.7 (.08) (61.4-93.5)	91.0 (.09) (55.1-98.8)
I can go to a non-relative adult with a problem	71.6 (.05) (62.1-79.8)	64.6 (.08) (48.2-78.2)	75.5 (.08) (56.4-88.0)	65.4 (.10) (44.1-81.9)	100.0
This non-relative adult has made a difference in my life	81.9 (.04) (73.2-88.3)	75.8 (.07) (59.2-87.1)	86.3 (.06) (68.5-94.8)	87.9 (.07) (67.8-96.1)	75.6 (.12) (44.9-92.2)
Scale score (sum of previous items)	4.4 (.08) (4.2-4.5)	4.2 (.13) (3.9-4.5)	4.4 (.13) (4.1-4.7)	4.4 (.18) (4.1-4.8)	4.6 (.20) (4.2-5.0)
Religion/Spirituality					
Importance of religion/spirituality to me*	3.1 (.09) (3.0-3.3)	3.4 (.12) (3.1-3.6)	3.1 (.18) (2.7-3.4)	3.0 (.21) (2.6-3.4)	2.9 (.35) (2.2-3.6)
How many times I have gone to religious services within the past year (average)**	3.3 (.12) (3.0-3.5)	3.4 (.19) (3.0-3.8)	3.4 (.25) (2.9-3.9)	3.3 (.27) (2.7-3.8)	2.8 (.30) (2.2-3.4)

*Scale of 1 to 4 with 1 = not important and 4 = very important

**Scale of 1 to 4 with 1=never, 2=not often, 3=often, and 4=all the time

Table D.14
Relationships with Others (Illinois sample)

	All children	Kinship foster care	Traditional foster care	Specialized foster care	Group/ residential care
Loneliness and Social Dissatisfaction	28.7 (1.0) (26.9-30.6)	28.7 (1.5) (25.8-31.7)	27.7 (1.6) (24.4-30.9)	27.5 (1.7) (24.1-31.0)	36.6 (4.1) (28.5-44.8)
Note: This is a scale with a range from 16 to 80, with 16 being the least lonely. Overall, children in Illinois fall toward the less-lonely side of this scale.					
Relationship with caregiver is important to child	394 (0.8) (37.9-40.9)	39.6 (1.3) (37.0-42.1)	39.3 (1.3) (36.8-41.8)	39.4 (1.5) (36.4-42.3)	--
Note: This is a scale with a range from 12 to 48, with 48 meaning that the child places the most importance on this relationship. Overall, children in Illinois fall closer to the end of the scale where they see these relationships as important.					

Table D.15
Future Expectation Scales,[41] Mean Scores[42]
(as reported by the youth, Illinois sample)

	All children	Kinship foster care	Traditional foster care	Specialized foster care	Group/ residential care
Child's chance of living to be at least 35	4.25 (0.1) (4.1-4.4)	4.17 (0.1) (3.9-4.5)	4.49 (0.1) (4.2-4.8)	4.30 (0.2) (3.9-4.7)	3.62 (0.4) (2.8-4.5)
Child's chance of being married by age 25	2.91 (0.1) 2.7-3.2)	3.09 (0.2) (2.7-3.5)	2.45 (0.2) (2.1-2.8)	3.13 (0.3) (2.6-3.7)	3.22 (0.5) (2.3-4.1)
Child's chance of graduating from high school	4.53 (0.1) (4.4-4.7)	4.46 (0.2) (4.2-4.7)	4.70 (0.1) (4.5-4.9)	4.66 (0.1) (4.4-4.9)	3.94 (0.4) (3.1-4.8)
Child's chance of getting a good job by age 30	4.28 (0.1) (4.1-4.5)	4.30 (0.1) (4.0-4.6)	4.38 (0.2) (4.0-4.7)	4.22 (0.2) (3.9-4.5)	3.97 (0.4) (3.1-4.8)
Child's chance of raising a family when he/she is older	3.62 (0.1) (3.4-3.9)	3.56 (0.2) (3.1-4.0)	3.39 (0.2) (3.0-3.8)	3.89 (0.3) (3.4-4.4)	3.93 (0.4) (3.1-4.8)
Child's chance of having a child before the age of 18	1.61 (0.1) (1.4-1.8)	1.60 (0.2) (1.2-2.0)	1.49 (0.2) (1.1-1.8)	1.49 (0.2) (1.1-1.8)	2.33 (0.6) (1.1-3.6)

[41] On a 6-point ordinal scale where 1 = no chance, 2 = some chance, 3 = about 50-50, 4 = pretty likely, 5 = it will happen, and 6 = it has already happened.

[42] Mean estimates within a 95% confidence interval.

Table D.16
Attachment to Current Placement
(as reported by the youth, Illinois sample)

	All children	Kinship foster care	Traditional foster care	Specialized foster care	Group/ residential care
Do not like living with current people	5.6 (.02) (2.9-10.5)	6.9 (.03) (82.6-97.4)	3.5 (.02) (0.9-13.1)	3.3 (.03) (0.5-20.2)	16.1 (.02) (2.9-10.5)
Tried to leave current home	10.3 (.03) (6.4-16.2)	9.4 (.04) (3.9-20.8)	7.2 (.03) (2.7-17.8)	14.9 (.06) (6.3-31.5)	16.4 (.02) (4.0-47.9)
Siblings do not live with you in current home	83.8 (.03) (77.1-88.9)	80.6 (.05) (67.9-89.0)	84.9 (.05) (72.4-92.3)	82.0 (.07) (65.1-91.8)	100%
Never see biological mother	26.5 (.04) (19.6-34.8)	11.5 (.08) (5.2-23.6)	40.2 (.08) (26.6-55.5)	35.3 (.09) (19.9-54.5)	18.1 (.12) (4.5-50.7)

Table D.17
Race/Ethnicity and Placement Stability

Race or Ethnicity	Number of moves (std. err.) 95% C.I.
African American	2.9 (0.2) 2.6 – 3.2
White	2.9 (0.2) 2.6 – 3.2
Latino/a or Other	2.8 (0.4) 2.0 – 3.6

Table D.18
Gender and Permanency Outcomes

Permanency outcome	Males	Females
Reunification	12.2 (2.0) 8.8 – 16.7	9.9 (1.8) 6.9 – 14.0
Guardianship/Adoption	44.8 (2.9) 39.2 – 50.6	51.1 (2.9) 45.4 – 56.9
Still in care	38.7 (2.9) 33.2 – 44.5	32.0 (2.8) 26.9 – 37.6
Impermanence	4.2 (1.0) 2.6 – 6.8	7.4 (1.3) 4.9 – 9.9

APPENDIX E: EDUCATION AND SCHOOL ENGAGEMENT: CAREGIVER REPORTS

Introduction

A number of questions about the caregivers' perspectives of the educational status of the children in their care were included in the interviews of caregivers carried out as part of the IL-CWB study, Round 2. This Appendix reports basic data representing these perspectives, including both overall percentages of children reported in each condition (for example, number of children reported as being over the chronological age expected given their grade levels, or overage in grade) and the association of the number of children in each condition with other, commonly associated demographic and placement variables (for example, the number of children who are overage in grade by gender). The section opens with a brief literature review and then presents findings concerning achievement, special needs, discipline, attendance, and school transfers. Comparisons between school engagement in Illinois and nationally conclude the results and are followed by a summary section.

Literature Review

Many studies have focused on the need for educational assessment and services, for foster children generally and for foster youth with learning disabilities in particular. Estimates of the percentage of children in foster care are receiving special education services range from 24% (Evans, Scott, & Schulz, 2004) to 44% (Geenen & Powers, 2006). In a focus group study, Zetlin (2006) noted that foster children are over-represented in special education; they are also often under-identified for special education; lack of information to schools about a child's foster care status often leads to confusion and delay of services, and caregivers are often not kept informed; special education procedures create problems, especially around accountability and appropriateness of services; and children in group homes are often required to attend restrictive schools on site that may not meet the children's needs.

In their comparison of children in an urban school district, Geenen and Powers (2006) found that youth in foster care and special education, compared with those in general education, had significantly lower GPAs and earned significantly fewer credits toward graduation. In addition, for all foster care youth, as the number of placements increased, GPA and performance on state math testing decreased. This study highlighted the fact that just being in foster care or just being in special education presented major challenges for the student; the interaction between the two systems multiplied these challenges.

Most studies on the educational needs of foster children point to the need for collaboration between the local school system and the child welfare system in order to provide the individualized services to meet these children's specialized needs (e.g., Geenen & Powers, 2006). Zetlin, Weinberg, and Kimm (2004) reported that having an education specialist (ES) as the liaison between the child welfare office and the local school district resulted in improved knowledge on the part of caseworkers about the school system. Findings from this study also demonstrated that caseworkers with access to the ES were more likely to complete documentation of educational status and to include comments about the educational needs of children on their case loads in the case files than was the case in control settings. The findings support the need for advocacy by child welfare and school systems to develop policies and practices that will have a positive impact on the educational achievement of children in foster care (Zetlin, Weinberg, & Kimm, 2004).

Results – Illinois Sample

Academic Progress

Overage in grade

A student's grade level relative to his or her chronological age is one of the most important factors in predicting school dropout (Jimmerson, Anderson, & Whipple, 2002). Research is conclusive in this regard, even when achievement status and a variety of other salient potential predictor variables are taken into consideration. Being "overage in grade" can result from a number of circumstances, including late entry into school and failure to advance because of school transfers, runaway, grade retention, and others. In order to analyze whether a student was overage in grade or not, a new variable was calculated. First, each child's age as of September 1, 2003 was calculated. This was compared to the caregiver's report of the grade the child was in as of that year. Caregiver interviews that were completed after June 15, 2004 were not included in the analysis because it was uncertain as to whether the caregiver would have answered with the grade the child was in the previous year or the grade the child would be in the following year. This resulted in minimal loss of cases, as most interviews were conducted prior to this time. Based on this strategy, 21.9% of caregivers (std. err. 2.9, 95% C.I. 16.7 – 28.2) indicated that the child was overage in grade. Based on caregiver reports, the likelihood of being overage in grade did not vary by race, gender, or living arrangement. The likelihood of being overage in grade also did not vary significantly by the child's age at entry into foster care or the number of years the child had spent in foster care. Another indicator of academic success is whether the child has been held back or has repeated a grade. While exact estimates of the impact of retention vary, Mann (1987) reported that students who were retained in one grade were 40% to 50% more likely to drop out of school, and students retained in two grades were 90% more likely to drop out of school than those who had not been retained. Overall, 22.1% of children were reported as having been "held back" (std. err. 3.1, 95% C.I. 16.6 – 28.8).

Grades and Test Scores

Caregivers were asked whether children were receiving grades of 'C' or higher and whether they were reading at or above grade level in reading and math. In all cases, while most caregivers indicated that children were performing well in school, a significant proportion indicated that the children in their care were struggling. A total of 70.2% of caregivers (std. err. 3.4, 95%. C.I. 63.2 – 76.3) indicated the children were receiving grades of 'C' or higher in all their classes. In terms of achievement, 63.4% of caregivers (std. err. 3.5, 95% C.I. 56.4 – 69.9) indicated that the children were reading at or above grade level.This finding appears to point to some level of conflict between caregiver perceptions and actual, reported achievement based on test scores as documented in Chapter 6 in this volume. Specifically, given that approximately 70% of children are functioning at less than the 50th percentile with regard to reading based on test scores (as reported in chapter 6) while approximately 63% of caregivers indicate that their children are reading at or above grade level, one may consider the possibility that caregiver are often not appraised of the functional achievement levels of the children in their care. While it is likely that some records are present in the educational record review data set that are not present in the caregiver interview data set and vice versa, there is likely to be considerable overlap, and this finding recommends further investigation into levels of communication between caregivers and schools. A total of 58.0% (std. err. 3.6, 95% C.I. 50.9 – 64.8) of caregivers indicated that the children in their care were performing at or above grade level in math. This finding also appears to conflict to some extent with the finding reported in Chapter 6 that 71.9% of children evaluated scored below the 50th percentile with regard to math achievement.

The likelihood of receiving grades of 'C' or higher on report cards was not reported to vary by race, gender, living arrangement, or years in care. However, grades as reported by caregivers did vary by age at entry into care such that children who were not receiving adequate grades were older, on average, at entry into foster care (Table E.1).

Table E.1

Variations in academic achievement by age at entry into care and years in care

	Mean age at entry into foster care	Mean years in care
Grades 'C' or higher		
Yes	6.2 (0.3, 5.6 – 6.8)	Ns
No	7.7 (0.5, 6.8 – 8.6)	Ns
Reading at grade level		
Yes	Ns	4.3 (0.3, 3.7 – 4.7)
No	Ns	5.5 (0.4, 4.7 – 6.4)
Performing math at grade level		
Yes	Ns	4.3 (0.3, 3.8 – 4.8)
No	Ns	5.1 (0.4, 4.4 – 5.9)

Grades 'C' or higher, mean age at entry: t (1, 187) = -2.6, $p < .01$
Reading at grade level, mean years in care: t (1, 191) = -2.5, $p < .01$
Math at grade level, mean years in care: t (1, 192) = -1.7, $p = .09$

The proportion of children reported to be reading at or above grade level did not vary by race or gender but varied in a marginally significant manner by placement type such that children in more restrictive types of care were more likley to be reported as not reading at grade level (Table E.2). Caregiver-rated reading abilities did not vary by age at entry into foster care, but children who were rated by caregivers as not reading at grade level had spent more years in foster care. This finding is reflected in Table E.1. Whether caregivers rated the children in their care as performing at or above grade level in mathematics did not vary by race, gender, type of care, or age at entry into foster care and varied in a marginally significant manner by years in care, as reflected in Table E.1. Children rated as not performing math at grade level had been in care longer.

Special Needs

Caregivers were asked a series of questions about special educational needs of the children in their care. The questions were:

- Has (child) been tested for learning problems, special needs, or developmental disabilities by an education or health professional? (Yes, 54.8% (std. err. 3.7, 95% C.I. 47.5 – 61.8)).
- Since (child) was placed with you, have you been told by an education or health professional that the child had learning problems, special needs, or developmental disabilities? (Yes, 40.8% (std. err. 3.5, 95% C.I. 34.1 – 47.8)).
- An Individualized Education Plan, or IEP, identifies problems a child with a disability might be having that interfere with his or her education and explains what services the school system will provide to help a child. An Individualized Education Plan is written with administrators, educators, and specialists from the school district and is not part of DCFS or your child welfare agency. Does (child) have an Individualized Education Plan (I.E.P.)? That is, has (child) been classified as needing special education? (Yes, 41.0% (std. err. 3.6, 95% C.I. 34.2 – 48.1).
- Is (child) receiving special education services? (Yes, 38.7% (std. err. 3.5, 95% C.I. 32.2 – 45.7)

Upon examination, the second and third questions were found to be highly correlated. Of caregivers who responded to these questions, 33.5% indicated that they had been told that the child had a learning problem, special need, or developmental disability by an education or health professional and that the child had an IEP, and 51.8% of caregivers indicated that neither was true. The 7.4% of caregivers who indicated that the child was receiving special education but did not have learning problems may have been caring for children who were receiving educational supports as a result of behavioral disturbances or health problems. The 7.3% of caregivers who said that they had been told the child had a learning problem but that the child was not receiving educational supportive services are noteworthy, but the circumstances in these cases are not really known. Additional research on this topic using standardized assessments and school records would be appropriate and beneficial. For purposes of this report, the indication of whether or not the child had been identified as needing special education services was used for subsequent analyses.

A number of differences in processes for identification of and in formal identification of special educational needs were found by demographic and placement variables. The proportion of children tested for learning problems varied by race, gender, and living arrangement. These results are presented in Table E.3. The relationships between having been identified as being in need of special education services and race, gender, and living arrangement were also

Table E.2
Variations in Academic Achievement by Placement Type

	Kinship care	Traditional foster care	Specialized foster care	Group or residential care
Reading at or above grade level	72.5 (5.8, 59.9 – 82.3)	66.3 (5.6, 54.5 – 76.4)	55.1 (6.9, 41.5 – 68.0)	32.6 (15.2, 11.1 – 65.2)

Reading at or above grade level, $\chi2$ (3, 191) = 7.0, *p* = .07

examined and were found to range from highly significant to marginally significant. The data suggest a differential pattern of likelihood of being identified as needing special education services by race and living arrangement among children who were tested. Some differences in reported delivery of special education services to children who are supposed to be receiving them are also evident based on caregiver data; for example, while females reported as having IEPs are all reported to be receiving services, this is not the case with males. Similarly, children in group or residential care who are reported to have IEPs appear to be less likely to be reported as receiving services than children in other care types. Again, these findings suggest a need for further examination of these dynamics.

The average number of years in care of children who were tested differed in a statistically significant manner from the average number of years in care of children who were not tested. Differences in age at entry were marginally significant. These results are presented in Table E.4. The finding that the average age of entry of children who were identified as not obtaining grades of at least ‘C’ on report cards is older than that of children obtaining adequate grades but that children who entered care at older ages are also less likely to be tested for special learning needs might have significance for assessment practices at intake. Children who were tested for learning problems, identified as being in need of special education, and receiving special education services had been in care for longer than children for whom this was not the case.

Discipline

Caregivers were asked how many in-school suspensions or detentions the children in their care had been assigned since the beginning of the school year, how many out-of-school suspensions had been assigned in the same time period, and whether or not the child had been expelled within the past two years. Given that the majority of the interviews were completed between March and May of 2004, the only adjustment for time made in the analyses reported here was to subpopulate the data set to include only those interviews

Table E.3
Differences in Rates of Testing for, Identification of Need for, and Receipt of Special Education Services by Demographic and Placement Variables

	Tested for learning problems, special needs, or devlopmental disabilities	Identified as needing special education services (child has an IEP)	Receipt of special education services
Sex			
Male	63.3 (5.1, 52.8 – 72.7)	51.7 (5.3, 41.4 – 61.8)	46.0 (5.1, 36.3 – 56.1)
Female	46.8 (5.2, 37.0 – 57.0)	31.4 (4.6, 23.1 – 41.2)	31.9 (4.7, 23.4 – 41.7)
Race			
White	48.4 (4.7, 39.4 – 57.4)	35.2 (4.4, 27.2 – 44.2)	NS
African American	62.0 (6.9, 47.8 – 74.3)	54.1 (6.9, 40.5 – 67.1)	NS
Latino/a or Other	77.9 (9.8, 53.5 – 91.4)	44.3 (11.2, 25.7 – 65.9)	NS
Living arrangement			
Kinship care	39.4 (6.6, 27.5 – 52.8)	21.6 (5.4, 12.9 – 33.9)	19.8 (5.2, 11.5 – 31.8)
foster care	46.3 (6.2, 34.5 – 58.6)	33.2 (5.7, 23.0 – 45.1)	29.2 (5.4, 19.8 – 40.8)
Specialized foster Care	72.9 (6.2, 59.1 – 83.3)	62.1 (6.7, 48.4 – 74.1)	63.0 (6.7, 49.1 – 75.0)
Group/ residential care	100	91.9 (7.8, 59.0 – 98.9)	83.5 (10.8, 52.2 – 95.9)

Gender, tested: $\chi2$ (1, 184) = 5.0, $p = .03$
Race, tested: $\chi2$ (2, 184) = 7.2, $p = .03$
Living arrangement, tested: $\chi2$ (3, 184) = 26.1, $p < .01$
Gender, IEP: $\chi2$ (1, 184) = 8.1, $p = .05$
Race, IEP: $\chi2$ (2, 184) = 5.1, $p = .08$
Living arrangement, IEP: $\chi2$ (3, 184) = 30.9, $p < .01$
Gender, service receipt: $\chi2$ (1, 184) = 4.07, $p = .04$
Living arrangement, service receipt: $\chi2$ (3, 184) = 32.6, $p < .01$

that took place prior to the end of the 2003-2004 school year. Caregivers, then, reported that:

- Children received an average of 1.1 in-school suspensions or detentions (std. err. 0.2, 95% C.I. 0.7 - 1.5). The range was from 0 to 22 with the mode at 0.
- Children received an average of 0.5 out-of-school suspensions (std. err. 0.1, 95% C.I. 0.2 - 0.7). The range was from 0 to 8 with the mode at 0.
- A total of 8.8% of children were reported as having been expelled within the past two years (std. err. 2.1, 95% C.I. 5.6 – 13.8).
- In-school suspensions were not significantly associated with gender or race. In-school suspensions were associated with living arrangement ((3, 197), F = 2.80, *p* = .04). These results are represented in Figure E.1. These data suggest that children in both kinship care and group or residential care received fewer in-school suspensions or detentions, as reported by caregivers, than children in specialized foster care.

Number of in-school suspensions was not significantly associated with age at entry or years in care.

Number of out-of-school suspensions was not associated with sex but was marginally associated with race. Children of Latino/a or Other race or ethnicity received an average of 0.2 suspensions (std. err. 0.1, 95% C.I. -0.1 - 0.4), and White children received an average of 0.2 suspensions (std. err. 0.1, 95% C.I. 0.1 – 0.4), but African American children received an average of 0.5 suspensions (std. err. 0.1, 95% C.I. 0.3 - .0.7) (F (2, 194) = 2.4, *p* = .09). However, number of out-of-school suspensions was not significantly associated with living arrangement, nor was it associated with age at entry or number of years in out-of-home care.

School expulsion was not associated with gender or race/ethnicity but was associated with living arrangement in a marginally significant fashion as reflected in Table E.5. Note that these results demonstrate that the only living arrangement that may be thought to offer a significant protective effect with regard to school expulsions is group or residential care. This may be the case due to the fact that children in these care types often go to therapeutic schools which are organized and staffed differently and may have different policies with regard to suspension and expulsion. Expulsion was not associated with age at entry into foster care or years in care.

Table E.4
Differences in Rates of Testing for, Identification of Need for, and Receipt of Special Education Services by age at entry into care and years in care

	Mean age at entry into foster care	Mean years in care
Tested for learning problems, special needs, or developmental disabilities		
Yes	6.1 (0.4,5.4-6.8)	5.4 (0.3, 4.7 -6.0)
No	7.1 (0.4,6.4-7.8)	4.0 (0.3, 3.3 -4.7)
Identified as needing special education services (has an IEP)		
Yes	NS	5.6 (0.4, 4.8 - 6.4)
No	NS	4.1 (0.3, 3.6 - 4.7)
Receipt of special education services		
Yes	NS	5.9 (0.4, 5.1 - 6.6)
No	NS	4.0 (0.3, 3.5 - 4.5)

Race, tested: $\chi 2$ (2, 184) = 7.2, *p* = .03
Tested, mean age at entry: *t* (1,184) = -1.68, *p* < .06
Tested, mean years in care: *t* (1,184) = 2.68, *p* < .01
IEP, mean years in care: *t* (1,192) = 2.89, *p* <.01
Service receipt, mean years in care: *t* (1,195) = 3.77, *p*<.01

School Attendance and School Transfers

Analyses of attendance were restricted to cases where interviews occurred prior to the end of the 2003-2004 school year in order to avoid confusion. The question asked of caregivers was how many days of school children had missed in the past month. Caregivers indicated that the children in their care have missed an average of 0.9 days (std. err. 0.2, 95% C.I. 0.7-1.2) with a range from 0 to 31 and the mode at 0. Clearly, children cannot miss 31 days of school in a month, as they are not required to attend school on weekends and holidays. Caregivers who responded in this fashion are understood to be indicating that the children did not go to school at all. Attendance was not related to gender, race/ethnicity, living arrangement, age at entry into foster care, or time in care. When asked about why children missed school, the vast majority of caregivers reported the main reason was illness. Some caregivers of children in the least restrictive settings, kinship care and traditional foster care, reported that children missed school because they refused to attend; this reason was not reported as a factor in specialized foster care nor in residential settings.

Caregivers were also asked, to the best of their knowledge, how many times the children had changed schools in the past two years. Caregivers indicated that children had changed schools an average of 1.1 times (std. err. 0.1, 95% C.I. 0.8 – 1.4) with a range from 0 to 8 and a mode at 0. School stability was not related to gender, race/ethnicity, living arrangement, age at entry into foster care, or years in foster care. Respondents were most likely to indicate that transfers occurred due to grade promotions or due to changes made to better meet the needs of the children.

Results - Illinois and National Comparison

The School Engagement questions utilized in the Illinois study of Well-being were based upon those used in the NSCAW, which were in turn based upon the Drug Free Schools Outcome Study questions (U.S. Department of Education). The questions were asked of children and youth; in Illinois, the sample included children ages 7 to 17, and for the NSCAW, the sample included children ages 6 to 15. For the purposes of this analysis, the sample was constrained

Figure E.1
Association Between In-School Suspensions and Living Arrangement

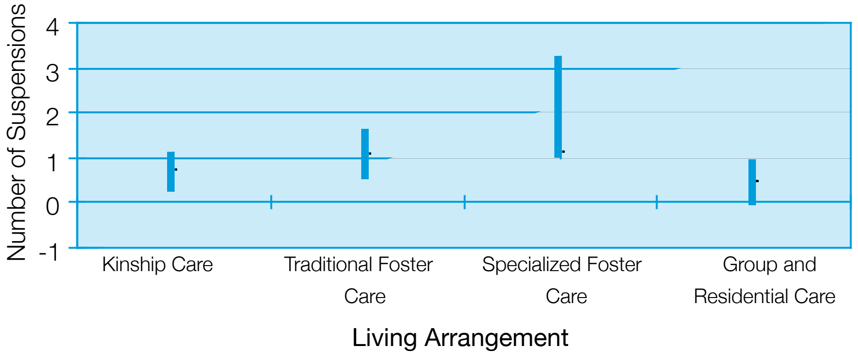


Table E.5
Variations in School Expulsion by Placement Type

	Kinship care	Traditional foster care	Specialized foster care	Group or residential care
School expulsion in the past two years	11.6 (4.1, 5.6 – 22.5)	7.5 (3.2, 3.1 – 16.9)	9.2 (3.9, 3.8 – 20.4)	0

Expulsion, χ2 (3, 191) = 7.81, *p* = .05

for both groups to children aged 7 to 15. With regard to educational engagement, Illinois generally manifests the outcomes of the nation at large. No significant differences emerge at the item level between the two samples, and a slight but statistically significant difference is evident for the scale score. Students in Illinois, overall, appear to be slightly more engaged educationally, according to their own reports, than children nationally (Table E.6). Educational engagement has been demonstrated to have a significant association with school achievement regardless of gender, race, or socioeconomic status (Finn, 1993). Overall, students report high levels of engagement; however, despite the fact that a majority of students report themselves as engaged, a sizeable minority appear to struggle with regard to interest, involvement, and relationships with people at school.

Summary

While many children appear to be functioning well educationally while in foster care, these data demonstrate that, from the perspectives of caregivers, a substantial proportion of children are struggling in terms of achievement. Caregivers report that 23% of children are over the chronological age expected given their grade levels, that 30% are receiving grades below ‘C’ in at least one subject, that 37% are not reading at grade level, and that 42% are not performing mathematics at grade level. Many students are reported to be receiving special education, but the likelihood of receipt of special education varies in complicated ways by a number of factors. Specifically, males are more likely to be tested for and to be identified as needing special education

Table E.6 School Engagement in Illinois and Nationally Among Children in Foster Care

	NSCAW Ages 7-15 N=371		ILLINOIS Ages 7-15 N=128	
	Estimated percentage within a 95% confidence interval[45]			
	Point Estimate	Confidence Interval	Point Estimate	Confidence Interval
Mean Score for 11-Item Scale: lowest possible score=11; highest possible score=44)	31.5	30.8 – 32.1	34.7	34.0 – 35.5
Percentage answering “Often” or “Always”				
How often do you enjoy being in school?	67.5	58.5 – 75.3	71.6	63.0 – 78.9
How often do you find your classes interesting?	56.8	49.1 – 64.1	71.6	54.1 – 71.0
How often do you find that school work is too hard to understand?	26.5	21.2 – 32.7	19.8	13.5 – 28.1
How often do you try to do your best work in school?	87.4	80.2 – 92.2	86.6	79.3 – 91.7
How often do you listen carefully or pay attention in school?	78.3	72.7 – 83.0	82.5	74.6 – 88.3
How often do you get your homework done?	80.7	74.6 – 85.6	82.5	74.0 – 88.3
How often do you fail to complete or turn in your assignments?	28.9	21.7 – 37.5	22.1	15.5 – 30.3
How often do you get along with your teachers?	73.7	66.7 – 79.8	81.2	73.3 – 87.2
How often do you get along with other students?	76.7	68.0 – 83.6	65.0	55.8 – 73.3
How often do you get sent to the office or have to stay after school for misbehavior?	7.7	4.8 – 12.1	7.9	4.1 – 14.4

---

[45] Wide confidence intervals are due to substantial variance.

services and are more likely, according to caregivers, to be receiving such services. The pattern of testing, identification, and services receipt has an association with race or ethnicity such that students of Latino/a heritage or other racial/ethnic backgrounds are more likely to be reported as having been tested for learning or developmental problems than White or African American students. White students are more likely than African American students to be identified as needing special education, and race/ethnicity has no relationship with the actual delivery of services as reported by caregivers. In all cases, children in more restrictive living arrangements are reported to be more likely to receive special education testing and services. A total of 39% of children overall are reported by caregivers to be receiving special education services, but 84% of children in group or residential care are reported to be receiving such services. Children who have spent more time in foster care are also more likely to be tested for and identified as needing special education services and to be receiving such services, according to caregivers.

Most children are also doing well in terms of behavior in the schools, as the most common report from caregivers of how many in-school suspensions and out-of school suspensions had taken place was 0. However, a small number of students are struggling in this regard with a maximum for in-school suspensions at 22 and a maximum for out-of-school suspensions at 8. A total of 9% of students were reported to have been expelled in the past two years. In-school suspensions were associated with placement such that children in specialized foster care received more in-school suspensions than children in kinship care or group care. Out-of-school suspensions were associated with race or ethnicity such that African American students were more likely to receive out-of-school suspensions than White or Latino/a students. Expulsion was associated with living arrangement such that children in group care were expelled at lower rates. This may be due to a higher rate of enrollment in therapeutic day schools among children in group and residential care.

Attendance was generally good, with most students not having missed any school in the past month. However, a small number of students were reported by caregivers as missing all their days of school in the past month. Most students were reported not to have changed schools within the past few years, but a small number of students had changed schools multiple times with the maximum number of school transitions at 8.

The findings presented suggest that, while most students are doing well in terms of behavior and attendance and while most have stability in their school placements, a small number of children are experiencing serious difficulties and are in need of additional interventions to allow them to succeed in their school settings. A much larger number of children are reported as doing well in terms attendance and behavior but nonetheless not receiving adequate grades and not working at grade level in reading and mathematics. These students may not appear to need supports, as they are not experiencing overt failure; however, they are not on track to graduate from high school with skills sufficient to equip them for higher education or advanced employment opportunities. Additional research on the services that are available to support students in their efforts to achieve at grade level, who is using them, how they are being used, and what their effectiveness might be is warranted for this vulnerable group of children.

ILLINOIS
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

School of Social Work
1207 W. Oregon Street
Urbana, IL 61801

http://cfrcwww.social.uiuc.edu