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

An Assessment Of Their Safety, Stability, Continuity, Permanence, And Well-Being

Children and Family Research Center

2009

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

An Assessment Of Their Safety, Stability, Continuity, Permanence, And Well-Being

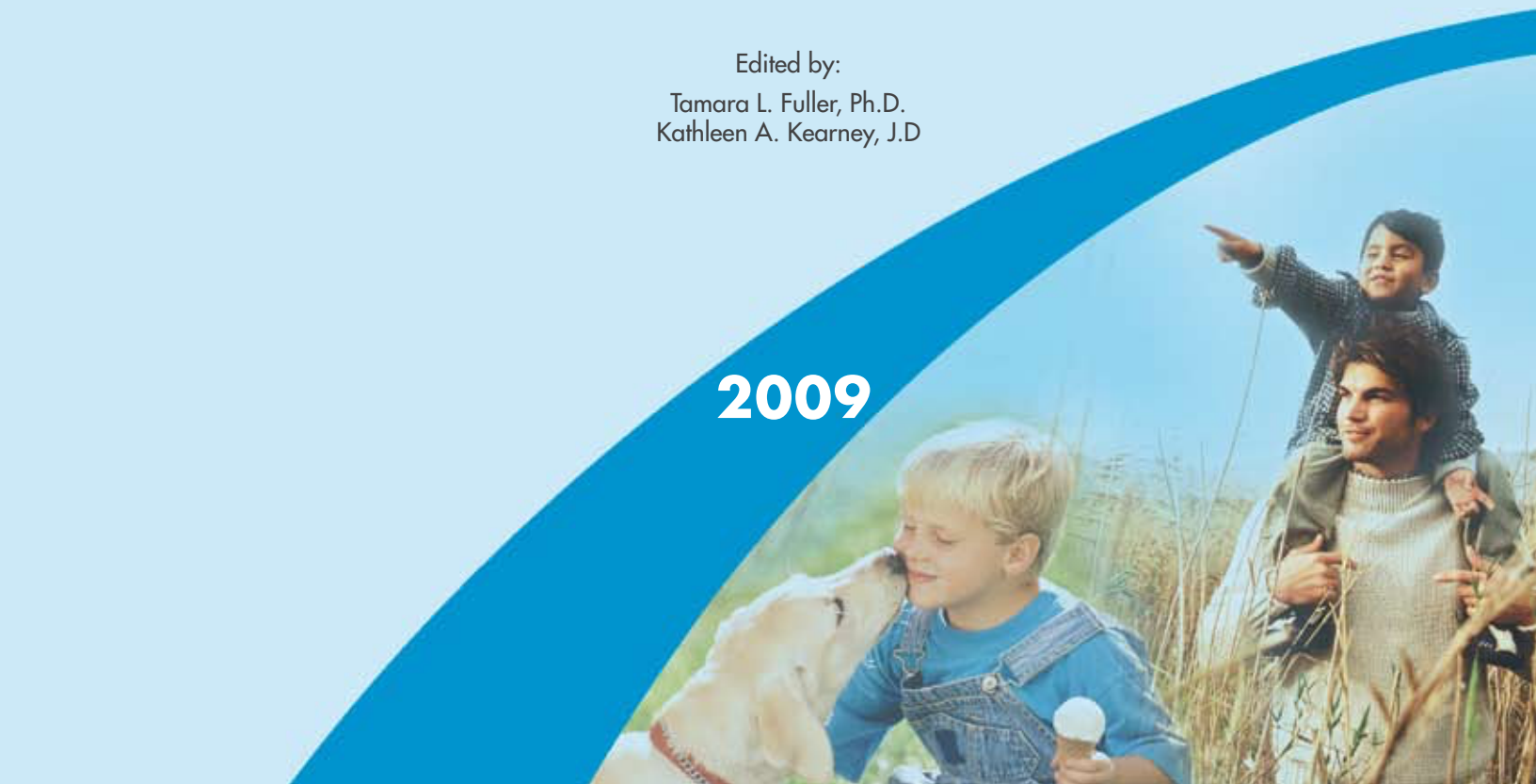
A report by the

Children and Family Research Center

University of Illinois at Urbana-Champaign

Edited by:

Tamara L. Fuller, Ph.D.
Kathleen A. Kearney, J.D



2009

Acknowledgements

The production of this report is the culmination of the efforts of many, if not most, of the staff at the Children and Family Research Center, and we thank each of them for their contributions to this report. Special thanks to Judge Kathleen Kearney, who agreed to serve as co-editor of this year's report and spent countless hours reviewing and editing chapters. Judge Kearney's years of child welfare and judicial expertise added invaluable insight that grounded the report in an important way.

Our long-time colleague, Nancy Rolock, left the Children and Family Research Center in 2009 to pursue a doctoral degree at the Jane Addams College of Social Work at the University of Illinois at Chicago. We are grateful for her assistance with this report and wish her the very best in her graduate studies.

Many thanks to the colleagues that allowed us to highlight their work in this year's report and took the time to write summaries: Sonya Leathers at Jane Addams College of Social Work (UIC), Judge Kathleen Kearney at the Children and Family Research Center, Twana Cosey at the Department of Children and Family Services, Deann Muehlbauer at the Department of Psychiatry (UIC), and Wendy Haight at the UIUC School of Social Work.

This report contains quotes taken from in-depth interviews that were conducted with Illinois foster youth who participated in the now defunct Foster Youth Seen and Heard (FYSH) Program. Although we cannot name them specifically to preserve their anonymity, these remarkable individuals provided invaluable knowledge and insight into the lives of foster children. Their willingness to share their stories is deeply appreciated.

Thank you to our reviewers Mary Hollie, Joe Ryan, Wendy Haight, and Dean Wynne Korr for their assistance prior to the publication of the report. The report is significantly better for their thoughtful comments.

Thank you to Rod Roberts and the staff at Roberts Design Company for the graphic design of the report.

The Children and Family Research Center is an independent research organization created jointly by the University of Illinois at Urbana-Champaign and the Illinois Department of Children and Family Services to provide independent evaluation of outcomes for children who are the responsibility of the Department. Funding for this work is provided by the Department of Children and Family Services. The views expressed herein should not be construed as representing the policy of the University of Illinois or the Department of Children and Family Services.

For questions about the content of the report contact

Tamara Fuller at (217)333-5837 or t-fuller@illinois.edu

This report will be available on our website: http://www.cfrc.illinois.edu/

For additional copies of this report contact

Children and Family Research Center
School of Social Work
University of Illinois at Urbana-Champaign
1010 West Nevada Street Suite 2080
Urbana, IL 61801
(217) 333-5837 (phone)
(800) 638-3877 (toll-free)
(217) 333-7629 (fax)
cfrc@illinois.edu
http://www.cfrc.illinois.edu

School of Social Work
University of Illinois at Urbana-Champaign

Children and Family Research Center
University of Illinois at Urbana-Champaign

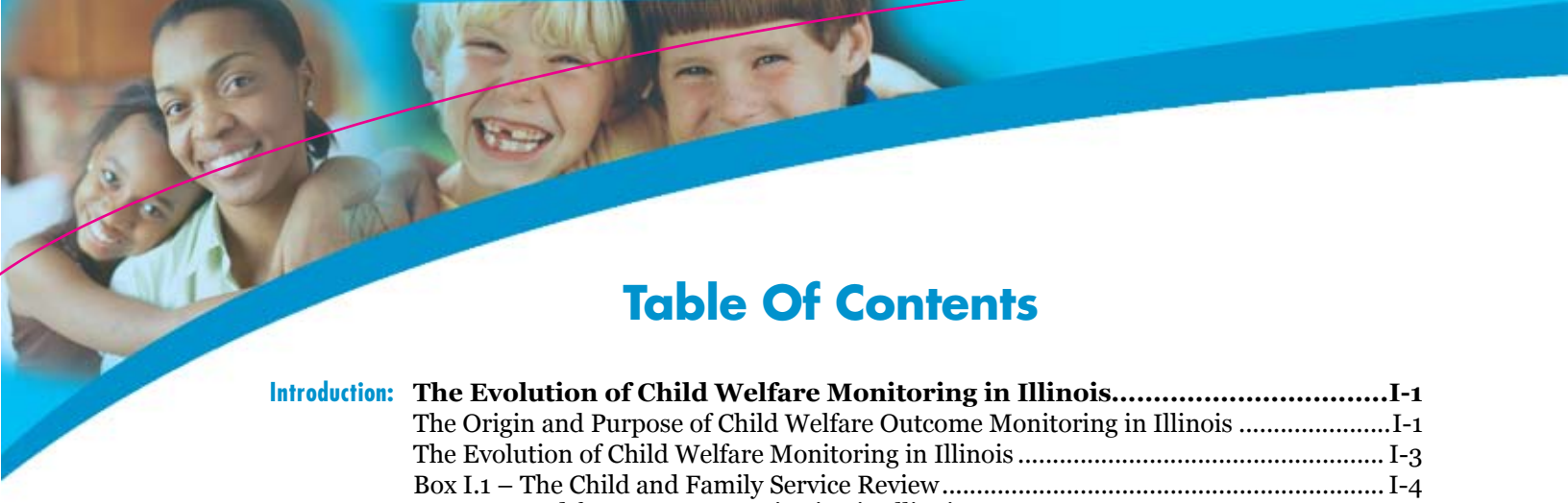


Table Of Contents

INTRODUCTION

The Evolution Of Child Welfare Monitoring In Illinois

Kathleen A. Kearney, J.D.
Tamara L. Fuller, Ph.D.
Children and Family Research Center
University of Illinois at Urbana-Champaign

This is the twelfth year the Children and Family Research Center (CFRC, the Center) has been responsible for the annual report on the performance of the Illinois child welfare system in achieving positive outcomes on behalf of abused and neglected children entrusted to the state's care. The mission of the Center as an independent research organization is to support and conduct research which contributes to the safety, permanency and well-being of children and families. The annual report on the conditions of children in, or at risk of, foster care in Illinois is an important opportunity for the child welfare system as a whole to reflect upon its performance and strive to better understand the policies and practices which may be impacting outcomes. This report is not an evaluation of the Illinois Department of Children and Family Services (DCFS, the Department), the juvenile courts, private providers and community-based partners, or the other human services systems responsible for child protection and welfare. Rather, it is a monitoring report that examines specific performance indicators and identifies data trends on selected outcomes of interest to the federal court, the Department, and members of the B.H. class and their attorneys. In many respects, this report may raise more questions for the reader than provide answers. What is causing the variance between geographic regions and sub-regions? How do we address the negative trends identified? It is our hope that this report will not sit on a shelf, but be used as a catalyst for dialogue between all child welfare stakeholders at the state and local level about the meaning behind these reported numbers and potential strategies for quality improvement. The children of Illinois deserve no less.

The Origin and Purpose of Child Welfare Outcome Monitoring in Illinois

The foundation of this report can be traced directly to the B.H. consent decree, which was approved by United States District Judge John Grady on December 20, 1991, and required extensive reforms of the Illinois Department of Children and Family Services over the subsequent two and a half years.[1] According to the Decree:

> "It is the purpose of this Decree to assure that DCFS provides children with at least minimally adequate care. Defendant agrees that, for the purposes of this Decree, DCFS's responsibility to provide such care for plaintiffs includes an obligation to create and maintain a system which assures children are treated in conformity with the following standards of care:
>
> a. Children shall be free from foreseeable and preventable physical harm.
> b. Children shall receive at least minimally adequate food, shelter, and clothing.
> c. Children shall receive at least minimally adequate health care.
> d. Children shall receive mental health care adequate to address their serious mental health needs.
> e. Children shall be free from unreasonable and unnecessary intrusions by DCFS upon their emotional and psychological well being.
> f. Children shall receive at least minimally adequate training, education, 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.

1 B.H. v. Suter, No. 88-cv-5599 (N.D. Ill., 1991). It should be noted that the name of the Defendant changes over time to reflect the name of the DCFS Director appointed at the time of the entry of a specific order. Susan Suter was the appointed Director at the time of the entry of the original consent decree in this case.

In order to meet this standard of care, it shall be necessary for DCFS to create and maintain a system which:

a. Provides that children will be timely and stably placed in safe and appropriate living arrangements;
b. Provides that reasonable efforts, as determined based on individual circumstances (including consideration of whether no efforts would be reasonable) shall be made to prevent removal of children from their homes and to reunite children with their parents, where appropriate and consistent with the best interests of the child;
c. Provides that if children are not to be reunited with their parents, DCFS shall promptly identify and take the steps within its power to achieve permanency for the child in the least restrictive setting possible;
d. Provides for the prompt identification of the medical, mental health and developmental needs of children;
e. Provides timely access to adequate medical, mental health and developmental services;
f. Provides that while in DCFS custody children receive a public education of a kind and quality comparable to other children not in DCFS custody;
g. Provides that while in DCFS custody children receive such services and training as necessary to permit them to function in the least restrictive and most homelike setting possible; and
h. Provides that children receive adequate services to assist in the transition to adulthood."

Under the terms of the *B.H.* Consent Decree, implementation of the required reforms was anticipated to occur by July 1, 1994. However, it became clear to the Court and to both parties that this ambitious goal would not be achieved in the two and a half years specified in the agreement. Consultation with a panel of child welfare and organizational reform experts led to the recommendation, among other things, to shift the focus of the monitoring from technical compliance (process) to the desired outcomes the parties hoped to achieve.[2] Both the plaintiffs and the defendants were in favor of a more results-oriented monitoring process, and together decided on three outcome categories: permanency, well-being, and safety.[3] The two sides jointly moved to modify the decree in July 1996,[4] outlining a series of new strategies based on measurable outcomes:

"The parties have agreed on outcome goals for the operation of the child welfare system covering the three areas of child safety, child and family well-being, and permanency of family relations.

a) The outcome goals agreed upon by the parties include the following:

i) Protection: Promptly and accurately determine whether the family care of children reported to DCFS is at or above a threshold of safety and child and family well-being, and if it exceeds that threshold, do not coercively interfere with the family.
ii) Preservation: When the family care of the child falls short of the threshold, and when consistent with the safety of the child, raise the level of care to that threshold in a timely manner.
iii) Substitute care: If the family care of the child cannot be raised to that threshold within a reasonable time or without undue risk to the child, place the child in a substitute care setting that meets the child's physical, emotional, and developmental needs.
iv) Reunification: When the child is placed in substitute care, promptly enable the family to meet the child needs for safety and care and promptly return the child to the family when consistent with the safety of the child.
v) Permanency: If the family is unable to resume care of the child within a reasonable time, promptly arrange for an alternative, permanent living situation that meets the child's physical, emotional, and developmental needs."[5]

2 Mezey, S.G. (1998). Systemic reform litigation and child welfare policy: The case of Illinois. *Law & Policy, 20* 203-230.
3 Puckett, K.L. (2008). *Dynamics of organizational change under external duress: A case study of DCFS's responses to the 1991 consent decree mandating permanency outcomes for wards of the state*. Unpublished doctoral dissertation, University of Chicago.
4 *B.H.* v McDonald (1996). Joint Memorandum in Support of Agreed Supplemental Order, No 88-cv- 5599 (N.D. Ill 1996).
5 Ibid, p. 2-4

In addition to specifying the outcomes of interest, the Joint Memorandum outlined the creation of a Children and Family Research Center "responsible for evaluating and issuing public reports on the performance of the child welfare service system operated by DCFS and its agents. The Research Center shall be independent of DCFS and shall be within an entity independent of DCFS."[6] Also, "the Research Center, in consultation with the Department and counsel for the plaintiff class, will develop outcome indicators to provide quantitative measures of progress toward meeting those goals. The Research Center will develop technologies and methods for collecting data to accurately report and analyze these outcome indicators. The Research Center may revise these outcome indicators after consultation with the Department and counsel for the plaintiff class to the extent necessary to improve the Center's ability to measure progress toward meeting the outcome goals."[7]

The Joint Memorandum spelled out the process through which the results of the outcomes monitoring would be disseminated: The Research Center shall also provide to the parties and file with this Court an annual report summarizing the progress toward achieving the outcome goals and analyzing reasons for the success or failure in making such progress. The Center's analysis of the reasons for the success or failure of DCFS to make reasonable progress toward the outcome goals shall include an analysis of the performance of DCFS (including both DCFS operations and the operations of private agencies), and any other relevant issues, including, where and to the extent appropriate, changes in or the general conditions of the children and families or any other aspects of the child welfare system external to DCFS that affect the capacity of the Department to achieve its goals, and changes in the conditions and status of children and plaintiffs' counsel as the outcome indicators and data collection methods are developed..."[8] Although Judge Grady rejected the formal appointment of the Center as monitor, a subsequent court order made clear that the Center could develop outcome measurements for the Department but would not monitor its compliance with the Decree. The parties agreed, instead, that there would be no monitor at all.[9]

Evolution of Outcome Monitoring in Illinois

The *B.H.* parties agreed to give discretion to the Center in developing the specific indicators used to measure safety, permanency, and well-being. They also recognized the importance of exploring the systemic and contextual factors that influence outcomes, as well as the need for outcome indicators to change over time as data technology grows more sophisticated and additional performance issues emerge. The first "Outcomes Report" was filed with the Court in 1998 and included information on outcomes for children in the custody of the Department through fiscal year 1997. The indicators included in this monitoring report were simple, and included safety indicators of 1) maltreatment recurrence among intact family cases at 30, 180, and 300 days and 2) maltreatment reports on children in substitute care (overall rate and rates by living arrangement) and permanence indicators: 3) rate of children who entered substitute care from intact cases; 4) percentage of children returned home from substitute care within 6, 12, 18, and 24 months; 5) percent of reunified children who re-enter foster care; 6) percent of children adopted from substitute care and median length of time to adoption; 7) adoption disruptions; and 8) percent of children moved to legal guardianship from substitute care. Each of these indicators was examined by child age, race, gender, and region.

During the course of the next twelve years the federal and state child welfare landscape has changed significantly and these reports have evolved accordingly. Although well-being indicators did not yet exist, separate studies were conducted by the Center to assess the well-being of children in substitute care beginning in FY2000. The most recent additions to the report occurred in FY2003, when two additional chapters on Continuity and Stability were added to examine placement stability, the use of least restrictive settings (i.e. most family like), and the continuity of family relationships while in care.

From the initial reports filed by the Center pursuant to the *B.H.* consent decree, the editors and authors were cognizant of the need for an outcome, rather than process, focus in child welfare. The 1999 Outcomes Report recognized a national shift to define and track outcomes of public child welfare systems in order to identify practices and services which produce desired results.[10] Child welfare administrators have struggled to determine the most effective way to hold

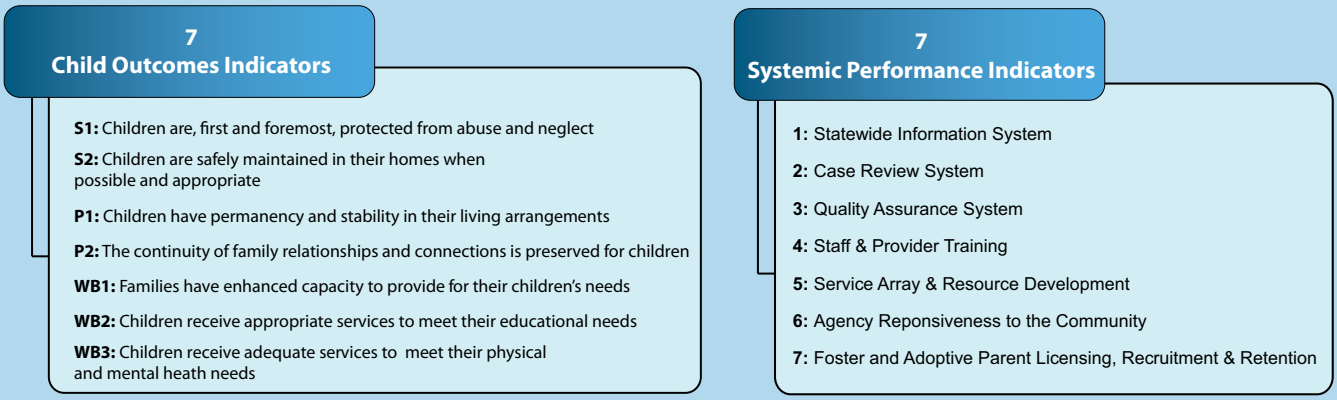
6 Joint Memorandum, p. 2
7 Joint Memorandum, p. 4
8 Joint Memorandum, p. 4
9 *B.H. v McDonald* (1997). Agreed Order Modifying Consent Decree, No 88-cv-05599 (N.D. Ill 1997).
10 Children and Family Research Center (1999). *Outcomes report 1999.* Retrieved from http://www.cfrc.illinois.edu/pubs/Pdf.files/outcomfis99.pdf.

states accountable for assuring positive outcomes for children and families. In an attempt to drive change in day-to-day casework practices, the federal government created the Child and Family Services Reviews (CFSRs). The Center is aware of the criticism leveled against the performance measurement methodology employed by the CFSRs.[11] Nevertheless, until the federal government chooses to revise the CFSR to address the concerns of its critics, it remains an important means by which state child welfare performance is assessed. Therefore, relevant findings from the 2009 Illinois CFSR Final Report are included in each of the subsequent chapters to allow the reader the opportunity to view these findings on the conditions of children in the Illinois child welfare system in concert with the Center's findings. Box I.1 contains an overview of the CFSR outcomes and performance indicators and the methodology used to determine them.

Box I.1—The Child and Family Services Review

The American child welfare system is the responsibility of both the federal and state governments. To ensure accountability, the federal government has invested in data collection processes through which performance could by assessed. The Adoption and Safe Families Act of 1997 (ASFA) required the United States Department of Health and Human Services to develop outcome measures designed to focus on core domains of safety, permanency and well-being. The Child and Family Services Review (CFSR) was intended to "offer a more balanced and child and family centered approach" to evaluating state child welfare performance when they were enacted by rule in March, 2000.[12] The rule established 7 child outcome indicators and 7 systemic performance indicators as depicted in Figure I.1.

Figure I.1 – CFSR Child Outcomes and Systemic Performance Indicators

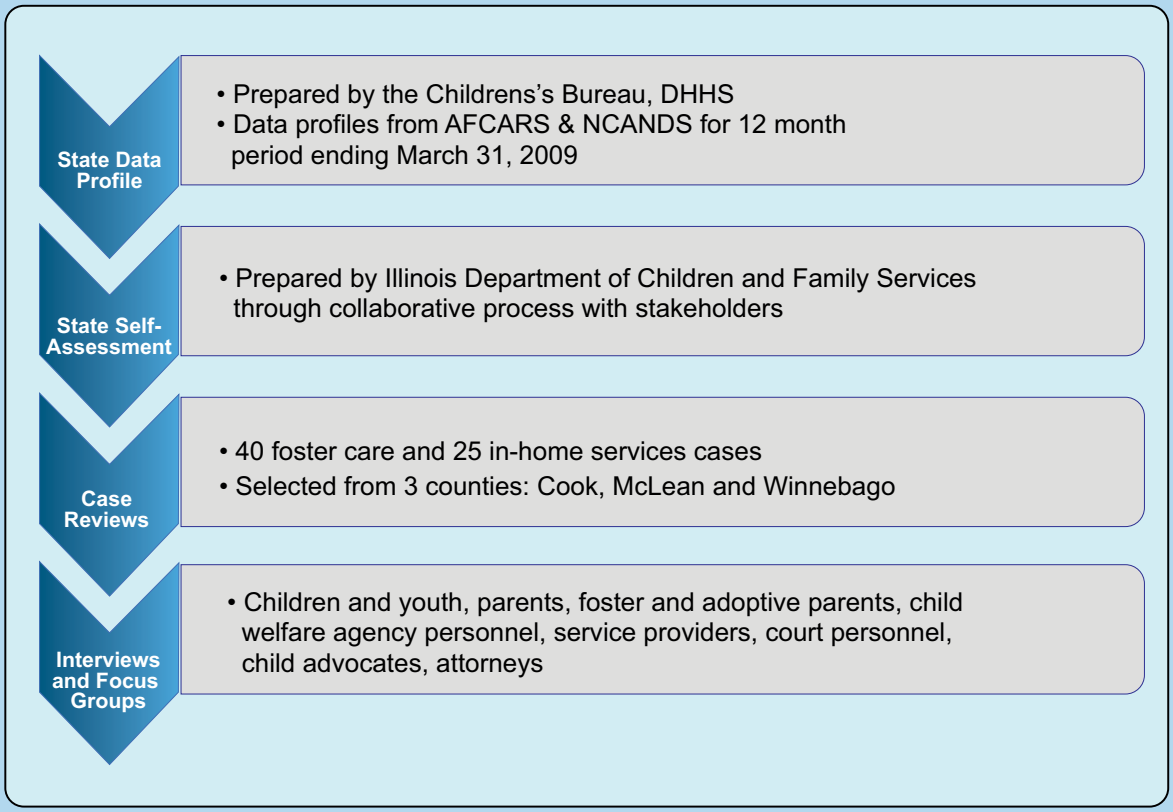


11 See Schuerman, J. & Needell, B. (2009). *The Child and Family Services Review Composite Scores: Accountability off the track*. Chicago: Chapin Hall at the University of Chicago. Courtney, M.E., Needell, B. & Wulczyn, F. (2004). Unintended consequences of the push for accountability: the case of national child welfare performance standards. *Children and Youth Services Review*, 26, p. 1141-1154.

12 U.S. Department of Health and Human Services, Administration of Children and Families, Administration for Children, Youth and Families, Children's Bureau, *Child Welfare Final Rule, Executive Summary*, retrieved from http://www.acf.hhs.gov/programs/cb/laws_policies/cblaws/execsumm.htm.

The CFSR process is multi-tiered and uses a mixed quantitative and qualitative approach. The Children's Bureau prepares and transmits data profiles to the state comprised of aggregate data on the state's foster care and in home services population. The data profiles allow the state to compare specific safety and permanency data indicators with national standards set by the Children's Bureau. A narrative report is prepared by the state and submitted to the Children's Bureau prior to an intensive on-site review. For the first round of CFSRs, 50 cases were selected in each state for this in-depth review drawn from 3 counties through negotiation between the Children's Bureau and the state. This was changed to a sample of 65 cases for the second round. The on-site visit is an intensive review conducted by a joint federal-state team which encompasses case record review and in-depth interviews with children, families, caseworkers, and service providers. Findings from the on-site review are then combined with the statewide data indicators to determine if the state is in substantial conformity on the outcomes. Interviews and focus groups with state and local child welfare stakeholders such as court personnel, foster and adoptive parents, are held to determine substantial conformity on systemic factors.

Figure I.2 – 2009 Illinois Child and Family Services Review Components



The first round CFSR was held in Illinois in 2003. The state was found not to be in substantial conformity for any of the seven child outcomes, but was for five of the seven systemic factors. No state was found to be in substantial conformity for all seven outcomes and systemic factors. States were required to implement Performance Improvement Plans (PIPs) to correct outcome areas not found to be in substantial conformity. In Illinois, the Department's Division of Quality Assurance and the Children and Family Research Center's Foster Care Utilization Review Program (FCURP) established a public-private partnership to advance PIP goals and monitor progress. The second round CFSR was conducted in 2009 with cases under review from April 1, 2008 through August 14, 2009. The on-site review was held during the week of August 10, 2009. The final report was issued on January 4, 2010.[13]

13 US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, (2010). *Final report Illinois Child and Family Services Review, January 4, 2010* retrieved from http://www.acf.hhs.gov/programs/cb/cwmonitoring/index.htm#cfsr

Current Need for Outcome Monitoring in Illinois

There is no question that the Illinois child welfare system looks quite different than the system described in the *B.H.* lawsuit filed in 1988 where basic needs of children were not being met. A decade later, at the time of filing of the Center's first *B.H.* report following FY1998, there were over 50,000 children in substitute care. Once in care, children languished with a median length of stay in excess of 44 months for children who entered care in FY1995. The number of children in residential treatment programs out of state had begun to decline from a high of 800 youth in FY1995, but still remained high at over 300. The concept of Subsidized Guardianship for foster children was being tested as part of a Home of Relative (HMR) Reform Plan. Performance based contracting was implemented to incentivize the attainment of permanency goals and is largely credited with reducing the number of children in care, although no formal evaluation was ever done of its efficacy. Simultaneously, the Department was in the process of redesigning the front end of the system to ensure children were only removed from their homes and placed in substitute care if their safety warranted it. The Child Endangerment Risk Assessment Protocol (CERAP) was implemented statewide as part of the Department's efforts to safely reduce the number of children coming into care through more accurate assessment of parental strengths and protective capacities. To improve accountability and to emphasize quality improvement, the Department began efforts to become the first public child welfare system in the nation to be accredited by the Council on Accreditation, a goal it achieved in 2000. Overall these reform efforts resulted in a reduction of children in care from 51,596 in FY1997 to 15,701 by the end of FY2009. Sue Badeau, the former Deputy Director of the Pew Commission on Children in Foster Care described the transformation in Illinois as "sort of the gold standard" for child welfare.[14]

Despite these impressive results over the past decade, the Illinois child welfare system still faces many challenges across all domains. The federal CFSR results are troubling, notwithstanding concerns by some regarding the methodology used to collect and analyze the underlying data upon which they rely. Although there have been dramatic reductions in the number of youth in substitute care, the needs of the current population have changed in significant ways. The youth in care are older with approximately 36.3% over the age of 13. They present with more severe behavioral health challenges, including a growing number of youth diagnosed with conduct disorder. Although the total number of youth placed in institutional and group home care has declined since the late 1990s, the length of stay has steadily increased. The need for higher end (severe) treatment services has increased since FY2004 when 29% of youth in residential care were placed in the most restrictive level of care to approximately 40% in FY2009.

This year's report contains noteworthy findings across all domains which should serve as warning signs requiring heightened vigilance on the part of all child welfare stakeholders. Significant differences were found at the regional and sub-regional levels which warrant further analysis as to the cause of these differences at both the state and local levels. Issues highlighted in this report include:

Safety

- Children in intact family cases have become less safe in recent years; non-recurrence rates have fallen from 90.3% in 2002 to 87.8% in 2008 statewide; with significantly higher recurrence rates occurring in the Springfield and Marion sub-regions.
- The rate of maltreatment recurrence within 12 months following an initial indicated report has remained relatively steady statewide; yet wide regional variances exist. Children in Cook County experience maltreatment recurrence less frequently than those located in the Springfield and Marion sub-regions.
- Low compliance (40%) with the Department's stated policy of completion of the CERAP safety assessment at the time of investigation closure for cases open longer than 30 days or where services are not given significantly elevates the risk of maltreatment recurrence.

[14] Price, T. (2005, April). Child welfare reform: The issues. *CQ Researcher, 15*(15). Retrieved from http://www.cwla.org/newsevents/cqresearcher050422.pdf.

Stability

- Stability rates among intact families served at home are high (97%) in Cook County, but significantly lower in the Central, Southern and Northern regions where only 91% to 92% of children stay at home and do not enter foster care within a year of their intact family case opening.
- Stability rates for the first year in out of home care remain low with only 79% of children statewide experiencing no more than two placements within a year of removal; significant variance exists between African American children (75%) and White children (86%); erratic swings in performance were noted at the sub-regional level, particularly in East St. Louis and Cook County North.
- The Multiple Move Study found 36% of youth experiencing three or more placements within an 18 month period were attributed to foster family related reasons, with over half of these moves related to allegations of maltreatment in the foster home; 34% were due to child behavior-related issues; and 26% were attributed to system or policy related issues.
- Although the percentage of children over the age of 12 who did not run away from care appears to have improved slightly over the past seven years from 76% to 81%; when the data is stratified by age only 71% of children over the age of 15 are stable; when stratified by geographic location, not surprisingly youth in Cook County are much more likely to run away than youth located in the rest of the state.

Continuity

- The percent of children placed with relatives upon first entering care has experienced slight decreases in Cook County since 2005 to 37%; while significant increases have occurred in the remainder of the state from 36% in 2003 to 55% in 2009.

Legal Permanence

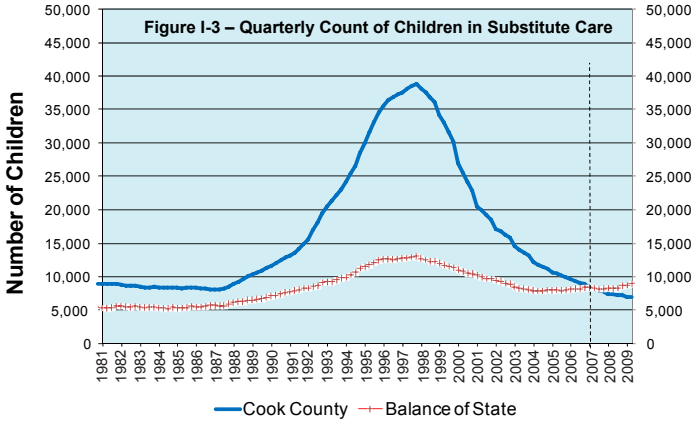
- While it appears from state level data that permanency rates have remained relatively stable over the past seven years, sub-regional analyses conducted for this report show disturbing trends in regions outside of Cook County; all of the downstate regions experienced drops in permanency rates after 12 months in care (reunifications only) with a 13% decline noted in the Springfield and East St. Louis sub-regions; startling drops in permanency rates within 24 and 36 months were also noted.
- The median length of stay in foster care has improved in Cook County from 37 months in 2002 to 18 months in 2007; but it has increased in the Northern and Central regions during this period. Median length of stay has increased for White children from 16 months in 2001 to 22 months in 2007.

Well-Being

- New findings from the Illinois Survey of Child and Adolescent Well-Being (ISCAW) of children who have been the subject of an indicated maltreatment investigation show those children face enormous risk in their homes from caregiver problems with alcohol abuse and domestic violence the most common problems noted; poverty was noted as a significant problem in rural areas of the state.
- Over one quarter of children removed from their homes in the ISCAW sample reported having a gun or knife pointed at them.
- Childhood obesity is prominent among foster children age 2 or older and exceeds the national average; 73.5% of African American children in foster care are overweight or obese which is twice the national average for this racial group.
- Overall, 40% of children involved with Illinois DCFS have a special health care need with need for remediation of a chronic or repeated health condition as compared to an estimated 13% to 19% of American children; a significantly higher proportion of these children are located in the Northern Region (51%) when compared to other regions of the state (33% to 37%).
- 64% of children aged 0-2 demonstrated risk of cognitive impairment on a standardized developmental measure indicating a substantial need among the youngest children coming into contact with DCFS for early intervention and treatment.
- Over one half of adolescents in substantiated maltreatment cases have engaged in delinquent behavior in the past six months; 41% have used alcohol.
- Emotional and behavioral problems continue to be evident, with percentages substantially higher for older youth and for children in traditional foster care.

Special Focus: Child Welfare Outcomes in Downstate Regions

For the past two decades, child welfare outcomes in Illinois have been driven largely by the case flow dynamics occurring in Cook County. This can be seen most dramatically in the 359% increase in the number of children in foster care in Cook County which occurred from 1987 to 1997 – from approximately 8,500 children to 39,000 children – and in the subsequent 457% decrease in these numbers to below 7,000 in 2007.



Although the number of children in substitute care outside of Cook County increased (and then decreased) as well during this same span of time, the magnitude of the change was far less striking than in Cook County. The foster care caseload in the "balance of the state" (BOS) went from approximately 6,000 in 1987 to 13,000 in 1997, to 9,125 at the end of FY2009. Because of the sheer size of the foster care caseload in Cook County in the last decade, many of the child welfare reforms focused on practice in this region. In 2007, however, the number of children in substitute care in the BOS surpassed that in Cook County for the first time, and it appears this trend will continue for the near future.

In addition to the changing caseload dynamics throughout the state, previous *B.H.* monitoring reports have detected significant differences in child welfare outcomes in the DCFS regions. For instance, maltreatment recurrence tends to be relatively lower in Cook County and relatively higher in the Central and Southern regions of the state, a trend which has persisted for several years. Stability of permanence at both the five and ten year intervals is significantly lower in the Southern and Central regions when compared to Cook County.

These two conditions – the shifting of the overall substitute care caseload toward the non-Cook County regions and the worsening performance on indicators in these regions – spurred interest in a closer examination of child welfare outcomes among children in the "downstate" regions of Illinois. This year's report therefore attempts to provide this level of detail by analyzing the safety, stability, continuity, and permanence indicators at the sub-region level and presenting these findings within the chapters as appropriate. This sub-regional analysis provides a more comprehensive picture of child welfare system functioning in Illinois, and in several instances revealed some startling findings that were not apparent when indicators were examined at the state-wide or even the regional level.

However, even analyses at the sub-regional level may mask important distinctions among families living in the "downstate" regions of Illinois. Each downstate region is composed of both urban and rural communities, and this may be the key distinction that influences child welfare outcomes rather than region per se. Although child welfare research on children and families in rural areas is much scarcer than that on urban families, the evidence that is available suggests children in remote rural areas may be removed from their homes and placed into foster care at rates much higher (12.1 per 1,000 in Illinois in 2007) than children in either metropolitan areas (7.4 per 1,000) or those in non-metro adjacent areas (5.6 per 1,000).[15] In addition, child mental health problems are a greater contributor to child welfare involvement in rural areas than in urban areas.[16] Children and families in rural areas experience numerous disadvantageous conditions, especially poverty, at rates equal

15 Mattingly, M.J., Wells, M., & Dineen, M. (2010). Out-of-home care by state and place: Higher placement rates for children in some remote rural places. Durham, NH: Carsey Institute. Retrieved May 13, 2010, from http://www.carseyinstitute.unh.edu/publications/FS_Mattingly_Out-of_Home.pdf.
16 Barth, R.P., Wildfire, J., & Green, R.L. (2006). Placement into foster care and the interplay of urbanicity, child behavior problems, and poverty. American Journal of Orthopsychiatry, 76, 358-366.

to or higher than their urban counterparts; these conditions influence not only their likelihood of coming into contact with child welfare, but also their safety, stability, continuity, permanence, and well-being once contact has occurred (see Box I.2 for a brief review of the research on rural families).

Unfortunately, there is no one, universally preferred definition of "rural" or "urban" that suits all policy and research purposes.[17] For instance, the U.S. Office of Management and Budget defines non-metropolitan as a county with fewer than 50,000 people not adjacent and without close economic and social ties to a metropolitan county.[18] To capture the differences in well-being between rural and urban/suburban children and families in Illinois, Center researchers Dr. Ted Cross and Dr. Jesse Helton created a variable which defined rural areas as those with a population density of less than 150 people per square mile. Children and families living in rural areas were then compared to those living in urban or suburban areas on each of the over 20 well-being indicators; the results of these analyses are presented in Chapter 5.

The results of the analyses in the following chapters represent a good beginning to a lengthier discussion that should occur about regional differences in child welfare outcomes in Illinois. Although the results are useful, and tell us how children involved with the Department vary across the state, they do not tell us why. The results are likely to leave readers unsatisfied in that they often raise more questions than they answer. Continued exploration by the child welfare research community of the factors influencing outcomes in rural communities should occur.

Box I.2 – Children In Rural Communities

Attention to the safety and well-being of rural children has often suffered from the "urban-centric" nature of most behavioral science research.[19] What research has been done suggests that rural children face threats to their safety and well-being that can match or exceed those faced by urban children.

- Poverty rates are higher in rural areas; children of rural single mothers are the poorest demographic group in the county.[20]
- The risk of poverty is especially significant for rural minorities: 12% of non-urban Whites lived below the poverty line in 2004, compared to 29% of non-urban Blacks and 26% of non-urban Latinos.[21]
- According to Rural Healthy People 2010, the total unemployment rate of 18% in rural areas is triple the national average.[22]
- Families in rural communities experience higher rates of chronic medical conditions and disability and are at greater risk for infant mortality.[23]
- Rural substance abuse is on the rise, while substance abuse in urban areas, particularly the inner city, is shrinking. Drug users in rural areas more likely to engage in binge drinking and methamphetamine use.[24]
- Social isolation can predispose rural inhabitants to depression,[25] and suicide is a bigger risk in rural than urban communities.[26]

Even though problems like these suggest their needs are substantial, rural inhabitants have poor access to services. Rural parents are less likely to have employer-provided health insurance, and the rural poor are less likely to be covered by Medicaid benefits than non-rural poor.[27] Only 10.7% of hospitals in rural areas offer substance abuse treatment, compared to 26.5% of metropolitan hospitals. Formal behavioral health services are scarce in rural areas; many areas do not have psychologists or psychiatrists.

17 Coburn, A.F., MacKinney, A.C., McBride,T.D., Mueller,K.J., Slifkin,R.T., & Wakefield, M.K. (2007). *Choosing rural definitions: Implications for health policy.* Retrieved June 21, 2010, from http://www.rupri.org/Forms/RuralDefinitionsBrief.pdf.
18 U.S. Census Bureau. (2010). *Metropolitan and micropolitan statistical areas.* Retrieved June 21, 2010, from http://www.census.gov/population/www/metroareas/metroarea.html.
19 Stamm, B.H. (Ed.). (2003). *Behavioral healthcare in rural and frontier areas: An interdisciplinary handbook.* Washington, DC: APA Books.
20 Belanger, K., & Stone, W. (2008). The social service divide: Service availability and accessibility in rural versus urban counties and impact on child welfare outcomes. *Child Welfare, 87*, 101-124.
21 Dew, B., Elifson, K., & Dozier, M. (2007). Social and environmental factors and their influence on drug use vulnerability and resiliency in rural populations. *Journal of Rural Health, 23*, 16-21.
22 Ibid, Dew et al. (2007)
23 Broffman, P. (1995). How can pediatric care be provided in underserved areas? A view of rural pediatric care. *Pediatrics, 96*, 816-821.
24 Ibid, Dew et al. (2007)
25 Hoyt, D.R., Conger, R.D., Valde, J.G., & Weihs, K. (1997). Psychological distress and help seeking in rural America. *American Journal of Community Psychology, 25*, 449–470.
26 Fiske, A., Gatz, M., & Hannell, E. (2005). Rural suicide rates and availability of health care providers. Journal of Community Psychology, 33(5), 537–543. Singh, G.K., & Siahpush, M. (2002). Increasing rural-urban gradients in US suicide mortality, 1970–1997. *American Journal of Public Health, 92*, 1161–1167.
27 Ibid, Dew et al. (2007)

Box I.2 – Children In Rural Communities

The poverty, unemployment, health risk and potential social isolation of those in rural communities increase the need for effective child welfare services, but child welfare in these communities often has a sparse service array with which to work. Rural child welfare agencies also deal with a myriad of special challenges in serving families: geographical barriers, transportation difficulties, scarcity of resources, professional isolation, confidentiality issues and retention of professional staff.[28]

The findings related to rural children should provoke considerable concern and suggest the need for continuing special attention to rural children involved with DCFS. The problems of children in rural areas are equal to those of other children, but the resources available to respond to these problems may not be. Additional analysis of the Illinois Survey of Child and Adolescent Well-Being (described in Chapter 5) will further explore issues related to access to services for children in rural areas.

Structure of the Report

This year's report retains the same format as earlier reports by discussing findings in five chapters: Safety, Stability of Family Life, Continuity, Legal Permanence, and Well-Being. Each chapter includes a box which informs the reader "at a glance" of significant performance indicators relevant to that chapter. The "bullet" preceding each of these indicators is a graphic image used to demonstrate whether the recent findings reflect a positive, negative, or static trend when compared to findings over the past seven year period. A discussion of significant findings and trends is found in each chapter with "warning signs" indicated when negative trends have been identified. Data for the indicators in the Safety, Stability, Continuity, and Legal Permanence chapters are obtained from the DCFS Integrated Database, a longitudinal database maintained by the Chapin Hall Center for Children that contains information about the children and families investigated by the Department and those served through intact family services or out-of-home care. Detailed breakdowns for each indicator in these chapters (by child gender, race, age, and geographic region) are located in Appendix A. All tables and figures in this report are presented in a format which characterizes positive changes and improvements over time by increasing numbers and trend lines. The state fiscal year is used throughout this data unless otherwise indicated.

In the initial *B.H.* reports, the authors stressed the importance of understanding the Department's performance in light of its legal and social context. In this report, each chapter includes mention of applicable federal child welfare legislation to inform the reader of the legal framework upon which the chapter is based. The editors of this year's report have also included updates on significant Illinois legislative and policy changes, for example the Department's implementation of Differential Response in the Safety Chapter (Chapter 1) and the 2009 Child Welfare Reform Legislation in the Legal Permanence Chapter (Chapter 4). Noteworthy initiatives have been highlighted to "spotlight" practice innovations, such as the Department's Home of Relative (HMR) licensing initiative and the Residential Discharge and Transition Protocol in the Continuity Chapter (Chapter 3). Finally, the editors have also included recent pertinent research, such as a study looking at physical aggression in rural girls and boys from methamphetamine-involved families found in the Well-Being Chapter (Chapter 5), and the impact of the *Striving for Excellence* project extending performance based contracting to institutional and congregate care in the Stability Chapter (Chapter 2). Contact information is located in each of these highlighted sections to assist the reader in obtaining additional details about any of these initiatives.

28 Landman, M.J. (2002). Rural Child Welfare Practice from an Organization-in-Environment Perspective, *Child Welfare, 81*, 791-81 9.

Looking to the Future

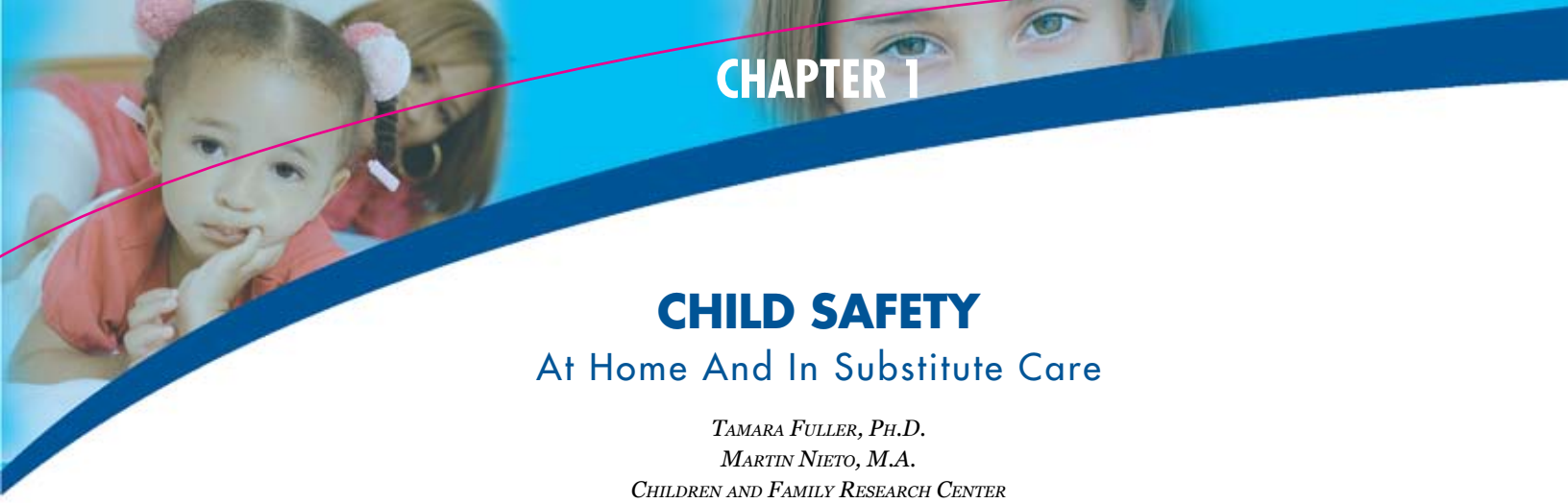
The Department is moving forward with several new initiatives aimed at "protecting children by strengthening and supporting families." First, the Department is implementing a new Differential Response model at the "front end" of the system – this is the first major child protective services reform in fifteen years. The Differential Response model in Illinois, known as Pathways to Strengthening and Supporting Families, is described more fully in Chapter 1 (Safety). Studies on the effectiveness of Differential Response in Minnesota and Ohio are promising. The randomized control trial being conducted by the Children and Family Research Center under the auspices of the National Quality Improvement Center on Differential Response in Child Protective Services will allow for an in-depth analysis of the efficacy of this strategy on child safety outcomes. Future monitoring reports will contain updates from this 4-year evaluation.

Another new initiative is the expansion of the Family Advocacy Centers (FACs) throughout the state. The goals of the Family Advocacy Centers are to prevent families from coming into care and to help families in care reunite as soon as possible. FACs strive to be an approachable resource for families and offer an array of services including: advocacy, parent coaching, intensive mediation services, referral and linkage, counseling, case management, 24-hour crisis response services, referral services for substance abuse treatment, mental health treatment, shelter and food assistance programs, after-school programs, summer and other out-of-school programming assessment, immigration services, parenting classes in English and Spanish, domestic violence counseling, parent support and mentoring support groups and skill building workshops, leadership development workshops, intervention strategies to support the family reunification process, and court-ordered supervised child visitation for non-custodial parents. DCFS established its first FAC in Bloomington in 2004, and there are 12 FACs currently operating throughout the state with several more slated to begin operation in FY11.[29] An evaluation of the effectiveness of the FACs is being conducted by the Chapin Hall Center for Children at the University of Chicago.

The substitute care population in Illinois has changed dramatically over the last decade. The population is now older, many with complex behavioral and emotional needs. These youth are much less likely to move to permanence through adoption or guardianship, and innovative and creative strategies must be sought to serve their needs. Permanency has many dimensions including relational, physical, and legal permanence.[30] Illinois, like the rest of the nation, has focused primarily on the attainment of legal permanence through reunification, adoption and subsidized guardianship. According to Stott and Gustavsson, a broader perspective and definition of permanence may be warranted, particularly for older adolescents with complex service needs. Permanency, particularly for older youth, must be balanced with stability. Disruption caused by a physical move in the middle of a school year, with concomitant losses of social and community networks, undermines a youth's sense of belonging and control.[31]

The 2009 Illinois child welfare permanency reform legislation recognizes the need to empower foster youth by requiring that the Court find compelling reasons to select a permanency goal of "continuing foster care" which includes a finding that the youth does not want to be adopted or be placed in the guardianship of a relative or foster care placement. Additionally, the law now requires the Department to assess whether contact should be permitted with a parent whose parental rights have been terminated for a minimum period of 3 years for any youth over the age of 13 who is not in a permanent placement. If contact is appropriate, the Department is to document its efforts to foster connections between the parent and child in the case plan. This law embodies a growing trend towards consideration of relational permanence. Likewise, the ground-breaking reinstatement of parental rights set forth in Public Act 096-0600 provides a mechanism by which a prior determination of legal permanence, i.e. the severance of parental rights, can be revisited under certain circumstances which may support the relational permanence of a child. The implementation of this new legislation should be monitored and assessed.

29 Bishop, A. (2010 January). *Family Advocacy Centers: Strengthening Families in Communities.* Presentation at the First Annual Illinois Child Welfare Leadership Summit. Chicago, IL.
30 Stott, T. and Gustavsson, N. (2010). Balancing permanency and stability for youth in foster care. *Children and Youth Services Review, 32*, 619-625.
31 Ibid.



CHAPTER 1

CHILD SAFETY

At Home And In Substitute Care

Tamara Fuller, Ph.D.
Martin Nieto, M.A.
Children and Family Research Center
School of Social Work
University of Illinois at Urbana-Champaign

Child safety is the paramount concern of the child protection and welfare systems. According to the most recent federal child welfare monitoring report, the "primary objective of State child welfare systems is to ensure that children who have been found to be victims of abuse or neglect are protected from further abuse or neglect, whether they remain in their own homes or are placed by the State child welfare agency in a foster care setting" (p. II-1).[1] Once a child becomes involved in an indicated report of child abuse or neglect, the child welfare system assumes partial responsibility for the safety and protection of the child from additional abuse or neglect (e.g., maltreatment recurrence).

There has been little change in Illinois law related to child safety and Child Protective Services (CPS) functioning over the past decade. However, on August 25, 2009, Illinois Governor Pat Quinn signed into law the Differential Response Program Act (SB807), which amends the Children and Family Services Act and the Abused and Neglected Child Reporting Act. Major provisions of the Act include: (1) beginning January 1, 2010, the Department of Children and Family Services may implement a 5-year demonstration of a "differential response program" which may provide that, upon receiving a report of suspected child abuse or neglect, the Department shall determine whether to conduct a family assessment or an investigation as appropriate to prevent or provide a remedy for child abuse or neglect (instead of providing that upon receiving a report, the Department shall determine whether to conduct a family assessment or an investigation); (2) the Department shall promulgate criteria, standards, and procedures that shall be applied in making such a determination, taking into consideration the Child Endangerment Risk Assessment Protocol of the Department; (3) the Department shall arrange for an independent evaluation of the "differential response program" to determine whether it is meeting the goals in accordance with the Abused and Neglected Child Reporting Act; and (4) the "demonstration" shall become a permanent program upon completion of the demonstration project period (see Box 1.1 for a more detailed description of the Differential Response model and evaluation).

Monitoring Child Safety

In some ways, child safety is the most straightforward of all child welfare outcomes – safety is the *absence* of child maltreatment. Even so, there are differences in the ways that child safety can be measured, which can lead to inconsistencies in reporting and confusion when interpreting results. With that in mind, it is important to be clear about the ways that child safety is measured in this chapter.

Maltreatment recurrence is the most common indicator used to assess child safety within the context of public child welfare. Typically, recurrence is defined as a *substantiated* maltreatment report following a prior *substantiated* report that involves the same child or family. Some measures, called re-referrals, take a broader view and include *all* subsequent reports following an initial report, regardless of the substantiation status of the subsequent report. Although recognizing the important of all future contacts with child welfare, the current report follows the more commonly-used indicator of maltreatment recurrence that includes only additional substantiated or indicated maltreatment reports.

Indicators of maltreatment recurrence also vary widely in the length of time over which recurrence is monitored. Studies of safety assessment focusing on immediate safety of children during the investigation typically use short recurrence follow-up periods, i.e., 60 – 120 days. The federal

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

Child Safety At A Glance

Children are safer if:

More children are protected from abuse or neglect:

Of all children living in Illinois, the number that did not have an indicated report of abuse or neglect has remained constant at 992 per 1,000 from 2002 to 2009.

More children are protected from repeated abuse or neglect:

Of all children with a substantiated report of abuse or neglect, the percentage that did not have another indicated report within a year has remained fairly level bewteen 88.3% in 2002 to 88.5% in 2008.

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

Of all children with initial indicated reports that did not receive either intact family or substitute care services, the percentage that did not have another indicated report within one year has remained level at around 89% from 2002 to 2008.

More children are protected from abuse or neglect while at home:

Of all children who were served at home in an intact family case, the percent that did not have another indicated report within a 12-month period has decreased from 90.3% in 2002 to 87.8% in 2008.

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

Of all children ever served in substitute care during the year, the percentage that did not have an indicated report during placement has decreased slightly from 98.7% in 2003 to 98.3% in 2009.

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

Of all children with an initial unfounded report of maltreatment, the percentage that did not have another report (either unfounded or indicated) within a year increased from 76.3% in 2002 to 81.7% in 2008.

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

Of all children with an initial unfounded report of maltreatment, the percentage that did not have another indicated report within a year remained relatively stable between 95 – 96% from 2008 to 2008.

recurrence measure used in the Child and Family Services Review examines maltreatment recurrence within 6 months following an initial indicated report. The current report uses a 12-month recurrence period for the majority of the safety indicators, although a special analysis on the impact of the Child Endangerment Risk Assessment Protocol (CERAP) on child safety replicates the federal recurrence measure using a 6-month recurrence period.

The final consideration when selecting safety indicators is the population of interest: Which groups of children should be included in the safety measure? In Illinois, the focus on child safety extends throughout the entire life of a case, and the mandate for ensuring child safety extends to all children investigated by the Department, regardless of the services response (i.e., intact family or substitute care services).

Thus, the current chapter monitors child safety among all children with an indicated report, children that receive no services following an indicated report, children served in intact families following an indicated report, and children in substitute care. In addition, based on concerns that children

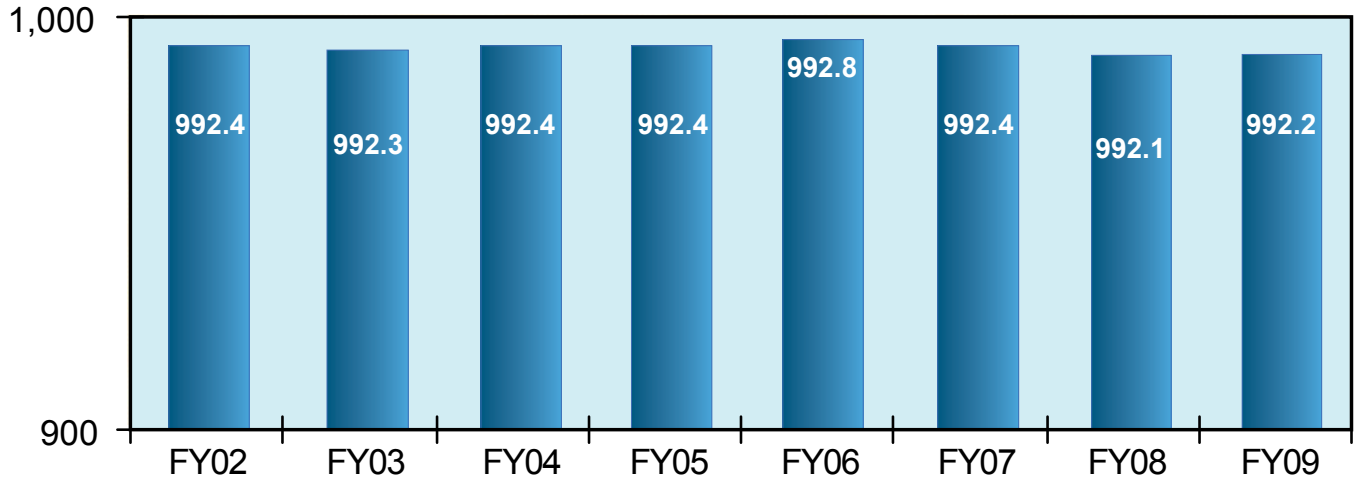
in initially unfounded investigations may have service needs as high as those in indicated investigations, the last section of the chapter examines maltreatment recurrence among children in initially unfounded investigations.

Prevalence Of Child Maltreatment

Maltreatment prevalence rates are not commonly used in state and federal child welfare monitoring efforts. Primary prevention of child abuse and neglect often falls outside the mandate of public child welfare systems, although there are signs that this philosophy may be changing in some states, including Illinois. However, to provide context for other indicators, the first indicator reported in this chapter is the prevalence of child maltreatment. In keeping with the convention used throughout this report, this indicator is computed so that increases over time correspond to improvement. Figure 1.1 displays the number of children without an indicated report of maltreatment in relation to the overall population of children in the state. This number has remained fairly constant at approximately 992 per 1,000 for the past several years.

However, not all children in the state are equally likely to experience maltreatment. When this data is examined by DCFS region (see Appendix A, Indicator 1.A), the rate of children without an indicated report is much higher in Cook County (995.2 in 2009) and the Northern region (993.8) than in the Southern (988.2) and Central (985.2) regions. The only region that has shown improvement in this indicator is Cook County – rates have increased from 994.3 per 1,000 in 2002 to 995.2 per 1,000 in 2009. Rates of non-maltreatment have dropped slightly (about 1 per 1,000) in both the Northern and Southern regions of the state, and have dropped more noticeably in the Central region, from 989.4 per 1,000 in 2002 to 985.2 per 1,000 in 2009. In addition, rates of non-maltreatment have significantly improved among African-American children – from 984.8 per 1,000 in 2002 to 986.6 per 1,000 in 2009 – and to a lesser degree among Hispanic children – from 996.1 to 997.6 per 1,000. Despite this increase, rates of non-maltreatment among African-American children (986.6 in 2009) are considerably lower than those for both White (993.1) and Hispanic (997.6) children (see Appendix A, Indicator 1.A).

Figure 1.1 – Number Of Children (Per 1,000) Without An Indicated Report Of Abuse Or Neglect



Box 1.1—Differential Response in Illinois: Pathways to Strengthening and Supporting Families

What is Differential Response?

Historically, there has been one response by the child protection agency to accepted reports of alleged maltreatment—an investigation. Given that the majority of families that come to the attention of child protection are not experiencing immediate child safety issues, there has been a developing trend for the past 15 years to respond to these families *differentially* in a manner that supports the families by applying available resources to services rather than conducting investigations. This approach is accompanied by greater efforts to identify, build, and coordinate formal and non-formal services and supports.

Differential Response (DR) models have at least two pathways to serve families: an investigation pathway and a non-investigation pathway. The non-investigation pathway has also been called *alternative response, family assessment response*, and similar terms. The National Quality Improvement Center on Differential Response (QIC-DR) has identified several core elements which define the presence of a DR approach in child protective services:

- Use of two or more discrete response pathways for cases that are screened-in and accepted;
- Establishment of discrete response pathways is formalized in statute, policy, or protocols;
- Initial pathway assignment depends on an array of factors (e.g., presence of imminent danger, level of risk, the number of previous reports, the source of the report, and/or presenting case characteristics such as type of alleged maltreatment and age of the alleged victim);
- Initial pathway assignment can change based on new information that alters risk level or safety concerns;
- Services are voluntary in a non-investigation pathway: (1) families can choose to receive the investigation response or (2) families can accept or refuse the offered services if there are no safety concerns;
- Families are served in a non-investigation pathway without a formal determination of child maltreatment, and
- Since no determination of maltreatment is made, no one is named as a perpetrator, and no names are entered into the central registry for those individuals who are served through a non-investigation pathway.

What will Differential Response look like in Illinois?

The Department began the planning process for Differential Response in 2009. In July 2009, a peer-to-peer technical assistance conference was held in which representatives from the Minnesota DR staff met with IDCFS administrators and other stakeholders to discuss how DR was implemented and has evolved in Minnesota (their DR system has been in place for over a decade and has achieved positive outcomes). Immediately following this conference, a DR steering committee was put in place to develop the DR model for Illinois. In August 2009, the National Quality Improvement Center on Differential Response (QIC-DR) issued a Request for Applications for Research and Demonstration sites to participate in a national cross-site evaluation. The selected sites would receive funding from the QIC-DR to apply toward their DR services and/or evaluation activities. The Department selected the Children and Family Research Center as the lead evaluator for the project and an application was submitted to the QIC-DR in October 2009. Illinois was selected as one of three research and demonstration sites for the QIC-DR cross-site evaluation.

In Illinois, the differential response model has been named Pathways to Strengthening and Supporting Families (PSSF). Under the PSSF approach, calls made to the "hotline" will be screened to determine if they meet the criteria for a child abuse or neglect report under Illinois statute. Accepted reports will be assigned to one of two pathways: Investigation Response (IR) or Family Assessment Response (FAR). Reports eligible for the family assessment pathway must meet <u>all</u> of the following criteria:

1. Either no prior family reports to the State Central Registry (SCR); OR no prior *indicated* allegations of abuse and/or neglect; OR prior indicated reports have been expunged within timeframes ranging from five to fifty years; AND
2. Alleged perpetrators are parents (birth or adoptive), legal guardian, or responsible relative; alleged victims are not currently in IDCFS care or custody or wards of the court; AND
3. Protective custody is not needed or taken; AND
4. Allegations include, singly or in combination:
   - Lock Out
   - Inadequate Food
   - Inadequate Shelter
   - Inadequate Clothing
   - Environmental Neglect

- Mental Injury
- Medical Neglect
- Inadequate Supervision unless the child or children are under the age of 8 or with an emotional/mental functioning of that of a child under the age of 8 and there was no adult present or able to be located or if the adult is present but impaired and unable to supervise.

Families assigned to the family assessment pathway will be served by a paired team consisting of one IDCFS Child Welfare Specialist (CWS) and one Family Assessment Caseworker employed by a community-based agency. The process for completing a thorough family assessment includes the following:

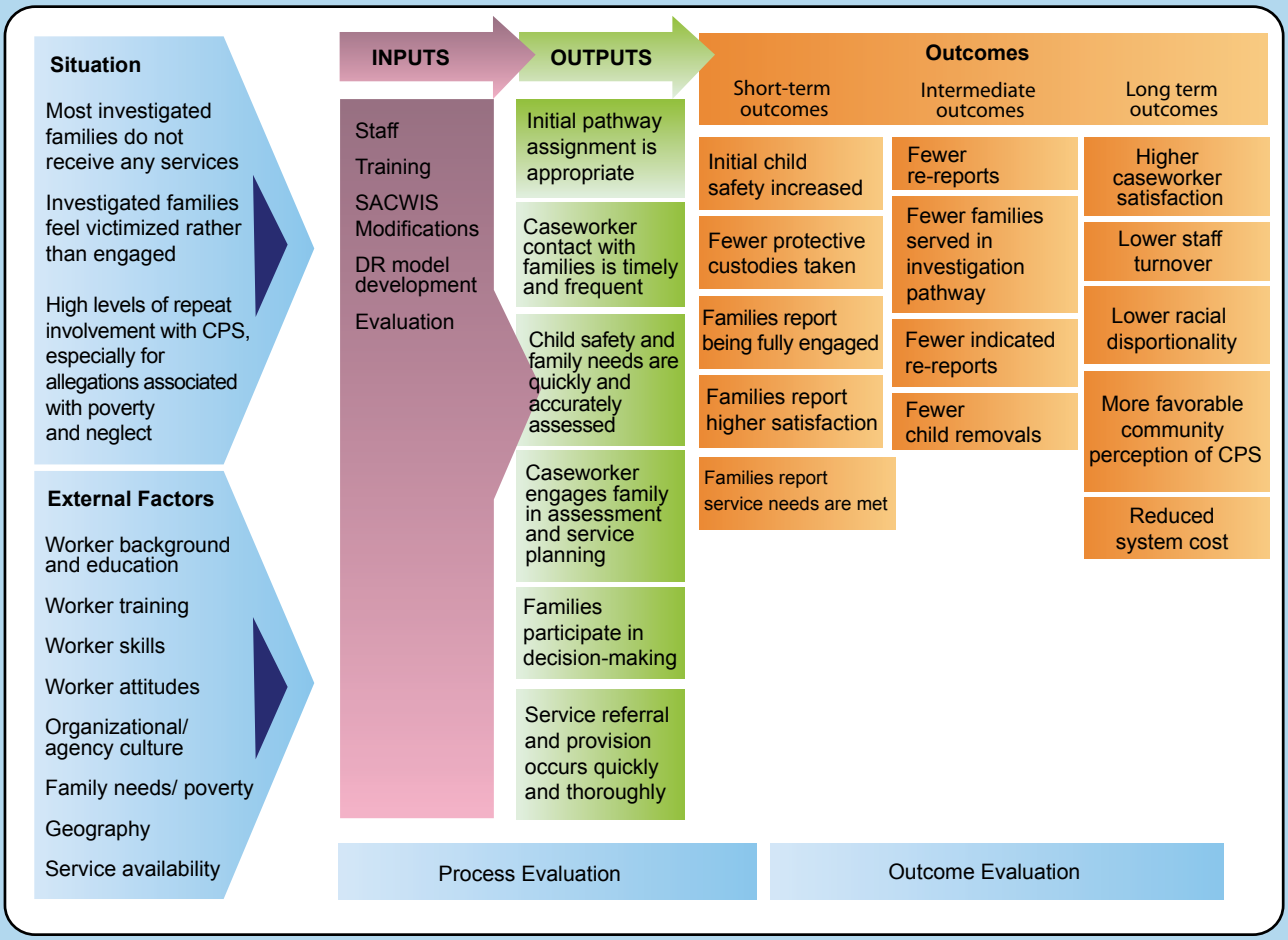
- CWS will assess the safety of all children and risk factors present in the home.
- If the child(ren) is determined to be unsafe, or if the level of risk is high, IDCFS supervisors have the authority to reassign a family to the investigation pathway.
- If there are no immediate safety concerns, the CWS will hand over all future services to the Family Assessment worker thereby ending DCFS involvement with the family.
- The Family Assessment worker will complete a family needs and strengths assessment.
- The Family Assessment worker will refer the family to or provide them with a wide array of services targeted to their specific concerns.
- The family assessment service case may remain open for up to 90 days. After 90 days, 30 day service extensions for up to an additional 90 days may be granted by the private agency providing the family assessment services in consultation with the family based upon their needs and the availability of funds.

How will Differential Response be evaluated in Illinois?

The Illinois DR evaluation builds off the logic model presented in the figure on the next page. Evaluation of the PSSF approach will consist of a randomized control experimental design with qualitative elaboration and pre-test/post-test comparisons of worker and agency contextual factors. Highlights of the evaluation design include:

- Contextual factors of worker background, training, satisfaction, and attitudes toward child protection and differential response, organizational culture and climate, and service availability will be assessed prior to and following PSSF implementation.
- A process evaluation will thoroughly document the steps taken to implement PSSF throughout the state, including detailed documentation of all steering committee meetings and decisions, training development, model fidelity, identification of implementation barriers and resolutions, and case tracking and cost data.
- Outcome data will be collected through a mixed-methods approach:
- Administrative data will capture information for comparing the investigation and non-investigation pathways on outcomes, including: initial safety determination and risk level; family strengths and family needs; % of children taken into protective custody; % of children re-reported, allegations of these re-reports; % of re-reports that are substantiated; and % children removed.
- To supplement the administrative data, caseworkers will complete a case report at closing that gathers information on time to first caseworker contact; number of total contacts and face-to-face contacts with family; case open and close dates (length of open case); date of first service; amount and type of services rendered or referred; adequacy of services offered to meet family needs; level of family engagement; rating of family outcomes, total time spent on each case; and reason for case closing.
- Paper and pencil surveys will be completed by the families prior to “case” closure. These surveys will include assessment of the caretakers’ engagement in the service process, the appropriateness of the services received, their perceptions of their caseworkers, and their overall satisfaction with services. Measures of child and family well-being may be included if time allows.
- Prior to and following program implementation, focus groups and structured interviews will be held with caseworkers, supervisors, administrators, and community providers to assess their perceptions regarding the PSSF program, organizational rules, procedures, and culture; the role of leadership in the implementation process; perceived barriers to implementation and strategies used to overcome those barriers.
- Focus groups will be conducted with families to obtain their perceptions about differential response, service availability and IDCFS in general. Focus groups will be conducted both Year 1 and Year 3 to assess how perceptions have changed over time, with separate Year 3 groups for investigation and non-investigation families.
- Naturalistic observation will be used to collect detailed information independent from caseworker and family perceptions about what occurs during caseworker-family interactions in both the investigation and non-investigation pathways, including: where the interactions occur, who is present during the interactions, who participates in the interactions, how decisions are made, specific skills used by caseworkers, which services are suggested, and whether family strengths are recognized.

Illinois Evaluation Logic Model



For more information about Differential Response in Illinois please contact:

Dr. Tamara Fuller, Project Evaluator
Children and Family Research Center
1010 W. Nevada, Suite 2080
Urbana, IL 61801
t-fuller@illinois.edu

Womazetta Jones, Project Director
Illinois Department of Children and Family Services
100 W. Randolph, Suite 6-100
Chicago, IL 60601
Womazetta.Jones@illinois.gov

Maltreatment Recurrence Among Children With Indicated Maltreatment Reports

The state has several methods through which it attempts to prevent maltreatment recurrence. All investigated households receive a safety assessment (the CERAP) at the beginning of the investigation that allows the investigator to determine whether the children in the household are in immediate danger of a moderate to severe nature. If it is determined that the children are unsafe, the investigator then works with the family to develop a safety plan which will eliminate the threats to child safety. The effectiveness of this process has been the subject of ongoing evaluation in the state of Illinois, and recent results suggest that investigator use of the CERAP at the conclusion of the investigation is significantly associated with reduced maltreatment recurrence among indicated children (see Box 1.2).

Although all investigated households receive a safety assessment, not all cases – even families where indicated maltreatment has occurred – received child welfare services. Some cases are closed immediately following case disposition. Others receive services while the children remain in the home in what are known as "intact family" cases. Finally, if less intrusive options to keep children safe are not feasible, one or more of the children can be removed from the home and placed into substitute care. Table 1.1 shows the total number of children with indicated reports each year, followed by the number and percent of these children that fall into each of the three categories: no post-investigation services, intact family services, and substitute care. The majority of indicated children (between 53-60% each year) do not receive post-investigation services, and the portion of children in this group has risen in the past two years. Around a quarter to a third of indicated children each year are served in intact family cases, and this percentage has been decreasing over the past seven years. A smaller portion of children – around 13 to 16 percent – are placed in substitute care, and this percentage has slightly declined over the past seven years.

Table 1.1 – Total Indicated Children By Service Disposition (FY2002-FY2008)

	Total number children with indicated reports	Indicated children with no post-investigation services		Indicated children served in intact families		Indicated children placed in substitute care	
		n	%	n	%	n	%
FY02	24,866	13,182	53.0	7,739	31.1	3,945	15.9
FY03	25,314	13,793	54.5	7,730	30.5	3,791	15.0
FY04	25,195	13,465	53.4	7,979	31.7	3,751	14.9
FY05	25,431	13,443	52.9	8,239	32.4	3,749	14.7
FY06	24,357	13,724	56.4	7,147	29.3	3,486	14.3
FY07	25,961	15,587	60.0	6,955	26.8	3,419	13.2
FY08	27,302	16,278	59.6	7,244	26.5	3,780	13.9

Each of these system responses has consequences for the family and their risk for maltreatment recurrence. Separate indicators examine the absence of maltreatment recurrence among 1) all children with indicated reports, 2) indicated children with no service case following investigation, 3) indicated children served in intact family cases, and 4) children in substitute care.

Figure 1.2 displays the rate of *all children* with an indicated maltreatment report that did not have another indicated report within 12 months (see Appendix A, Indicator 1.B). This includes children that did not receive services, those in intact family cases, and those in substitute care. The percentage of children who do not experience maltreatment recurrence within 12 months of an initial substantiated report has remained level (around 88.5%) between 2002 and 2008. However, maltreatment non-recurrence rates in Illinois vary considerably when examined by region and by sub-region; rates in Cook County (91.4% in 2008) are highest, followed closely by the Northern region (89.0%), with much lower rates in the Central (86.5%) and Southern (85.2%) regions.

An even closer examination of maltreatment non-recurrence rates at the sub-region level reveals that rates are quite different even within a single region (see Figure 1.3). For example, the Northern region includes the Rockford and Aurora sub-regions. Non-recurrence rates in the Rockford sub-region are 3-4% lower than those in the Aurora sub-region. The Central region is comprised of the Springfield, Champaign, and Peoria sub-regions, and rates in the Springfield sub-region are 4-5% lower than those in the other two Central sub-regions. The Southern region includes the East St. Louis and Marion sub-regions. The non-recurrence rates in the Marion sub-region are the lowest in the entire state – around 82-84% -- while rates in the East St. Louis sub-region are similar those in the Peoria and Champaign sub-regions (around 87-88%).

Figure 1.2 – Percent Of Children With A Substantiated Report Of Abuse Or Neglect That Did Not Have Another Substantiated Report Within A Year

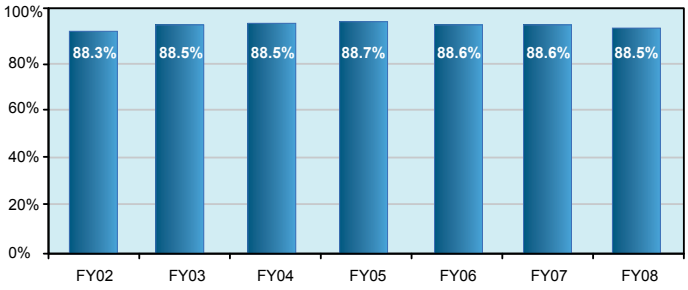
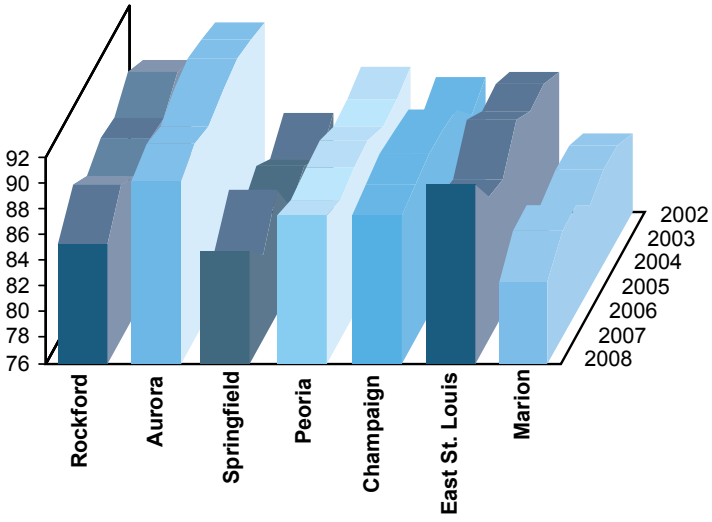


Figure 1.3 –12 Month Maltreatment Non-Recurrence Rates In DCFS Sub-Regions



Non-recurrence rates among Hispanic children (92.8%) are the highest, followed by African American children (88.9%), with White children having the lowest rate of non-maltreatment (87.6%). Non-recurrence rates demonstrate a positive relationship with child age, i.e., non-recurrence rates go up as child age increases: the rate among children less than three years was 87.5% in 2008, compared to 92.4% among children 15 years or older (see Appendix A, Indicator 1.B).

Maltreatment Recurrence Among Indicated Children Who Do Not Receive Services

Figure 1.4 displays the 12-month maltreatment non-recurrence rate for children with an indicated maltreatment report that did not receive services (either intact family or substitute care) following the investigation (i.e., the case was indicated and closed). This percentage has remained fairly constant at approximately 89% for the past seven years. When these rates are examined by region (see Appendix A, Indicator 1.C), rates in the Cook County region (91.2%) and Northern region (90.4%) are much higher than those in the Central (86.3%) and Southern (86.9%) regions of the state. Non-recurrence rates were higher for Hispanic children (93.8% in 2008) compared to White (88.5%) or African American (87.9%) children. Rates of non-recurrence increase with child age: the rate for children less than 3 years was 85.5% in 2008 compared to 94.7% among those 15 to 17 years.

Maltreatment Recurrence Among Children In Intact Family Cases

In some instances, the Department will indicate a family for child maltreatment, but decide that it is in the best interest of the child and family to receive services at home rather than place the child into substitute care. These cases, known as "intact family cases," are of special interest to the Department because their history of indicated maltreatment places them at increased risk of repeat maltreatment. Maltreatment non-recurrence rates among intact families have slowly declined from 90.3% in 2002 to 87.8% in 2008 (Figure 1.5; see Appendix A, Indicator 1.D).

Figure 1.4 – Percent Of Children That Did Not Receive Services Following A Substantiated Report Of Abuse Or Neglect Without A Second Indicated Report Within 12 Months

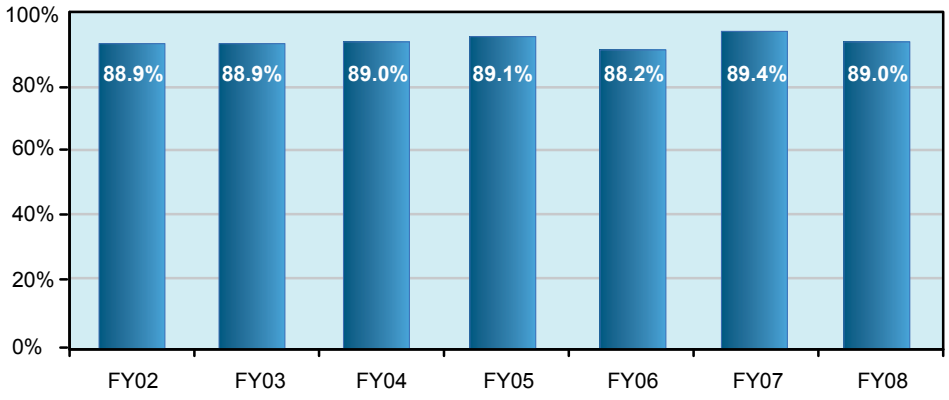
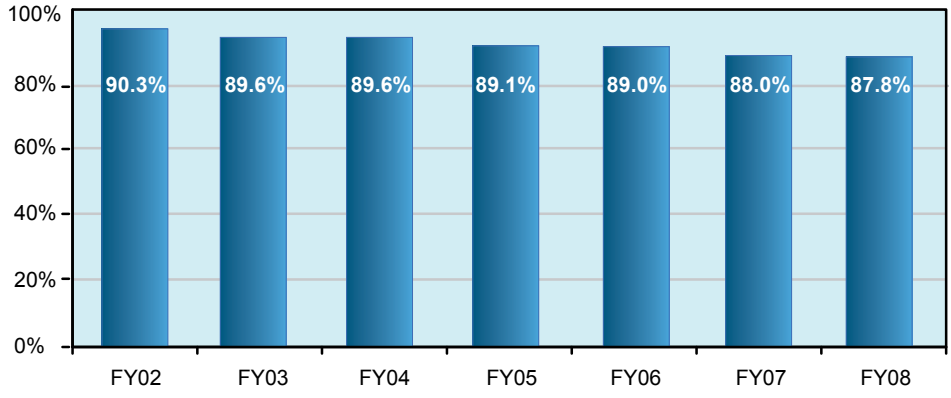
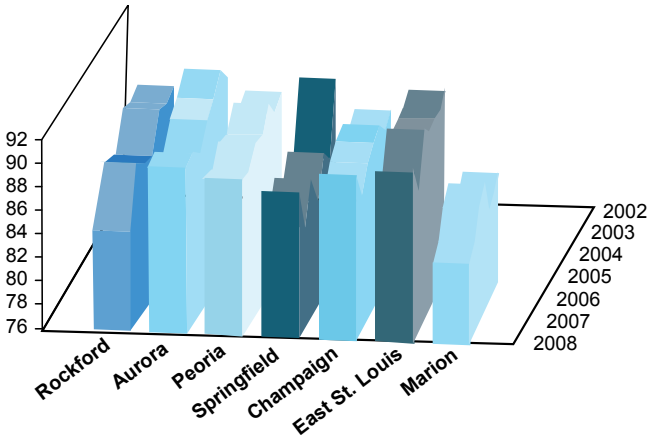


Figure 1.5 – Percent Of Children Served In Intact Family Cases That Did Not Have A Substantiated Report Within 12 Months



When non-recurrence in intact families is examined by DCFS region (see Appendix A, Indicator 1.D), rates in the Cook region are significantly higher (92.0% in 2008) than those in all other regions (Northern = 84.1%, Central = 85.7%, and Southern = 83.7% in 2008). Closer inspection of these rates at the sub-region level reveals some startling differences (see Figure 1.6). Rates in the Aurora, Peoria, Champaign, and East St. Louis sub-regions are consistently higher (over 86% for most years) than those in the Springfield and Marion sub-regions. Non-recurrence rates among intact families in the Marion sub-region are considerably lower than anywhere else in the state – which suggests the need for additional investigation to determine the source of the problems in this area. In addition, rates in the Rockford regions dropped almost 5% in 2008, which could signal the development of a negative trend in this area as well.

Figure 1.6 –Maltreatment Non-Recurrence Rates Among Intact Families In DCFS Sub-Regions



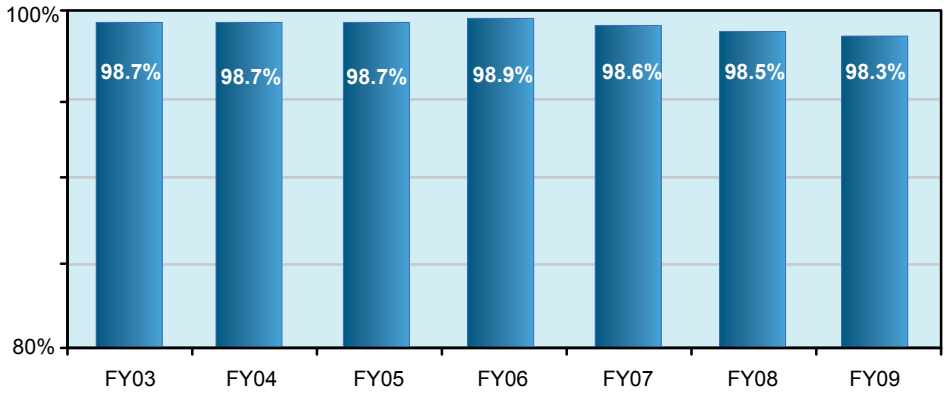
Examination of this indicator by racial group reveals that non-recurrence rates for White children served in intact families were at their highest in 2002 (88%), but have since fallen to 85.2% in 2008, which is much lower than rates for either African American (89.8% in 2008) and Hispanic children (91.0% in 2008). Rates of non-recurrence among intact families increase with child age – older children are much less likely to experience recurrence in this setting than younger children (see Appendix A, Indicator 1.D).

Maltreatment Recurrence In Substitute Care

If children are taken from their home of origin and placed into substitute care for protective reasons, the expectation is that their new living arrangement will provide them with safety from additional abuse or neglect. The following indicator examines the safety of children in substitute care, i.e., the percentage of children who *do not* experience a substantiated report of maltreatment during placement. This percentage dropped slightly from 98.9% in FY06 to 98.3% in FY09 after remaining fairly stable over the past several years (Figure 1.7; see Appendix A, Indicator 1.E). Please note: This data excludes reports of recurrence that involve sexual abuse. Recurrence rates are calculated using data that contains the date the incident was reported to the Department (report date) rather than the date the incident occurred (incident date). Research conducted by the CFRC has revealed that use of the report date rather than the incident date results in an overestimation of abuse and neglect in substitute care.[2] According to this research, a portion of the maltreatment reported while children are in substitute care actually occurred prior to a child's entry into care, i.e., the incident occurred prior to entry but the report occurred during substitute care. The most common "retrospective reporting" errors are reports of sexual abuse. DCFS administrative data does not distinguish between report date and incident date, so the effects of retrospective reporting errors must be estimated. Recurrence reports of sexual abuse have therefore been excluded from this indicator.

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

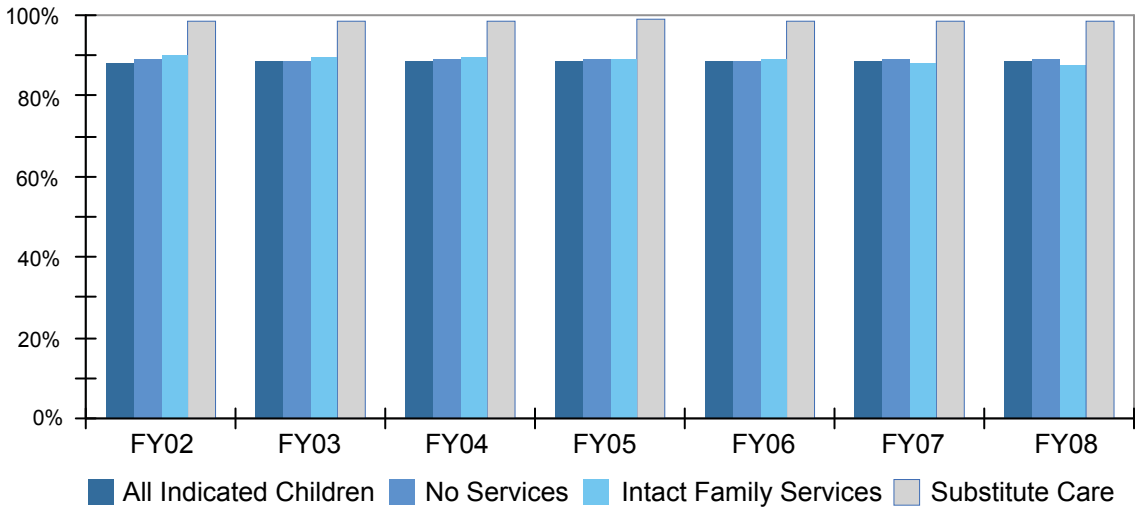
Figure 1.7 – Percent Of Children Served In Substitute Care That Did Not Have A Substantiated Report During Placement



There are no significant differences between groups when this indicator is examined by age, race, and gender (see Appendix A; Indicator 1.E). However, rates of non-recurrence were higher (i.e., more children were safe from additional maltreatment while in substitute care) in the Cook County regions (98.9% in 2009) than in the Southern (98.2%), Northern (97.7%) and Central (97.6%) regions.

Maltreatment recurrence is influenced by many factors, including characteristics of the maltreated child, type of maltreatment, and prior indicated reports.[3] Maltreatment recurrence is also affected by the service response to the initial report — although the research on this topic suggests that the relationship between post-investigation service provision and recurrence in complex.[4] Figure 1.8 compares the maltreatment recurrence rates among all indicated children, those that received no post-investigation services, those that received intact family services, and children in substitute care placement. Please note that this last group includes all children in substitute care during a given fiscal year, not just indicated children. As would be expected, children who are removed from their maltreating caregivers and placed into substitute care experience maltreatment recurrence far less frequently than those who are left in the home either with or without services. Children served in intact family cases are slightly, but not significantly, safer from maltreatment recurrence than those that receive no post-investigation services.

Figure 1.8 – Maltreatment Non-Recurrence Rates



3 See, e.g., Fluke, J.D., Shusterman, G.R., Hollinshead, D., & Yuan, Y.T. (2008). Longitudinal analysis of repeated child abuse reporting and victimization: Multistate analysis associated factors. *Child Maltreatment, 13,* 76-88. Fuller, T.L., & Wells, S.J. (2003). Predicting maltreatment recurrence among CPS cases with alcohol and other drug involvement. *Children and Youth Services Review, 25,* 553-569

4 Fluke et al., ibid.

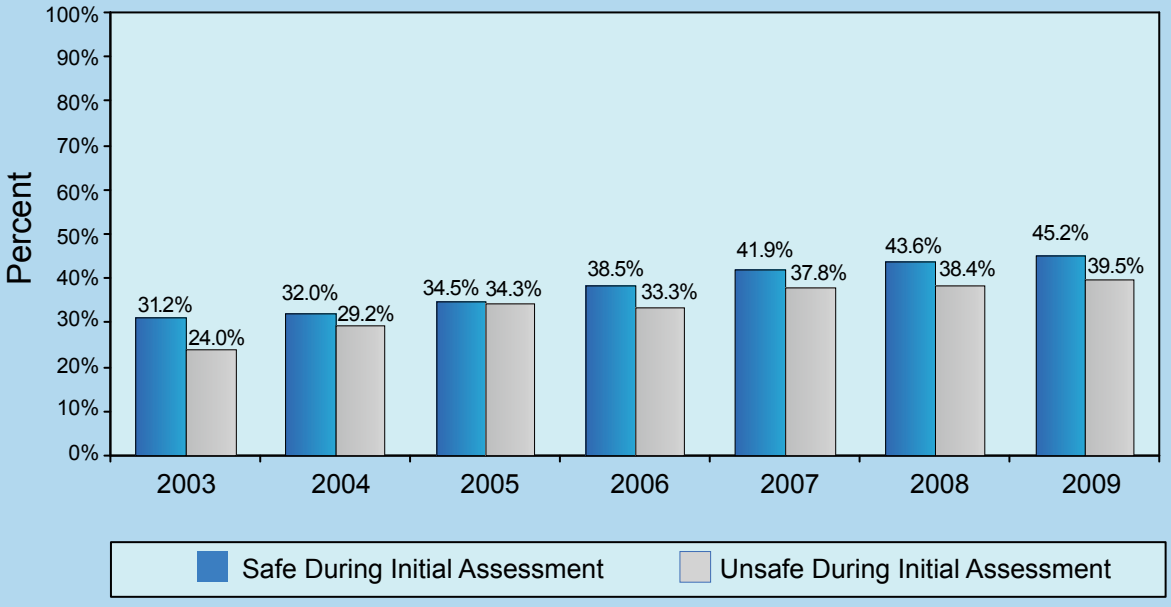
Box 1.2—Warning Sign: Compliance with Safety Re-assessment at the Conclusion of a Maltreatment Investigation

Public Act 88-614 mandates that the Department "submit an annual evaluation report to the Illinois General Assembly, which includes an examination of the reliability and validity" of the Child Endangerment Risk Assessment Protocol (CERAP). Since 1997, researchers at the Children and Family Research Center have conducted a program of research that examines the impact of the CERAP on child safety in Illinois. Early evaluations used a historical cohort comparison to compare child safety before and after CERAP implementation. Results indicated that short-term (60-day) maltreatment recurrence declined 53% from 1995 (the year prior to implementation) to 2007.

More recent CERAP evaluations have examined how CERAP use in the field is related to maltreatment recurrence in an effort to pinpoint areas of potential intervention. According to DCFS policy, the first CERAP assessment should be completed "within 24 hours after the investigator first sees the alleged child victims" (see Procedures 300, Appendix G, page 3). If any of the children in the household are determined to be "unsafe" (the safety decision), several actions must occur (these are not required if the children are determined to be "safe"). First, a safety plan must be developed and implemented to protect the children from immediate harm of a moderate to severe nature. In addition, these cases require close monitoring of the children's safety, which occurs through additional CERAP assessments every five working days until either all the children are assessed as being safe or all unsafe children are removed from the legal custody of their caretakers. Finally, these cases must have a CERAP assessment completed "at the conclusion of the formal investigation, unless a service case is opened." According to current DCFS policy, there are circumstances in which the requirement for safety re-assessment at the conclusion of the investigation can be waived: 1) if the investigation is completed within less than 30 days, 2) if the investigation involves an already opened service case, or 3) if a service case is opened during or immediately following the investigation.

Worker compliance with the requirement for CERAP assessment at the conclusion of the investigation was examined in the most recent CERAP evaluation (after excluding those cases which do not require this assessment). Figure 1.9 presents the percentage of indicated children with CERAP assessments at the conclusion of the investigation (of those that require one per policy). It should be noted that only those households with an initial safety determination of unsafe require additional safety assessment. The percentage of households with a re-assessment has increased steadily from 2003 to 2009 for both safe and unsafe households, but the **majority of indicated households are not re-assessed at the conclusion of the investigation** (see Figure 1.9). In other words, in 2009, **568 of the 1,438 children who were considered to be in immediate danger of moderate to severe harm did not receive additional safety assessment before their case was closed**.

Figure 1.9 – Percentage of Indicated Children With CERAP Assessment At The Conclusion Of The Investigation



Further analysis found that CERAP re-assessment at the conclusion of the investigation has a significant relationship with decreased maltreatment recurrence. This holds true regardless of the initial safety determination (safe or unsafe) made at the beginning of the investigation (Figures 1.10 & 1.11).

Figure 1.10 – Maltreatment Recurrence Among Safe Children

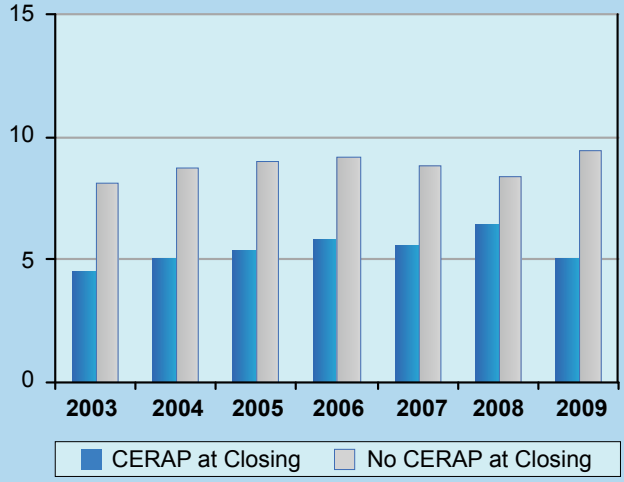
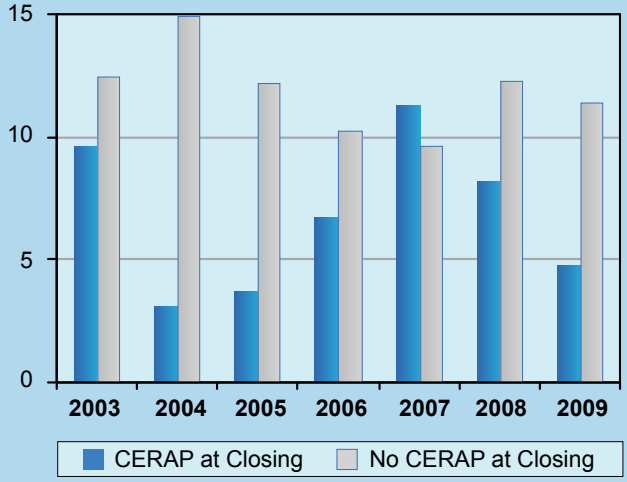


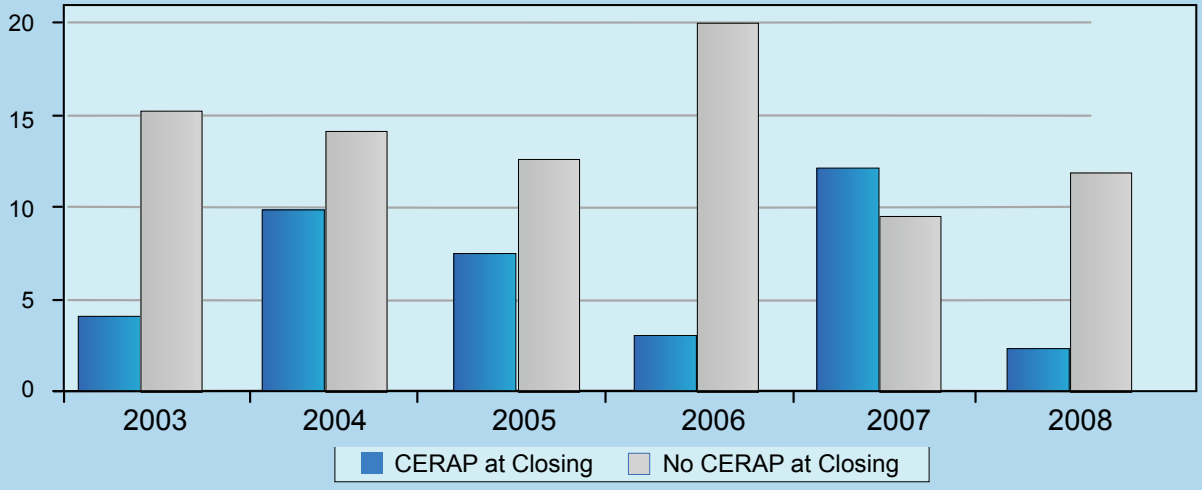
Figure 1.11 – Maltreatment Recurrence Among Unsafe Children



These results support the hypothesis that CERAP assessment at the end of the investigation provides a protective effect against additional maltreatment for those cases in which a service case is *not* opened. Although the exact mechanism through which this occurs is unknown, increasing investigator compliance above its current level of 40% may decrease maltreatment recurrence rates in the state. In addition, since the protective effect of CERAP re-assessment extends to those cases initially assessed as safe, and these cases comprise about 85-90% of indicated investigations each year, extending the requirement for re-assessment to ALL cases could make an even bigger impact on overall recurrence rates.

The analyses described above excluded investigations that were completed within 30 days of report date, because these do not require safety re-assessment at the conclusion of the investigation, even if the children were considered unsafe during the initial safety assessment and no case was opened. Additional analysis examined whether the relationship between CERAP re-assessment and decreased recurrence holds true for investigations closed within 30 days. As Figure 1.12 shows, the relationship between safety re-assessment and lower rates of maltreatment recurrence is present among investigations completed in less than 30 days.

Figure 1.12 – Maltreatment Recurrence Among Unsafe Children In Brief Investigations (<30 Days)

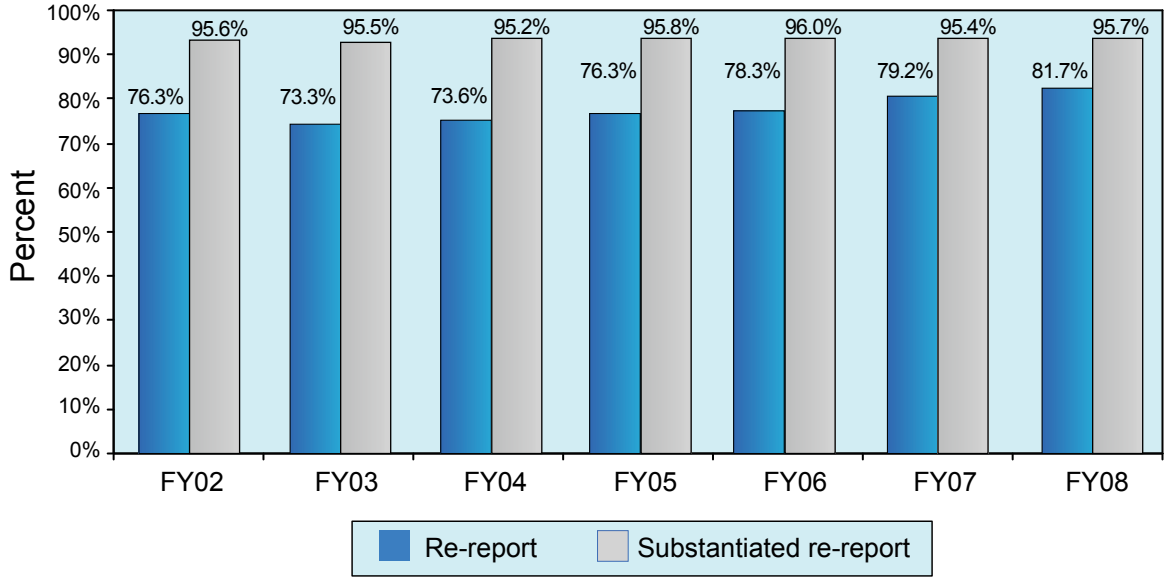


The Safety Of Children After An Initially Unfounded Report

The majority of investigations — about 75% — conclude with a case disposition of unsubstantiated (also called unfounded in Illinois). Although children with an initially unsubstantiated maltreatment report are at lower risk for re-reporting than those with initial substantiated reports, they are still at increased risk of further contact with child protective services when compared to children in the general population. This section explores the safety of children with initially unsubstantiated maltreatment reports by looking at the portion that experiences a re-report (regardless of disposition) or recurrence (a substantiated re-report). In 2001, about 15% of children in unsubstantiated investigations had a service case opened within 60 days; by 2008 that proportion had declined to around 10%. Thus, of the over 75,000 children with an unsubstantiated report in 2007, about 68,000 received no further service from the Department during or immediately following the investigation.

The percentages of children in unsubstantiated investigations that did not experience maltreatment recurrence within 12 months – measured as both any re-report (blue bars) and any indicated re-report (grey bars) – are displayed in Figure 1.13. About 18% of children with unsubstantiated reports come into contact with DCFS again (are re-reported) within 12 months, and this percentage has improved in the past seven years (see Appendix A; Indicator 1.F). About 4-5% of children with unsubstantiated reports of maltreatment experience a substantiated re-report within 12 months, and this has remained level for the past seven years (Appendix A; Indicator 1.G).

Figure 1.13 – Percentage Of Children With An Initially Unfounded Maltreatment Report That Did Not Have A Second Report Within 12 Months



Box 1.3—2009 CFSR Findings Related to Safety

CFSR Safety Outcome 1 assesses whether "**children are, first and foremost, protected from abuse and neglect**." Illinois is **not in substantial conformity with Safety Outcome 1**: 85.7% of the cases reviewed substantially achieved the outcome, which is below the 95% benchmark for substantial conformity. There are two national data indicators and two case review items related to this safety outcome:

- **Illinois did not meet the national standard for either of the Safety data indicators:**
  - Absence of Maltreatment Recurrence: Of all children who were victims of a substantiated or indicated maltreatment allegation during the first 6 months of the reporting period, what percent were not victims of another substantiated or indicated maltreatment allegation within a 6-month period? **The national standard is 94.6% or higher; the Illinois rate was 92.9%**
  - Absence of Maltreatment of Children in Foster Care: Of all children in foster care during the reporting period, what percent were not victims of substantiated or indicated maltreatment by a foster parent or facility staff member? **The national standard is 99.68% or higher; the Illinois rate was 99.47%**.

- Item 1 (**Timeliness of Initiating Investigations of Reports of Child Maltreatment**) determined whether the response to a maltreatment report had been initiated in accordance with the State child welfare agency policy requirements. Of the 28 cases reviewed, **96%** were deemed a "strength" by the reviewers; this item was therefore rated as a **strength**.
- Item 2 (**Repeat Maltreatment**) determined if there had been a substantiated maltreatment report on the family during the period under review, and, if so, whether another substantiated report involving similar circumstance has occurred within a six month period before or after that identified report. This was an **area needing improvement**, with **81%** of the cases rated as a strength. In addition, reviewers reported the following findings with regard to the number of maltreatment reports on the family during the "life of the case" (i.e., from the date of the first allegation of abuse to the time of the review):
  - In 17 cases, there was one maltreatment report
  - In 39 cases, there were between two and nine maltreatment reports
  - In 5 cases, there were between 10 and 19 maltreatment reports.
  - In one case, there were 21 maltreatment reports.

CFSR Safety Outcome 2 assesses whether "**children are safely maintained in their homes whenever possible and appropriate**." Illinois is **not in substantial conformity with Safety Outcome 2:** 70.8% of the cases reviewed substantially achieved the outcome, which is below the 95% benchmark for substantial conformity. There are two case review items related to this safety outcome:

- Item 3 (**Services to Families in Protect Children in the Home and Prevent Removal or Reentry into Foster Care**) determined whether, in responding to a substantiated maltreatment report or risk of harm, the agency made diligent efforts to provide services to the families that would prevent placement of children in foster care and at the same time ensure their safety. Of the 39 cases reviewed, **60%** were deemed a "strength" by the reviewers; this item was therefore rated as a **an area needing improvemen**t.
- Item 4 (**Risk Assessment and Safety Management**) assessed the agency made diligent efforts to address the risk of harm to the children involved in each case reviewed. Of the 65 cases reviewed, **72%** were deemed a "strength" by the reviewers; this item was therefore rated as **an area needing improvement**. In the 18 cases where this item was an area of concern:
  - There was no initial safety assessment in one case
  - There was no ongoing safety assessment in the child's home during the period under review in nine cases
  - There were continued risk concerns in the home that were not addressed and/or monitored by the agency in 12 cases
  - There was no ongoing safety assessment in the foster home in one case.
  - The case was closed without any safety assessment in two cases.

Observations On Child Safety In Illinois

The primary indicator used to assess child welfare performance with regard to child safety is the rate of maltreatment recurrence, typically measured as the occurrence of a second indicated report of maltreatment that occurs within a certain time period following an initial indicated report. In Illinois, the overall rate of maltreatment recurrence within 12 months has remained at a constant level for the past several years. However, this overall rate masks large differences in recurrence rates among indicated children that live in different regions of the state. In general, children in Cook County experience maltreatment recurrence far less frequently than children in all other regions. Outside of Cook County, there are still wide variations in recurrence – with the highest rates occurring in the Springfield and Marion sub-regions. These differences in rates do not tell us why children are less safe in these sub-regions. Additional data are needed that examine investigation practices and the local contexts (e.g., service availability) to provide a clearer picture.

Following an indicated report, one of several things can occur: the case can be closed without further services to the family, services are provided to the family while the children remain at home (intact family services), or one or more of the children can be removed from the home and served in substitute care. The majority of children (and families) in indicated maltreatment reports are given no services at all – the investigation is indicated and then closed – and this number has gone up in recent years. The implementation of Differential Response in Illinois, which will occur in the fall of 2010, will introduce a new practice model that allows the Department to provide supportive services to families without a formal investigation. The impact of Differential Response on child safety will be closely monitored through rigorous evaluation.

The safety (i.e., non-recurrence of maltreatment within 12 months of an initial indicated report of maltreatment) among children who do not receive services has remained stable at around 89%. Children served in intact families have become less safe in recent years, however, with non-recurrence rates falling from 90% in 2001 to below 88% in 2008. While the decline in the safety rates over the years is slow, the fact that the downward trend continues deserves closer attention. There are large regional variations in this indicator as well, with substantially higher recurrence rates among intact families in the Springfield and Marion sub-regions (and more recently the Rockford sub-region).

All investigated households should receive a safety assessment at the beginning of the investigation, within 24 hours after the investigator first sees the alleged victim. In addition, if any of the children are determined to be unsafe during the initial assessment, Department policy requires at least one more safety assessment at the conclusion of the investigation, although this requirement is waived when a service case is opened or if the investigation is completed in less than 30 days. Data from the annual CERAP evaluation suggest that safety CERAP re-assessment for these unsafe cases only occurs in about 40% of investigations that require it. The low compliance with this policy is unfortunate, because comparison of maltreatment recurrence rates among cases with and without a safety re-assessment at investigation close finds that cases without additional assessment are at a significantly higher risk of recurrence. The relationship between CERAP re-assessment and lower maltreatment recurrence is robust, holding true for cases regardless of the initial safety determination (safe or unsafe) that occurred at the beginning of the investigation, as well as for investigations completed within 30 days. The consistency of this finding across several evaluations suggests that ongoing safety monitoring and assessment is crucial to child safety, and the Department should emphasize the importance of investigation compliance with CERAP re-assessment.

CHAPTER 2

STABILITY OF FAMILY LIFE

At Home And In Substitute Care

Nancy Rolock
Jane Addams College of Social Work
University of Illinois at Chicago

"It [moving from house to house] is kind of like playing Russian Roulette: just kind of get in, see what it is like. And I think the hardest thing is adjusting to the different rules in each house. That's not easy. It's never easy to adjust to a new rule of anything. I mean, me having a problem adjusting to the new rules, didn't help the fact that the parent was frustrated. And then the parent was frustrated because I was not adjusting to the new rules and I was frustrated because the parent was frustrated because I couldn't adjust to the new rules because it's new. I don't adjust to new stuff too well. And the fact that I am just expected to be jumped to house to house anyway kind of burned out my fact that I was going to stay anywhere permanently."
(former foster youth Mercedes, 2008)

Since the inception of the Adoption and Safe Families Act of 1997 and the implementation of the Child and Family Services Review (CFSR) process, renewed focus has been paid to the stability of children *in* foster care; however, the concept of stability for the child protection and welfare system overall is much broader and includes maintaining children's "home life" with their parents, siblings and other family members if removal from the family can be safely avoided. The child welfare system's concern with ensuring stability begins when there is a maltreatment report and a decision is made regarding how to proceed. This chapter therefore begins with a discussion of stability related to the non-removal rate for children in Illinois – the rate at which children in Illinois remain in their homes without removal and placement into foster care. Stability among children served at home while in the custody of their families, known as "intact family" cases, is then examined, followed by an exploration of stability in out of home care.

The stability of children removed from home is not a new concern. Maas and Engler's seminal study from fifty years ago found that "symptomatic behavior in the children was positively associated, not with the length of time they spent in care, but with the number of different moves they had made in foster care" and that having an enduring place to live is essential to a child's emotional health.[1] A recent study using data obtained from the National Survey of Child and Adolescent Well-Being (NSCAW) established that children who fail to achieve placement stability while in foster care, independent of a child's problems at the time of entry into care, have a 36% to 63% increased risk of behavioral problems compared to those children who remained in stable placements.[2]

1 Maas, H. S. & Engler, R. E., Jr. (1959). *Children in Need of Parents*. New York: Columbia University Press.
2 Rubin, D.M., O'Reilly, A.L., Luan, X, & Localio, A.R. (2007). The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics, 19*, 336-344.

Family Stability At A Glance

Children have more stability if:

Fewer children are removed from their home of origin:

Of all children in Illinois, the rate of those who were not removed from their home of origin has remained constant over the past seven years, from 998.4 per 1,000 in 2003 to 998.6 in 2009.

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

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

Fewer children move from one living arrangement to another while they are in out of home care:

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

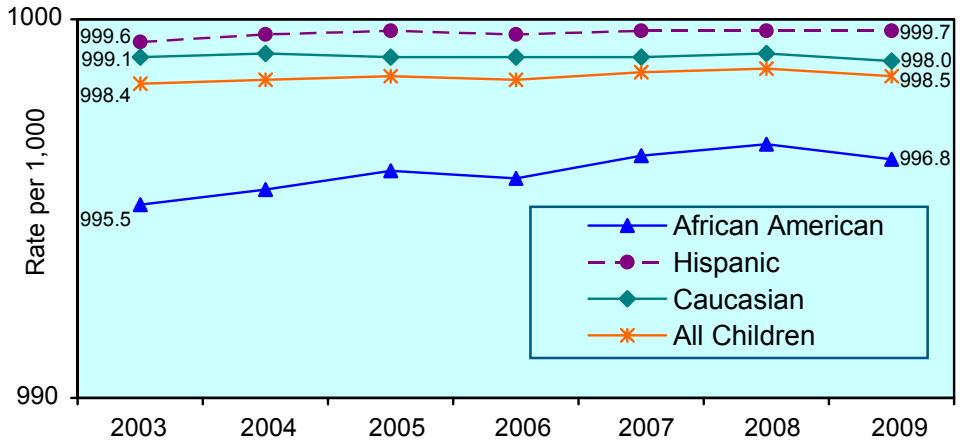
Fewer children run away while they are in out of home care:[3]

Of all children entering substitute care at the age of 12 or older, the percentage that did not run away from a foster care placement within their first year in care has steadily increased from 76% in 2002 to 81% in 2008.

Preserving Family Stability: Keeping Families Intact

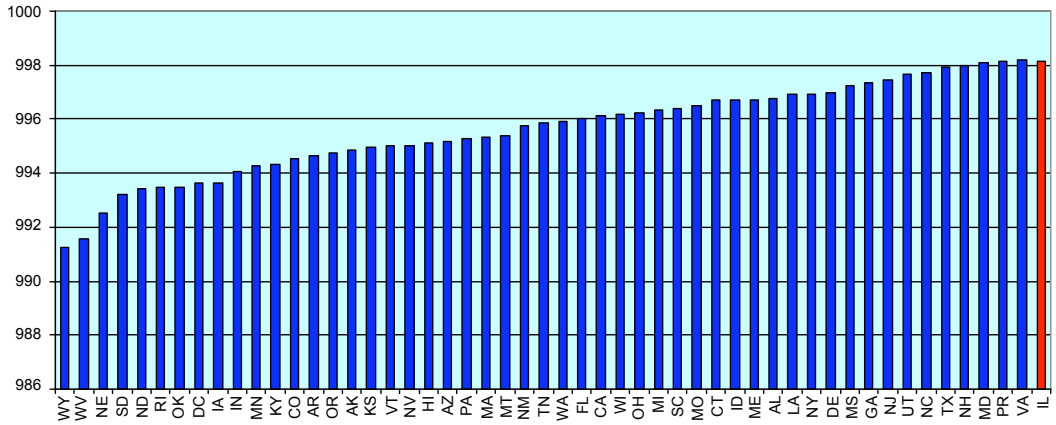
The preference for children to remain at home, when safety can be ensured, can be quantified as the rate of child non-removal: that is, for every 1,000 children, the number of children that have *not* been removed from their home of origin. In Illinois, the overall rate of non-removal has remained fairly constant from 2003 to 2009. The non-removal rate for African American children has shown the greatest improvement, from 995.5 in 2003 to 996.8 in 2009; however, this rate remains significantly lower than for any other group of children (see Figure 2.1). Research shows that African American children in all regions of the state are more likely to be removed from home and enter foster care than any other group of children.[4]

Figure 2.1 — Rate of Non-Removal



3 This indicator also includes youth over 18 in foster care who are "absent without approval" from care.
4 Rolock, N. (2008). *Disproportionality in Illinois Child Welfare*. Children and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign.

Figure 2.2 — Non-Removal Rates (per 1,000) by State



The rate of non-removal is central to understanding child welfare outcomes. Non-removal rates vary widely across the country. National data presented in Figure 2.2 show that Illinois is tied with Virginia for the highest non-removal rate in the country at 998.2 per 1,000 children – they remove the fewest children and place them into care. Some states have a rate as low as 991.2 (Wyoming) and 991.5 (West Virginia), with the median around 995.9 (Washington and Tennessee).[5] It has been speculated that the non-removal rate in a region or state can impact other child welfare outcomes, such as reunification rates. If so, Illinois' high non-removal rate may influence certain aspects of stability, permanence, and even child safety.

Often what happens at the community level is masked by trends at the state level. Recognizing the importance of looking at data at the community level to understand how practice varies from one community to the next, an analysis of county-level removal rates is presented in Box 2.1. Removal rates in Illinois vary, in general, by racial and ethnic group: African American children are investigated and removed at a higher rate than White children and children of Hispanic origin are investigated and removed at a lower rate than White children.

Box 2.1—Removal Rates and Racial/Ethnic Disparities

Note that this analysis examines removal rates (as opposed to non-removal rates) to accommodate a discussion of county level disparity rates associated with removal rates.

Prior to a decision to remove a child there is an investigation. For this reason, the disparities associated with investigations are examined first, followed by disparities associated with removals. State-wide, African American children are more than twice as likely (2.07) to be investigated for maltreatment than White children. In addition, African American children are 1.5 times as likely to enter foster care after an investigation. However, when examined at a county level, these disparity rates vary across the state. For this analysis, all Illinois counties that removed on average at least 50 children during the past three years (2007 – 2009) are included. In addition to the average number of children removed over this three year period, and the average removal rate, the disparity indices for African Americans and Hispanic children (the last four columns) provide insight into the relative rate at which children are investigated and removed by race or ethnicity in each county. (The calculations of these indices are explained at the bottom of this box.)

The disparity indices in bold represent counties where this population is more likely to be represented (a disparity of 1.10 or higher), while the non-bold font represents either equal representation (between .9 and 1.10) or counties where the children are less likely to be represented (a disparity of .9 or lower).

For example, Champaign county has one of the higher removal rates in the state (4.6 per 1,000 children). African American children in this county are more than three times (3.65) as likely to be investigated as White children, and 1.52 times as likely to enter foster care. However, children of Hispanic origin in Champaign county are less likely (0.59) to be investigated or enter foster care (.50) than White children.

5 Analysis by the author based on data from: US Department of Health and Human Services, Administration for Children and Families. Statistics & Research. *In Adoption and Foster Care Statistics.* Retrieved April 12, 2010, from http://www.acf.hhs.gov/programs/cb/stats_research/index.htm.

Table 2.1 Illinois County Removal Rate 2007-2009

Region	County	Average Removals	Average Removal Rates (per 1,000)	African American Disparity Index: Investigations	African American Disparity Index: Removals	Hispanic Disparity Index: Investigations	Hispanic Disparity Index: Removals
Southern	Jefferson	57	6.0	**2.87**	**1.21**	0.30	**1.89**
Central	Macon	152	5.8	**2.12**	**1.42**	0.29	--
Central	Vermilion	106	5.5	**2.02**	**1.16**	0.16	**1.12**
Central	Peoria	227	5.0	**2.25**	**1.42**	0.40	**1.98**
Central	Champaign	176	4.6	**3.65**	**1.52**	0.59	0.50
Southern	Williamson	62	4.4	**2.86**	**1.20**	0.18	**3.32**
Central	McLean	166	4.1	**3.36**	**1.62**	0.46	1.01
Central	Rock Island	128	3.8	**2.93**	**1.36**	0.39	**1.50**
Northern	Winnebago	273	3.4	**2.67**	**1.97**	0.27	**1.88**
Central	Tazewell	88	2.9	**4.19**	**1.29**	0.25	**1.12**
Central	Sangamon	139	2.9	**3.04**	**1.57**	0.15	**5.45**
Southern	Madison	167	2.6	**1.98**	**1.43**	0.37	**1.23**
Central	La Salle	61	2.1	**3.00**	**2.16**	0.31	**1.17**
Southern	St. Clair	130	1.9	**2.01**	**1.82**	0.35	**2.79**
Cook	Cook	1224	0.8	**2.89**	**2.43**	0.61	**1.21**
Northern	Will	156	0.8	**4.03**	**1.35**	0.67	0.84
Northern	Kane	91	0.6	**4.85**	**1.40**	0.68	0.92
Northern	Lake	114	0.5	**5.22**	**3.05**	0.58	**1.67**
Northern	DuPage	75	0.3	**5.21**	**1.44**	0.64	**2.43**

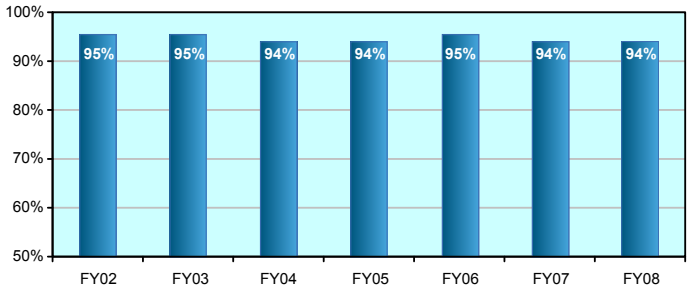
As evident in the table, high disparity indices are not limited to high removal counties, but also occur among low removal counties. Perhaps other community factors, such as the percent of the population that is of minority status, or the poverty level of the county, could help explain what it is about some counties that result in higher than average removal rates among African American children.

The disparity indices are calculated to compare African American children to White children, and then children of Hispanic origin to White children. For the index related to investigations, the percent of investigations where African American children were the subject of the investigation were divided by the percent of the general population that were African American in that county (called the disproportionality index). The disproportionality index for African Americans was then divided by the disproportionality index for Whites to arrive at the investigations disparity index. The removal disparity index is calculated in the same fashion, but the denominator is different in that the percent of foster care entries that are African American are divided by the percent of African American children involved in investigations. Divide the disproportionality index for African Americans by the disproportionality index for White children to arrive at the disparity index for removals. The disparity index is blank when there were not enough children in the data to make the calculation.

Stability Among Families Served At Home

Another measure of how well the state is doing in preserving family stability is the number of children served in intact family cases that do not experience an out of home care placement within a year of initial report (see Appendix A, Indicator 2.A). Figure 2.3 shows that the number of children not removed from a home when there is an open intact family case has remained between 94% and 95% since 2002. Additional analyses reveal that the age of a child at the time of intervention is important – older children are less likely to enter substitute care from intact family cases than younger children. Analysis of regional differences shows that children in intact family cases in Cook County are more likely to stay home and not enter care than children in the remainder of the state. In the last year 97% of children in Cook County were stable compared to 91% in the Central region and 92% in both the Southern and Northern regions. When these data are looked at by race or ethnicity it demonstrates that children and youth of Hispanic ethnicity tend to be more stable than other children. In 2009, 97% of Hispanic youth, compared to 94% of African American and 92% of White youth, did not experience an out-of-home placement within a year of their intact family case opening. There are virtually no gender differences in this indicator.

Figure 2.3 – Children Served In Intact Families That Did Not Experience An Out Of Home Placement Within A Year

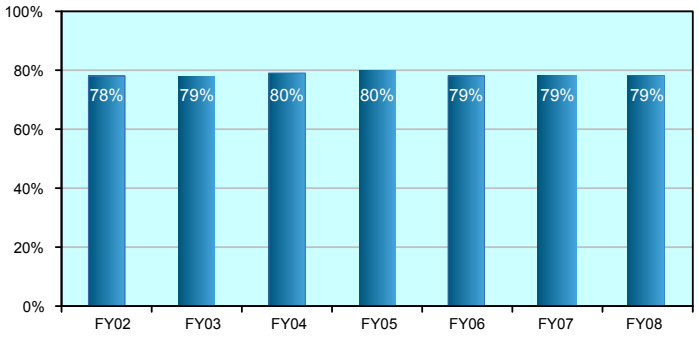


Stability In Out Of Home Care

The current chapter tracks stability in foster care through two measures, stability for all children in their first year of care and stability among older youth as measured by the rate at which they do not run away from their foster home. For purposes of this report, stability in out of home care is defined as "no more than two placements," following the Adoption and Foster Care Analysis Reporting System (AFCARS) definition.[6] The current definition differs from the AFCARS definition in that it tracks only children who have been in care for at least one year, excluding children in care only a few days or months. As with the AFCARS definition, the following types of placements were excluded from the calculation of placement stability: runaway, detention, respite care (defined as a placement of less than 30 days where the child returns to the same placement), any type of hospital stay, and placements coded as "unknown whereabouts."

Results displayed in Figure 2.4 reveal that the percentage of children who experience stability in substitute care has fluctuated between 78% and 80% over the past several years.

Figure 2.4
Children In Substitute Care For At Least One Year Who Had No More Than Two Placements Within A Year Of Removal



Examination of trends in specific subgroups of children reveals that African American children experience less stability than White children (75% and 86% in 2008, respectively), and that Hispanic children have experienced the least amount of stability (73% in 2008). Also, over the past seven years, stability has steadily increased for White children (from 78% in 2002 to 83% in 2008) while stability for African American children has decreased (from 79% in

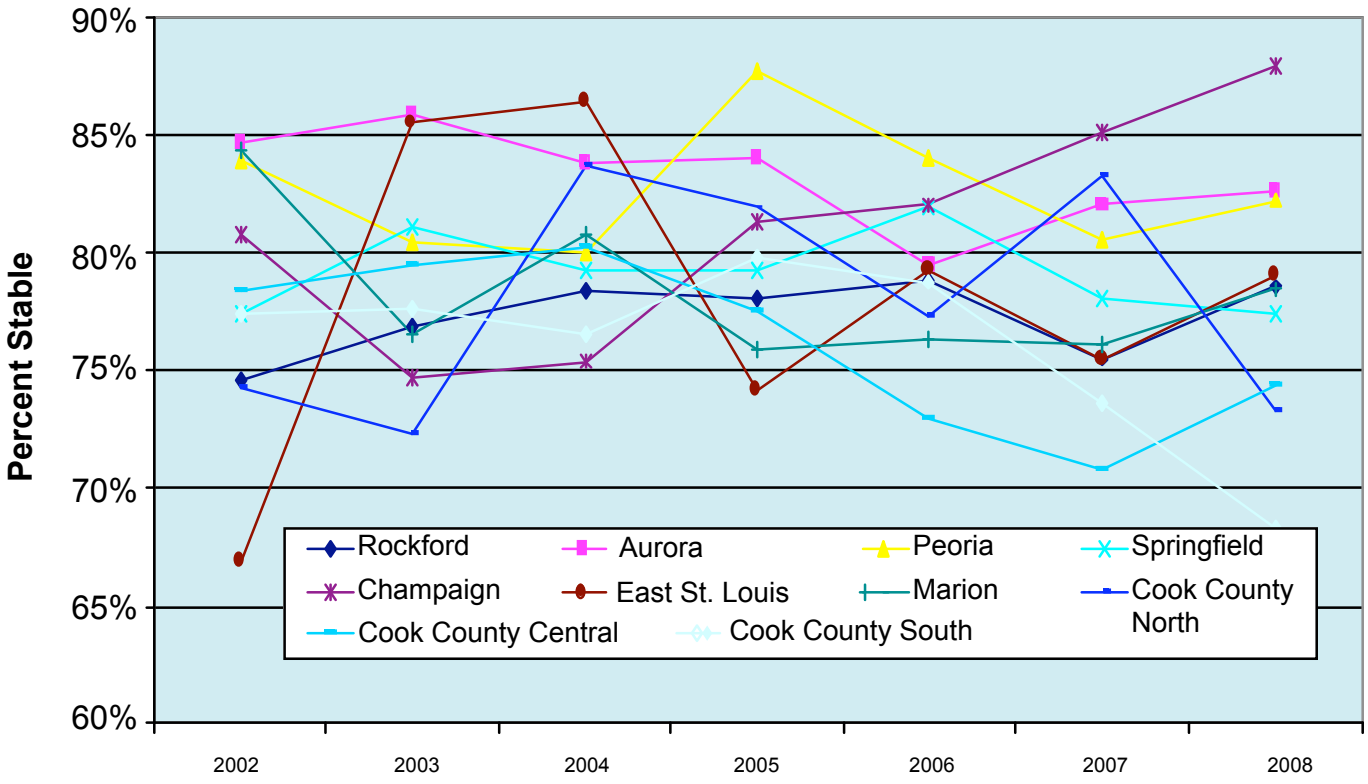
6 U.S. Department of Health and Human Services, Administration of Children and Families, Administration for Children, Youth and Families, Children's Bureau (2009). Child welfare outcomes 2003–2006: Report to Congress. Retrieved June 1, 2010, from www.acf.hhs.gov/programs/cb/pubs/cwo05/index.htm

2002 to 75% in 2008). Stability for Hispanic children has fluctuated over the past seven years between 68% in 2003 and 82% in 2004; the rate in 2009 was 73%.[7] Children in the Northern and Central regions have the greatest amount of stability (81% and 83%, respectively), followed by those in the Southern region (79%) and Cook County region (72% in 2008). In addition, the data show that as children age, they are more likely to experience instability (see Appendix A, Indicator 2.B).

Sub-Regional Analysis Of Stability In Foster Care

Analysis of 2009 data indicates significant variance in placement stability across Illinois at both the regional and sub-regional levels (see Figure 2.5).

Figure 2.5 – Sub-regional Analysis Of Stability In Foster Care



Northern Region:
In the Rockford sub-region, between 75% and 79% of children were in stable homes each year, over the past seven years. In the Aurora sub-region, between 80% and 86% of youth were in stable homes over the past seven years.

Southern Region:
In the East St. Louis sub-region, between 74% and 87% were in stable homes over the past seven years. In the Marion sub-region, between 77% and 84% were in stable homes over the past seven years.

Central Region:
In the Peoria sub-region, between 80% and 88% of children were in stable homes annually. In the Springfield sub-region, between 77% and 82% of youth were in stable homes annually. In the Champaign sub-region, between 75% and 88% of youth were in stable homes over the past seven years.

Cook County:
In Cook North, between 72% and 84% of youth were in stable placements over the past seven years. In Cook Central, between 70% and 80% of youth were in stable placements over the past seven years, and in Cook South, between 77% and 80% of children were in stable homes over the past six years, and this has dropped to 68% in the past year.

7 Much of the fluctuation among the Hispanic population is due to the small number of Hispanic children in care.

Research suggests that many placement moves are attributed to administrative or judicial decisions seemingly unrelated to the behavioral characteristics of the child.[8] Changes in case workers or a foster care case management agency (in Illinois, "purchase of service agency" or POS agency) may undermine the stability of a placement. Judicial orders for change of placement without a thorough examination of the appropriateness of the request when weighed against the potential harm to the child can also directly impact positive outcomes.

Concern regarding placement stability in Illinois prompted the plaintiffs' attorneys in the *B.H.* Consent Decree to ask the Children and Family Research Center to gather information to better understand the reasons for instability in foster care. The resulting Multiple Move Study focused on those children who moved most frequently. The findings from this study (summarized in Box 2.2) suggest that placement with kin had a positive effect on stability and that the commitment of the caregiver was essential in understanding what distinguished children who moved frequently from children who were relatively stable. Less than one-third of the placement moves were a result of child behavior issues, the remaining were system-related or foster parent-related. These findings suggest that better training and recruitment of foster parents may be warranted. Findings from a pilot study conducted by the University of Illinois at Chicago (summarized in Box 2.3) support the use and continued study of foster parent management training as a means to reduce child behavior issues and potentially increase placement stability.

Box 2.2—Multiple Move Study in Illinois

This study examined and compared the case records of two groups of foster children. The multiple move sample consisted of 61 children from foster family and kinship homes who had three or more placements within an 18-month period. Each child in the multiple move sample was matched to a child who looked similar at the beginning of the review period (matching variables included age, race, gender, and length of time in foster care) but who had fewer than three placement moves during the same timeframe. The purpose of the matching of multiple-move and stable cases is to ensure that the two samples were comparable at the beginning of the review period so that other determinants of placement instability could be identified.

Key Findings

Caregivers play a significant role in placement stability for foster children:

- *A caregiver's commitment and relationship to a child distinguishes the stable group from the multiple-move group: 93% of caregivers from the stable group were committed to the permanence for the child in their care compared to 42% for the multiple-move group.*
- *67% of children from the stable group but only 26% of the multiple mover group were placed with their relatives.*

The reasons for placement changes were categorized into three groups. During the study period:

- *36% of the moves were attributed to foster family-related reasons (e.g., change in employment status, or allegations of maltreatment in the foster home), with over half of such moves related to maltreatment allegations in the foster home;*
- *34% were due to child behavior-related reasons; and*
- *26% were attributable to system- or policy-related reasons (e.g., move to live with siblings).*

These findings suggest that caregivers are central to placement stability for children in foster care; placements with relatives and with caregivers who were willing to commit to the child were predictive of stability. Moreover, in many of the child behavior-related moves, a pattern was observed in which these behavior problems emerged only after children experienced one or more caregiver-related placement disruptions. A better understanding of how foster parents are recruited, trained and supported in their important work of caring for foster youth and children is needed. Understanding these areas could translate to fewer placement moves related to maltreatment in the foster home or related to the caregiver's difficulty with the foster child's behavior, both of which were found to be the most common reasons for placement moves in the study.

The full report: Rolock, N., Koh, E., Cross, T., Eblen-Manning, J. (2009). *Multiple move study: Understanding reasons for foster care instability.* Urbana, IL: Children and Family Research Center. Available at: http://cfrc.illinois.edu

8 Rubin, D.M., O'Reilly, A.L., Luan, X, & Localio, A.R. (2007). The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics, 19*, 336-344.

Box 2.3—Adaptation of Parent Management Training for Urban Foster Parents: A Pilot Study

Findings from the Multiple Move study (see Box 2.2) showed that one source of placement disruptions was foster parent's inability to cope with child behavior issues. Findings from a new study suggest that the provision of foster parent management training has resulted in reduced child behavior issues, a hopeful sign for increased placement stability.

Background and Purpose:

Although entry into the child welfare system facilitates children's access to mental health services[9], the quality of the mental health services provided to foster children is limited by poor follow-through with service recommendations, low caregiver involvement, and reliance on individual child treatment even for behavioral disorders, which require caregiver involvement for effective treatment.[10] [11] Understanding how to adapt evidence-based mental health treatments for foster children with behavior problems is particularly important, given the consequences for placement stability and attaining permanency. This pilot study tested the effectiveness of an adaptation of parent management training (PMT) for urban foster parents provided in groups, during home visits, and by telephone. PMT has been shown to be effective in treating child behavior problems, but only a limited amount of research has focused on its use with foster children. The primary goal of this research study was to assess the feasibility of providing this intervention to foster parents.

Methods:

This study used an experimental intent-to-treat design, with 27 foster parents of 31 children (age 4-11) in specialized foster care assigned to either an intervention (PMT) or a control group where parents received the usual services offered by the agency. The site of the research was a large, urban child welfare agency. The intervention group received a version of PMT that was an adaptation of a 16-week Project KEEP group intervention.[12] Adaptations were made to address children's academic needs and the high level of mental health needs in the sample. The control group received individual child treatment instead of the PMT. Most of the foster parents and children (95%) were African American. Data were collected across four time points (baseline, 3, 6, and 12 months) using standardized measures, with the Child Behavior Checklist used as the outcome measure.

Results:

80% of intervention foster parents received at least 2 in-person sessions of the intervention and all received at least 3 intervention phone calls. At the baseline, both groups had comparable CBCL mean scores (66 total T-score in control and 68 in intervention groups). Over time, the results indicate that children's behavior problems were significantly reduced in the intervention group relative to the control group across the first three time points (Intervention Group X Time B = -4.73, $p < .05$ for externalizing T-score). At the fourth time point, too few children remained in the sample due to adoptions and reunifications for this time point to be included in the analyses, but slight increases in behavior scores appeared to occur in the intervention group.

Conclusions and Implications:

Results support use and continued study of Project KEEP and other PMT interventions with foster parents. Significant improvements in child behavior problems also support effectiveness of the intervention with urban, African American foster children. By reducing foster children's behavior problems, a significant source of placement disruptions could potentially be addressed. An ongoing effectiveness study funded by NIMH is focused on dissemination of the intervention within a Chicago-based child welfare agency.

This box was written by Dr. Sonya Leathers, Jane Addams College of Social Work, University of Illinois at Chicago. For additional information on this study, contact Dr. Leathers at sonyal@uic.edu

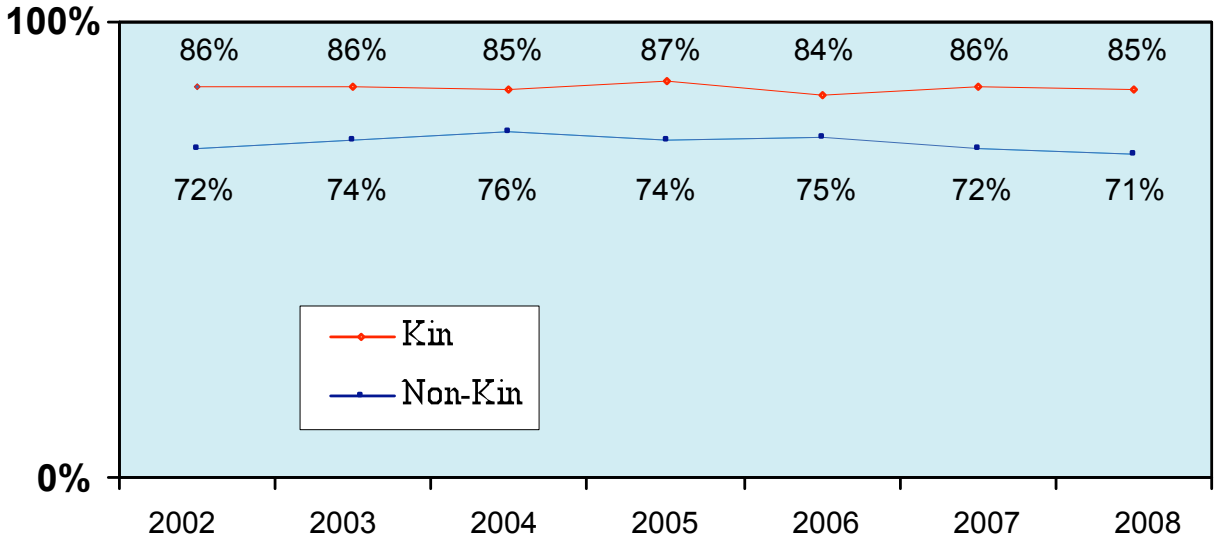
9 Leslie, L.K., Hulburt, M.S., James, S., Landsverk, J., Slymen, D.J., & Zhang, J. (2005). Relationship between entry into child welfare and mental health services use. *Psychiatric Services, 56*, 981-987.
10 Barth, R.P, Landsverk, J., Chamberlain, P., Reid, J.B., Rolls, J.A., Hurlburt, M.S., Farmer, E.M., James, S., McCabe, K.M., & Kohl, P.L. (2005). Parent Training Programs in Child Welfare Services: Planning for a more evidence-based approach to serving biological parents. *Research on Social Work Practice, 15*, 353-371.
11 Orme, J.G. & Buehler, C. (2001). Foster family characteristics and behavioral and emotional problems of foster children: A narrative review. *Family Relations, 50*, 3-15.
12 Chamberlain, P. (2002). Treatment in foster care. In B. Burns & K. Hoagwood (Eds.), *Community Treatment for Youth* (pp. 117-138). New York, NY: Oxford University Press.

Kinship Care And Placement Stability

Research on kinship foster care has shown that placement with kin, after appropriate safety checks, is the most stable form of substitute care available to children who are removed from parental custody. [13] [14] [15] [16] In addition, placement with grandparents, aunts and uncles may help reduce the trauma of separation that accompanies a child's removal from the home and may preserve important connections to siblings, family, and local community. Figure 2.6 shows that Illinois children initially placed with kin are much more likely to experience placement stability than those initially placed with non-kin. An analysis at the regional level shows that the difference between stability among kin and non-kin is the greatest in Cook County. In Cook North, for instance, over the past seven years 88% of kin homes have been stable, compared to 68% of non-kin homes; in Cook South stable kin homes are 86% compared to 68% of non-kin homes, and in Cook Central 85% of kin homes compared to 69% of non-kin homes have been stable. In the Central region, 85% of kin homes and 77% of non-kin homes were stable over the past seven years; in the Northern region, 85% of kin and 76% of non-kin homes have been stable; and in the Southern region, 84% of kin and 73% of non-kin homes have been stable. When broken out by race, the difference between kin and non-kin homes stands out among the Hispanic population: 83% of the kin and 68% of the non-kin population are in stable homes; this differential is not as great among the African-American population (85% vs. 72% respectively) or the White population (86% vs. 76% respectively).

Illinois data shows that children placed with kin are more likely to have at least 90 days of stability than children placed with non-kin. Of the children that move, 81% of those placed with non-kin experience their first move within the 90 days of entry into substitute care compared with 58% of children placed with kin. In addition the overall number of moves within the first year is less for children and youth initially placed with kin. As depicted in Figures 2.7a and 2.7b, in the past year 63% of children placed with kin and 37% of children placed in non-kin homes have no moves within their first year in care.

Figure 2.6
Percent Of Children With No More Than Two Placments
During Their First Year In Care By First Placement Type



13 Testa, M. (2002). Kinship care and permanency. *Journal of Social Service Research, 28*, 25-43.
14 Webster, D., Barth, R. P., & Needell, B. (2000). Placement stability for children in out-of-home care: A longitudinal analysis. *Child Welfare, 79*, 614-632.
15 Rolock, N., Koh, E., Cross, T., & Eblen-Manning, J. (Nov., 2009). *Multiple move study: Understanding reasons for foster care instability.* Children and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign.
16 Koh, E, (2010) Permanency outcomes of children in kinship and non-kinship foster care: Testing the external validity of kinship effects, *Children and Youth Services Review, 32*, 389-398.

Figure 2.7a – Number of Moves Within One Year For Kin Placements

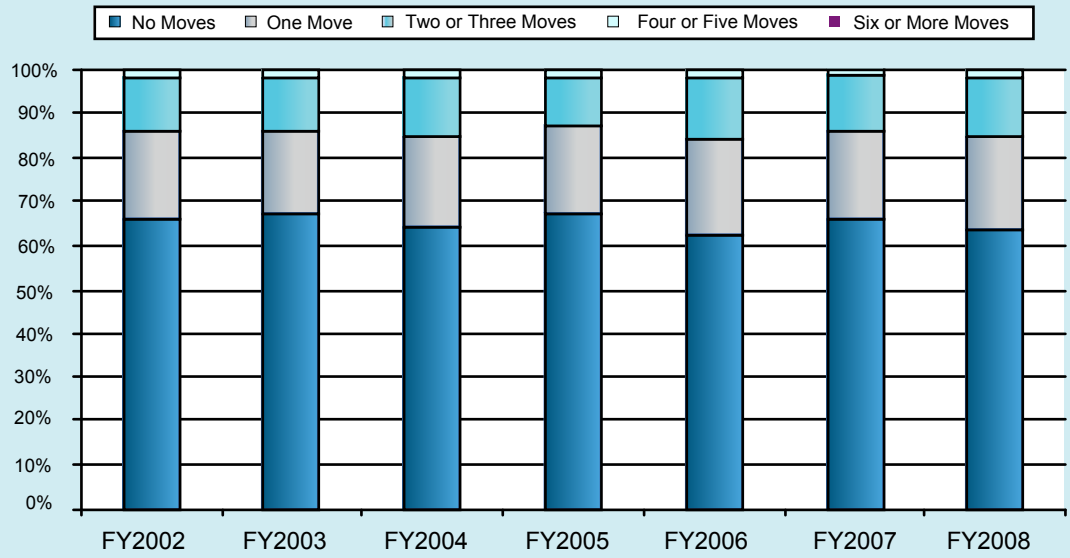
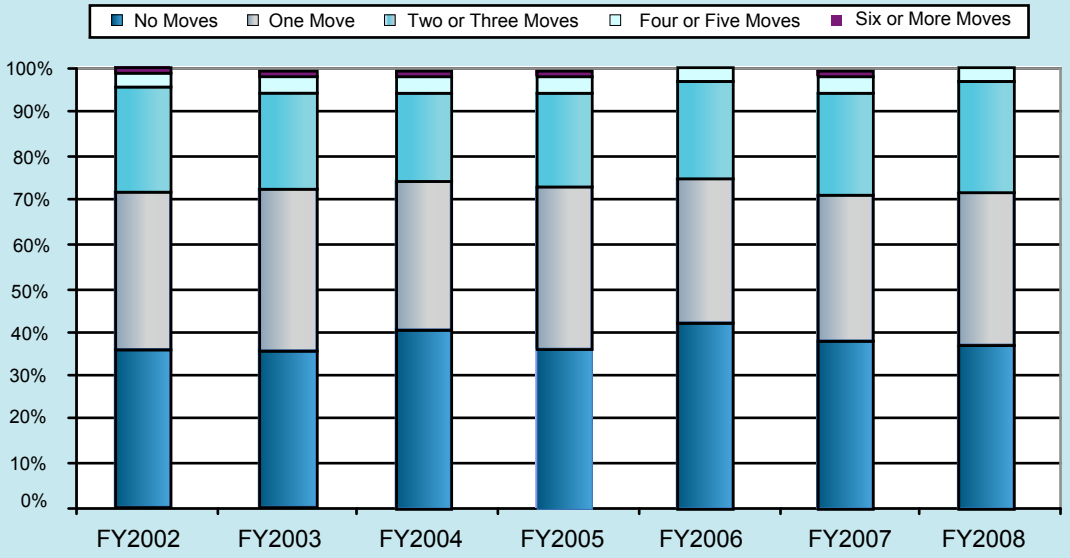


Figure 2.7b – Number of Moves Within One Year For Non-Kin Placements

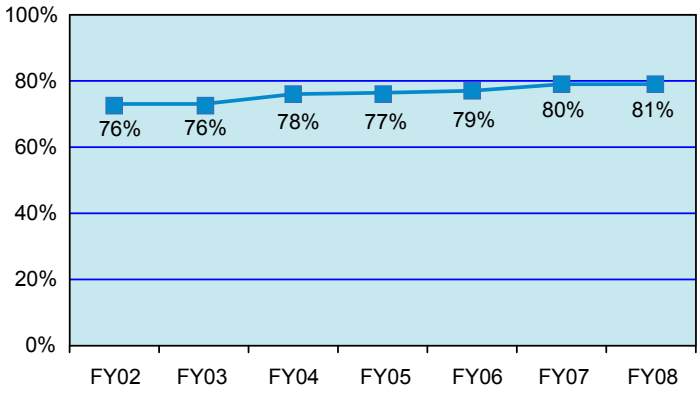


Youth Who Run Away From Out Of Home Care

Another way to measure stability in substitute care is to look at the number of children who run away from their placement. This indicator examines only those children who entered care at the age of 12 or older (see Appendix A, Indicator 2.C) in an effort to examine the foster children most likely to run away from placement.[17] Figure 2.8 displays the number of children 12 or older at entry that did not run away from substitute care during the first year of placement, and shows an increase from 76% in 2002 to 81% in 2008. While this is an improvement, the fact that each year over 200 of the approximately 1,200 youth over the age of 12, run away during their first year in care indicates a problem that needs to be addressed.

17 This indicator also includes youth over 18 who are technically "absent without permission" from their placement. For ease of use, the term "run away" is used to include both groups.

Figure 2.8
Percent Of Children 12 Or Older Who Did Not Run Away During The Year Following Entry



Children 15 and older are most likely to run: while 91% of children aged 12 to 14 were stable in fiscal year 2008, only 71% of children 15 and older were stable. African American children constitute over half of the youth who run away. While the percentage of African American youth who do not run away has increased from 72% in 2003 to 80% in 2008, this is lower than White or Hispanic youth. Since 2004, at least 85% of White youth did not run away from their placements, but in the last year this had dropped to 82%. The number of Hispanic youth in care over the age of 12 is much less than the other two groups of youth, so there is greater variability in the trends for these youth.

Children residing in Cook County are much more likely to run away than children in the remainder of the state. In Cook, 72% did not run as compared to 81% in the Northern, 84% in the Central and 83% in the Southern regions. In addition, teen males have generally been more stable (less likely to run away) than teen females. In sum, these data indicate that efforts to increase stability, and prevent runs among these youth, should target African American youth, teens aged 15 or older, and youth in Cook County.

Box 2.4—2009 CFSR Findings Related to Stability

CFSR Permanency Outcome 1 assesses whether "children have permanency and stability in their living situations." There is one national data indicator related to placement stability and one case review item:

Illinois did not meet the national standard for the stability data indicator.

Performance on individual measures included in the composite data measure varied (there are no national standards for the individual measures):

- For children in foster care for at least 8 days but less than 12 months, 84.1% experienced two or fewer placements. While this exceeds the national median of 83.3%, it is less than the national 75th percentile of 86%.
- For children in foster care for more than 12 months, but less than 24 months, 70% experienced two or fewer placements. This exceeded the national 75th percentile standard of 65.4%.
- For children in foster care longer than 2 years, 40.9% experienced two or fewer placements. This exceeded the national median but less than the national 75th percentile standard of 41.8%

- **Item 6 (Stability of Foster Care Placements)** is specifically related to placement stability; it addresses whether children experienced multiple placement settings during the period under review and, if so, whether the changes in placement settings were necessary to achieve either the child's permanency goals or meet the child's service needs. Reviewers also assessed the stability of the child's most recent placement. Of the 40 foster care cases reviewed, **85%** were deemed a "strength" by the reviewers; this item was therefore rated an **area needing improvement**. Of the 40 cases reviewed, 30 experienced one placement during the period under review, five experienced two placements, and five experienced three or more placements.

Box 2.5—Stability in Institutional and Group Home Care

Over the past fifteen years Illinois has significantly reduced the use of institutional and group home care from a high of over 4,000 youth in these placements in 1995 to 1,368 at the close of FY 2009. Steep declines in residential treatment entry rates were noted from the late 1990s and early 2000s, but entry rates have stabilized and remained relatively flat for the past four years. A review by Chapin Hall found that the entry rate downstate declined faster thereby resulting in higher utilization of residential treatment in Cook County at the present time.[18] Concomitantly, lengths of stay in residential care have been steadily increasing due in part to a decrease in the rate of step-downs. During FY 2009, the rate of discharge was higher in Cook County at 33% than downstate at 25%.[19] The population served in residential care has grown increasingly complex. Half of the youth in residential treatment during FY 2009 have histories of runaways, detention and prior residential treatment placements.[20]

In January 2007 Illinois was selected as a demonstration site by the National Quality Improvement Center on the Privatization of Child Welfare Services to evaluate the use of performance based contracting in residential treatment. The Children and Family Research Center is conducting this evaluation.[21]

The *Striving for Excellence* project established the following goals for the project:

1) Improve the safety and stability of youth during their residential stay;
2) Reduce the severity of clinical symptoms and increase functional skills effectively and efficiently; and
3) Improve outcomes at and following discharge from treatment.

Using a collaborative planning model the project established two performance indicators directly related to stability to measure these goals:

1) Treatment Opportunity Days Rate (**TODR**)
which measures the percentage of time youth placed at each residential treatment agency were available for active treatment, i.e. not in detention, on runaway or in a psychiatric hospital

2) Sustained Favorable Discharge Rate (**SFDR**)
which measures the percentage of the total residential spells resulting in positive discharges (defined as "step-down" to a less restrictive setting) wherein the youth remains stable in their subsequent placement without disruption for 180 days.

Contracts for FY 2009 included agency specific performance benchmarks which were adjusted for risk based upon varying child and agency characteristics which had a statistically significant relationship to TODR and SFDR. Agencies which failed to attain their TODR benchmark were assessed fiscal penalties. Fiscal incentives were awarded to agencies which exceeded their SFDR benchmark which could be used to reinvest in agency program enhancements and services for wards. System-wide, there was little change overall in TODR from FY 2008 to FY 2009 although there were slight declines in the number of runs and psychiatric hospital placements and a slight increase in the number of detentions. There is preliminary evidence of an increase in sustained favorable discharges.

Stability in Transitional Living Programs

Transitional Living Programs (TLP) provide older youth with the opportunity to practice skills necessary to live independently while continuing to receive supervision and support services. To be eligible for placement in a TLP a youth must be at least 17.5 years of age or older, have a permanency goal of Independence, be making progress in attaining educational and/or vocational goals, and have the demonstrated capacity to learn to manage themselves in a non-residential, community based setting. Performance based contracts were developed for both TLPs and Independent Living (ILO) programs by the *Striving for Excellence* project in 2009. The FY 2011 contracts include a specific performance measure to address stability in placement. Transitional Living Placement Stability Rate (TLPSR) applies to TLPs only and is determined by dividing the number of days youth were present at the TLP, (i.e. not on runaway, in detention, or psychiatrically hospitalized) by the total number of bed days for all TLP spells during the fiscal year. Like TODR for institutional and group home care, expected TLPSR performance was determined by applying a risk adjustment model to each provider's case mix at the contract level. At the close of FY2010 agencies' TLPSR will be combined with other performance measure rankings to arrive at an overall TLP agency contract ranking used to determine the distribution of incentive payments.

This box was written by Judge Kathleen A. Kearney
Children and Family Research Center, University of Illinois at Urbana-Champaign.
Additional questions can be directed to Judge Kearney at kkearney@illinois.edu.

18 Zinn, A. (2010, January). *The population dynamics of DCFS-contracted residential treatment 1993 to 2009.* Presentation at the First Annual Illinois Child Welfare Leadership Summit, Chicago, Illinois.
19 Zinn, 2010, ibid
20 Jordan, N. (2010, January). *Using risk factors to describe the recent residential treatment population.* Poster presentation at the First Annual Illinois Child Welfare Leadership Summit, Chicago, Illinois.
21 For more detailed information on the *Striving for Excellence* project see Kearney, K., McEwen, E., Bloom-Ellis, B., & Jordan, N. (in press). Performance-based contracting in residential care and treatment: Driving policy and practice change through public-private partnership in Illinois. *Child Welfare.*

Observations On Stability In Illinois

Non-removal rates vary widely across the United States and within Illinois. Data from Illinois show that there are counties where children are removed at a relatively low rate, like Cook, Lake and Will counties, while there are counties like Champaign and Peoria where children are more than four times more likely to be removed from their homes than children in other parts of the state. To further complicate the removal picture in Illinois, the data show that African American children are more likely to be investigated and removed from their homes than White children, while children of Hispanic origin are less likely to be investigated and removed than White children. If stability of family life is to be achieved for children and youth in Illinois, a better understanding of investigation dynamics in high removal areas is needed. The implementation of Differential Response in Illinois may have an impact on removal rates and should be closely monitored by the Center's evaluation team.

Stability for children who have been removed from their homes and placed in foster care has remained fairly stable over the past seven years, and for older youth there has been an increase in stability as measured by the percent of youth aged 12 or older who run away from home. While the majority of children and youth in foster care in Illinois are stable, a small subset experience periods of extreme instability. *The Multiple Move Study* suggests that additional efforts should be targeted toward recruiting and supporting foster parents as they play a critical role in the stability of children and youth in foster care. A recent study examined foster parenting characteristics which led to increased placement stability. The researchers determined a significant relationship existed between parental support (defined as the level of emotion and social support a parent receives) and limit-setting (defined as discipline practices) as predictors of placement stability.[22] Future work in this area should include an evaluation of how foster parents are recruited, licensed, trained and supported to successfully manage the behaviors and reactions of children in foster care.

The *Striving for Excellence* project, which expands the use of performance based contracting to residential treatment services, has shown promising results in decreasing runs and days absent from treatment without permission due to psychiatric hospitalizations. There was a slight increase in the number of days youth were absent from care due to placement in juvenile detention or correction facilities. This should be closely monitored during the upcoming year because of the potential merger of the Illinois Department of Juvenile Justice into the Department of Children and Families. Although it is too soon to assess the impact of performance based contracting on the stability rate in the Transitional Living Programs (TLP), the state's interest in collecting this data and using it to drive administrative decisions on systemic improvements made on behalf of older wards is encouraging.

22 Crum, W. (2010). Foster parent parenting characteristics that lead to increased placement stability or disruption. *Children and Youth Services Review, 32*, 185-190

CHAPTER 3

CONTINUITY

Kinship, Community, And Sibling Ties

Nancy Rolock
Jane Addams College of Social Work
University of Illinois at Chicago

Question: "What are the challenges to keeping in contact with members of the family?"
Answer: *"I could not talk to them [biological parents] until I was 18. That was a big challenge. But, it's not really hard once you start something. I don't know, I'm pretty good at continuing things – I didn't just like talk to my mom once and like just not talk to her again. We would call each other and meet up. I would go and see her. They are my family, that's what I do. I'm not just going to abandon my family, or people I consider family."*
(former foster youth Quinn, 2008)

When substitute care is necessary to foster or protect children, federal and state policy favors placement in settings that conserve children's existing kinship, community, and sibling ties. The Adoption Assistance and Child Welfare Act of 1980 (AACWA) established a requirement for states to institute a "case review system" wherein each child had "a case plan designed to achieve placement in the least restrictive (most family-like) setting available and in close proximity to the parents' home, consistent with the best interests and special needs of the child." [1] This was widely inferred as promulgating a preference which prioritized foster family care over group homes, institutions, and other forms of congregate care. At the time AACWA was enacted, most foster families recruited by the state were unrelated to the children taken into custody. While formal kinship foster care was not often used, informal kinship care has a long history among African American families.[2] Only in the late-1980s did formal placement with relatives become a prominent feature of the foster care system after states passed "kinship preference" laws that encouraged placement with relatives over non-relatives. Federal law subsequently incorporated this preference when Congress amended the IV-E state plan requirements to provide that states "shall consider giving preference to an adult relative over a non-related caregiver when determining a placement for a child, provided that the relative caregiver meets all relevant State child protection standards."[3]

The most recent federal Adoption and Foster Care Analysis Report (AFCARS) data indicate that placements with relatives account for 24% of the foster care placements in the United States.[4] Illinois has a long history of utilizing relative foster homes and does so to a greater extent than the national average; in 2009, 39% of Illinois' foster children were living with kin. The Home of Relative Reform implemented in Illinois in 1995 gave families who meet safety standards the choice between providing care as an extended family member or becoming a licensed foster home. One of the reasons behind this reform was to motivate relatives to become licensed relative caregivers. Despite the higher reimbursement available to relatives who operate a licensed foster home, over 70% elected to receive the slightly lower reimbursement as a non-licensed relative caregiver. Children in non-licensed care received the same services as children placed with licensed providers and until recently the federal government reimbursed states for the cost of placing these children.

The Fostering Connections to Success and Increasing Adoptions Act of 2008 created a new plan for states to provide kinship guardianship assistance payments under Title IV-E to relatives taking legal guardianship of children who have been in foster care.[5] The Illinois guardianship waiver has expired, but the state has amended its Title IV-E

1 Adoption Assistance and Child Welfare Act of 1980, Pub. L. 96-273.
2 Hill, R., (1977). *Informal adoption among black families*. Washington, D.C.: Urban League
3 42 U.S.C. §671(a) (19). (2009).
4 U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2009). *The AFCARS report: Pre liminary FY 2008 estimates as of October 2009 (16)* Retrieved from http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report16.htm.
5 Foster Connections to Success and Increasing Adoptions Act of 2008, Pub. L. 110-351.

plan to allow it to draw down federal funds for eligible kinship placements effective October 1, 2010. While recognizing the need to support relative caregivers and improve outcomes for children in foster care, the Fostering Connections legislation also requires the state to exercise due diligence by requiring fingerprint-based criminal records checks of relative guardians, as well as child abuse and neglect registry checks of relative guardians and adults living in the guardian's home before a relative guardian can receive Title IV-E guardianship assistance payments on behalf of a child. States may waive, on a case-by-case basis, a non-safety related licensing standard for a relative foster family home. The law also mandated that adult relatives be identified and notified within 30 days of a child's removal of the relatives' options to become a placement resource for the child. The Department expended considerable effort during 2009 toward increasing the number of kinship homes that are licensed (see Box 3.1 for additional discussion).

Despite consistent findings of increased continuity and stability for children placed with kin reported in this and in previous editions of this report, research on kinship care suggests that kinship placements are not a homogenous group. A recent study cautions that the kinship family population in Illinois may not be representative of programs and populations in other states, noting in particular the percentage of African American children in substitute care is much higher than the percentage nationally.[6] National and state law and policy has been predicated on the assumption that kinship foster families constitute a homogeneous population. As this study has noted, further research is warranted to identify differences in family attributes and circumstances which may lead to different outcomes for children and youth thereby testing the assumption that differences between kinship and non-kinship foster families are greater than those between kinship families themselves. The level of kin altruism or sense of duty,[7] family attributes and circumstances,[8] and state-specific policies and practice[9] may lead to different outcomes for children and youth in kin placements. An assessment of kinship placements should take these variations into consideration.

Another means of attaining continuity is for children to be placed close to their home of origin. The emphasis on keeping foster children in close proximity to their parents' home was documented decades ago by Maas and Engler, "every parent needs to be encouraged and helped to remain as close to his child as possible and to take as much responsibility for him as possible even though the child cannot live in the parents' home."[10] While initially intended to facilitate regular visitation between parents and children, research suggests that it was also conducive to family reunification.[11] Equally important, placement near the home of origin preserves the continuity of children's connections to friends, school, local neighborhood, and other social institutions familiar to the child.[12] Qualitative studies of foster youth underscore the devastating effects of severing friendships and the difficulty in forming new peer networks. Children in foster care are often going "through a constant state of loss."[13]

Continuity is also preserved through placement of children with their siblings in foster care. One consistent finding from research with foster youth is the importance of sibling bonds. Maas & Engler found that "relationships with siblings seem to be a major source of support in about 70 percent of the cases of the children in foster care;"[14] Emlen and colleagues found in the 1970s that "the strength of their attachment to each other, as well as the relationship of each child to each parent, had to be considered."[15] The importance of the maintaining sibling ties is often mentioned when former foster youth reflect on their time in foster care[16] and placement stability and permanency outcomes for children

6 Zinn, A. (2010). A typology of kinship foster families: Latent class and exploratory analyses of kinship family structure and household composition. *Children and Youth Services Review 32*, 325-337.
7 Testa, M. F. (2005). When a child cannot return home: Adoption and guardianship. *The Future of Children, 14*, 115-129.
8 Zinn, A. (2010). A typology of kinship foster families: Latent class and exploratory analyses of kinship family structure and household composition. *Children and Youth Services Review 32*, 325-337.
9 Koh, E. (2010). Permanency outcomes of children in kinship and non-kinship foster care: Testing the external validity of kinship effects, *Children and Youth Services Review, 32*, 389-398.
10 Maas, H. S. & Engler, R. E., Jr. (1959). *Children in Need of Parents.* New York: Columbia University Press, p. 392.
11 Fanshel, D., & Shinn, E. (1978). *Children in foster care: A longitudinal investigation*. New York: Columbia University Press.
12 Christiansen, O., Havik, T., & Anderssen, N. (2010) Arranging stability for children in long-term out-of-home care. *Children and Youth Services Review, 32, 913-921.*
13 Geene, S. & Powers, L.E. (2007). "Tomorrow is another problem": The experiences of youth in foster care during their transition to adulthood. *Children and Youth Services Review, 29* (8) 1085-1101.
14 Ibid, Maas & Engler (1959), p. 139.
15 Emlen, A. Lahti, J., Downs, G., McKay, A. & Downs, S. & Regional Research Institute for Human Services. (1978). *Overcoming barriers to planning for children in foster care* (DHEW Publica tion No. OHDS 78-30138). Washington, DC: U.S. Government Printing Office, p. 49.
16 Brown, W. K. & Seita, J. R. (2009). *Growing up in the care of strangers: The experiences, insights and recommendations of eleven former foster kids*. Florida: William Gladden Foundation Press.

Continuity At A Glance

Continuity is preserved if:

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

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

More children are placed with kin:

Of all children entering foster care, the percentage placed with kin in their first placement increased from 37% in 2003 to 51% in 2009.

Of all children in substitute care, the percentage living with kin at the end of the fiscal year has fluctuated between 38% to 40% over the past several years.

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

Of all children living in institutions or group homes at the end of the fiscal year, the percentage placed within the state has remained over 99% for the past seven years.

More children are placed in or near their community of origin:

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

For children entering **kinship care**, their median distance from home is substantially lower (closer to home) than those placed in traditional care. The median has fluctuated between 3 and 4 miles over the past seven years.

More children are placed with their siblings:

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

For sibling groups of two or three:

has increased for siblings in traditional foster care, from 52% in 2003 to 59% in 2009, and

is significantly higher and has increased for siblings in kinship foster care, from 64% in 2003 to 71% in 2009

For sibling groups of four or more:

has remained between 13% and 17% over the past seven years for siblings in traditional foster care, and

is significantly higher and has increased for siblings in kinship foster care, from 27% in 2003 up to 42% in 2009.

Box 3.1—Spotlight on Practice: New DCFS Home of Relative (HMR) Initiative

The Department has implemented a new Home of Relative Initiative that seeks to increase the number of licensed relative foster homes. The Department's interest in licensing relative homes began even prior to the Fostering Connections legislation, when research conducted by the Children and Family Research Center revealed that children are safer in licensed traditional relative homes than in unlicensed relative homes. This initial impetus was then intensified by the Fostering Connections legislation, which allows the Department to claim Title IV-E funds on behalf of relative placements if these homes were licensed. The focus of the Home of Relative Initiative is to license relative homes that are currently unlicensed. DCFS and private agency staff were asked to prioritize licensing those relative homes with children with a subsidized guardianship or adoption goal because it is essential to achieve licensure prior to achieving the permanency goal for the purpose of Title IV-E claiming. However, the Department's goal is to license 80% of *all* eligible relative homes by June 2010.

The Department is tracking and monitoring progress by requiring each licensing agency to report information to the Director's Office and the Department's Agency Performance Team on a weekly basis. The information submitted includes: the date the licensing application was submitted; the date the authorization form and fingerprint slip was submitted; the date the license was issued; the date that a Director's waiver was requested; and the date granted or denied. Any barriers to licensure are also reported as required by the Fostering Connections legislation. The Director's designee makes personal phone calls to those relative caretakers that the agencies report are uninterested in licensure. The purpose of the phone calls is to provide support to the agencies in their effort to educate relatives on the benefits of licensure. The Director's Office also documents the number of relative homes that cannot be licensed because of criminal background, tax identification number, and those that are simply not interested.

Barriers to licensure that have been reported include fingerprinting locations, inconvenient meeting times, medical exams, background checks and tax identification numbers. The Department has made efforts to address these barriers; for example, by scheduling fingerprinting on Saturdays rather than during the week to make it more convenient for caregivers. The Department worked with the Illinois Department of Public Health to provide free medical exams at a centralized location. The Department intends to increase these efforts.

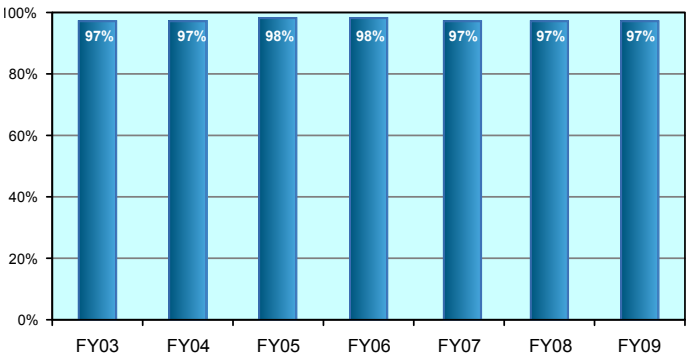
The Department has established a Public/Private HMR workgroup that will attempt to address barriers as well. The workgroup will look at systemic and policy issues as well as marketing and training issues. Relatives will be informed of the benefits of licensure at placement in an effort to increase the number of licensed relative homes. The workgroup will develop a protocol that will ensure that relatives will be informed of the benefits of licensure and to encourage participation in the licensure process. The protocol may also require licensing staff to make contact with the relative within a specified timeframe. The details of the protocol have not yet been established.

Although the Department has not yet attained its goal of 80% licensure of relative homes, there has been significant progress. Tracking began in March 2009 at which time only 29.3% of these homes were licensed. By December 31, 2009 the percentage of licensed relative placements had risen to 49.2%

This box was written by Twana Cosey, MSW of the Illinois Department of Children and Family Services. Additional questions can be directed to Ms. Cosey at Twana.Cosey@illinois.gov

are associated with being consistently placed in the same home as their siblings.[17] Sometimes, however, placement decisions need to be made that put policy and practice priorities in conflict with one another. A recent study found that for children who "initially show a low level of behavior problems…separation [from siblings] may be detrimental to behavioral adjustment at follow up. On the other hand, for siblings who have extremely elevated levels of behavior and conduct problems…separation [from those siblings] may be beneficial to subsequent behavioral adjustment (p.742)." [18] When, for instance, is it necessary to place a child with particularly difficult behavioral needs in a more restrictive setting? When is it better to split siblings to protect one sibling from another? Although child welfare policy is based on the recognition that the preservation of sibling relationships is an important tenet in child welfare practice, the importance of assessing the relationship between siblings cannot be overlooked.

Figure 3.1 – Percent Of Children Under 12 Not Living In Institutions Or Group Homes At Year End



Least Restrictive Care

Although best practice recognizes a need for residential treatment for a residual segment of older youth who cannot be appropriately served in a family setting, there is general consensus that the institutionalization of children interferes with normal developmental growth.[19] [20] In addition, research conducted in the mid-1990s suggested that many institutionalized children could be living in less restrictive settings.[21] In response, DCFS implemented a series of gate-keeping policies to restrict entries into residential treatment facilities and to move youth to less restrictive settings.[22] As a result of these efforts, the percentage of foster children under the age of 12 years old who are not placed in a group home or institution has remained at or above 97% since 2003 (see Figure 3.1 and Appendix A, Indicator 3.A).

During 2009 and the first two quarters of 2010 increased emphasis has been placed on the length of stay in residential care which has steadily increased. The *Striving for Excellence* project is attempting to reduce lengths of stay in residential care by restructuring the Sustained Favorable Discharge (SFDR) performance measure for the FY2011 contracts to incentivize shorter lengths of stay. This emphasis on increasing the number and frequency of "step-downs" to less restrictive settings may impact the successful transition of youth from residential care to community settings. Youth have described the unsettling experience of moving from a highly structured residential treatment center to a less structured environment for which they were unprepared.[23] Increased emphasis on discharge planning and a coordinated process to ensure successful and sustained step-downs is embodied in the Discharge and Transition Protocol.

17 Leathers, S. (2005). Separation from siblings: Associations with placement adaptation and outcomes among adolescents in long-term foster care. *Children & Youth Services Review, 27,* 793-819.
18 Linares, L.O., Li, M., Shrout, P.E., Brody, G.H., Pettit & Pettit, G.S. (2007). Placement shift, sibling relationship quality, and child outcomes in foster care: a controlled study. *Journal of Family Psychology 21,* 736-743.
19 Lyons, J. S., Libman-Mintzer, L. N., Kisiel, C. L., & Shallcross, H. (1998). Understanding the mental health needs of children and adolescents in residential care. *Professional Psychology: Research and Practice, 29,* 582-587.
20 Budde, S., Courtney, M., Goerge, R., Dworsky, A., & Zinn, A. (2004). *Residential care in Illinois: Trends and alternatives interim report. Descriptive findings from analysis of DCFS administrative data.* Chicago: Chapin Hall Center for Children.
21 Ibid Lyons et al.
22 Ibid Budde et al.

Box 3.2—Spotlight on Practice: Illinois Residential Discharge and Transition Protocol

The Illinois Department of Children and Family Services (IDCFS) implemented the Residential Transition and Discharge Protocol in FY09. The purpose of the protocol is to establish sustainability and longitudinal responsibility as major goals of residential care to promote the stability of young people following discharge from residential and group home programs to less restrictive service settings. Accordingly, the protocol conceptualizes transition planning as a responsibility shared by multiple stakeholders who are committed to supporting the health and well-being of young people over time and across placements. This requires stakeholders to:

- Support the development of the young person's relationships with family members and other caring adults;
- Link young people to community service systems; and
- Ensure strength-based programming balances needs for behavioral stabilization with needs for skill development.

DCFS and private agency caseworkers, residential program staff and receiving placement resources are the primary stakeholders responsible for implementing the protocol utilizing an interdisciplinary team approach that promotes collaborative decision making, individualized planning, and access to services. These primary stakeholders are responsible for engaging other stakeholders (e.g., the GAL, family members and other caring adults, education representatives, community service providers) with a connection and interest in supporting the youth's successful transition.

The protocol outlines three distinct transition phases for young people in residential or group home settings. These phases include a transition-oriented active treatment phase, a three to four month transition phase, and a 90 day post-discharge phase. Underlying the three phases are a collaborative staffing process and on-going communication among treatment team members.

Each phase has in common activities designed to increase continuity of care by:

1) Increasing communication, coordination and team decision-making;
2) Engaging the young person in treatment and transition planning with consideration to the young person's age, developmental level, maturity, strengths, needs, etc.;
3) Expanding clinically-based transition planning and services;
4) Clarifying areas of responsibility and accountability; and
5) Promoting relationship continuity and connections to the community through greater permeability between residential treatment programs, families and community systems.

Phase I, beginning at admission, includes:

- Assessment activities and primary treatment services including skill and relationship development;
- Engagement of the young person into the treatment and transition planning process;
- Nurturing/support of the Child and Family Team; and
- Preliminary transition planning.

By addressing each of these elements, the treatment team establishes a strong foundation for active transition planning and discharge-related services completed in Phase II.

23 Hyde, J. & Kammerer, N. (2009). Adolescents perspectives on placement moves and congregate settings: Complex and cumulative instabilities in out-of-home care. *Children and Youth Services Review 31,* 265-273.

Box 3.2 Cont.—Spotlight on Practice: Illinois Residential Discharge and Transition Protocol

Comprehensive transition planning is initiated in Phase II and evolves to incorporate the identified placement resource. The goals of comprehensive transition planning are to:

- Identify a placement resource with a capacity to further build the young person's strengths and meet his or her needs;
- Complete all service linkages prior to discharge;
- Develop a partnership between the young person, sending residential program and receiving program; and
- Provide opportunities for the young person to practice new skills first in simulated situations and then in a variety of natural environments similar to that of the level of care to which he or she will be transitioned.

Unconditional care is a key expectation during the Phase III stabilization period, which begins upon the young person's discharge from the sending residential program and may be extended for up to 90 days. The treatment team, including the sending residential program and Child and Family Team, is expected to address the "context effect" which may limit the ability of the young person to maintain treatment gains across placement types. The treatment team is also responsible for responding to emerging adjustment issues as needed to stabilize the young person in the new placement. Accountability of the treatment team, and ongoing communication and treatment planning, is facilitated by one or more post-discharge stabilization staffings. Additionally, supportive intervention is offered by the Department to address accountability issues and/or system barriers that may interfere with the young person's stability. When placement instability is identified, Phase III includes requirements for exploring all potential options and completing comprehensive planning.

This box was written by Deann Muehlbauer MPH, Department of Psychiatry, University of Illinois at Chicago. Additional questions may be directed to Ms. Muehlbauer at dmuehlbauer@psych.uic.edu.

Kinship Foster Care

Nationally, 24% of children in foster care are living with kin, compared to 39% in Illinois. Two indicators are examined in this report regarding kinship placement: the number of children initially placed with kin and the percentage of the foster care population placed with kin at the end of the fiscal year. Figure 3.2 depicts the increased use of kin homes for initial placements – from 37% in 2003 to 51% in 2009.

Much of this increase is a result of an increase in the use of relatives for initial placements outside Cook County where placement with kin has risen from 36% in 2003 to 55% in 2009 (see Figure 3.3 and Appendix A, Indicator 3.B.1).

Figure 3.2 – Percent Of Children Entering Care And Initially Placed With Kin

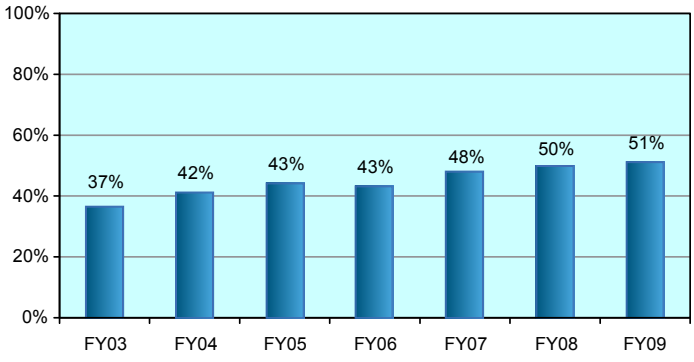
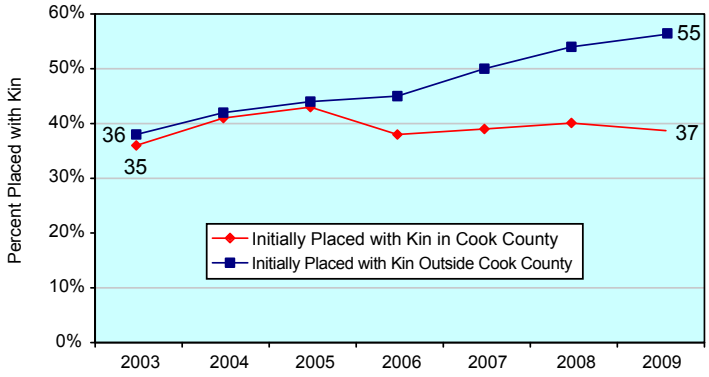


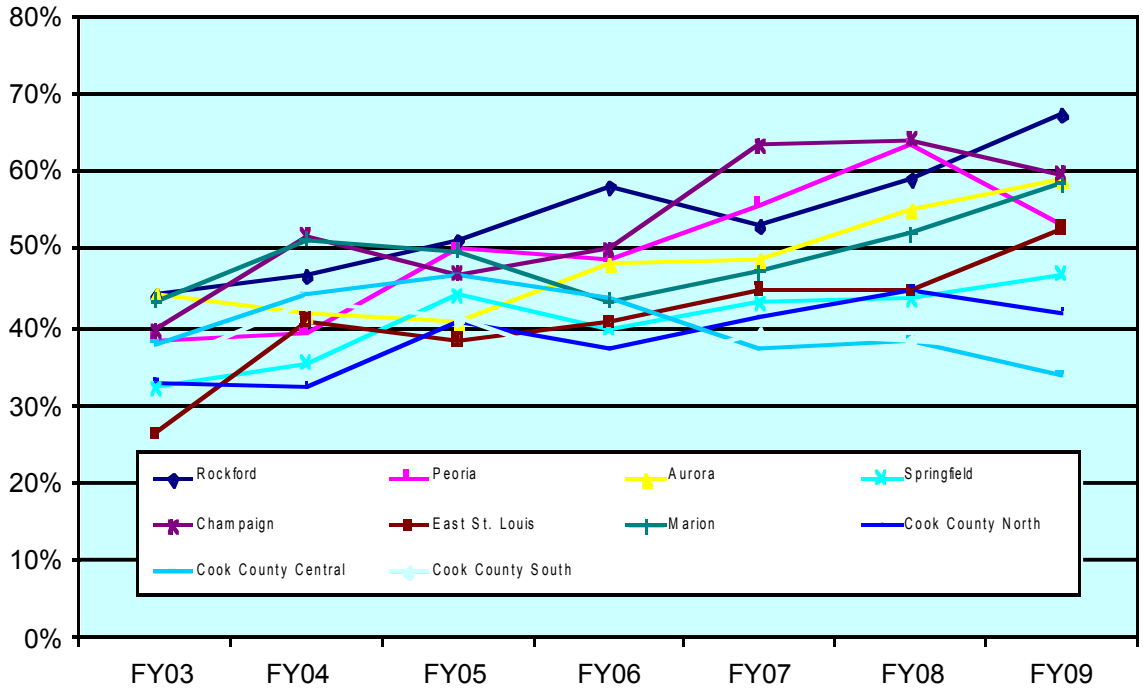
Figure 3.3 – Percent of Children Initially Placed with Relatives
Cook County vs. Balance of the State



The racial makeup of children initially placed with relatives has also changed; a smaller percentage of the kin population is African American in 2009 than in 2003. In 2003 outside Cook County, 56% of relative placements were Caucasian, 38% African American, and 3% of Hispanic ethnicity. By 2009, 59% of relative placements outside Cook County were Caucasian, 34% African American and 4% of Hispanic ethnicity. In Cook County in 2003, 81% of relative placements were African American, 11% Caucasian, and 6% of Hispanic ethnicity. By 2009 this had changed so that 72% of kin placements in Cook County were African American, 16% Caucasian, and 10% of Hispanic ethnicity.

Sub-Regional Analysis: Children Initially Placed With Relatives

Figure 3.4 – Percent Of Children Initially Placed With Relatives By Sub-Region



Northern Region:
The two sub-regions that make up the Northern region have both seen an increase in the number of children initially placed with kin. In the Rockford sub-region the number of children initially placed with kin has increased from 44% to 67% over the past seven years. The Aurora sub-region experienced an increase from 44% to 59% during the same time period.

Central Region:
The three sub-regions that make up the Central region have also seen an increase in the percentage of children initially placed with kin. In the Peoria sub-region the percentage of children initially placed with kin has increased from 38% to 53% over the past seven years; in Springfield from 32% to 47% and in Champaign from 40% to 60%.

Southern Region:
The two sub-regions in the Southern region have also seen an increase in the percentage of children initially placed with kin. In East St. Louis the percentage has more than doubled, from 26% to 53% over the past seven years. In the Marion sub-region, the percentage has increased from 43% to 58% over the past seven years.

Cook County Regions:
In comparison to the rest of the state, the use of kin initially in the three Cook County regions has remained somewhat constant, with the exception of Cook North. Cook North has seen an increase from 33% to 42%, a slight decrease in Cook Central from 38% to 34%, and a slight increase from 35% to 37% in Cook South over the past seven years.

The increased use of kin for initial foster care placements in all the sub-regions outside of Cook County may result in additional stability for children in the future (see Chapter 2 where findings indicate that children are more stable when placed with kin) and perhaps increased permanency (see Chapter 4 where findings suggest that children are more likely to exit to a permanent home, and remain in that permanent home, if placed with kin). The impact of the increased reliance on kinship foster care in these regions should be monitored.

Figure 3.5 shows the trend for the percentage of the foster care population living with kin; a relatively stable percentage of the foster care population has been living with kin over the past seven years. The increased use of kin for initial foster care placements does not necessarily translate to more children living in foster care. However, Figure 3.2 shows that more children are initially placed with kin and Chapter 4 shows that more children are exiting foster care to permanence if placed with relatives. The dynamics of entries and exits from foster care results in a relatively stable percentage of children in foster care living with relatives.

Sub-regional analysis of the foster care population indicates that there has been an increase in the population of children living with kin in all of the regions outside of Cook County (see Figure 3.6). In the Northern region the percentage of foster children living with kin increased over the past seven years: in Rockford from 37% to 53% and in Aurora from 37% to 45%. In the Central region the percentage of foster children living with kin increased: in Peoria from 32% to 45%, in Springfield from 25% to 33%, and in Champaign from 35% to 51% over the past seven years. In the Southern region, the percent living with kin increased from 30% to 40% in East St. Louis and from 35% to 43% in Marion. The Cook County regions all experienced a decrease in the percentage of children living with relatives: Cook North from 36% to 31% and 40% to 33% in both Cook Central and Cook South.

Figure 3.5 – Percent Of Children Living In Kinship Foster Care At Year End

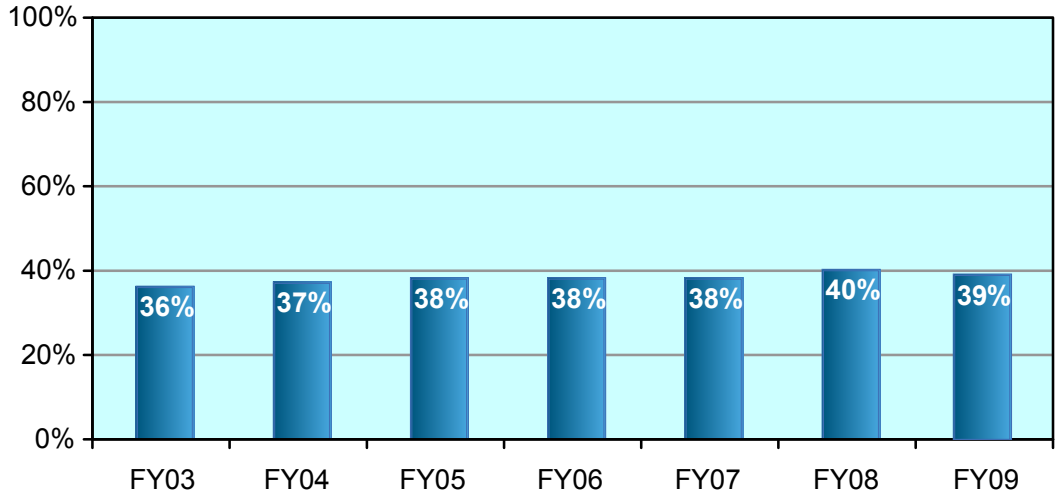
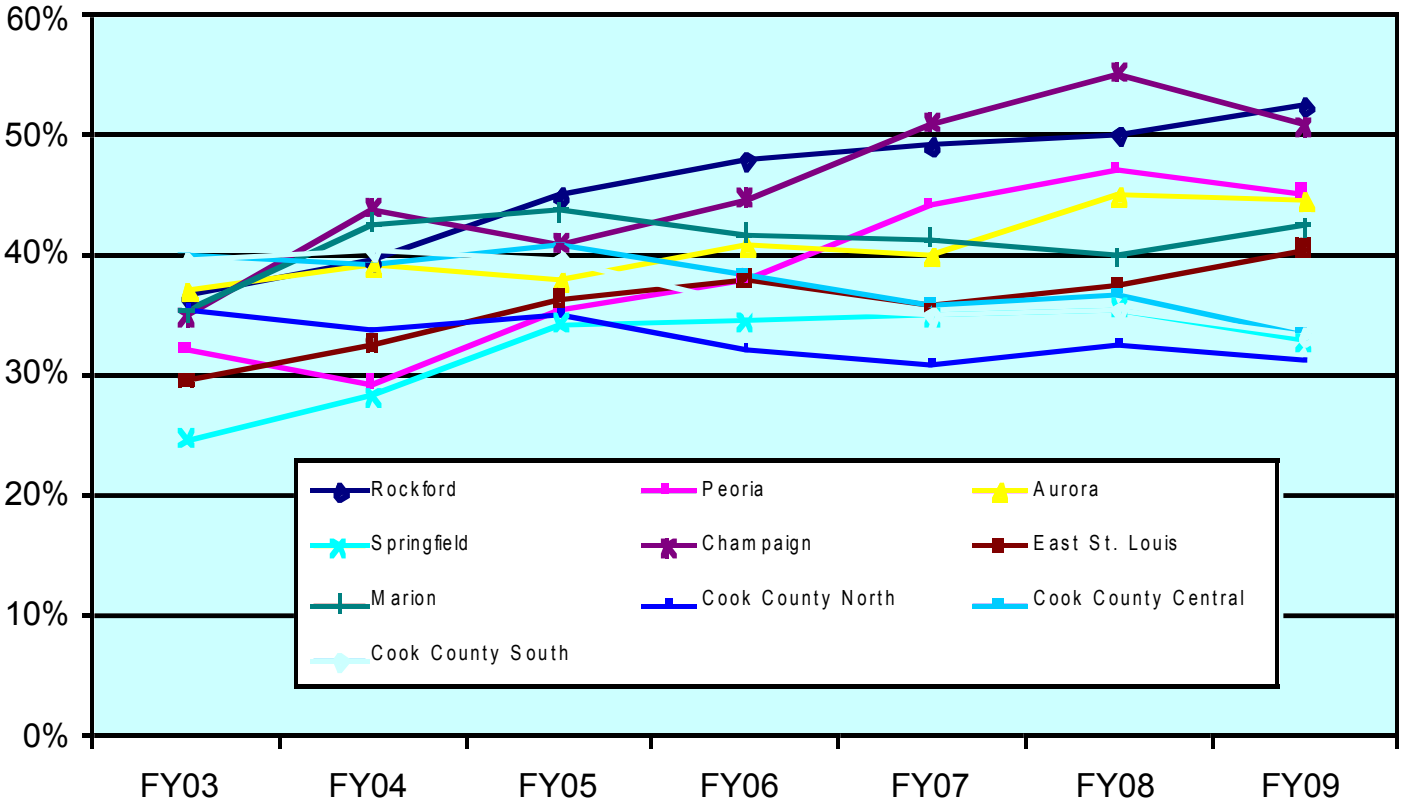


Figure 3.6 – Percent Of Children Living In Kinship Foster Care At The End Ofthe Fiscal Year By Sub-Region

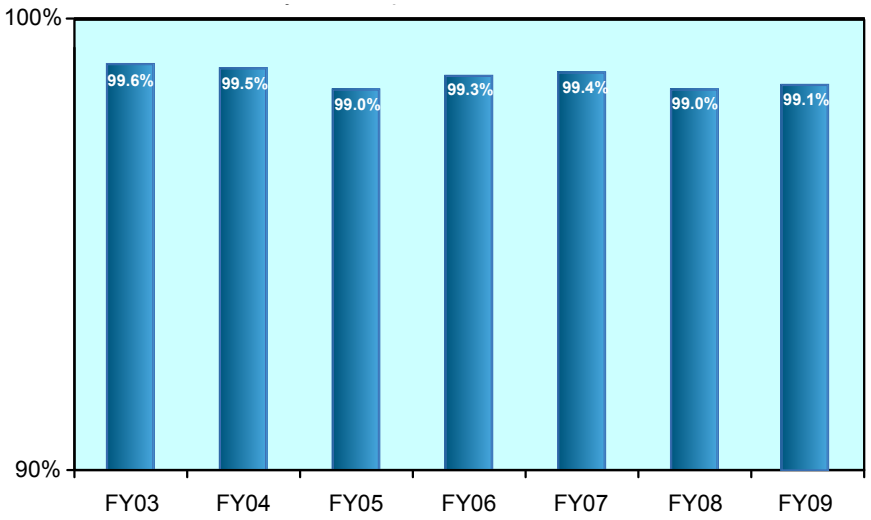


DCFS allows foster children to live with kin as long as safety can be ensured. Consistent with federal law, DCFS has waived some licensing standards associated with traditional foster care placements for some kinship homes. However, with the passage of the Fostering Connections Act federal reimbursement for unlicensed kin placements has changed, and DCFS has increased efforts towards licensing kinship foster care homes as discussed in Box 3.1. In addition, the Department has added licensing rates to contract performance measures for foster care purchase of service (POS) agencies. The impact of this licensing effort on indicators of safety, stability, and permanence should be monitored.

Preservation Of Community Connections

Community connections are defined through two measures in this report: the percent of children who are placed in institutions or group homes within the state, and the distance children are placed from their biological families if living in traditional foster care or kinship placements. The percentage of children in group homes or institutions that are located within Illinois has remained at or over 99% for the past seven years (see Figure 3.7 and Appendix A, Indicator 3.C); 17 children were placed outside Illinois in 2009, and over half these children (53%) were African American.

Figure 3.7 – Percent Of Children Living In Institutions Or Group Homes At Year End Placed Within Illinois



Keeping Children Close To Home

Federal law mandates that foster children be placed in close proximity to their parents' home unless their best interests would be better served by a more distant setting. This is measured in the current report as the median number of miles between the home of origin and the first placement in foster care for the year. Because the circumstances which warrant placement in traditional foster care versus placements with relatives differ, these two populations are looked at separately.

Children living in traditional placements live, on average, 9 to 10 miles from home, compared to children placed with kin, who live between three and four miles from home. The bars on Figures 3.8 & 3.9 represent the two middle quartiles of the population (i.e., the middle half of the population) and exclude those that live quite close and those that live quite far to provide a sense of how far *most* children live from their home of origin. For children living in traditional foster care placements this range is growing, as shown by the lengthening bars across the seven years – more children are living up to 30 miles away in 2009 than in 2002 – while the range has remained fairly constant for children living with relatives (see Figures 3.8 and 3.9 and Appendix A, Indicator 3.D).

Regional differences play a significant role in how one thinks of distance from home – in some communities living close to home would mean living within one or two miles, and in other communities it might mean living within ten miles.

Figure 3.8 – Median Miles From Home
Illinois Total Traditional Foster Care Population

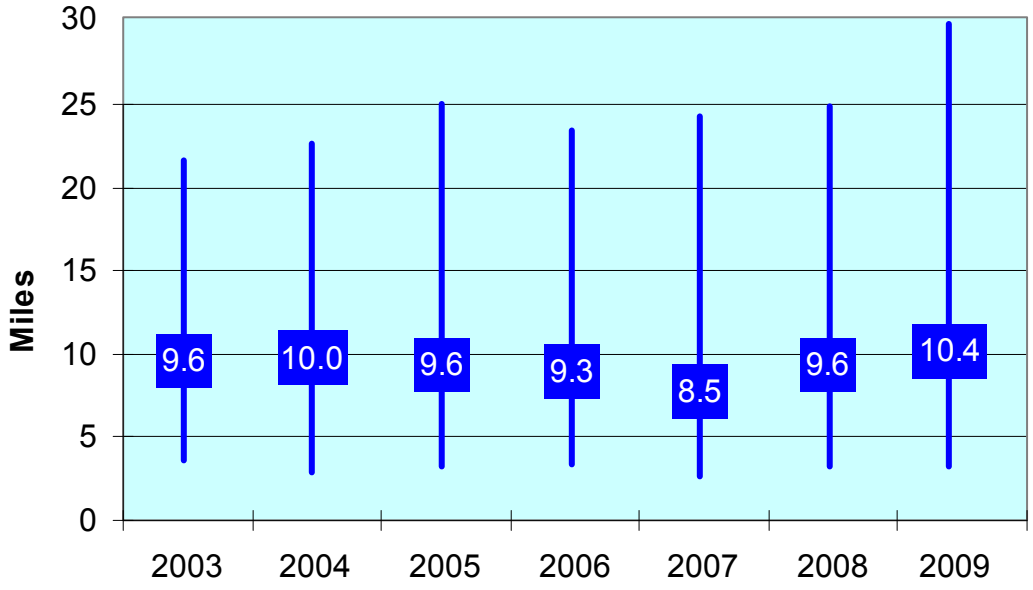
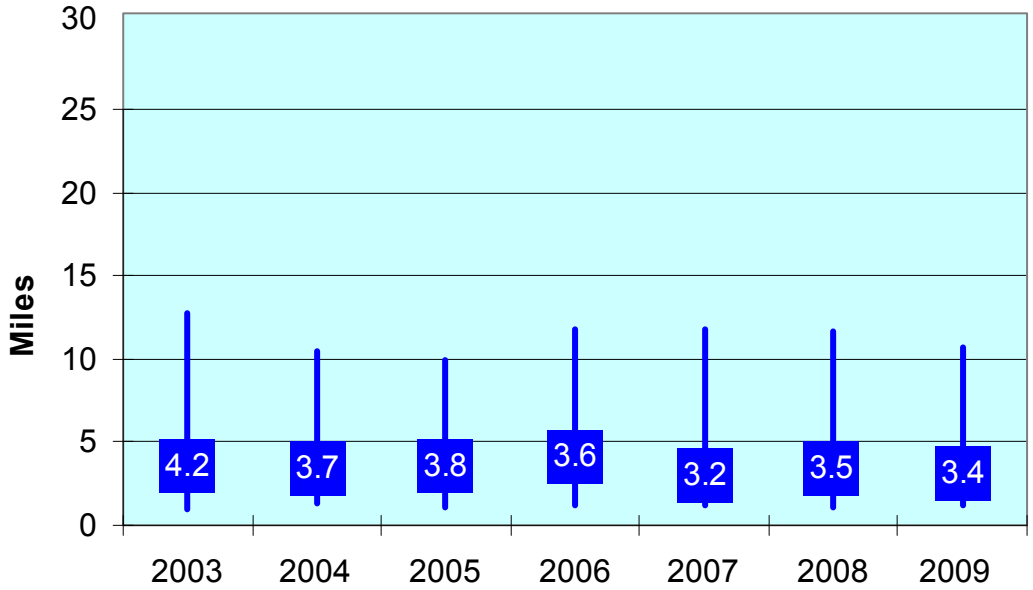


Figure 3.9 – Median Miles From Home
Illinois Total Kinship Foster Care Population



When the distance from home is evaluated by region, data from the past seven years shows:

- In the Northern region, children placed in traditional foster care generally live about 10 miles from their biological families compared to children in kinship homes who live three to five miles from home.
- Children placed in traditional foster care in the Central region live much further from home (9 miles in 2003 and 12 miles in 2009) than those placed with kin (about 3 miles over the seven years), but the range of distance is as high as 36 miles in traditional settings compared to 23 miles in kinship homes.
- In the Southern region, children living in traditional foster care live between 10 and 15 miles from their biological families, and similar to the Central region, the range is quite large, extending to over 35 miles. Children in kinship homes are usually placed within five miles of home, with the range extending up to 20 miles from their biological families.
- In Cook County over the past seven years the traditional caseload has remained constant at between 9 and 10 miles from home, and the kinship caseload has been between 4 to 5 miles, on average, over the past seven years.

It remains to be seen whether the lengthening distances between the homes of parents and substitute care homes seen among children in traditional foster homes are damaging to patterns of regular family visitation, as well as community and school continuity.

Conservation Of Sibling Ties

Research shows that sibling relationships play a major role in how children develop and learn to interact with other people.[24] Sibling bonds, just like parent-child bonds, influence children's developing sense of attachment.[25] Siblings are an important source of emotional comfort during childhood, and in adulthood, siblings can also become a vital source of material and financial assistance.[26] In addition, decades of child welfare research show that conservation of sibling bonds is something foster children and former foster children value highly; these youth describe their relationships with their siblings as some of the most important relationships they have.[27] [28] The opportunities for sibling association while in foster care are related to the type of living arrangement into which children are placed (see Appendix A, Indicator 3.E). Figures 3.10 and 3.11 show that sibling groups of varying sizes are more likely to be placed together when they are living with relatives than when they are in unrelated traditional foster care. Overall, there has been steady improvement – siblings are more often placed together in 2009 than they were in 2003. For sibling groups of 2 or 3, children placed with kin are generally 10% more likely to be placed together than children in traditional foster care homes. For larger sibling groups (four or more), there has been a steady and substantial increase in the percentage of siblings placed together among kinship placements, while in traditional foster care, placements only a slight increase is observed.

Figure 3.10 – Percent Of Children Placed With All Their Siblings In Care By Placement Type
WITH 2 OR 3 SIBLINGS IN CARE

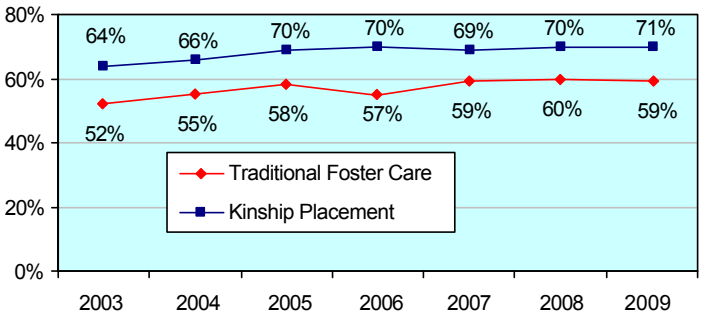
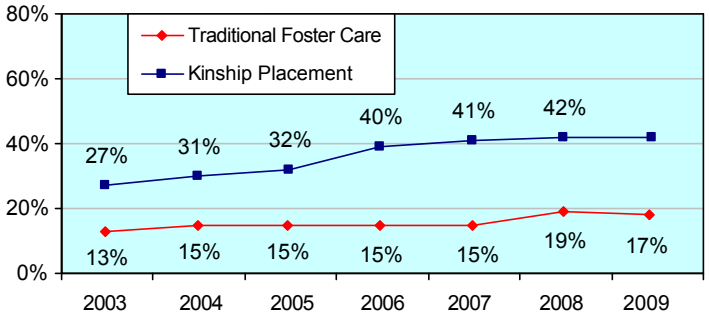


Figure 3.11 – Percent Of Children Placed With All Their Siblings In Care By Placement Type
WITH 4 OR MORE SIBLINGS IN CARE



24 Begun, A.L. (1995). Sibling relationships and foster care placements for young children. *Early Child Development & Care, 106*, 237-250.
25 Hegar, R. (1988). Sibling relationships and separations: Implications for child placement. *Social Service Review, 62*, 446-467.
26 Cicirelli, V.G. (1991). Sibling relationships in adulthood. *Marriage & Family Review, 16*, 291-310.
27 Festinger, T. (1983). *No one ever asked us...A postscript to foster care.* New York: Columbia University Press.
28 Ibid Maas & Engler (1959).

Box 3.3—2009 CFSR Findings Related to Continuity

CFSR Permanency Outcome 2 assesses whether "the continuity of family relationships and connections is preserved for children" during the period under review. Illinois was not in substantial conformity with this outcome measure in 2009 – only 55% of the cases reviewed substantially achieving this outcome (substantial conformity requires 95% achievement). The outcome was partially achieved for 42.5% of the cases reviewed and not achieved for 2.5%. The state's performance on the items which comprise Permanency Outcome 2 varied:

- Item 11 **(Proximity of Foster Care Placement)** assessed whether the child's current foster care setting was near the child's parents or close relatives. This item was deemed a strength in **100%** of the 29 applicable cases reviewed.
- Item 12 **(Placement with Siblings)** determined whether children who had siblings in foster care were placed together, or if separated, whether the separation was necessary to meet the service or safety needs of one or more of the children. Of the 30 applicable cases reviewed, 26 **(87%)** were rated as a strength. Although close to the 90% required for an overall rating of strength, this item was rated as an **"area needing improvement."**
- Item 13 **(Visiting with Parents and Siblings in Foster Care)** looked at whether diligent efforts were made to facilitate visitation between children in foster care with their parents and between siblings in separate placements. This item also addressed whether the visits occurred with sufficient frequency to meet the needs of children and families. The reviewers deemed this item as a strength for only 20 of the 33 applicable cases **(61%)**; the overall rating was **"area needing improvement."** Visitation occurred more frequently with mothers (74%) than with fathers (44%) in the cases applicable for review.
- Item 14 **(Preserving Connections)** examined the preservation of a child's connections to neighborhood, community, heritage, extended family, faith and friends. This was an **area needing improvement**, with **75%** of the cases rated as a strength. In each of the 10 cases needing improvement, the agency did not make concerted efforts to maintain the child's connections to extended family members.
- Item 15 **(Relative Placements)** considers whether diligent efforts were made to locate and assess both maternal and paternal relatives as potential placement resources for children in foster care. Overall, this was an **area needing improvement** in Illinois, with **67%** of reviewed cases attaining a "strength" rating.
- Item 16 **(Relationship of Child in Care with Parents)** received the lowest rating of all continuity-related measures: only **38%** of the eligible cases were deemed in substantial conformity by demonstrating diligent efforts to support or maintain the bond between children in foster care and their parents through efforts other than arranging visitation.

Observations On Continuity In Illinois

Illinois has emphasized in both policy and practice the importance of maintaining familial and supportive relationships for youth placed in substitute care. During the course of the next year, the Department's new initiative to increase licensing of kinship homes should be monitored to determine its impact on child outcomes. The barriers to licensing kinship placements need to be closely examined to determine potential strategies for overcoming them. Although many of the logistical barriers to attaining licensure for relative foster providers may be remedied, there may be a subset of relatives that do not wish to become licensed for other reasons, therefore a better understanding of these reasons should be sought. Center research shows that licensed relative placements are safer than those that are unlicensed, but a fuller understanding is needed about the characteristics of unlicensed homes related to safety. The push towards licensing relative foster homes may have an impact on the availability and use of relative placements overall if it discourages potential kin caregivers from becoming foster parents – this too needs to be carefully monitored.

There is growing recognition in the field of the importance of collaborative discharge planning and transition for youth in residential and congregate care. This trend is embodied in the Discharge and Transition Protocol designed to guide successful and sustained step-down placements and should be strongly encouraged. With the increased emphasis on reduction in length of stay in residential care for the coming year, the continued evaluation of the impact of the *Striving for Excellence* project which assesses the effectiveness of performance-based contracting in improving outcomes for children and youth in residential treatment, Independent Living, and Transitional Living Programs, is warranted. Providers may feel pressured to prematurely discharge youth from higher end placements in order to avoid fiscal penalties imposed for failure to reach contractual performance benchmarks.

The increasing distance from home that some children face when placed in traditional foster care should be examined more closely. The relationship between proximity to home, visits with biological family, and the likelihood of reunification needs to be better understood. The Department's efforts to increase placement of siblings together in kinship foster care have been successful, particularly for placements of sibling groups of four or more. Additional effort should be extended to find appropriate means to increase the rate at which large sibling groups are placed together in traditional foster care. Finally, growing evidence suggests that supportive and caring relationships for youth within their schools, social networks and communities support positive child development. The Department should strive to ensure that current and former foster youth have supportive and caring relationships within these social structures that they can rely on during and after foster care.

CHAPTER 4

LEGAL PERMANENCE

Reunification, Adoption And Guardianship

Nancy Rolock
Jane Addams College of Social Work
University of Illinois at Chicago

Question:"What was so appealing about adoption?"
Answer: *"The fact that you knew that you were going to be there forever and you didn't have to move all your stuff and lose things going here and there – that was your home. That was a place you could call home. Those were your parents, they belonged to you." (former foster youth Santana, 2008)*

The cornerstone of American child welfare policy since the enactment of the Adoption Assistance and Child Welfare Act of 1980 (AACWA) has been the mandate for permanency planning on behalf of children by states receiving Title IV-E foster care funds. The law established a case review system which required judicial or administrative agency review of a child's status at a minimum of every six months to determine if the child should be returned to the parent, continued in foster care for a specified period, placed for adoption, or, because of the child's special needs and circumstance, be continued in foster care on a long-term or permanent basis.[1] Despite AACWA legislation, by the late 1980s foster care caseloads were on the rise and children were spending ever-longer periods of time in care.

To address these long lengths of stay and to bring additional focus on adoptions from foster care, Congress passed the Adoption and Safe Families Act (ASFA) in 1997. This Act expanded upon the AACWA requirements by requiring permanency hearings to be held no later than twelve months after a child is placed in foster care and establishing a timeframe for the initiation of termination of parental rights proceedings after a child has been in foster care for fifteen of the previous twenty-two months unless the child is in the care of a relative or termination is not in the best interest of the child.[2] ASFA also allowed for expedited termination of parental rights proceedings in certain egregious circumstances and provided incentives to states for increasing the number of children adopted from foster care. As Congress was passing ASFA, the Illinois General Assembly passed a series of laws which sought to move foster youth to permanency quickly through a series of innovative reforms, including the use of performance-based contracting which awarded incentives to private agencies providing foster care case management services to increase their permanency rates, and the subsidized guardianship waiver which provided an alternative permanency option.

1 Adoption Assistance and Child Welfare Act of 1980, Pub. L. 96-273.
2 Adoption and Safe Families Act of 1997, Pub. L. 105-89.

Legal Permanence At A Glance

Children have permanent homes if:

Children are reunified with their parents more quickly:

Of all children who entered substitute care during the year and stayed at least 7 days, the percentage reunified *within 12 months* from the date of entry into care had remained fairly constant until FY2007, when it decreased from 20% to 18% the following year.

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

Of all children who entered substitute care during the year and stayed for longer than 7 days, the percentage attaining permanence through reunification or adoption *within 24 months* from the date of entry into foster care has remained consistently between 35% and 38% over the past seven years.

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

More children who have attained permanence are not displaced from home:

Of all children who attained permanence *two years ago* the percentage not experiencing a rupture in permanence has remained stable over the past seven years: between 98% and 99% for adoptions, 96% to 97% for guardianships and 82% to 85% for reunifications.

Of all children who attained permanence *five years ago* the percentage not experiencing a rupture in permanence has remained stable over the past seven years for adoptions (95% to 96%), guardianships (89% to 90%) and reunifications (75% to 76%).

Of all children who attained permanence *ten years ago* the percentage not experiencing a rupture in permanence has been stable for adoptions (90%) and for subsidized guardianship (84% to 85%),

But has increased from 64% to 75% for reunifications over the past seven years.

Children spend less time in foster care:

Of all children entering care for the first time, the median number of months a child stays in care has decreased from 26 to 24 months over the past seven years.

In 2008 the Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351) was passed, based in part on research findings from subsidized guardianship waiver evaluations in Illinois, Tennessee, and Wisconsin showing that providing kin with an alternative to adoption, when reunification cannot be achieved, was successful in increasing the number of children exiting foster care to permanent homes.[3] While Illinois has been offering subsidized guardianship as an option since 1997, the Fostering Connections Act provides all states the option to implement a subsidized guardianship (kinship guardianship assistance) program, an option previously available to only a select number of jurisdictions.

In August, 2009, the Illinois General Assembly enacted a series of legislative reforms related to permanency. Public Act 96-600 allows the Court, under specific and limited circumstances to set a permanency goal of "continuing foster care." This legislation also establishes a legal process by which parental rights which have been previously terminated could be reinstated (see Box 4.1). While it is too soon to know the impact of this legislation, the implementation of these permanency reforms should be closely monitored.

This chapter explores permanency options available for foster children in Illinois, including children exiting foster care to reunification with biological family, or when reunification is not possible, through subsidized adoptive or guardianship placements with kin or non-kin caregivers. This chapter also uses DCFS data to track foster children and youth after they achieve reunification, adoption, or guardianship to monitor the stability of these homes.

Box 4.1—2009 Child Welfare Reform Legislation Related to Permanency

On August 25, 2009 Illinois Governor Pat Quinn signed legislation amending the Children and Family Services Act to enact a series of child welfare reform initiatives related to permanency, including:

Permanency Goal of "Continuing Foster Care"

Public Act 096-0600 recognizes that for a discrete group of youth a permanency goal of reunification, legal guardianship or adoption may not be in their best interest. The new law adds a case plan goal of "continuing foster care" as a permanency goal if the Court makes the following findings of fact:

1. The Department of Children and Family Services has custody and guardianship of the minor;

2. The Court has ruled out other permanency goals based on the child's best interest;

3. The Court has found compelling reasons, based on written documentation reviewed by the Court, to place the minor in continuing foster care. Compelling reasons include:
    a. the child does not wish to be adopted or to be placed in the guardianship of his or her relative or foster care placement;
    b. the child exhibits an extreme level of need such that the removal of the child from his or her placement would be detrimental to the child; or
    c. the child who is the subject of the permanency hearing has existing close and strong bonds with a sibling, and achievement of another permanency goal would substantially interfere with the subject child's sibling relationship, taking into consideration the nature and extent of the relations, and whether ongoing contact is in the subject child's best interest, including long-term emotional interest, as compared with the legal and emotional benefit of permanence;

4. The child has lived with the relative or foster parent for at least one year; and

5. The relative or foster parent currently caring for the child is willing and capable of providing the child with a stable and permanent environment.

The Court is to conduct the same "best interest" analysis as for other permanency goals including consulting with the minor in an age appropriate manner regarding the proposed permanency or transition plan.

Fostering Connections Post Termination of Parental Rights

Public Act 096-0600 also enacts statutory authority for the Department to make reasonable efforts to locate parents whose rights have been terminated for a minimum of three years and the subject child is 13 years old or older and is not

3 Testa, M. F. (2010). Evaluation of child welfare interventions. In M. F. Testa & J. Poertner (Eds.), *Fostering accountability: Using evidence to guide and improve child welfare policy*. New York: Oxford Press.

in a placement likely to achieve permanency unless the Court determines that the Department's efforts would be futile or inconsistent with the child's best interests. The Department is to assess the appropriateness of the parent whose rights have been terminated, and shall, as appropriate, foster and support connections between the parent whose rights have been terminated and the youth. The Department's efforts to foster the connections between parent and child shall be documented in the child's case plan.

Motion to Reinstate Parental Rights

Illinois adopted a unique statutory scheme which would allow, under very limited circumstances, a motion to be filed by the Department of Children and Family Services to reinstate parental rights. The motion may only be filed by the Department after very restrictive conditions are all met:

1. While the minor was under the jurisdiction of the Court, the minor's parent or parents surrendered the minor for adoption to an agency legally authorized to place children for adoption, or the minor's parent or parents consented to his or her adoption, or the minor's parent or parents consented to his or her adoption by a specified person or persons, or the parent or parents' rights were terminated pursuant to a finding of unfitness and the guardian was appointed with the power to consent to adoption; and

2. Since the signing of the surrender, the signing of the consent, or the unfitness finding, the minor has remained a ward of the Court; or
    a. The minor was a ward of the Court, the minor was placed in the private guardianship of an individual or individuals, and after the appointment of a private guardian, the minor was again brought to the attention of the Juvenile Court and the private guardianship was vacated; or
    b. The minor was made a ward of the Court, wardship was terminated after the minor was adopted, after the adoption of the minor was again brought to the attention of the Juvenile Court and made a ward of the Court under this Act and either:
        i. The adoptive parent or parents are deceased;
        ii. The adoptive parent or parents signed a surrender of parental rights; or
        iii. The parental rights of the adoptive parents or parents were terminated.
    c. The minor is not currently in a placement likely to achieve permanency;
    d. It is in the minor's best interest that parental rights be reinstated;
    e. The parent named in the motion wishes parental rights to be reinstated and is currently appropriate to have rights reinstated;
    f. More than 3 years have lapsed since the signing of the consent or surrender, or the entry of the order appointing a guardian with the power to consent to adoption;
    g. The child is 13 years of age or older or the child is a younger sibling of such child for whom reinstatement of parental rights is being sought and the younger sibling independently meets the criteria set forth above; and
    h. If the Court previously denied a motion to reinstate parental rights filed by the Department, there has been a substantial change in circumstances following the denial of the earlier motion.

The law sets forth notice and service requirements. Motions to dismiss with prejudice may be filed by any party on the basis that the parent has intentionally acted to prevent the child from being adopted or intentionally acted to disrupt the child's adoption. If the Court finds by a preponderance of the evidence that this is the case the Court shall dismiss the petition to reinstate the petition with prejudice.

The burden of proof for reinstatement of parental rights is by clear and convincing evidence. The Court must conduct an analysis to determine the best interests of the child. The Court shall consider the reasons why the child was brought to the attention of the Court, the history of the child's case as it relates to the parent seeking reinstatement, and the current circumstances of the parent for whom reinstatement is sought. If parental rights were terminated based upon allegations of unfitness, the Court must consider the specific findings upon which the unfitness findings were made. The Act sets forth the manner by which rights are restored following the granting of the motion to reinstate.

The Department shall conduct an assessment of all children in its custody over the age of 12 who meet criteria for reinstatement of parental rights to assist in future planning for the child including a determination regarding the appropriateness of the motion to reinstate. The General Assembly specifically noted this section of the law would be repealed after 4 years.

This box was written by Judge Kathleen A. Kearney of the Children and Family Research Center. Judge Kearney may be contacted at kkearney@illinois.edu.

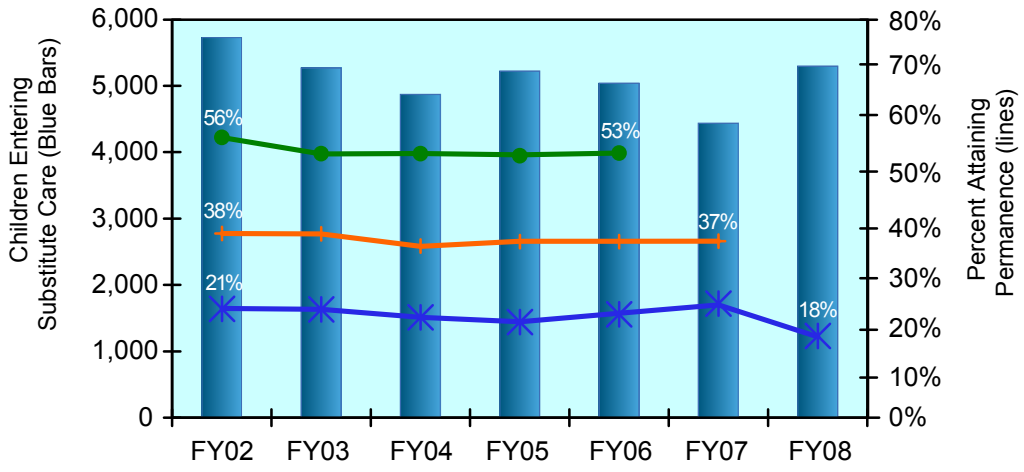
Legal Permanence In Illinois

Ideally, permanence for children in foster care is achieved through reunification with the biological family. If that is not possible, adoption or subsidized guardianship should be considered. While permanency options are straightforward, how to measure permanence is not. The permanency measures used in this report are different than those used in the federal Child and Family Services Reviews (CFSRs), which have been criticized by several in the field.[4] In order to capture the experience of all foster children in Illinois, this report looks at all children who entered foster care during a given year, and calculates the percent of those children who attain permanence by the time one year, two years, or three years has passed. While Illinois has performed poorly on the CFSR permanency measures, results in this chapter reveal that permanency is either stable or improving in many parts of the state.

Figure 4.1 (also Indicators 4.A., 4.B & 4.C in Appendix A) shows the number of children entering care each year since 2002 and the percent of those children who have attained permanence. As discussed in Chapter 3, the number of children entering care decreased from 5,637 in 2002 to 4,504 in 2007, but increased in 2008 to 5,211. Permanency rates have remained relatively stable since 2002, although slight decreases in the past year may signify the beginning of a downward trend which bears watching. One year after entry, approximately 20% of children have been reunified. Two years after entry, a little over one-third (37% to 38%) of children have attained permanency – largely through reunification but also through adoption. Three years after entering care, approximately half (53% to 56%) of the children have exited to permanence – through reunification, adoption or subsidized guardianship. Again, the majority of these permanencies are reunifications.[5]

To assess the difference in permanency rates by age, data was examined for children and youth who had been in care for at least three years; the data was examined for children less than 12 years of age, and youth 12 and older. Permanence – through reunification, adoption or subsidized guardianship – was attained for 58% of the younger children and 37% of the older youth; 41% of the younger children and 56% of the older youth were still in care after three years; 7% of the older youth had aged out of care.

Figure 4.1 – Children Moving To Permanent Homes
One (Blue), Two (Orange) And Three (Green) Years After Entry*



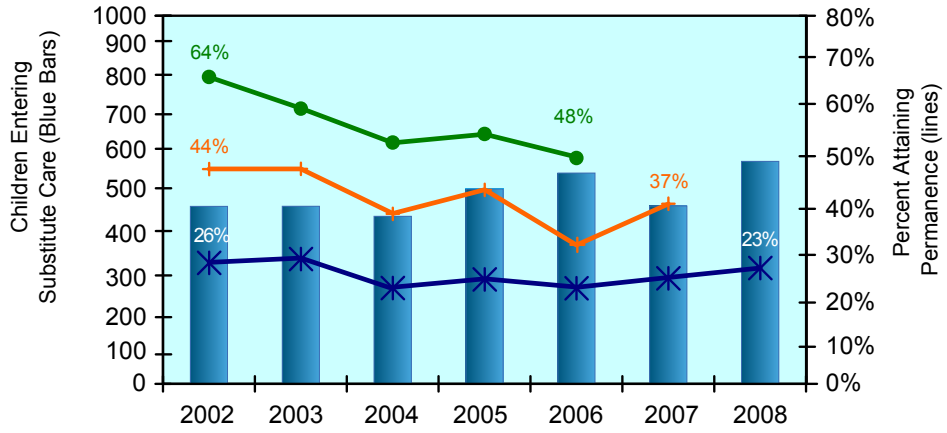
*Note: Permanence at one year is reunification only, at two years reunification and adoption and at three years reunification, adoption and subsidized guardianship

4 Testa, M. F., & Poertner, J. (2010). *Fostering accountability: Using evidence to guide and improve child welfare policy*. New York: Oxford Press.
5 These numbers exclude children who entered substitute care and stayed less than 7 days.

Sub-Regional Permanency Rates

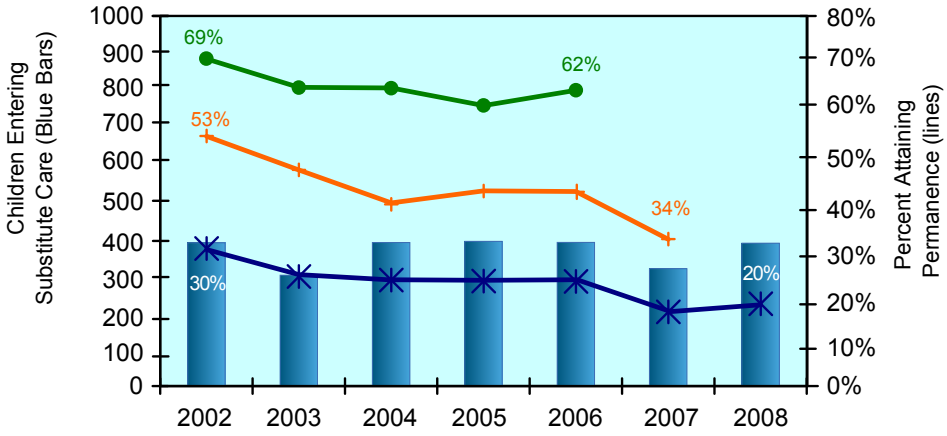
While the state-wide permanency numbers do not show much variation over the years, a closer examination at the sub-regional level shows wide variations and some disturbing trends in regions outside of Cook County. Of the two sub-regions that make up the Northern region, a larger number of children enter care in Aurora than in Rockford, and these numbers have increased in Aurora while remaining relatively constant in Rockford (see the blue bars in graphs 4.1a and 4.1b). Both of these sub-regions have experienced alarming drops in the percent of children attaining permanence. In the Aurora sub-region, for instance, three years after entering foster care, the percentage of children who have attained permanence has decreased from 64% to 48%. The largest decrease in the Rockford sub-region has been in the percentage of children moving to permanent homes after two years, from 53% in 2002 to 34% in 2007.

Figure 4.1a – Aurora Sub-Region Children Moving To Permanent Homes One (Blue), Two (Orange) And Three (Green) Years After Entry*



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

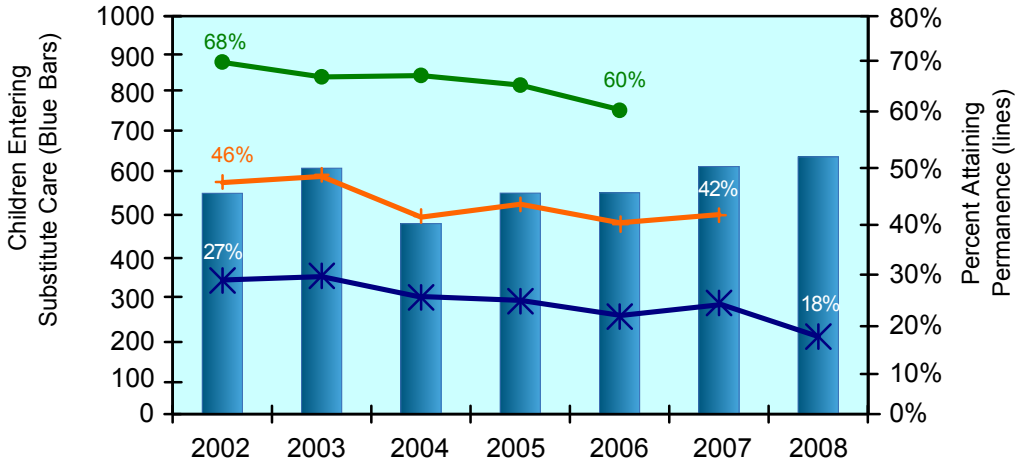
Figure 4.1b – Rockford Sub-Region Children Moving To Permanent Homes One (Blue), Two (Orange) And Three (Green) Years After Entry*



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

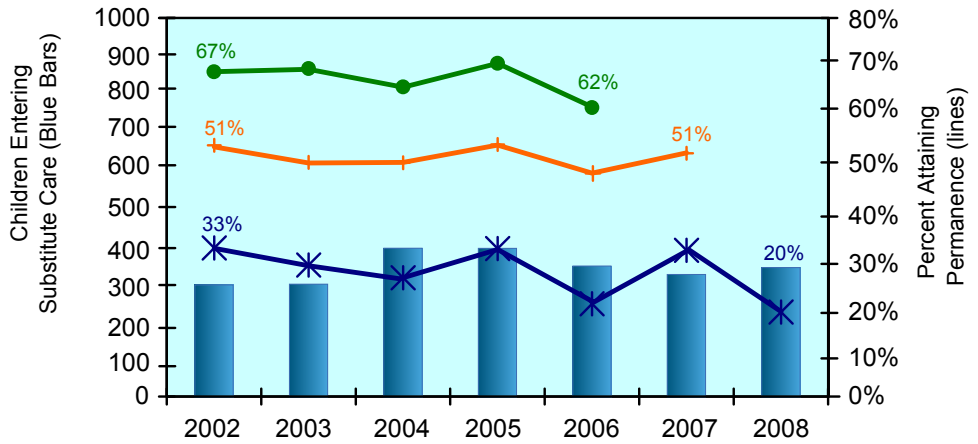
There has been an increase in the number of children entering care in each of the three sub-regions that make up the Central region: Peoria, Springfield and Champaign. The largest increase occurred in the Champaign sub-region, where 505 children entered care in 2002 and 715 entered in 2008. These sub-regions have also witnessed a startling decline in permanency rates, particularly among reunification rates within one year. In the Peoria sub-region, the rate fell from 27% in 2002 to 18% in 2008; in the Springfield sub-region the rate dropped from 33% to 20%, and in the Champaign sub-region the rate fell from 31% to 24% (see Figures 4.1c, 4.1d and 4.1e).

Figure 4.1c – Peoria Sub-Region Children Moving To Permanent Homes One (Blue), Two (Orange) And Three (Green) Years After Entry*



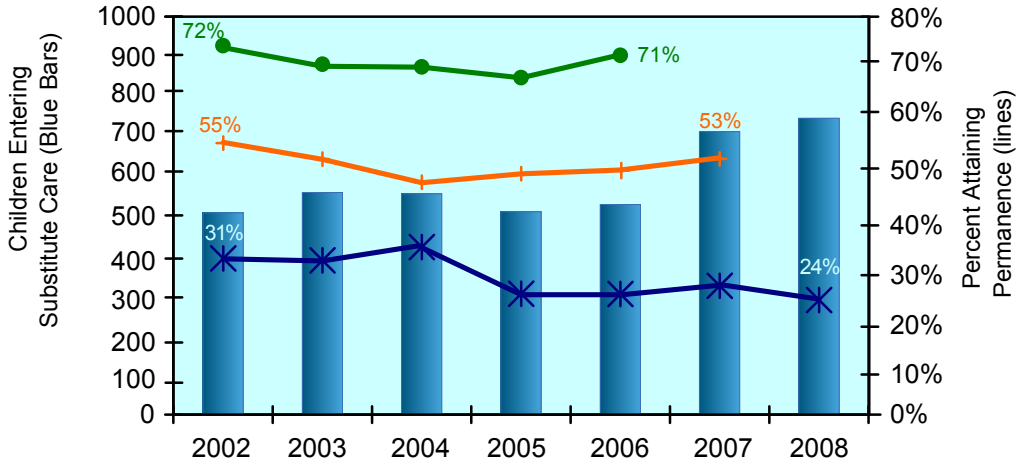
*Note: Permanence at one year is reunification only, at two years reunification and adoption and at three years reunification, adoption and subsidized guardianship

Figure 4.1d – Springfield Sub-Region Children Moving To Permanent Homes One (Blue), Two (Orange) And Three (Green) Years After Entry*



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

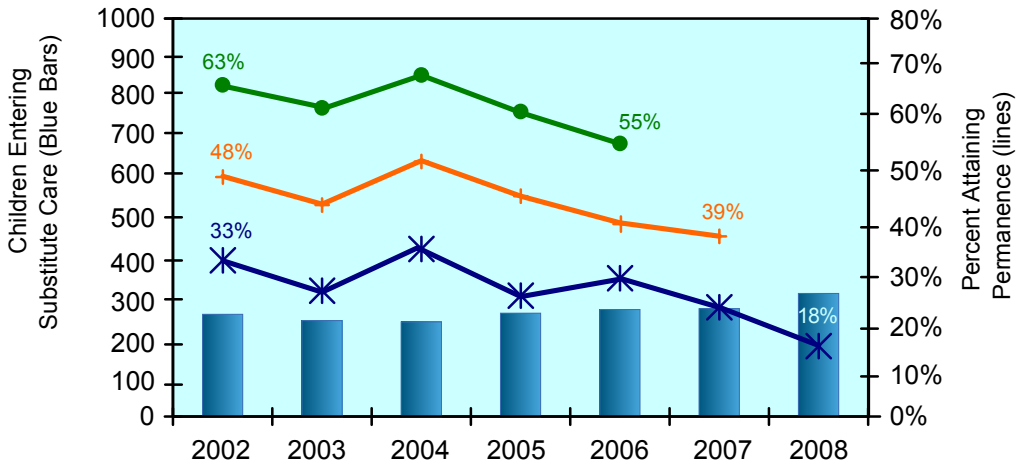
Figure 4.1e – Champaign Sub-Region Children Moving To Permanent Homes One (Blue), Two (Orange) And Three (Green) Years After Entry*



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

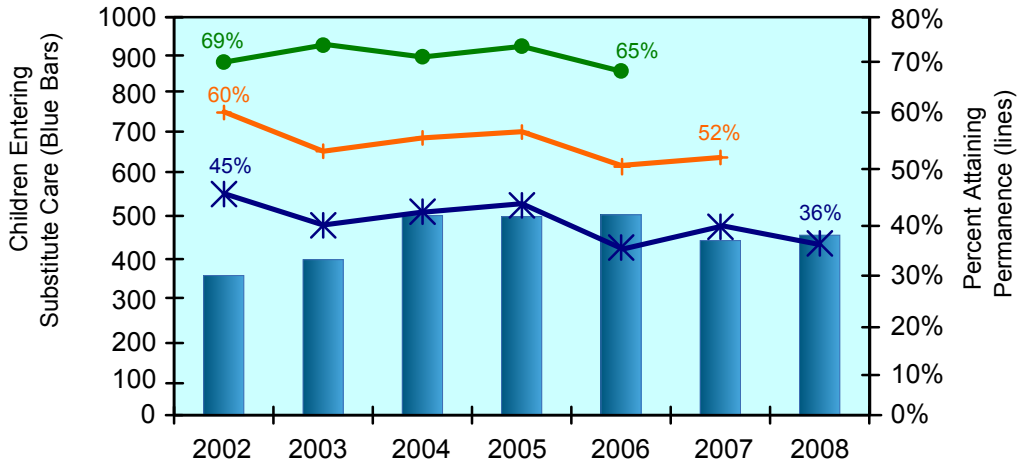
Two sub-regions make up the Southern region -- East St. Louis and Marion – and both sub-regions have seen an increase in entry rates. The largest increase occurred in the Marion sub-region; 357 children entered care in 2002 and 471 in 2008. The permanency rate at the one-year milestone in the East St. Louis sub-region has decreased from 33% in 2002 to 18% in 2008 – a *45% decrease* (see Figure 4.1f); the Marion sub-region has seen a decrease from 45% in 2002 to 36% in 2008 (see Figure 4.1g).

Figure 4.1f – East St. Louis Sub-Region Children Moving To Permanent Homes One (Blue), Two (Orange) And Three (Green) Years After Entry*



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

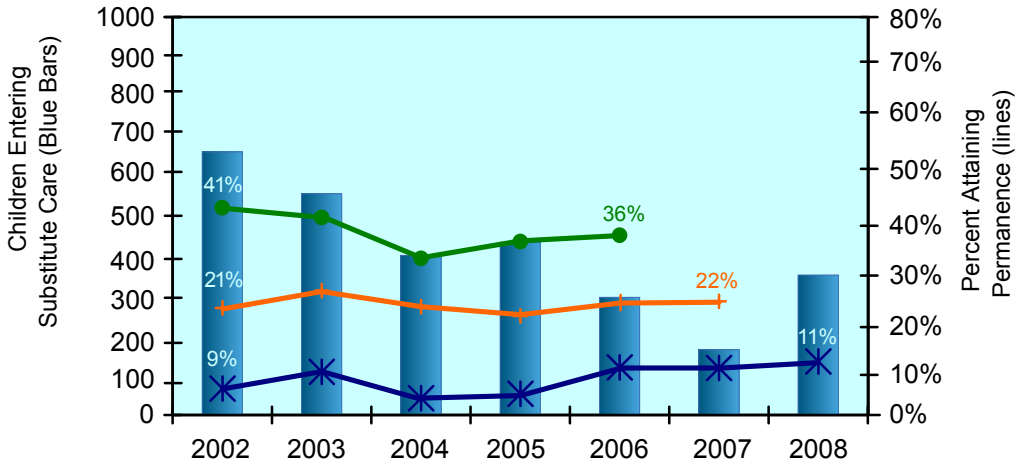
Figure 4.1g – Marion Sub-Region Children Moving To Permanent Homes
One (Blue), Two (Orange) And Three (Green) Years After Entry*



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

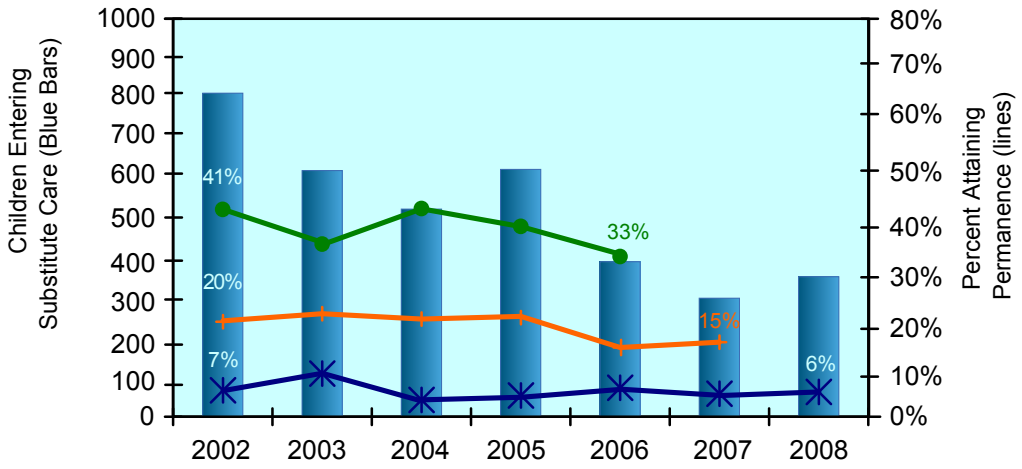
Cook County has seen a large decrease in entries into substitute care. About half as many children entered care in Cook North and Cook Central in 2008 compared to 2002. In 2002, 649 children entered care in Cook North compared to 360 in 2008 (see Figure 4.1h); the number of children entering care in Cook Central decreased from 798 to 400 between 2002 and 2008 (see Figure 4.1i). Cook South saw a less dramatic decrease – from 855 to 616 children entering care over the same period of time (see Figure 4.1j). The three Cook County sub-regions followed a similar pattern in terms of permanency rates: the one year rate fluctuated between 5% and 14% over the past seven years; the two year rate was between 14% and 27% and the three year rate between 33% and 43%. Along with substantially lower permanency rates than the other regions, Cook County has also witnessed a significant decrease in the number of children entering substitute care.

Figure 4.1h – Cook North Region Children Moving To Permanent Homes
One (Blue), Two (Orange) And Three (Green) Years After Entry*



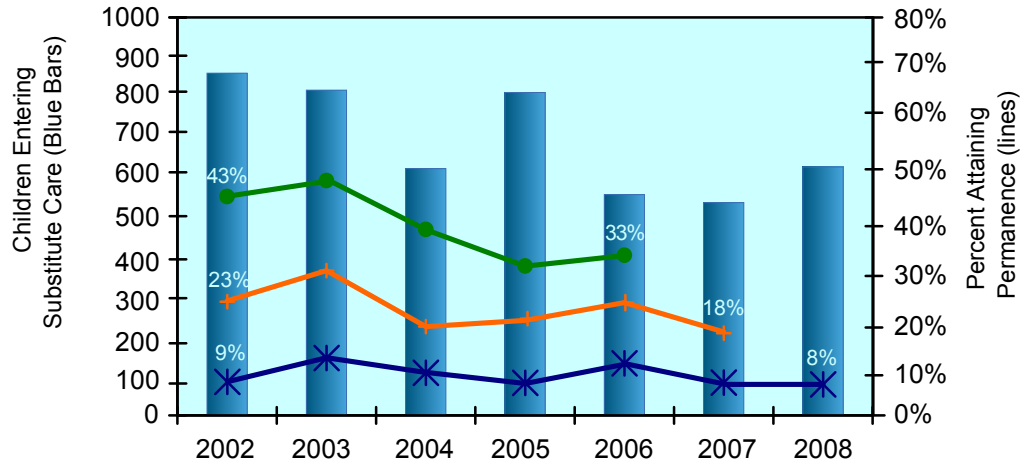
*Note: Permanence at one year is reunification only, at two years reunification and adoption and at three years reunification, adoption and subsidized guardianship

Figure 4.1i – Cook Central Region Children Moving To Permanent Homes One (Blue), Two (Orange) And Three (Green) Years After Entry*



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

Figure 4.1j – Cook South Region Children Moving To Permanent Homes One (Blue), Two (Orange) And Three (Green) Years After Entry*



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

Box 4.2—Warning Sign: Plummeting Permanency Rates in Downstate Regions

While the permanency rates at the state level hint at the beginning of a possible decline in the rate that children are exiting foster care to reunification, adoption, and subsidized guardianship, closer examination at the sub-regional level reveals some truly alarming trends that were otherwise masked. First, although the number of children entering foster care has dramatically declined over the past seven years in the Cook North and Cook Central regions, the numbers have increased in others: the Aurora (Northern) and Marion (Southern) sub-regions experienced a 30% increase in entries, and the Champaign sub-region has seen a 40% increase. At the same time, there have been large declines in permanency rates in each of the downstate regions. These declines have occurred at each time frame (12 month, 24 month, and 36 month) and in each of the downstate sub-regions. Table 4.1 shows the number of percentage points permanency rates dropped from 2002 to 2008 in each sub-region and at each time frame. (Please note: Permanence at 12 months is reunification only, at 24 months it is reunification plus adoption, and at 36 months it is reunification, adoption, and subsidized guardianship.) These disturbing numbers deserve closer scrutiny.

Table 4.1 Change in Permanency Rates in Downstate Regions (2002-2008)

Sub-Region	12 months	24 months	36 months
Aurora	-3%	-17%	-16%
Rockford	-10%	-19%	-7%
Peoria	-9%	-4%	-8%
Springfield	-13%	0%	-5%
Champaign	-7%	-2%	-1%
East St. Louis	-13%	-9%	-8%
Marion	-9%	-8%	-4%

Length Of Time In Substitute Care

Table 4.2 shows the median number of months a child stays in foster care when entering for the first time. In general, the African American and Latino children spend more time in foster care than White children. When the median length of stay is explored by region, children in Cook County have historically had the longest length of stay (37 months in 2002) however in more recent years this has decreased – to 24 months in 2003 and 18 months in 2007. In the Northern region, the length of stay has increased from 23 to 28 months over the past seven years and the Central region has seen an increase from 21 to 23 months. Median length of stay is shortest in the Southern region, although it has increased slightly from 13 to 15 months (see Indicator 4.G in Appendix A).

Table 4.2 – Median Length of Stay for Children in Care

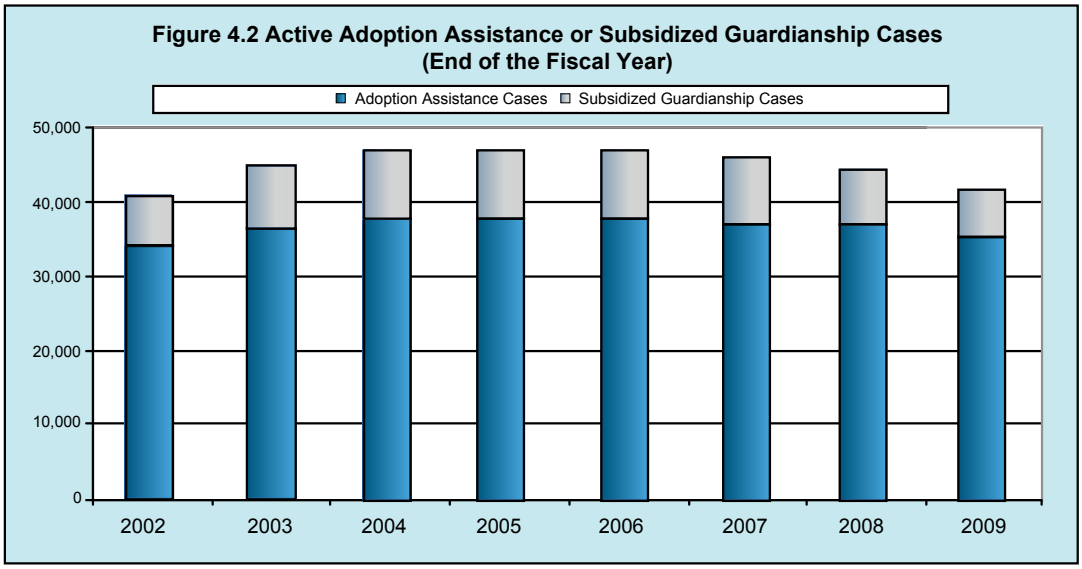
	2001	2002	2003	2004	2005	2006	2007
Number of Months							
African American	31	31	27	30	32	30	26
Hispanic	24	32	15	31	31	29	20
Caucasian	16	18	19	18	19	21	22
All Children	26	28	23	25	26	25	24

Stability Of Permanence

In 2000, the number of children in publicly-assisted homes with adoptive parents and legal guardians in Illinois surpassed the number of children in foster care. Currently in Illinois there are approximately 15,500 children in foster care and 40,700 children living in state-subsidized homes (6,100 in guardianship homes and another 34,600 in adoptive homes; see Figure 4.2). Although the shifting balance from foster care to family permanence is generally regarded as salutary, there continue to be reservations about the abilities of families to access the services they need for their former foster children.

While there may be every intention that reunifications, adoptions, and guardianships will last forever, sometimes these permanent homes do not end up being permanent. Emlen and colleagues suggested that, "a permanent home is not one that is certain to last forever, but one that is intended [emphasis in original] to last indefinitely." [6] Fortunately, data from previous *B.H.* monitoring reports shows that most adoptive and guardianship homes do endure and that ruptures are rare, particularly when compared to re-entries from reunification and instability that children experience

Figure 4.2 Active Adoption Assistance or Subsidized Guardianship Cases (End of the Fiscal Year)



6 Emlen, A. Lahti, J., Downs, G., McKay, A. & Downs, S. & Regional Research Institute for Human Services. (1978). *Overcoming barriers to planning for children in foster care* (DHEW Publication No. OHDS 78-30138). Washington, DC: U.S. Government Printing Office.

when they remain in care. However, these findings on ruptures are not without their critics. Anecdotally, field staff, court personnel and many involved in the provision of services to this population assert that many of these permanent living arrangements were made in haste and will eventually result in children returning to care. In 1997 (the year subsidized guardianship was introduced in Illinois), there were 11,800 children receiving adoption subsidies and 1% ruptured, impacting 155 children. In 2009, 1% of the 34,600 children receiving adoption subsidies ruptured, representing 426 children. Although the front line staff and court personnel working with this group of families have seen an increase in the actual number of children returning to court and asking for assistance from DCFS, the rate of rupture has remained constant. While this should not be construed as poor systemic performance, it does signal a need for attention considering the growing number of children in need of services post-adoption.

Box 4.3—Spotlight on Practice: Adoption Preservation and Linkage (APAL) and Maintaining Adoption Connections (MAC) Programs

With the growing number of children living in subsidized adoptive or guardianship homes came concern about the well-being of these children. While research suggests that the vast majority of children and youth are doing well,[7] lingering concerns about these families prompted DCFS to create the Adoption Preservation Assessment and Linkage (APAL) and Maintaining Adoption Connections (MAC) programs, which were designed to provide targeted outreach to families of older youth, ask caregivers about their needs, and make service linkages for families who identified needs. Researchers at the Children and Family Research Center conducted a survey of caregivers of older youth who had been adopted or entered guardianship with the dual goals of assessing the service needs of these youth and families and determining if the APAL/MAC programs were effective in reducing these needs. Half of the caregivers surveyed had participated in the APAL/MAC programs at least six months prior while the other half had not received APAL/MAC outreach.

Preliminary results from this research show that the vast majority (80%) of caregivers in the total sample reported that their children had no unmet service needs. Approximately 14% of the caregivers said that they had one unmet service need for their adopted or guardian child; approximately 2% said they had two unmet needs; 3% had three unmet needs; and 1% had four or more unmet service needs.[8] For those who had service needs, counseling was the most common need identified – 38% of caregivers said they needed counseling for their child. Fortunately, most of the caregivers who sought this service were able to receive it (86%). Caregivers were least likely to receive orthodontia (14% of caregivers said that they needed it; 76% of those caregivers sought out this service, but only 57% actually received it), respite care (6% said they needed it; 64% of those caregivers sought it, but only 42% of those who sought it actually received it), and preservation services (5% said they needed these services; 57% sought these services, but only 62% received preservation services).

To assess the effectiveness of the APAL/MAC programs, service needs among families that received services and those that did not were compared. There were no significant differences in the needs or services sought and received between those receiving the APAL/MAC services and the comparison group. This suggests that the additional outreach provided through APAL/MAC does not seem to have reduced the amount of unmet service needs of families over and above those served through the traditional DCFS post-adoption/guardian support unit. Most families that have adopted or taken guardianship are able to obtain the services they need for their children, either on their own or through the post-adoption unit. A small subset of families have more intense service needs, which do not appear to be alleviated by the outreach and support provided by APAL/MAC. Finding a service delivery model that meets the needs of these families is critical and alternative strategies should continue to be explored. Rather than investing in outreach to a targeted population, perhaps gaining a better determining of what brings children and youth back into foster care could help in determining what might be most effective in preventing future ruptures from adoptive and guardianship homes.

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

8 Testa, M. F., Rolock, N., Liao, M., Cohen, L. (January 2010). *Adoption, guardianship, and access to post-permanency services.* Presentation at the Society for Social Work Research Conference.

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

Box 4.4 Permanency Ruptures Defined

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

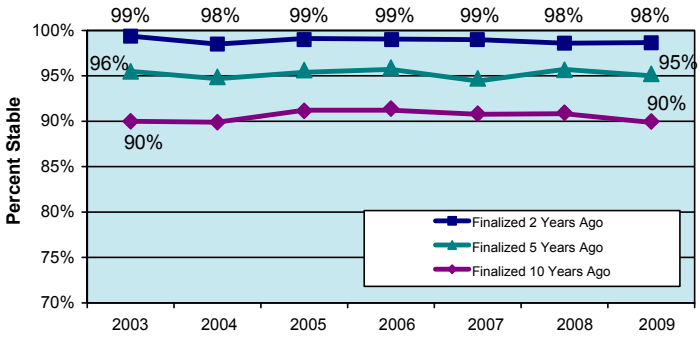
- ***Displacement*** occurs when a child is *no longer in the physical care* of his/her guardian(s) or adoptive parent(s), but guardianship / parental rights remain intact.
- ***Dissolution*** occurs when guardianship is vacated or adoptive parent(s)' rights are terminated *for a reason other than 'death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

Ruptures can also be distinguished from:

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

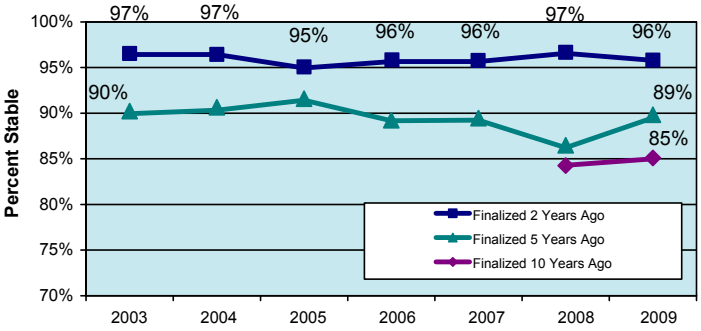
Adoption: For children who have been in adoptive placements for two years, 98% to 99% are in stable placements; after five years 95% to 96% are in stable placements; and after ten years 90% are in stable placements (Figure 4.3).

Figure 4.3 – Post-Adoption Stability



Subsidized Guardianship: Approximately 96% of guardianships are stable for at least two years, and after five years 89% to 90% are stable. In Illinois, subsidized guardianship began in 1997, therefore only two groups of youth can be tracked for 10 years. Among those who entered subsidized guardianship in 1998 and 1999, 84% and 85% respectively were in stable homes for at least ten years (see Figure 4.4). While the percentage of subsidized guardianship ruptures is higher than rates of adoption ruptures, they are slightly lower than the comparable rates among reunified children (see Figure 4.5). Furthermore, additional research shows that when controlling for the age of the caregiver and other demographics, children in subsidized guardianship homes are no more likely to rupture than children in subsidized adoptive placements,[9] but since relative guardians tend to be older, contingency plans should be made accordingly for the children in these guardianship homes.

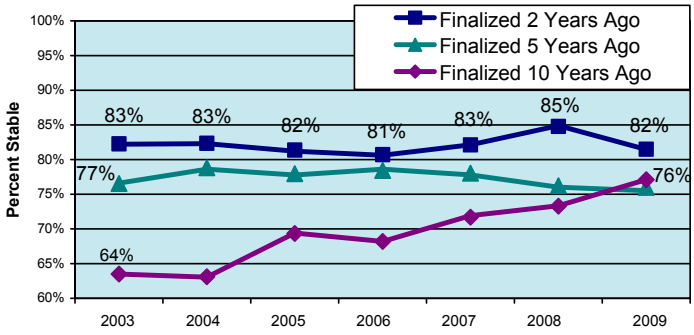
Figure 4.4 – Post-Subsidized Guardianship Stability



9 Testa, M. F. (January 2009). *Why states should implement the new federal Guardianship Assistance Program (GAP)*, unpublished presentation.

Reunification: When compared to adoption and subsidized guardianship, children reunified with their parents experience significantly less post-discharge stability (Figure 4.5). The two-year post-reunification stability rate has remained relatively stable between 81% and 85% over the past seven years, and the five-year post-reunification stability rate has been decreasing from 79% to 75% over this period. Improvement has been seen, however, in the ten-year post-reunification rate, from 64% in fiscal year 2003 to 76% in fiscal year 2009.

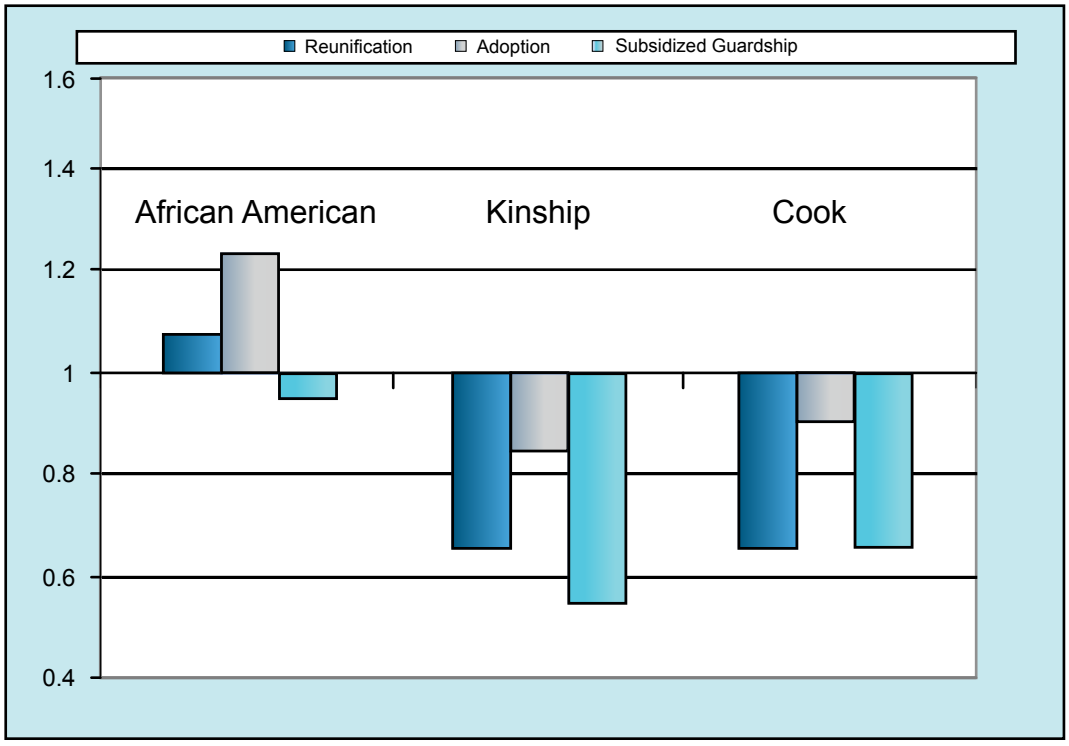
Figure 4.5 – Post-Reunification Stability



In an effort to better understand these post-permanency trends, multivariate analysis was conducted to look at the impact of race, kinship and region on reunification, adoption, and subsidized guardianship ruptures within three years of finalization among children who exited foster care between 1987 and 2006.

African American children were 9% more likely to re-enter foster care after reunification, 22% more likely to rupture from an adoptive home, and had about equal likelihood of rupture from a subsidized guardianship home when compared to children of other races. Compared to children placed with non-kin, children placed with kin were 34% less likely to re-enter foster care following reunification, 15% less likely to rupture from an adoptive home, and 44% less likely to rupture from subsidized guardianship homes. Children and youth in Cook County are less likely to rupture than children and youth in the rest of the state: they are 32% less likely to re-enter foster care following reunification and 33% less likely to rupture from subsidized guardianship homes (see Figure 4.6).

Figure 4.6 – Impact Of Kinship, Race And Region On Rupture From Permanence



Box 4.5—2009 CFSR Findings Related to Permanency

CFSR Permanency Outcome 1 reports whether **"children having permanency and stability in their living situations." Illinois was not in substantial conformity with Permanency Outcome 1**: 12.5% of the cases reviewed substantially achieved the outcome, which is well below the 95% benchmark. There are four national data indicators and six case review items related to this permanency outcome (two of these are discussed in the Stability chapter):

Composite 1 (Timeliness and Permanency of Reunification):

- Of all children discharged to reunification that had been in foster care 8 days or longer, what percent were reunified in less than 12 months? Illinois = 42.2%; National median = 69.9%.
- Of all children discharged to reunification who had been in foster care 8 days or longer, what was the median length of stay in months? Illinois = 14.6 months; National median = 6.5 months.
- Of all children entering foster care for the first time in the 6-month period just prior to the target 12-month period, and who remained in foster care for 8 days or longer, what percent was discharged to reunification in less than 12 months from the date of the latest removal from home? Illinois = 18.3%; National median = 39.4%.
- Of all children discharged from foster care to reunification in the 12-month period prior to the target period, what percent re-entered foster care in less than 12 months from the date of discharge? Illinois = 8.6%; National Median = 15%.

Composite 2 (Timeliness of Adoptions):

- Of all children who were discharged from foster care to a finalized adoption in the target 12-month period, what percent was discharged in less than 24 months from the date of the latest removal from home? Illinois = 15.2%; National median = 26.8%.
- Of all children who were discharged from foster care to a finalized adoption in the target 12-month period, what was the median length of stay in foster care (in months)? Illinois = 39.5 months; National median = 32.4 months.
- Of all children in foster care (FC) on the first day of the target 12-month period, and who were in FC for 17 continuous months or longer (and who, by the last day of the year shown, were not discharged from FC with a discharge reason of live with relative, reunify, or guardianship), what percent was discharged from FC to a finalized adoption by the last day of the year shown? Illinois = 15%; National median = 20.2%.
- Of all children in foster care (FC) on the first day of the target 12-month period, and who were in FC for 17 continuous months or longer, and were not legally free for adoption prior to that day, what percent became legally free for adoption during the first 6 months of the year shown? Illinois = 9.3%; National median = 8.8%.

Composite 3 (Permanency for Children and Youth in Foster Care for Long Periods of Time)

- Of all children in foster care for 24 months or longer on the first day of the target 12-month period, what percent was discharged to a permanent home prior to their 18th birthday and by the end of the fiscal year? A permanent home is defined as having a discharge reason of adoption, guardianship, or reunification. Illinois = 22.6%; National median = 25%.
- Of all children who were discharged from foster care in the target 12-month period, and who were legally free for adoption at the time of discharge (i.e., there was a parental rights termination date reported to AFCARS for both mother and father), what percent was discharged to a permanent home prior to their 18th birthday? Illinois = 98.7%; National median = 96.8%.
- Of all children who, during the 12-month target period, either (1) were discharged from foster care prior to age 18 with a discharge reason of emancipation, or (2) reached their 18th birthday while in foster care, what percent were in foster care for 3 years or longer? Illinois = 68.8%; National median = 47.8%.

- Item 5 (**Foster Care Reentries**) determined whether the entry into foster care during the period under review occurred within 12 months of discharge from a prior foster care episode. In Illinois, none of the cases eligible for review were reentries; thereby the state was **100%** in substantial conformity across all three review sites.

- Item 7 (**Permanency Goal for Child**) assessed whether the agency has *established* a permanency goal for the child in a timely manner and whether the most current permanency goal was appropriate. This item also looks specifically at whether the state has sought termination of parental rights in accordance with the Adoption and Safe Families Act. Of the 40 cases reviewed, only 15 **(37.5%)** were determined to have an appropriate permanency goal which had been established in a time manner and was in compliance with ASFA.

- For Item 8 (**Reunification, Guardianship, or Permanent Placement with Relatives**), reviewers determined whether the agency had actually *achieved* the permanency goals of reunification, guardianship, or permanent placement with relatives in a timely manner; and if not, whether the agency is making diligent efforts to achieve those goals. Of the 17 cases were eligible for review under this item, only 2 cases **(12%)** were deemed in substantial conformity.

- Item 9 (**Adoptions**) evaluated whether diligent efforts were made to achieve a finalized adoption in a timely manner for the 18 eligible cases under review. Two cases **(11%)** were found to be in substantial conformity.

- Item 10 (**Other Planned Permanent Living Arrangement**) accounts for whether the state had made or was making diligent efforts to assist youth in attaining their goals related to the ASFA goal of OPPLA. This looks at whether the agency has made concerted efforts to ensure a long term placement for the child and/or provide necessary services to prepare the youth for independent living: 4 of the 8 cases eligible for review were in need of improvement **(50%)**.

Observations On Permanence In Illinois

This chapter highlights the finding that reunifications that occur in Cook County are more likely to endure – fewer children re-enter foster care from a reunified home in Cook County than in the remainder of the state. This is a relatively new occurrence; the trend toward increased stability after reunification is something that has occurred in the past decade, since the permanency initiatives of the late 1990s. Is the make-up of the children exiting to reunification different today than it was in 1997, suggesting that children who would have been reunified prior to the permanency initiatives are now exiting to subsidized adoptive or guardianship homes? Additional research is needed to better understand these trends.

As mentioned in Chapter 2 of this report, Illinois has the highest non-removal rate in the country; per capita fewer children are removed from their homes in Illinois than in any other state in the nation. For those children and youth who are removed, Illinois also has a comparatively low reunification rate. While state-wide permanency rates do not show much variation over the past seven years, there is wide variation in permanency rates at the regional level. Perhaps Illinois removes children who present with more complex needs and therefore take longer to reunify than children removed in other states where low risk children are removed and then quickly reunified. Do permanency goals and permanency hearings impact these rates? These and other questions need to be addressed in a comprehensive manner and should be the subject of future research in the upcoming year.

Finally, the impact of Public Act 96-600 which significantly reforms the Children's Services Act should be closely monitored.

CHAPTER 5

WELL-BEING

Children, Parents, And Foster Parents

Theodore Cross, Ph.D.
Jesse Helton, Ph.D.
Children and Family Research Center
School of Social Work
University of Illinois at Urbana-Champaign

The well-being of children served by the Illinois Department of Children and Family Services is at the heart of Illinois' commitment to child welfare, and has long been a major interest of the parties to the *B.H.* Consent Decree. *B.H.* from its inception required DCFS to address mental health needs in treatment plans and *B.H.* status conferences have focused on both educational and mental health services and outcomes.[1] DCFS has numerous initiatives to improve the well-being of children in its care, including the Integrated Assessment Program, the Statewide Provider Database, and a host of programs to support wards staying in school and pursuing higher education.[2] Data on child well-being is an opportunity to get to know these children more fully, to better understand their development and the quality of their lives.

This chapter adopts a new approach in the examination of the health and well-being of children in or at risk of foster care in Illinois because of the recent availability of data from the Illinois Survey of Child and Adolescent Well-Being (ISCAW). ISCAW is the first study to track over time the well-being of the entire range of children who become involved with the Department because of substantiated investigations of abuse and/or neglect (see Box 5.1). This chapter presents a first analysis of ISCAW data which became available in April 2010. The analysis was conducted with a "beta" version of the ISCAW data so all results should be considered preliminary, but given the significance of the data, it is included in this year's report.

Data analysis for this chapter first calculated statewide estimates (percentages or means). Additional comparative analyses were then done to explore how key groups differed on well-being. One important comparison was between children who had been placed in out-of-home care at ISCAW baseline and those who remained in the home. One might expect greater problems for children who were placed out-of-home, because the maltreatment precipitating the removal would usually be more severe for these children than for children who remained in their home; out-of-home placement is often difficult for children due to disruption related to removal; and because these children's problems may have contributed to the decision to remove them in some cases. When the sample size allowed it, well-being outcomes were examined by three different "child setting" categories: in-home, traditional foster care, and kinship care. In keeping with the theme of this year's report, children in rural areas were also compared to children in more densely populated areas. Additional comparisons were made by region, child sex, child race-ethnicity, and child age. The sections in this chapter present an overview of the results of these analyses. Statistical tables with more detailed results are presented in Appendix B. A more comprehensive well-being report – including results on health and mental health service delivery – is being prepared by the Children and Family Research Center for FY2011.

1 Kosanovich, A, & Joseph, R.M. (2005). *Child welfare consent decrees: Analysis of thirty-five court actions from 1995 to 2005*. Washington, DC: Child Welfare League of America.
2 Cross, T.P. (in press). Obstacles and opportunities in accessing mental health services for children in foster care: Lessons from recent history in Illinois. *Illinois Child Welfare*.

Box 5.1—The Illinois Survey of Child and Adolescent Well-Being

New data from a beta version of the Illinois Survey of Child and Adolescent Well-Being (ISCAW) became available in April 2010 and this chapter is the first report using this new data. The study is a component of the National Survey of Child and Adolescent Well-Being (NSCAW), a longitudinal probability study of well-being and service delivery for children who become involved with child welfare services. ISCAW includes 818 cases sampled to be representative of the entire population of Illinois' children involved in substantiated maltreatment reports. To provide accurate statewide estimates, the study used two stage random sampling (geographic units were randomly sampled within the state and children randomly sampled within these geographic units). ISCAW will be able to provide longitudinal data on hundreds of relevant variables covering a wide array of well-being domains. Results reported in this chapter come from the baseline assessment of the ISCAW study, which utilized caseworker, child, caregiver and teacher interviews conducted approximately 3 to 4 months following the end of the investigation.

The sample represents a significant departure in several ways from the Illinois Child Well-Being (ILCWB) Study that was utilized for recent *B.H.* monitoring reports. The ILCWB studied children in out-of-home care, while ISCAW studies *all* children involved in a substantiated report, a large majority of whom remained in their home following the investigation. Information about children that remain home following substantiated maltreatment will be a valuable tool in the Department's efforts to develop and improve services at the "front end" of DCFS involvement. Because the baseline ISCAW interview takes place 3-4 months following the investigation, a portion of the cases included in the sample are closed following investigation and no longer involved with the Department. These families, along with those receiving intact family services and those with children removed from the home and placed into foster care, will be tracked over time. Round two data collection with these families, which occurs approximately 18 months after investigation, has already begun and the data will be available in 2011.
Even when *only* the children in foster care are considered, there is an important difference in the composition of the ILCWB and ISCAW samples. The ILCWB studied the entire population of children in foster care who had been in care at least three months at a given point in time, however long they had been in care. In Round 2 of the ILCWB, for example, half the sample had been in care more than three years.[3] A point-in-time study has the advantage of profiling all DCFS children in care in a given year, but it biases estimates of outcomes of foster care because children who have been in foster care longer are overrepresented.[4] ISCAW is a cohort study, not a point-in-time study, so it studies an entire cohort of children, all of whom begin contact with DCFS at about the same time. Thus the out-of-home subgroup in ISCAW is very different from the ILCWB sample, most of whom had been out of the home much longer. *Because ISCAW is longitudinal and children will be tracked over time, knowledge about long-term foster care outcomes will accrue over time as repeated measurements are made.*

ISCAW has a wide array of measures of child well-being. Caregivers complete measures about their own lives and a number of measures about their children's health, development and problem behaviors. School age children complete measures of academic achievement and self-report measures about their feelings, opinions and problems. Caregiver and child interviews are completed using an audio computer-assisted self-interview (ACASI) technique that enhances families' privacy while also increasing consistency in the interview method. Caseworkers complete measures about the family. Teachers complete measures of children's academic progress and behavior in school. Many of the measures are *standardized.* That means that standard forms of the measures have been developed, allowing for comparison across studies. Often a *clinical range* has been established that indicates a level of difficulty in which professional intervention is needed—the clinical range might include very low scores indicating diminished ability (as in tests of development) or it might include very high scores indicating heightened problems (as in depression or behavior problem measures). A *normative rate* is the percentage of children who would be expected to score in the clinical range in the general population of children, based on previous research. Comparing the percentage of children in the clinical range in the ISCAW sample to the normative rate tells us whether children involved with DCFS are more likely to have a problem than the average child.

3 Hartnett, M.A., Bruhn, C., Helton, J., Fuller, T., Steiner, L. (2009). Illinois Child Well-Being Study: Year Two Final Report. Urbana, IL: Children and Family Research Center.
4 See, for example, Wulczyn, F. (1996). A statistical and methodological framework for analyzing the foster care experiences of children. *Social Service Review, 70*, 318-329.

Because of ISCAW sampling procedures, the percentages throughout this chapter and in Appendix B can be viewed as good estimates of the percentages in the entire population of children in substantiated cases. The standard errors (SE) indicate how much the estimates could vary because of chance involved in sampling. The mathematics of sampling tell us that there is a 95% likelihood that the true percentage lies within two standard errors of the percentages reported here.

Table 5.1 presents the characteristics of the ISCAW sample. Over four fifths of the children live at home and were not removed following the investigation. Only 5% are in traditional foster care and 13% in kinship care. The percentages of the sample from Cook County, the Northern Region and the Central Region are about the same (28% to 31%), while the Southern region has 12% of the sample. The population is about 2/3 non-rural and 1/3 rural (defined as living in an area with an average of less than 110 people per square mile). Girls and boys are about evenly represented. African American children are a majority (42%) but there are substantial percentages of White children (34%) and Hispanic children (20%). A majority of children (57%) are age 5 or younger. Neglect was most frequently the most serious type of maltreatment (26%), but exposure to domestic violence, physical abuse, sexual abuse, exposure to drugs, and other forms of maltreatment were also present, with the percentage of cases in which these were the most serious type of maltreatment ranging from 10% to 18% across types.

Table 5.1 – Characteristics of the ISCAW Sample

	Percent (SE)	N
Total		818
Child Setting[a]		
Traditional Foster Care	5% (0.1)	146
Kinship Care	13% (1.6)	174
In-Home	82% (1.8)	476
Region		
Cook	28% (1.6)	417
Central	31% (1.9)	197
Northern	29% (3.3)	130
Southern	12% (2.5)	74
Non-rural vs. rural		
Non-rural	65% (15.6)	632
Rural	35% (15.6)	186
Sex		
Male	49% (1.9)	416
Female	51% (1.9)	402
Race/Ethnicity		
African-American	42% (5.3)	442
White	34% (6.1)	192
Hispanic	20% (3.1)	155
Other	4% (0.1)	27
Child Age		
0 to 2	32% (2.7)	497
3 to 5	25% (1.4)	125
6 to 8	15% (3.2)	69
9 to 11	14% (1.8)	6
12 to 17	14% (1.1)	63
Maltreatment[b]		
Physical Abuse	15% (2.6)	100
Sexual Abuse	10% (2.6)	35
Neglect	26% (3.1)	143
Substance Exposure	13% (2.9)	155
Domestic Violence	18% (2.9)	83
Other	18% (3.6)	154

[a] Two placement categories were not included in this report due to small sample size: adopted (N=8) and other (N=4).
[b] Neglect: both physical and supervision; Substance Exposure: substance-abusing parent or substance exposure to child; Other: other, emotional abuse, abandonment, moral abuse, exploitation, child in need of services, investigation only way to get services. The maltreatment variable is missing 148 cases.

The Importance of Monitoring Child Well-Being

What we know about the lives of maltreated children strongly indicates the need to monitor their well-being. Considerable research shows that abuse and neglect can cause substantial harm. The damage not only affects children immediately but has an enduring impact over time, and its effect can grow when it leads to deficits that hinder children as they mature. The evidence for damage is even clearer in recent years with new research that shows specific effects of child maltreatment on brain development.[5] Abused and neglected children often have a disrupted capacity to attach to others, making forming and maintaining relationships with caregivers difficult.[6] In addition to the effects of abuse and neglect, maltreated children tend to come from unstable, high risk environments and their caregivers are often substantially affected by poverty, unemployment, domestic violence, mental health and substance abuse problems.[7] As a result of the threats to their well-being, children involved with child welfare services are at elevated risk of chronic health problems, emotional and behavioral difficulties, and learning and educational deficits, even when compared to other children with a similar social and economic background.[8] Maltreated children are over-represented in special education, have lower educational achievement and are less likely to graduate from high school.[9] Yet many children are resilient and experience healthy development and well-being despite their maltreatment.[10] Data on the frequency of different threats to well-being in this population helps identify issues DCFS will need to address in serving these children. Data identifying children's strengths engenders hope and helps provide a balanced perspective on their potential.

THE WELL-BEING OF CHILDREN INVOLVED WITH DCFS

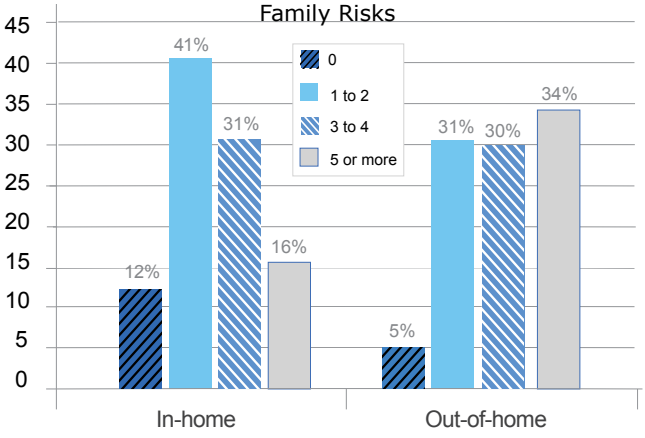
Risk In Children's Environment

Caseworker-reported risk factors

A central element of children's well-being is the capacity of their caregivers to provide safety, security and opportunities for healthy development. Problems experienced by caregivers often compound the risk to these children's well-being and development. The ISCAW caseworker interview asked about the presence of risk factors in the caregiver's home during the investigation. For children in out-of-home care at ISCAW baseline, these questions pertained to the caregivers from whom the children had been removed. For children who remained in their homes, the questions pertained to their primary caregivers with whom they continued to live. Identified risk factors included the following caregiver problems: alcohol abuse, substance abuse, emotional or mental health problems, history of arrests or jail time, intellectual impairment, physical impairment, low social support, and high stress related to situations such as unemployment and poverty.

Figure 5.1 shows the number of caseworker-identified risk factors experienced both by children who had been removed (out-of-home) and children who remained in their homes following a substantiated investigation (in-home). The overall average was 2.7 risk factors, but children in out-of-home care had experienced 3.5 risk factors in the home they were removed from, significantly more than the 2.5 risk factors of children in-home. Over a third (34%) of children in out-of-home care had experienced 5 or more risk factors.

Figure 5.1 – Number of Caseworker Identified Family Risks



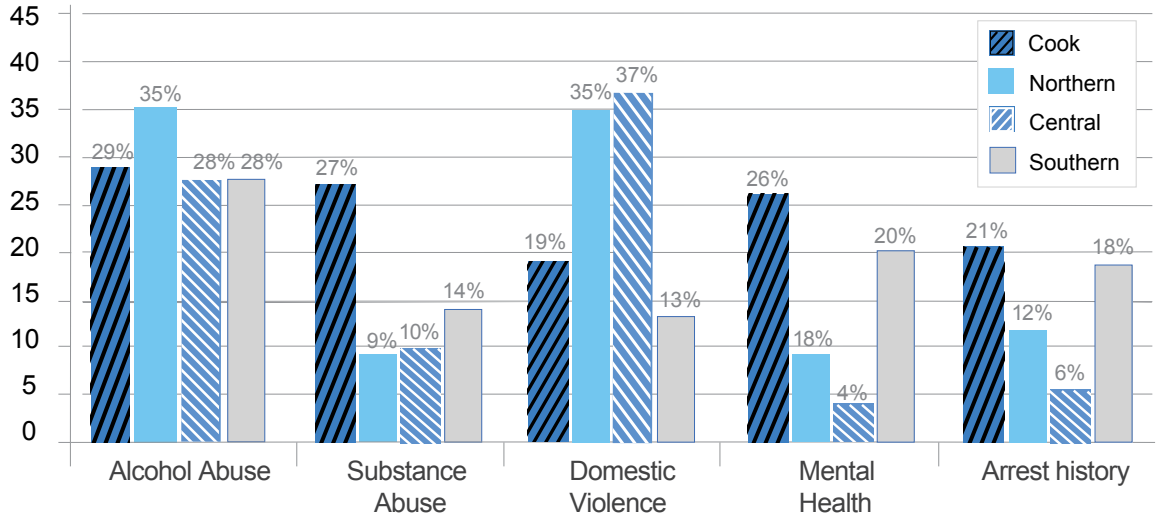
5 See, e.g., Twardosz, S. & Lutzker, J.R. (2010). Child maltreatment and the developing brain: A review of neuroscience perspectives. *Aggression and Violent Behavior, 15*, 59–68.
6 Aber, J. L., & Allen, J. P. (1987). The effects of maltreatment on young children's socioemotional development: An attachment theory perspective. *Developmental Psychology, 23*, 406–414.
7 See e.g., Edleson, J. L. (1999). The overlap between child maltreatment and woman battering. *Violence Against Women, 5*, 134–154. Merritt, D. (2009). Child abuse potential: Correlates with child maltreatment rates and structural measures of neighborhoods. *Children and Youth Services Review, 31*, 927-934. Walsh, C., MacMillan, H.E., & Jamieson, E. (2003). The relationship between parental substance abuse and child maltreatment: Findings from the Ontario Health Study. *Child Abuse & Neglect, 27*, 1409-1425. Debellis, M.D., Broussard, E.R., Herring, D.J., Wexler, S., Moritz, G., & Benitez, J.G. (2001). Psychiatric co-morbidity in caregivers and children involved in maltreatment: A pilot research study with policy implications. Child *Abuse & Neglect, 25*, 923-944.
8 Gilbert, R., Widom, C.S., Browne, K., Fergusson, D., Webb, E., & Jannson, S. (2009). Burden and consequences of child maltreatment in high income countries. *Lancet, 373*, 68 -81.
9 Gilbert, R., et al., ibid.
10 See, e.g., Cicchetti, D., Rogosch, F. A., Lynch, M., & Holt, K. (1993). Resilience in maltreated children: Processes leading to adaptive outcome. *Development and Psychopathology, 5*, 629-647.

Looking at specific risk factors, caseworkers noted caregiver alcohol use as a risk factor in 31% of cases and domestic violence in 28%. Smaller but meaningful proportions of cases were reported with caregiver mental health problems (18%), history of arrest (16%) and substance abuse (15%). Not surprisingly, several caregiver risk factors were significantly more common when children had been removed from the home than when they remained: history of arrest (35% vs. 13%), mental health problems (32% vs. 16%), and substance abuse (25% vs. 14%). However, there were no significant differences between out-of-home and in-home cases on alcohol abuse or domestic violence.

According to caseworkers, children in rural areas experienced most risk factors at about the same rate as children in non-rural areas, but experienced domestic violence at a significantly higher rate (35%) than non-rural children (24%). Substance abuse problems were more common among parents of female (20%) compared to male children (11%). Significantly fewer caregivers of children under 3 were identified as having a problem with alcohol (0%) compared to all other age groups (18% to 78%), whereas more caregivers of children under 3 were identified as having a substance abuse problem (26%) compared to all other age groups (5% to 14%).

Caseworker reports of caregiver risk factors for children who remained in-home differed by region (see Figure 5.2). Caretaker substance abuse was reported far more frequently in Cook County (27%) than in all other regions (on average 10%). Domestic violence was reported at a much higher rate in the Northern and Central regions (35% and 37%) compared to all other regions (on average 17%). Caretaker history of arrest was higher in Cook County and the Southern region (21% and 18%, respectively) and was quite low in the Central region (6%).

Figure 5.2 - Caseworker Identified Caregiver Risk Factors by Region for In-home Families

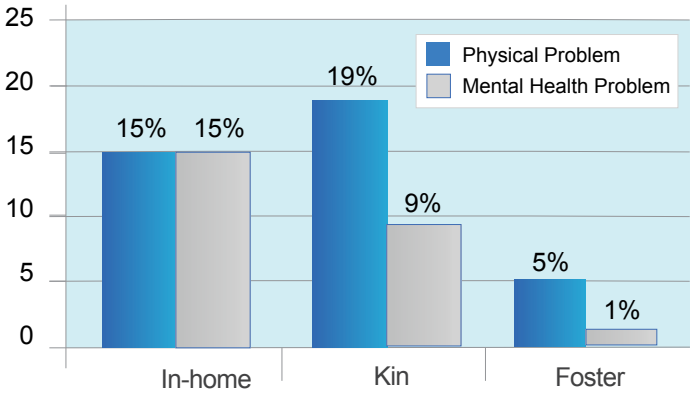


Note: Numbers above the bars represent the percentage of cases in a region with that risk factor

Caregiver Problems

Additional questions in the caregiver interview asked current caregivers about life problems they experienced. The child's parent answered these questions when children remained in the home. Kin or foster caregivers answered these questions when children had been removed. As Figure 5.3 shows, 15% of in-home caregivers reported physical health problems and 15% mental health problems. Kin caregivers had a similar rate of physical health problems and a slightly lower rate of mental health problems. Only very small percentages (5% or less) of caregivers in traditional foster homes reported these problems, but this estimate is hampered by the small number (n=20) of traditional foster caregivers in the sample. Low social support (not shown on the graph) was reported by 26% of in-home caregivers and 26% of kin caregivers, but not by any traditional foster caregivers. Based on caregivers' self-report, these results suggest that family stresses are sometimes an issue for children with kin caregivers as well as for children who remain in-home. The very low frequency with which traditional foster caregivers self-reported may reflect strengths among these families but may also reflect some reluctance to disclose problems in the context of a child welfare study.

Figure 5.3 – Percent Of Caregivers With A Physical Or Mental Health Problem



Poverty

Insufficient income is an additional risk factor for many families in this population. In-home caregivers had a significantly lower income than kin caregivers and traditional foster caregivers. On average in-home caregivers reported an annual household income of $24,533; kin caregivers $38,834; and traditional foster caregivers $55,916. Income in rural communities was significantly lower than in non-rural communities, and in-home caregivers in rural communities reported the lowest income, making on average just $12,500 a year.

Children's Exposure To Violence

Another indicator of environmental risk is child exposure to violence. Children and youth age 8 and older completed the Violence Exposure Scale for Children (VEX-R), a 23-item measure of witnessing or being the victim of different violent actions in the home, ranging in severity from spanking to stabbing or shooting. Of the 135 youth who completed the measure, 66% reported *witnessing* one or more items on the severe violence subscale, such as a gun or knife being pointed (witnessed by 8%), stabbing (8%), shooting (3%), someone getting arrested (51%), adult stealing in the home (27%), and dealing drugs (12%). There were no significant differences between sub-groups, except for a difference between youth in rural and non-rural areas: 74% of youths in rural areas had witnessed severe violence versus 60% in non-rural areas. There is also an *experiencing* severe violence scale on the VEX-R, which is scored positively if a child reports that an adult pointed a knife or a gun at them. Out of the 135 youths responding, 6% reported that this happened, but this increased to 27% among youths who had been placed in out-of–home care. There were no other significant differences on this scale.

Some caution should be used in interpreting the VEX-R scale. Questions have been raised about the reliability of the VEX-R in the first NSCAW cohort,[11] leading researchers to increase the lower age limit to 8 in an attempt to produce more reliable results in current ISCAW/NSCAW data. However, even if there is some question about what the exact percentages are, the magnitude of the results on the VEX-R still suggest reasons for considerable concern and speak to the enormous stress children can be under in substantiated investigations.

Child health

Monitoring physical health is a priority for tracking any child's well being, and is particularly important given the increased risk that maltreated children have for experiencing health problems.[12] A disproportionate percentage of children involved with child welfare services have chronic health conditions.[13] Children can be injured or otherwise physically harmed because of abuse or neglect (e.g., head trauma or fractures caused by physical abuse; malnutrition caused by neglect).[14] Neglect can also interfere with the delivery of health care (e.g., children not going to the doctor because of a parent's medical neglect).[15] In addition, children who have pre-existing health conditions may be at greater risk for maltreatment,[16] probably because of the greater demands of caring for them.

Overall Health

For ISCAW, caregivers were asked to provide an overall assessment of their children's health. The overwhelming majority (95%) reported that children were in good, very good or excellent health. Caregivers also reported that the vast majority of children (88%) received a well-child visit with a pediatrician in the past year. Children under the age of three were substantially more likely to have a well-child visit than older children.

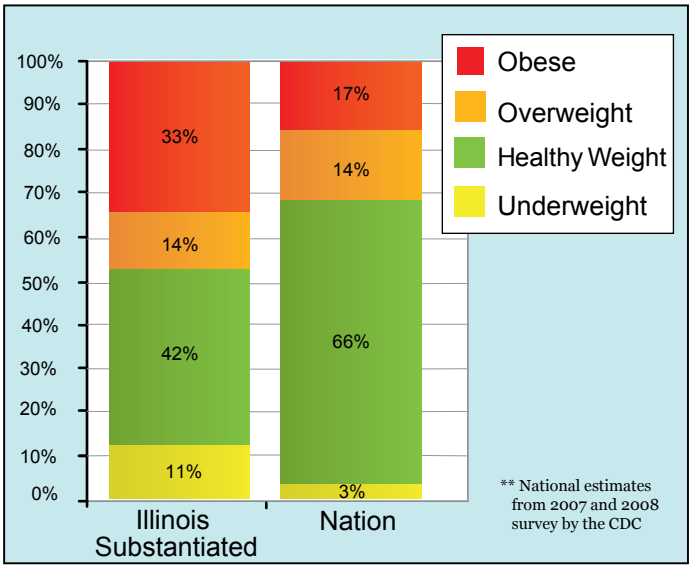
11 Biemer, P., Christ, S. L., & Wiesen, C. (2006). *Reliability Assessment of the National Survey on Child and Adolescent Well-Being*. Chapel Hill, NC: Odlum Institute, University of North Carolina.
12 Kortenkamp, K. & Ehrle, J. *The Well-Being of Children Involved with the Child Welfare System: A National Overview*. Series B, No. B-43. Washington, DC: The Urban Institute. Palaszynski, K.M. & Nemeroff, C.B. (2009). Medical consequences of child abuse and neglect. *Psychiatric Annals, 39*, 1004-1009.
13 Ringeisen, H., Casanueva, C., Urato, M., & Cross, T.P. (2008). Special health care needs among children in child welfare. *Pediatrics, 122*, 232-241.
14 See e.g., Block, R.W. & Krebs, N.F. (2005) Failure to thrive as a manifestation of child neglect. *Pediatrics, 116,* 1234-1237. Makaroff, K.L., & Putnam, F.W. (2003). Outcomes of infants and children with inflicted traumatic brain injury. *Developmental and Medical Child Neurology, 45,* 497–502
15 Dubowitz, H., Giardino, A., & Gustavson, E. (2000). Child neglect: Guidance for pediatricians, *Pediatric Review, 21*, 111–116.
16 Jaudes, P.K., & Mackey-Bilaver, L. (2008). Do chronic conditions increase young children's risk of being maltreated? *Child Abuse & Neglect, 32*, 671–681.

Body Mass Index

An important dimension of children's health is their physical growth. Obesity is a major risk for American children: a recent study shows that 31% of American children met criteria for overweight or obesity.[17] Children involved with DCFS may be at special risk for obesity both because neglectful caregivers may be less likely to provide good nutrition and because disadvantaged families have less money for and less access to healthier foods. At the other extreme, but of equal concern, are children who are dangerously underweight. ISCAW includes measures of child height and weight, which can be used to calculate body mass index (BMI). BMI can then be compared to growth charts developed by the Centers for Disease Control to identify which children are underweight, at a healthy weight, overweight, and obese (see Figure 5.4).

Overall 11 percent of children in substantiated investigations were underweight, which is substantially larger than the 3.3% of children nationally. At the other end of the continuum, 14% of these children were overweight and 33% were obese. This is much higher than American children in general, 14% of whom are overweight and 17% obese.[18] Only 42% of children with a substantiated investigation had a body mass index in the healthy range. Box 5.2 provides a detailed analysis of variables that may be related to unhealthy weight for children involved with DCFS.

Figure 5.4 – Body Mass Index for Children 2 Years and Older for Children in Illinois Foster Care and the U.S. Population**



Box 5.2—Warning Sign: Unhealthy Child Weight

The percentage of youth overweight or obese is about equal for those out-of-home (49%) and in-home (47%), but better understanding of this problem is gained by examining the percent overweight or obese by race and gender. Table 5.2 shows that **73.5% of African American children in foster care in Illinois are overweight or obese**, which is over twice the national average of 35.9% for this racial group and also substantially higher than the 43.6% of children in-home.

A disproportionately high number of Hispanic males left in-home following investigation are overweight or obese compared to Hispanic children in out-of-home care. Looking across the different races, African American males in foster care are 9.2 times more likely and African American females in foster care are 13.9 times more likely to be overweight or obese compared to Caucasian children in foster care. Likewise, Hispanic males in-home are 11.1 times more likely to be overweight or obese compared to Caucasian males in home.

17 Ogden, C.L., Carroll, M.D., Curtin, L.R., Lamb M.M., & K.M. Flegal (2010). Prevalence of high body mass index in US Children and Adolescents, 2007-2008. *Journal of the American Medical Association, 303*, 242-249.

18 Ogden et al., ibid.

Table 5.2 – Percent of Children Two Years and Older who are Overweight or Obese

	Illinois Children in Foster Care	Illinois Children in Home	National Child Population
Total			
Both sexes	48.2	46.6	31.7
Boys	41.1	48.0	32.1
Girls	55.8	45.6	31.3
African American			
Both sexes	73.5	43.6	35.9
Boys	70.8	52.4	33.0
Girls	76.5	36.3	39.0
Caucasian			
Both sexes	30.8	38.3	29.3
Boys	24.7	26.7	29.5
Girls	36.7	47.8	29.2
Hispanic			
Both sexes	28.7	61.4	38.2
Boys	N/A	80.9	39.9
Girls	N/A	46.2	36.4

Thus male and female African-American children out-of-home and male Hispanic children in-home are at the greatest risk of being overweight or obese and may be lacking the proper nutrition and/or the appropriate exercise to remain at a healthy weight. More work is urgently needed to understand how type of maltreatment and community and family factors contribute to these disproportionate numbers.

Physical Disability And Special Health Care Need

Other important indicators of well-being are whether children had a physical disability or a special health care need. A physical disability is a physical impairment that interferes with daily functioning, while a special health care need (SHCN) is an ongoing or long-term need for remediation of a chronic or repeated health condition. SHCNs include physical disabilities but also other disabilities like mental retardation or learning disabilities and chronic medical conditions like asthma.

An estimated 13% to 19% of American children have SHCNs [19] but a previous national NSCAW study found that 35% of children who had been involved with child welfare investigations had an SHCN.[20] Overall 40% of children involved with DCFS had a SHCN. This included asthma (16%), mental retardation (7%), repeated ear infections (7%), language impairment, learning disability and vision problems (each 4%). The high rate of SHCNs occurred in every segment of the sample, but some children were at higher risk. A greater proportion of boys (48%) had SHCNs than girls (31%), probably because several of the health conditions such as learning disabilities have a higher incidence among boys. Children under the age of 3 were significantly less likely to have an SHCN, probably because several of these conditions (e.g., language impairments, learning disabilities) are usually evident only at later developmental periods. In addition, a significantly higher proportion of children had SHCNs in the Northern region (51%) compared to other regions (33% to 37%). An estimated 2.2% of children 5 years of age and older had a physical disability, which is similar to the national estimate of 1.1%.

19 Bethell, C.D., Read D., Blumberg S.J., & Newacheck, P.W. (2008) What is the prevalence of children with special health care needs? Toward an understanding of variations in findings and methods across three national surveys. *Maternal Child Health Journal, 12*, 1–14.

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

Child Development

The opportunity to grow and develop in step with one's peers unperturbed by harm from the environment is central to children's well-being. The relevance of this for child welfare has become clearer with research which details the many specific ways in which child maltreatment can sidetrack children's cognitive, physical, social and emotional development at every age from infancy to adolescence.[21] ISCAW includes a number of standardized measures of development with national norms that allow us to compare children in substantiated cases against average American children and thereby identify children with developmental lags as well as children who are developing in step with their peers.

Development Of Young Children

The data are particularly concerning for young children. Almost two-thirds of children age 0-2 score as "at risk" on a measure of neurological development and more than one quarter of children age 0 to 6 score as "at risk" on a measure of language development (see Box 5.3).

Box 5.3—Warning Sign: Early Childhood Developmental Delays

Infants and Toddlers (0-2)

The Bayley Infant Neurodevelopmental Screener (BINS) is a screening tool designed to pick up possible signs of developmental delays or neurological impairments in children from 3 months to 24 months old. The BINS is intended to identify which children need more diagnostic testing and might need early intervention services. Overall 64% of children aged 0-2 scored in a range that indicates high risk on the BINS. This rate is comparable to that of a sample of children specifically identified for clinical intervention. This means that 64% of children under 2 showed limitations in one or more of these areas: neurological functioning, sensation and perception, fine and gross motor skills and oral skill, memory/learning and thinking/reasoning. Among the families with a child scoring in the high risk range, only 9% of caregivers were told by a professional that the child had a learning problem or disability.

Preschool Children (3-6)

The Preschool Language Scale (PLS) is a measure both of the development of children's ability to comprehend language and express themselves using language. Low scores on the PLS could indicate developmental delay in language or neurological impairment and should be followed by further testing and potentially by early intervention. Average PLS Expressive Communication and Total Scores were both more than one standard deviation below national norms for the general child population and Auditory Comprehension was .8 of a standard deviation below. In addition, 28% of children involved with DCFS had extremely low scores on the PLS (two or more standard deviations below the mean), a rate more than 13 times higher than that of the general population. Among the families with a child with an extremely low PLS score, only 29% of caregivers were told by a professional that the child had a learning problem or disability.

These rates indicate *substantial* lags in the development of cognitive and language functioning among many infants and preschool-aged children involved with DCFS that may need to be addressed by early intervention programs. However, the low numbers of caregivers being told by a professional that their child with these lags has a learning problem or disability suggests that many of these problems are going unnoticed by service providers.

21 See, e.g., Bolger, K. E., Patterson, C. J., & Kupersmidt, J. B. (1998). Peer relationships and self-esteem among children who have been maltreated. *Child Development, 69*, 1171-1197. Culp, R.E., Watkins, R.V., Lawrence, H., Letts, D., Kelly, D.J., & Rice, M.L. (1991). Maltreated children's language and speech development: Abused, neglected, and abused and neglected. *First Language, 11*, 377-389. Mackner, L.M., Starr, R.H. Jr., & Black, M.M. (1997). The cumulative effect of neglect and failure to thrive on cognitive functioning. *Child Abuse & Neglect, 21*, 691-700.

Box 5.4—Spotlight on Practice: A Mental Health Intervention for Rural Foster Children from Methamphetamine-involved Families

A recent mixed methods study by Wendy Haight, James Black, and Kathryn Sheridan describes the cultural-adaptation, implementation and impact of a mental health intervention for individual children aged 7-17 from rural, methamphetamine-involved families who are in foster care. Features of the culturally-shaped intervention include: 1) close collaboration with local professionals who provide the intervention; 2) provision of the intervention in and around children's homes; and 3) the use of local story telling traditions in a narrative- and relationship-based intervention. As a group, children (N=15) showed problematic levels of Child Behavior Checklist (CBCL) externalizing and total problem behaviors and symptoms of PTSD/dissociation during the pretest. Children were randomly assigned to an experimental group who received the intervention immediately (n=8) or a wait-list control group (n=7) who received the intervention at the end of the study. There was a significant interaction effect of time (pre- and post-test) and group on externalizing behavior with the trajectory of the experimental group improving while that of the control group worsened. Gains made by the experimental group were maintained over a seven-month follow-up period. Comparative case studies, individual qualitative interviews and open-ended questionnaires provided rich elaboration of participants' experiences and illuminated complexities and challenges of the intervention.

Haight, W., Black, J., &Sheridan, K. (in press). A mental health intervention for rural, foster children from methamphetamine-involved families: Experimental assessment with qualitative elaboration. *Children and Youth Services Review*. For additional information, please contact Dr. Wendy Haight at wlhaight@illinois.edu. Acknowledgement: This research was supported by a grant to the University of Illinois from the Illinois Department of Children and Family Services and NIDA grant R21DA020551-01A2.

Adaptive Living Skills

Other measures assessed dimensions of child development in children who are older than two. The Vineland Adaptive Living Skills scale measures skills that children ages one to ten need in everyday life, such as dressing themselves, performing household tasks and using a telephone. Scored in reference to the skills that are expectable at different ages, the Vineland is a fairly sensitive measure of developmental delay. About 70% of children in the Illinois study had adequate to high daily living skills, which is less than in the general population, and 12% had low daily living skills, which is six times higher than the general child population.

Intellectual Functioning

The Kaufman Brief Intelligence Test (K-BIT) measures intellectual functioning in children aged 4 and older. The mean K-BIT Composite score was 93, which is significantly below the average for the general child population, and 7% had extremely low scores (more than two standard deviations below the mean), which is more than 3 times the rate for children generally. The Vineland and K-BIT results suggest that, while most children involved with DCFS do not have substantial problems with cognitive functioning, a disproportionate percentage do and are likely to need special education services.

Child Emotional and Behavioral Functioning

Maltreatment can do emotional harm and impair emotional and social development, contributing to both immediate and long-term emotional and behavioral problems.[22] Abused and neglected children are more likely to experience conduct problems, depression, delinquent behavior, substance abuse, and sexual activity. Environmental stressors like parental alcoholism that can accompany child maltreatment also take a toll on children's mental health. Youth with mental health problems also sometime become involved with child welfare services because parents act abusively in a desperate attempt to deal with their children's behaviors, or because families without resources to provide care for their emotionally disturbed children have turned to child welfare agencies for help, often surrendering custody to qualify youth for mental health services.[23]

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

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

Emotional and Behavioral Problems

Three standardized measures, parallel in content, were used to assess child emotional or behavioral problems: the Child Behavior Checklist (CBCL, completed by caregivers), the Teacher Report Form (TRF) and the Youth Self-Report (YSR, completed by youths age 11 or older). Emotional and behavioral problems are prevalent among children involved with DCFS. On the CBCL, 29% scored in the clinical or borderline clinical range. On the TRF, 34% scored in the clinical or borderline clinical range. On the YSR, 27% scored in the clinical or borderline clinical range. Thus each measure identified somewhere between one-quarter and one-third of the sample as in need.

The sample size was substantially larger for the caregiver-completed CBCL (N=401) than for the teacher-completed TRF (N=96) and the youth self-reported YSR (N=85), so it is not surprising that there are more statistically significant differences for the CBCL. There were striking differences by placement on the CBCL. Among children and youth in foster care, 59% were in the clinical/borderline clinical range compared to 28% of children and youth in kinship care and 29% of children and youth in home. The high level of mental health need among children in foster care is consistent with previous *B.H.* monitoring reports, even though children in this sample had not been in foster care long. There was no difference between rural and non-rural children. A significantly lower percentage of children in the Southern region (15%) scored in the clinical/borderline clinical range compared to all other regions (28% to 36%). Boys were more likely to score in the clinical/borderline clinical range (37%) than girls (22%). Mental health need was highly related to child age: only 18% of children age 1 1/2 to 4 scored in the clinical/borderline clinical range but the percentage was 31% or higher for all the older age groups and was highest for youth age 14 to 17, 43% of whom scored in the clinical/borderline clinical range.

The only significant difference on the Teacher Report Form was substantial: teachers rated almost two thirds of children in out-of-home care (63%) as having clinical/borderline clinical levels of emotional and behavior problems, compared to about one-quarter (28%) of children in-home. Sample sizes were too small to calculate percentages separately for traditional foster care and kinship care. There were no significant differences by group for the Youth Self Report form.

Depression and Trauma Symptoms

Two measures completed by youth captured specific types of mental health problems: depression and trauma symptoms. The Children's Depression Inventory (CDI), completed by youths age 7 to 17, captures children's own reports of symptoms of depression. Also used was an adaptation of the Trauma Symptom Checklist for Children (TSCC), which measures symptoms like nightmares and intrusive thoughts which are lasting remnants of past traumas children have experienced. On the CDI, 9% scored in the clinically significant range for depression, which is similar to the normative population (7%).[24] There were no differences between in-home and out-of-home children on the CDI. Nor were there any differences noted between rural and non-rural settings. On the TSCC, completed by youth age 8 to 17, 8% of youth scored in the clinical/borderline range, which is very similar to the normative rate. Unexpectedly, significantly fewer children who had been removed from the home (2%) experienced trauma symptoms compared to children in-home (9%). Fewer older youth (ages 12 to 17) experienced trauma symptoms (2%) compared to younger (14% for ages 9 to 11, and 11% for ages 7 to 8). Rural and non-rural children did not differ on trauma symptoms.

24 Kovacs M. (2003) *Children's Depression Inventory (CDI)*: Technical Manual Update. North Tonawanda, NY, USA: Multi-Health Systems Inc.

Social Skills

An important step in developing the emotional and behavioral mastery to avoid problems is the development of social skills. Children who have been maltreated often struggle more in relationships with peers and adults because they have poorer social skills such as the abilities to share, inhibit aggressive behaviors, and understand others' feelings.[25] Such skills are important for making friends and prospering in school and the neighborhood, the very experiences that can help children overcome the effects of maltreatment and difficult environments. ISCAW used a caregiver version of the Social Skills Rating System to gather information about children's social skills (i.e., cooperation, assertion, responsibility, and self-control in social relationships) for youth in third to twelfth grade. Caregivers rated 30% of children as below average in social skills, which is nearly twice the normative rate.[26] But caregivers also rated a majority of children (62%) in the average range in social skills and a small percentage (8%) above average.

Box 5.5—Understanding Physical Aggression in Rural Girls and Boys from Methamphetamine-Involved Families

A mixed method study examined the mental health and experiences of physical aggression in 41 children aged six to 14 years from rural families involved with methamphetamine misuse and the child welfare system. Each child was seen for a minimum of 3 hours total by experienced clinicians on at least three sessions conducted at the child's home. Fifty percent of children scored in the clinical range (98th percentile and above) on externalizing and 26% on aggression scales of the Child Behavior Checklist (CBCL). More girls (75%) scored in the clinical range on CBCL externalizing behaviors than did boys (32%). During individual, semi-structured interviews, 17 children spontaneously produced 58 narratives of past physical aggression. These were primarily set at home and involved adults and the children themselves. Children primarily attributed physical aggression to anger and adult substance misuse, and described negative outcomes of the aggression. In contrast, a subgroup of girls with clinically significant levels of CBCL externalizing behaviors characterized their own physical aggression as appropriate retaliation with emotionally satisfying consequences. Many of these girls also scored in the clinically significant range on CBCL internalizing behaviors and total problems. Clinicians who collected the data expressed concern about these girls, in particular because they were ostracized from non-delinquent peer groups, viewed others' continuing physical aggression against them as an inevitable part of their future, and described their own physical aggression as unavoidably driven by that violence. The perspectives of this subgroup of girls are elaborated through a case study of a physically aggressive 12-year-old. Implications for intervention are discussed.

Haight, W., Marshall, J., Hans, S., Black, J., & Sheridan, K. (in press). "They mess with me, I mess with them": Understanding physical aggression in rural girls and boys from methamphetamine-involved families. Children and Youth Services Review. For more information, please contact Dr. Haight at wlhaight@illinois.edu. Acknowledgements: This research was supported by NIDA grant R21DA020551-01A2.

25 Dodge, K. A., Pettit, G. S., & Bates, J. E. (1994). Effects of physical maltreatment on the development of peer relations. *Development and Psychopathology, 6*, 43–55.
26 Gresham, F. M., & Elliott, S. N. (1990). *Social Skills Rating System Manual*. Circle Pines, MN: American Guidance Service.

Delinquent And High Risk Behavior

ISCAW also measured delinquent and other high risk behaviors among youth age 11 and older who completed a Self-Report Delinquency scale about behavior in the last six months. Of 85 adolescents completing the measure, 14% committed minor delinquent acts like being unruly in public, skipping school, and shoplifting, while 14% reported serious delinquent acts like participating in gang fights, concealing a weapon, and stealing. In the previous six months, 8% had been arrested. There were no significant differences found between out-of-home and in-home children, by region or child race. Youth in non-rural communities were significantly more likely to be arrested (10%) than youths in rural communities (2%). Youth ages 14 to 17 were significantly more likely to be arrested than younger children.

Figure 5.5 shows the percent of youth who have participated in several specific delinquent behaviors in the past six months. The same youth also completed questions about substance abuse. Response rates indicated 41% of youths reported having used alcohol, 10% cigarettes, 15% marijuana and 21% hard drugs. In addition, 23% reported riding in a car while the driver was intoxicated.

Adolescents were also asked about sexual behaviors: 20% reported that they had had consensual sex and 6% reported that they had been forced to have sex. Of the group who had had consensual sex, 48% reported having more than one partner. Comparing these rates of delinquent and high risk behavior to rates from the general population is complex because studies vary in the youth sampled, the questions asked, and time period surveyed. This issue will be examined more thoroughly in the upcoming well-being report completed during FY2011.

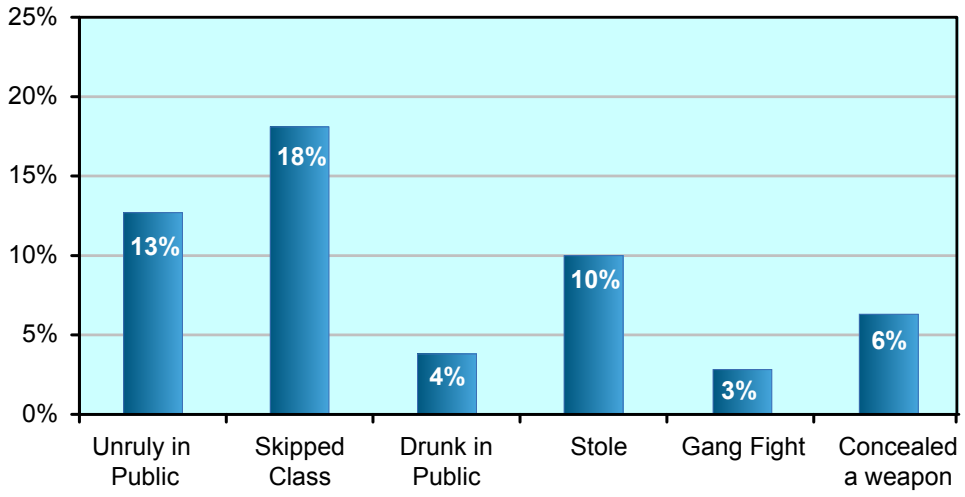
Learning And Education

Given the many other challenges to their development and well-being, it is not surprising that children who have been maltreated often have learning problems and struggle with school achievement. Poor grades, repeating a grade and engagement with special education services are more common for maltreated children than for other children.[27]

Grade Level Proficiency

Teachers were asked whether students had achieved grade level proficiency in math, science, and language. Because many children in the sample were too young to be in school and because teacher reports were not obtained for a number of eligible children, data on this measure were available for a subsample of 94 children. Substantial proportions of children were below grade level in each academic domain (see Figure 5.6): 46% in math, 43% in science, and 56% in language. There are no national norms on this measure, but we would expect about 16% to be below average grade level if scores on these measures had normal (bell curve) distributions.[28] At the same time, a number of children were performing well: 43% were in the average range in science, 37% in math, and 23% in language. Some children were above grade level: 18% in math, 21% in language and 13% in science. There were no significant differences between children placed in-home or out-of home. There were no differences found by region, race-ethnicity, sex, or age. In addition, rural and non-rural children did not differ.

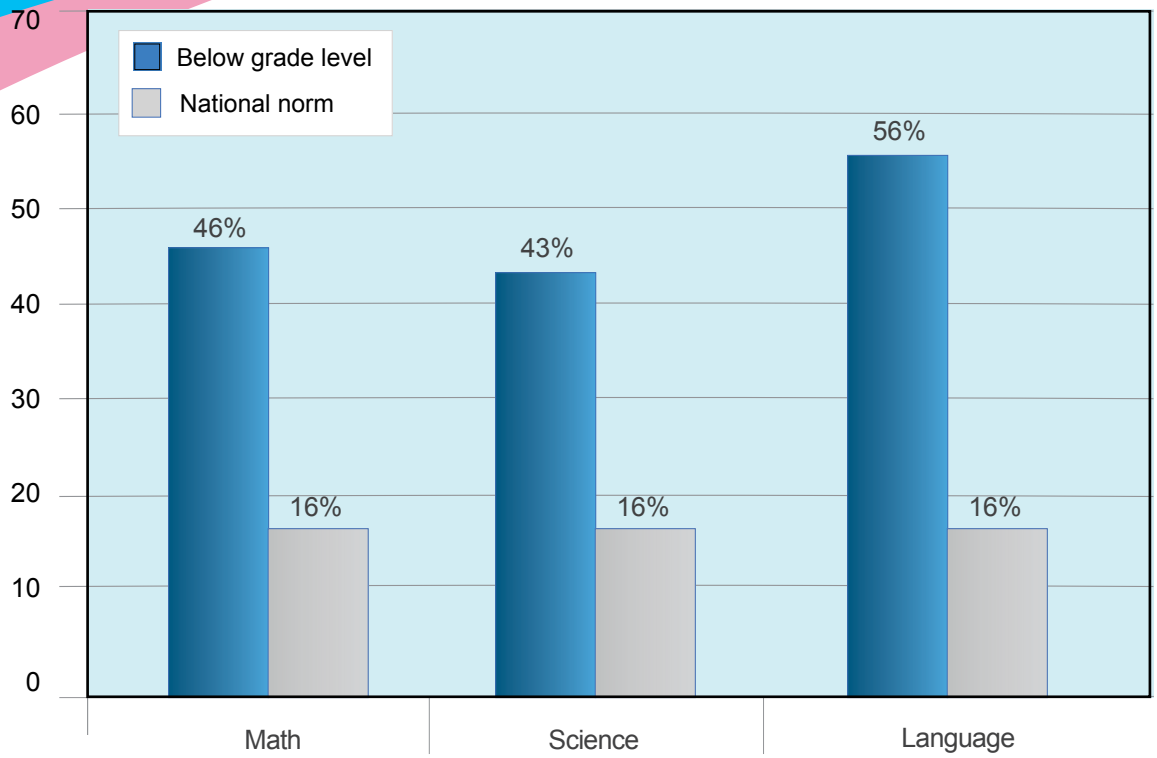
Figure 5.5 – Percent of Youth Participating in Delinquent Behaviors



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

28 See U.S. Department of Health and Human Services, Administration for Children and Families. (2007). *From Early Involvement with Child Welfare Services to School Entry: A Five Year Follow-Up of Infants in the National Survey of Child and Adolescent Well-Being.*

Figure 5.6 – Percent Rated Below Grade Level by Teachers



Standardized Achievement Measures

Academic progress was also measured through a standardized academic achievement measure imbedded within the child interview – the Woodcock Johnson III Tests of Cognitive Abilities. Each scale -- Letter Identification, Passage Comprehension and Applied Problems -- has national norms for each age and an average score of 100 and standard deviation of 15. The ISCAW population had about the same average on Letter Identification as the national average but was below national averages on both Passage Comprehension and Applied Problems with average scores of 93 on each. The mean score for this population were at a level designated as low average, meaning that on average Illinois children involved with DCFS did somewhat worse than the general population of children nationally. On this measure, 10% had scores more than 2 standard deviations below the mean, 5 times the national rate. Children in out-of-home placements had a substantially higher percentage of extremely low scores on at least one Woodcock Johnson's scale (27%) than children who remained in the home (6%). There were no significant differences between rural and non-rural youths between boys and girls, and between different racial-ethnic groups.

Resilience

Although it is essential to focus on the problems that children involved with child welfare have, it is also important to recognize that children involved with child welfare have strengths. They persevere and develop capabilities and record achievements despite the obstacles they face. Assessing resilience in this population both helps us to recognize these children's achievement and suggests the potential for other children in this population to thrive with the right help despite the odds against them. In addition, to the extent children have problems, an assessment of resilience helps us determine the extent to which problems are contained in one area or are more global in nature.

Assessing resilience requires a different analytic approach than the one used elsewhere in this chapter. Rather than a calculation of the percentage of children who have problems, the resilience analysis calculated the percentage of children who demonstrated competence and did *not* show evidence of problems across multiple measures.[29] This is a reasonable indication of whether children were able to function in a successful, age-appropriate way despite their experience of child maltreatment. Many of the measures discussed above like the Children's Depression Inventory (CDI), Child

29 This method was adapted from Walsh, W.A., Dawson, J. and Mattingly, M.J. (2010). How Are We Measuring Resilience Following Childhood Maltreatment? Is the Research Adequate and Consistent? What is the Impact on Research, Practice, and Policy? *Trauma, Violence and Abuse, 11*, 27-41

Behavior Checklist (CBCL), the Social Skills Rating System, and the Woodcock Johnson Test of Cognitive Abilities were used in the resilience analysis. Because measures differ by child age, resilience was measured in two domains for children (i.e. emotional/behavioral and educational) and three domains for youths age 11 to 17 (i.e. emotional, behavioral and educational.)

Many of the children in the younger group demonstrated resilience. On three measures of emotional/behavioral functioning, 49% of the younger group had scores indicating adequate functioning on all measures and 69% on two or more out of three. On four measures of educational functioning, 60% of the younger group were competent on all measures and 81% on three or more out of four.

Many in the adolescent group also showed resilience. Demonstrating behavioral resilience was somewhat difficult because there were six measures of behavioral functioning used representing a number of potential problems which adolescents could present. Nevertheless, 27% of adolescents functioned adequately on all six measures and 61% on five or more out of six. On three measures of emotional functioning, 67% of adolescents showed adequate functioning on all measures and 94% on two or more out of three. On three measures of adolescent educational functioning, 50% of adolescents were competent on all measures and 73% on two or more out of the three.

This analysis suggests that some children and youth in substantiated cases show little evidence of problems in functioning. Perhaps more importantly, in every domain for both age groups, a majority of children and youth scored in a problematic range on no more than one measure, so their problems may be to some degree circumscribed. There are limitations in this analysis; for example, some measures are inherently broader in scope than others and can indicate widespread difficulty and yet all measures are counted equally. Nevertheless, the resilience analysis suggests that most of these children and youth have strengths and that, in some cases, problems may be more specific and less global than one might imagine given the broad array of risks to which children and youth are subject to in substantiated cases.

Box 5.6—2009 CFSR Findings Related to Well-Being

CFSR Well-Being Outcome 1 assesses whether "families have enhanced capacity to provide for their children's needs" during the period under review. **Illinois was not in substantial conformity with this outcome** measure in 2009 – only 43.1% of the cases reviewed substantially achieving this outcome (substantial conformity requires 95% achievement). The state's performance on the items which comprise Well-Being Outcome 1 varied:

- Item 17 (**Needs and Services of Child, Parents, and Foster Parents**) assessed whether the agency had adequately assessed the needs of children, parents, and foster parents and provided the services necessary to meet those needs. This item includes the assessment of children's needs pertaining to education, physical health, and mental health. This item was deemed **an area needing improvement**; only **55%** of the 65 cases reviewed received appropriate assessment and services.
- Item 18 (**Child and Family Involvement in Case Planning**) determined whether parents and children (when appropriate) had been involved in the case planning process, and, if not, whether their involvement was contrary to the child's best interest. Of the 61 applicable cases reviewed, 29 (**48%**) were rated as a strength, meaning that this was an "**area needing improvement**."
- Item 19 (**Caseworker Visits with Child**) looked at whether the frequency of the visits between the caseworkers and children was sufficient to ensure adequate monitoring of the child's safety and well-being, and whether visits focused on issues pertinent to case planning, service delivery, and goal attainment. The reviewers deemed this item as a strength for 52 of the 65 cases (**80%**); the overall rating was "**area needing improvement.**"
- Item 20 (**Caseworker Visits with Parents**) looked at whether the caseworker's face-to-face contact with the children's mothers and fathers was of sufficient frequency and quality to promote attainment of case goals and ensure the children's safety and well-being. The reviewers deemed this item as a strength for 23 of the 53 applicable cases (**43%**); the overall rating was "**area needing improvement.**"

CFSR Well-Being Outcome 2 assesses whether "children receive services to meet their educational needs." **Illinois was not in substantial conformity with this outcome in 2009**, although 91.1% of the cases reviewed substantially achieving this outcome (substantial conformity requires 95% achievement). Item 23 (**Educational Needs of the Child**) required reviewers to assess whether children's educational needs were appropriately assessed and whether services were provided to meet those needs; this item was achieved in **91%** of applicable cases, but is still considered an **area needing improvement**.

CFSR Well-Being Outcome 3 assesses whether "children receive services to meet their physical and mental health needs." **Illinois was not in substantial conformity with this outcome** measure in 2009 – 78.6% of the cases reviewed substantially achieving this outcome (substantial conformity requires 95% achievement). The state's performance on the items which comprise Well-Being Outcome 3 varied:

- Item 21 (**Mental/Behavioral Health of Child**) was rated a strength in **89%** of the eligible cases by demonstrating that mental health needs had been appropriately assessed and appropriate services to address those needs had been offered or provided. Although very close to the 90% required for a strength rating, this is still an **area needing improvement**.

- Item 22 (**Physical Health of Child**) considers whether children's physical health needs (including dental needs) had been properly assessed, and the services designed to meet those needs had been, or were being, provided. Overall, this was an **area needing improvement** in Illinois, with **80%** of reviewed cases attained a "strength" rating.

OBSERVATIONS ON CHILD WELL-BEING IN ILLINOIS

Children In Need

The ISCAW data indicate that many children involved in substantiated reports are in need. The degree of need is substantial both for children who have been removed from their homes and those who remained in their homes. Many children have faced and/or currently face enormous risks in their homes from caregiver problems: caregivers had 2-3 risk factors on average, with the most common being alcohol abuse (in almost a third of cases) and domestic violence (in over one quarter of cases). In-home caregivers often faced poverty, particularly those in rural areas. Two-thirds of children reported witnessing severe violence in the home, usually someone getting arrested or an adult stealing in the home, but occasionally stabbing, shootings and other severe violence. Over one quarter of children who had been removed from the home reported having a knife or gun pointed at them.

Health concerns are prominent: a little less than half of the children were either overweight or obese and over one in ten was significantly underweight. Almost half have a special health care need such as asthma, mental retardation, or learning disabilities. Given the data on BMI and the prevalence of other health problems, indicate a substantial need for effective health promotion interventions for this population.

Problems with development are common in this population, particularly among young children. Almost two-thirds of children aged 0-2 demonstrated risk of cognitive impairment on a standardized developmental measure, and almost one-quarter young children lagged on a measure of language development. These data indicate a very substantial need among the youngest children coming into contact with DCFS for early intervention to change the course of development, which can make a substantial difference over the entire course of their maturation. Developmental delay and mental retardation are issues in this population, as there were comparatively high rates of problems with daily living skills and low intellectual functioning.

Emotional and behavioral problems are common as well. Regardless of who was reporting the problems, a substantial proportion of these children had scores on checklists of emotional and behavior problems that indicated a need for help. The data shows a need for help for these children was indicated by the caregiver checklist in just under one-third of cases, by the teacher checklist in one-third of cases and by the self-report checklist in about one-quarter of cases. The percentages were substantially higher for older children and for children in traditional foster care. Other measures provided more specific information on emotional and behavior problems. Over half of adolescents in substantiated maltreatment cases have engaged in delinquent behavior in the past six months and 41% have used alcohol. A fifth of these youth report having had consensual sex with 6% reporting they were forced to have sex. Many children face further problems in school. Large proportions (over 40% in most subjects and 56% in language) are behind grade level, and children scored significantly below national averages on standardized academic achievement tests.

Mental health has been identified as a major issue for victims of child maltreatment, particularly those who enter foster care. DCFS has taken numerous initiatives to improve mental health services, but previous data from the 2003 and 2005 Illinois Child Well-Being Study suggest a gap in mental health services for children in foster care as reported in last year's report. The new ISCAW data reported here suggest that the need is great even among those children who are first coming into contact with DCFS. Analysis of service data over the next year will assess how well delivery of mental health services matches need.

Normal Child Functioning And Resilience

Because this report and this chapter in particular focus on children's problems, it is easy to lose sight of the fact that a number of children in this population are doing reasonably well. Poverty is an issue for some caregivers in this population, especially in-home caregivers in rural areas, but the vast majority of kin and traditional foster caregivers do not have major problems, and some caregivers of children who remained in the home were dealing with a limited number of caregiver risk factors despite being involved in substantiated investigation. Ninety-five percent of children are reported to be in good health and the majority of children do not have a special health care need. Substantial percentages of children did not show delays in cognitive development, and most children had adequate to high daily living skills. Substantial proportions of children and youth do not show evidence of mental health problems and most adolescents did not engage in risky behaviors. The majority

of children and youths had average social skills and 8% had above average social skills. Although the average score in this population on the standardized academic tests was significantly below the national mean, it still placed them in the range designated as average, and a large proportion of children were functioning at grade level and 14% or more above grade level across subjects. In the resilience analysis, a number of children did not show evidence of difficulty in different domains, and most children showed evidence of difficulty on no more than one measure per domain. Thus ample data suggest that children and youth in substantiated cases have strengths. Moreover, the problems they have may be more limited in scope. All of this suggests that interventions with these children and youth to address their problems and needs can be effective.

The Well-Being Of Children In Rural Illinois

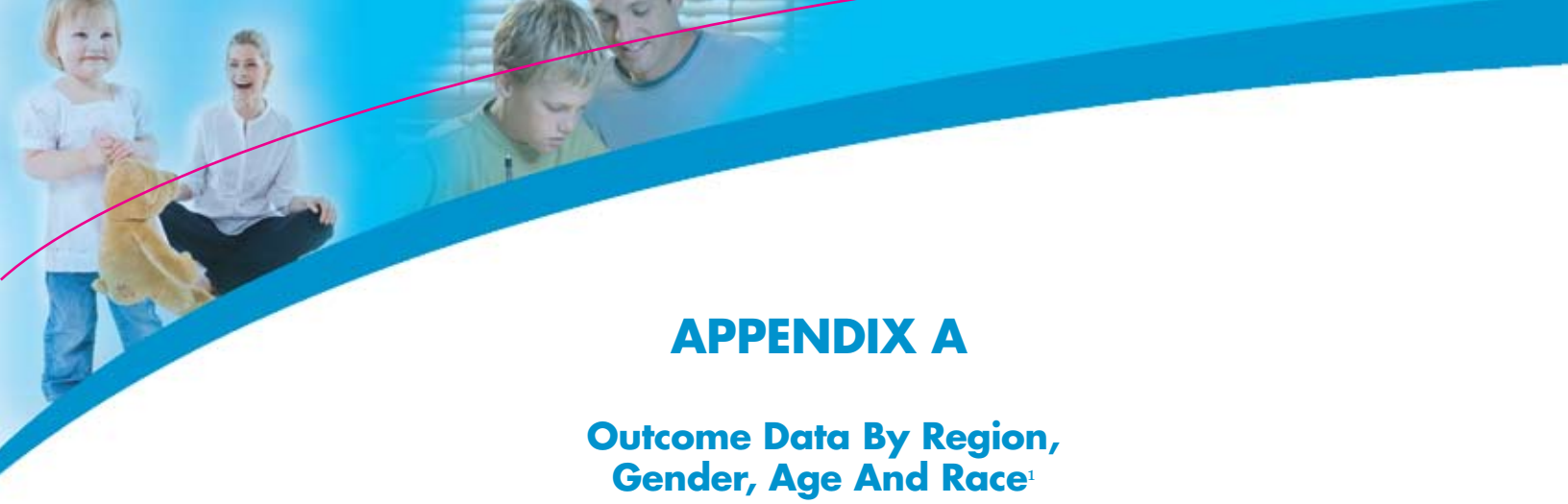
The results in this chapter indicate that children in rural communities have needs that equal those of children in urban and suburban communities and in some areas exceed them. In general, rural children often experienced risk factors in the home environment, just like non-rural children. Rural children and youth contended with health, developmental, behavioral and learning problems at the same rate as other children. Yet rural children sometimes were at greater risk than non-rural children. Caseworkers for rural children were significantly more likely to identify domestic violence as a risk factor, and rural children were significantly more likely to report witnessing severe violence. Income in rural, in-home cases was the lowest of any category, just an average of $12,500. The one difference favoring rural youths is hardly reassuring: they were less likely to be arrested, even though they were as likely as their non-rural peers to engage in delinquent behavior.

The findings related to rural children should provoke considerable concern and suggest the need for continuing special attention to rural children involved with DCFS. The problems of children in rural areas are equal to those of other children, but the resources available to respond to these problems may not be. Rural areas can lack sufficient services to meet the needs of children who live there. A broader child well-being report currently being developed from the ISCAW will analyze services data and explore the match between children's needs and the services they receive. The additional analysis should illuminate access to services for children in rural areas.

The Need For Early Intervention

The population in this report is very different from that of previous years' monitoring reports. Most of these children were not and have never been placed in out-of-home care, although they could be classified as "at risk" of being so. Even those who were placed outside their home had experienced only brief stays at the time of data collection, 3-4 months following an investigation. This is very different from the population of children examined in previous monitoring reports that were sampled from all children in foster care at a given point in time and which contained large proportions of cases whose children had been in the foster care system for several years.

Even though these children are by and large new to DCFS, they bring with them substantial problems but also great opportunities to prevent the lasting effects of maltreatment and avoid the disruptive effects on children that can follow from long-term involvement in out-of-home care. They make it clear that the problems of children in out-of-home care do not begin when children are removed but perhaps could be prevented if addressed before they need to be removed. This makes the Department's efforts to enhance front-end services through programs like Differential Response and the local Family Advocacy Centers, important to track and monitor. Understanding the well-being of these children could help DCFS respond in ways that prevent the much more serious threats to well-being that can affect children in out-of-home care.



APPENDIX A

Outcome Data By Region, Gender, Age And Race[1]

Please note that the tables and figures in this report present data in such a way that positive changes or improvements over time are characterized by increasing numbers and trend lines. The State Fiscal Year is used.

1 This data was generated by the Children and Family Research Center from the December 31, 2009 data extract of the Illinois Department of Children and Family Services Integrated Database. Due to missing data on some variables, the sum of demographic breakouts may not always add up to the total for that indicator. For instance, data on geographic region is not always available for each child; therefore, the total number of children in Central, Cook, Northern and Southern regions will sometimes be less than the total for the state.

Prevalence of Child Abuse and/or Neglect

Indicator 1.A	Of all children under age 18, what number and rate per 1,000 did not have an indicated report of child abuse and/or neglect?													
	2003		2004		2005		2006		2007		2008		2009	
						Illinois								
Children Under 18	3,340,467		3,372,754		3,405,352		3,438,266		3,471,497		3,505,050		3,538,927	
No Indicated Reports	3,314,662		3,347,041		3,379,455		3,413,468		3,445,039		3,477,235		3,511,400	
Rate	992.28		992.38		992.40		992.79		992.38		992.06		992.22	
	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate
Illinois	3,314,662	992.28	3,347,041	992.38	3,379,455	992.40	3,413,468	992.79	3,445,039	992.38	3,477,235	992.06	3,511,400	992.22
Central	537,071	988.94	535,099	987.30	533,998	987.25	533,259	987.88	531,085	985.84	529,820	985.47	528,597	985.18
Cook	1,428,801	994.60	1,442,721	995.03	1,456,456	995.20	1,470,469	995.93	1,483,903	995.20	1,497,614	995.01	1,512,242	995.20
Northern	1,067,076	995.34	1,091,108	995.38	1,115,528	995.29	1,140,577	995.27	1,165,250	994.45	1,190,694	993.82	1,217,465	993.83
Southern	292,805	989.75	291,929	989.57	290,865	988.74	290,307	989.62	288,942	987.74	288,037	987.42	287,456	988.20
African American	616,237	985.20	622,716	986.14	628,793	986.34	635,249	987.03	640,953	986.47	646,818	986.07	653,317	986.55
Hispanic	645,370	996.77	680,587	996.92	717,868	997.26	756,970	997.31	798,099	997.24	841,580	997.31	887,623	997.59
White	2,166,457	993.77	2,169,967	993.60	2,173,554	993.47	2,178,244	993.83	2,181,208	993.41	2,184,395	993.08	2,188,389	993.12

Safety From Maltreatment Recurrence at 12 Months

Indicator 1.B	Of all children with a substantiated report, what percentage did not have another substantiated report within 12 months?													
	2002		2003		2004		2005		2006		2007		2008	
						Illinois								
Children with Substantiated Report	25,267		25,805		25,713		25,897		24,798		26,458		27,815	
Children without Substantiated Recurrence within 12 months	22,313		22,839		22,748		22,957		21,967		23,430		24,614	
Percent	88.3%		88.5%		88.5%		88.6%		88.6%		88.6%		88.5%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	22,313	88.3%	22,839	88.5%	22,748	88.5%	22,957	88.7%	21,967	88.6%	23,430	88.6%	24,614	88.5%
Central	4,993	86.2%	5,064	84.3%	5,898	85.7%	5,983	86.8%	5,692	87.1%	6,555	85.9%	6,758	86.5%
Cook	7,096	91.1%	7,104	91.6%	6,496	91.1%	6,333	91.6%	6,028	91.3%	6,485	91.6%	6,843	91.4%
Northern	4,269	89.7%	4,510	90.2%	4,569	90.2%	4,719	89.4%	4,847	89.3%	5,846	89.8%	6,581	89.0%
Southern	2,434	83.1%	2,584	85.2%	2,619	85.4%	2,808	84.6%	2,608	85.2%	3,058	85.3%	3,121	85.2%
Female	11,615	88.9%	11,812	89.1%	11,551	88.8%	11,785	88.9%	11,336	89.6%	11,868	88.9%	12,538	88.7%
Male	10,606	87.6%	10,904	87.8%	11,024	88.0%	11,001	88.2%	10,479	87.5%	11,398	88.1%	11,920	88.2%
Under 3	6,120	88.2%	6,223	88.4%	6,285	88.2%	6,308	87.7%	6,342	88.6%	6,680	88.1%	7,208	87.5%
3 to 5	4,202	86.1%	4,319	87.1%	4,392	86.3%	4,597	87.4%	4,285	86.6%	4,697	87.0%	4,939	87.5%
6 to 8	3,826	86.9%	3,970	87.3%	3,862	87.8%	3,901	87.5%	3,739	86.7%	4,181	88.2%	4,178	87.9%
9 to 11	3,531	89.1%	3,519	88.4%	3,445	89.2%	3,252	89.5%	3,087	89.0%	3,131	88.3%	3,399	88.5%
12 to 14	2,822	89.6%	2,923	89.9%	3,023	90.6%	3,011	90.6%	2,672	91.0%	2,738	90.5%	2,900	90.7%
15 to 17	1,787	93.6%	1,858	93.0%	1,722	91.8%	1,873	93.1%	1,830	93.3%	1,984	92.4%	1,971	92.4%
African American	8,477	90.3%	8,319	89.9%	7,839	89.6%	7,819	89.8%	7,502	89.9%	7,882	89.6%	8,121	88.9%
Hispanic	2,231	92.0%	1,912	91.4%	1,972	93.6%	1,837	93.2%	1,855	91.0%	2,024	91.6%	2,110	92.8%
Other	907	88.2%	778	88.5%	811	91.7%	830	90.0%	818	91.5%	901	92.1%	1,049	88.7%
White	10,698	86.1%	11,830	87.1%	12,126	86.8%	12,471	87.3%	11,792	87.2%	12,623	87.2%	13,334	87.6%

Safety From Maltreatment Recurrence Among Families Receiving No Services

Indicator 1.C	Of all children in an initial substantiated report who did not receive intact or foster care services, what percentage did not have another substantiated report within 12 months?													
	2002		2003		2004		2005		2006		2007		2008	
	Illinois													
Number of Children not Receiving Services	13,182		13,793		13,465		13,443		13,724		15,587		16,278	
Children without Substantiated Report	11,718		12,255		11,979		11,979		12,189		13,935		14,479	
Percent	88.9%		88.9%		89.0%		89.1%		88.2%		89.4%		89.0%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	11,718	88.9%	12,255	88.9%	11,979	89.0%	11,979	89.1%	12,189	88.2%	13,935	89.4%	14,479	89.0%
Central	2,938	86.7%	2,985	85.6%	3,442	87.3%	3,475	87.4%	3,327	86.5%	3,898	86.0%	4,171	86.3%
Cook	3,954	90.2%	4,116	90.8%	3,628	90.5%	3,212	91.5%	3,585	91.0%	3,984	92.4%	3,933	91.2%
Northern	3,354	91.1%	3,507	90.6%	3,298	90.6%	3,667	90.8%	3,767	90.4%	4,318	91.3%	4,658	90.4%
Southern	1,472	85.3%	1,647	86.7%	1,611	85.9%	1,625	84.8%	1,510	85.4%	1,735	86.2%	1,717	86.9%
Female	6,317	89.5%	6,513	89.4%	6,349	89.6%	6,314	89.6%	6,421	89.7%	7,223	89.9%	7,585	89.2%
Male	5,401	88.2%	5,742	88.2%	5,630	88.3%	5,665	88.5%	5,768	87.9%	6,712	88.9%	6,894	88.7%
Under 3	2,617	85.2%	2,697	85.3%	2,693	84.7%	2,600	85.1%	2,841	86.2%	3,353	86.1%	3,642	85.5%
3 to 5	2,270	88.1%	2,372	88.2%	2,427	88.1%	2,474	88.4%	2,357	86.8%	2,870	88.8%	2,932	88.3%
6 to 8	2,136	88.2%	2,208	88.3%	2,153	89.7%	2,142	89.0%	2,211	88.6%	2,595	90.1%	2,539	88.5%
9 to 11	1,899	90.0%	2,039	89.6%	1,904	90.5%	1,837	90.2%	1,905	89.7%	1,977	90.4%	2,104	90.2%
12 to 14	1,618	91.8%	1,717	91.0%	1,740	92.0%	1,767	91.7%	1,665	91.8%	1,789	91.2%	1,899	92.5%
15 to 17	1,178	95.2%	1,222	95.6%	1,062	93.8%	1,159	95.3%	1,210	94.8%	1,351	94.3%	1,363	94.7%
African American	4,018	89.6%	4,025	88.4%	3,700	89.0%	3,545	88.7%	3,661	88.6%	4,333	90.3%	4,281	87.9%
Hispanic	1,401	92.4%	1,206	91.7%	1,197	93.3%	1,083	93.2%	1,261	91.3%	1,384	92.4%	1,396	93.8%
Other	439	90.1%	433	89.7%	463	93.2%	465	92.1%	487	93.1%	558	93.2%	660	91.3%
White	5,860	87.5%	6,591	88.6%	6,619	87.9%	6,886	88.5%	6,780	88.2%	7,660	88.1%	8,142	88.5%

Safety From Maltreatment Recurrence Among Intact Family Cases

Indicator 1.D	Of all children served at home in intact families, what percentage did not have another substantiated report within 12 months?													
	2002		2003		2004		2005		2006		2007		2008	
	Illinois													
Number of Children in Intact Family Cases	21,068		19,992		20,011		19,309		17,161		16,457		15,466	
Children without Substantiated Report	19,031		17,920		17,926		17,206		15,269		14,490		13,577	
Percent	90.3%		89.6%		89.6%		89.1%		89.0%		88.0%		87.8%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	19,031	90.3%	17,920	89.6%	17,926	89.6%	17,206	89.1%	15,269	89.0%	14,490	88.0%	13,577	87.8%
Central	6,063	88.5%	5,405	86.6%	5,914	87.7%	5,360	86.0%	4,930	86.4%	3,826	84.4%	3,308	85.7%
Cook	7,334	93.1%	7,689	93.4%	6,624	92.8%	7,039	93.4%	6,019	94.6%	6,484	92.4%	5,655	92.0%
Northern	2,339	89.7%	2,461	89.9%	2,536	88.2%	2,149	86.2%	1,998	86.2%	1,959	86.2%	2,445	84.1%
Southern	2,283	86.0%	1,911	83.7%	1,978	84.8%	2,284	87.5%	1,948	85.0%	1,851	83.2%	1,857	83.7%
Female	9,506	90.5%	8,964	89.7%	8,787	89.7%	8,475	89.4%	7,605	89.6%	7,225	88.4%	6,734	88.6%
Male	9,516	90.2%	8,946	89.6%	9,116	89.5%	8,703	88.8%	7,629	88.3%	7,236	87.7%	6,827	87.1%
Under 3	4,198	86.6%	3,974	85.3%	3,962	85.9%	3,928	84.2%	3,720	85.4%	3,491	83.9%	3,286	82.4%
3 to 5	3,454	88.1%	3,197	88.3%	3,207	86.6%	3,096	87.3%	2,894	86.7%	2,669	86.7%	2,571	86.2%
6 to 8	3,345	90.6%	3,132	89.4%	2,972	88.8%	2,868	88.2%	2,501	87.4%	2,463	87.2%	2,291	87.9%
9 to 11	3,144	90.6%	2,909	90.6%	2,885	91.2%	2,567	91.3%	2,179	90.1%	1,985	88.2%	1,900	89.3%
12 to 14	2,533	93.2%	2,500	92.0%	2,560	92.3%	2,434	91.9%	1,980	92.3%	1,904	91.1%	1,763	91.7%
15 to 17	2,357	97.5%	2,208	96.8%	2,340	97.1%	2,313	97.0%	1,995	97.6%	1,978	96.5%	1,766	96.1%
African American	8,489	92.5%	7,827	92.3%	7,674	91.4%	7,483	91.6%	6,623	91.8%	6,582	89.7%	5,765	89.8%
Hispanic	1,902	91.8%	2,021	93.5%	1,565	92.8%	1,536	92.8%	1,327	91.6%	1,432	91.7%	1,398	91.0%
Other	545	88.2%	393	89.3%	470	91.3%	439	87.5%	390	93.8%	462	92.0%	395	87.8%
White	8,095	88.0%	7,679	86.1%	8,217	87.2%	7,748	86.2%	6,929	85.7%	6,014	85.2%	6,019	85.2%

Safety From Maltreatment Recurrence in Substitute Care

Indicator 1.E	Of all children ever served in substitute care during the year, what percentage did not have a substantiated report during placement?													
	2003		2004		2005		2006		2007		2008		2009	
	Illinois													
Children ever in Substitute Care	29,065		26,306		24,971		23,467		22,472		22,121		21,827	
Children without Substantiated Reports	28,683		25,974		24,649		23,210		22,168		21,780		21,455	
Percent	98.7%		98.7%		98.7%		98.9%		98.6%		98.5%		98.3%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	28,683	98.7%	25,974	98.7%	24,649	98.7%	23,210	98.9%	22,168	98.6%	21,780	98.5%	21,455	98.3%
Central	4,985	98.4%	4,872	97.9%	4,937	97.7%	5,022	98.6%	5,270	98.1%	5,454	98.2%	5,458	97.6%
Cook	16,207	98.9%	13,860	99.2%	12,481	99.1%	10,897	99.2%	9,717	99.1%	9,083	99.2%	8,534	98.9%
Northern	3,115	98.1%	2,974	98.4%	3,085	98.7%	3,199	98.7%	3,183	98.3%	3,313	97.9%	3,596	97.7%
Southern	2,062	98.2%	2,155	98.5%	2,280	98.6%	2,381	98.1%	2,404	97.8%	2,441	96.9%	2,561	98.2%
Female	13,593	98.8%	12,257	98.8%	11,596	98.7%	10,941	99.0%	10,395	98.5%	10,224	98.4%	10,195	98.2%
Male	15,075	98.6%	13,706	98.7%	13,036	98.7%	12,241	98.8%	11,746	98.8%	11,522	98.5%	11,229	98.4%
Under 3	10,540	98.7%	9,416	98.6%	9,083	98.6%	8,714	98.7%	8,410	98.5%	8,287	98.3%	8,259	98.1%
3 to 5	5,227	98.5%	4,605	98.4%	4,319	98.4%	4,083	98.6%	3,835	98.1%	3,836	98.4%	3,682	98.0%
6 to 8	4,705	98.5%	4,224	98.6%	3,885	98.8%	3,562	99.1%	3,286	98.6%	3,114	98.1%	2,977	98.1%
9 to 11	3,998	98.7%	3,583	98.9%	3,242	98.8%	2,876	99.3%	2,665	98.9%	2,506	98.4%	2,395	98.4%
12 to 14	3,051	98.9%	2,936	99.1%	2,800	99.1%	2,647	99.1%	2,581	99.2%	2,544	98.9%	2,524	98.7%
15 to 17	1,159	99.5%	1,207	99.8%	1,319	99.5%	1,327	99.6%	1,391	99.4%	1,493	99.5%	1,618	99.4%
African American	19,290	98.9%	16,884	98.9%	15,483	99.0%	14,131	99.1%	13,154	98.9%	12,517	98.7%	12,080	98.5%
Hispanic	1,596	98.4%	1,401	98.8%	1,418	98.9%	1,322	99.1%	1,288	99.0%	1,301	98.4%	1,253	98.7%
Other	659	97.2%	537	98.4%	513	98.5%	484	98.2%	492	98.6%	489	97.6%	504	98.6%
White	7,138	98.3%	7,152	98.3%	7,235	98.1%	7,273	98.5%	7,234	98.2%	7,473	98.1%	7,618	97.9%

Safety From Maltreatment Re-Reports Among Children in Initially Unfounded Investigations

Indicator 1.F	Of all children with an initial unfounded report, what percentage did not have a re-report during the year?													
	2002		2003		2004		2005		2006		2007		2008	
	Illinois													
Children with Initial Unfounded Report	55,124		56,437		62,332		67,669		67,385		67,716		66,281	
Children without Additional Reports	42,031		41,373		45,878		51,645		52,734		53,647		54,164	
Percent	76.3%		73.3%		73.6%		76.3%		78.3%		79.2%		81.7%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	42,031	76.3%	41,373	73.3%	45,878	73.6%	51,645	76.3%	52,734	78.3%	53,647	79.2%	54,164	81.7%
Central	9,164	71.2%	9,284	68.2%	10,313	67.9%	11,889	71.0%	12,460	72.7%	13,086	74.2%	13,384	77.3%
Cook	17,349	81.5%	16,900	79.7%	18,256	80.0%	19,850	82.3%	19,479	83.9%	18,790	84.5%	18,651	86.5%
Northern	10,238	76.2%	10,139	73.2%	11,250	73.8%	13,068	76.8%	13,779	78.7%	14,593	80.0%	14,729	82.2%
Southern	5,285	71.5%	5,050	65.4%	6,059	66.7%	6,838	70.0%	7,016	73.8%	7,178	75.0%	7,400	78.2%
Female	20,803	75.8%	20,405	72.8%	22,559	72.9%	25,252	75.9%	25,739	77.6%	26,469	78.7%	26,611	81.3%
Male	20,384	76.1%	20,086	73.1%	22,186	74.5%	24,930	75.9%	25,665	78.2%	26,136	79.3%	26,384	81.6%
Under 3	8,460	76.7%	8,131	72.9%	8,995	73.0%	9,850	76.5%	10,208	79.6%	10,557	80.1%	10,726	82.6%
3 to 5	8,259	74.2%	8,227	71.5%	9,029	71.8%	10,106	74.8%	10,045	76.4%	10,551	78.5%	10,466	80.9%
6 to 8	7,767	73.9%	7,617	71.9%	7,973	70.9%	9,270	74.7%	9,558	76.9%	9,715	77.5%	9,870	80.1%
9 to 11	6,763	74.1%	6,638	71.2%	7,287	72.5%	8,189	75.1%	8,257	77.1%	8,098	77.9%	8,289	81.4%
12 to 14	5,669	75.6%	5,956	72.5%	6,911	73.7%	7,628	74.8%	7,775	76.1%	7,767	76.9%	7,779	79.9%
15 to 17	5,111	87.7%	4,784	85.1%	5,683	84.3%	6,602	85.1%	6,890	85.8%	6,959	85.6%	7,034	86.6%
African American	14,610	78.2%	14,764	76.5%	16,291	77.0%	17,940	79.4%	17,879	80.6%	17,944	81.4%	17,479	83.4%
Hispanic	4,644	82.0%	3,606	78.4%	4,027	79.8%	4,323	82.4%	4,521	83.0%	4,678	84.4%	4,444	86.3%
Other	2,326	83.9%	1,769	82.6%	2,162	82.4%	2,366	86.1%	2,363	86.4%	2,383	88.0%	2,528	87.7%
White	20,449	73.0%	21,214	69.8%	23,398	69.8%	27,016	72.9%	27,970	75.5%	28,642	76.5%	29,713	79.7%

Safety From Maltreatment Recurrence Among Children in Initially Unfounded Investigations

Indicator 1.G	Of all children with an initial unfounded report, what percentage did not have a substantiated report during the year?													
	2002		2003		2004		2005		2006		2007		2008	
						Illinois								
Children with Initial Unfounded Report	55,124		56,437		62,332		67,669		67,385		67,716		66,281	
Children without *Substantiated* Report	52,686		53,865		59,365		64,815		64,667		64,606		63,430	
Percent	95.6%		95.5%		95.2%		95.8%		96.0%		95.4%		95.7%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	52,688	95.6%	53,885	95.5%	59,365	95.2%	64,815	95.8%	64,668	96.0%	64,606	95.4%	63,430	95.7%
Central	12,228	94.3%	12,803	93.9%	14,175	93.4%	15,798	94.3%	16,169	93.4%	16,522	93.7%	16,274	94.0%
Cook	20,662	96.7%	20,586	97.0%	22,103	96.8%	23,466	97.3%	22,638	97.5%	21,591	97.1%	20,988	97.3%
Northern	12,854	95.7%	13,261	95.7%	14,619	95.9%	16,345	96.0%	16,847	96.2%	17,486	95.8%	17,167	96.0%
Southern	6,944	94.4%	7,235	93.6%	8,468	93.2%	9,206	94.2%	9,014	94.8%	9,007	94.1%	9,001	95.1%
Female	26,168	95.4%	26,734	95.4%	29,422	95.1%	31,840	95.7%	31,775	95.8%	32,083	95.4%	31,297	95.6%
Male	25,632	95.6%	26,218	95.4%	28,747	95.3%	31,435	95.7%	31,476	96.0%	31,418	95.3%	30,916	95.6%
Under 3	10,457	94.8%	10,531	94.5%	11,516	93.4%	12,178	94.6%	12,183	94.9%	12,348	94.2%	12,275	94.5%
3 to 5	10,601	95.3%	10,942	95.1%	11,959	95.1%	12,899	95.4%	12,541	95.3%	12,757	94.9%	12,316	95.2%
6 to 8	10,030	95.5%	10,129	95.6%	10,675	94.9%	11,854	95.5%	11,906	95.8%	11,898	94.9%	11,772	95.6%
9 to 11	8,722	95.5%	8,913	95.6%	9,627	95.8%	10,468	96.0%	10,318	96.3%	9,938	95.6%	9,748	95.7%
12 to 14	7,175	95.7%	7,877	95.9%	9,016	96.2%	9,828	96.3%	9,862	96.5%	9,708	96.2%	9,372	96.2%
15 to 17	5,701	97.9%	5,473	97.3%	6,572	97.5%	7,588	97.9%	7,857	97.8%	7,957	97.8%	7,947	97.9%
African American	17,931	96.0%	18,592	96.3%	20,332	96.1%	21,797	96.4%	21,410	96.5%	21,153	95.9%	20,162	96.2%
Hispanic	5,484	96.8%	4,430	96.4%	4,874	96.6%	5,100	97.2%	5,282	97.0%	5,332	96.7%	4,984	96.8%
Other	2,671	96.4%	2,077	96.6%	2,540	96.8%	2,682	97.5%	2,679	97.9%	2,628	97.0%	2,804	97.3%
White	26,600	95.0%	28,766	94.7%	31,619	94.4%	35,236	95.1%	35,296	95.3%	35,493	94.8%	35,480	95.2%

Stability in Intact Family Homes

Indicator 2.A	Of all children served in in intact family cases, what percentage did not experience substitute care placement within 12 month period?													
	2002		2003		2004		2005		2006		2007		2008	
	Illinois													
Children in Intact Families	21,068		19,992		20,011		19,309		17,161		16,457		15,466	
No Substitute Care Placement	19,945		18,942		18,901		18,131		16,240		15,411		14,482	
Percent	95%		95%		94%		94%		95%		94%		94%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	19,945	95%	18,942	95%	18,901	94%	18,131	94%	16,240	95%	15,411	94%	14,482	94%
Central	6,506	95%	5,854	94%	6,361	94%	5,842	94%	5,322	93%	4,109	91%	3,511	91%
Cook	7,479	95%	7,903	96%	6,856	96%	7,247	96%	6,273	97%	6,784	97%	5,937	97%
Northern	2,451	94%	2,586	94%	2,641	92%	2,233	90%	2,137	92%	2,093	92%	2,662	92%
Southern	2,481	93%	2,119	93%	2,167	93%	2,412	92%	2,130	93%	2,047	92%	2,041	92%
Female	9,947	95%	9,499	95%	9,260	95%	8,940	94%	8,040	95%	7,688	94%	7,149	94%
Male	9,987	95%	9,432	94%	9,616	94%	9,162	94%	8,165	94%	7,691	93%	7,313	93%
Under 3	4,465	92%	4,288	92%	4,229	92%	4,256	91%	4,027	92%	3,770	91%	3,588	90%
3 to 5	3,709	95%	3,434	95%	3,475	94%	3,306	93%	3,138	94%	2,871	93%	2,777	93%
6 to 8	3,515	95%	3,333	95%	3,175	95%	3,079	95%	2,719	95%	2,659	94%	2,458	94%
9 to 11	3,292	95%	3,070	96%	3,008	95%	2,673	95%	2,309	95%	2,128	95%	2,031	95%
12 to 14	2,588	95%	2,582	95%	2,648	95%	2,503	95%	2,051	96%	1,972	94%	1,835	95%
15 to 17	2,376	98%	2,235	98%	2,366	98%	2,314	97%	1,996	98%	2,011	98%	1,793	98%
African American	8,694	95%	8,044	95%	7,871	94%	7,703	94%	6,865	95%	6,905	94%	6,060	94%
Hispanic	1,971	95%	2,103	97%	1,636	97%	1,583	96%	1,416	98%	1,488	95%	1,493	97%
Other	567	92%	415	94%	480	93%	479	95%	402	97%	482	96%	424	94%
White	8,713	95%	8,380	94%	8,914	95%	8,366	93%	7,557	93%	6,536	93%	6,505	92%

Stability in Substitute Care

Indicator 2.B	Of all children entering substitute care and staying for at least one year, what percentage had no more than two placements within a year of removal?													
	2002		2003		2004		2005		2006		2007		2008	
	Illinois													
Entering and Staying One Year	4,183		3,892		3,769		3,995		3,563		3,569		4,131	
No More than Two Placements	3,265		3,064		3,016		3,210		2,831		2,824		3,251	
Percent	78%		79%		80%		80%		79%		79%		79%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	3,265	78%	3,064	79%	3,016	80%	3,210	80%	2,831	79%	2,824	79%	3,251	79%
Central	811	81%	925	78%	911	78%	967	83%	978	83%	1,110	82%	1,202	83%
Cook	1,454	77%	1,128	77%	967	80%	1,096	80%	673	76%	612	75%	816	72%
Northern	500	80%	456	82%	517	81%	583	81%	594	79%	475	79%	649	81%
Southern	321	76%	378	80%	426	83%	412	75%	449	77%	477	76%	487	79%
Female	1,632	78%	1,478	79%	1,420	80%	1,592	80%	1,408	79%	1,388	79%	1,572	78%
Male	1,631	78%	1,586	79%	1,595	80%	1,611	80%	1,412	80%	1,435	80%	1,669	80%
Under 3	1,529	86%	1,469	86%	1,392	87%	1,524	88%	1,379	86%	1,314	85%	1,482	84%
3 to 5	523	77%	451	76%	463	79%	487	80%	440	74%	438	79%	558	80%
6 to 8	407	76%	384	77%	362	78%	390	80%	335	77%	350	78%	388	77%
9 to 11	352	73%	336	77%	309	78%	318	73%	228	77%	255	73%	292	73%
12 to 14	295	63%	267	65%	310	69%	293	67%	239	70%	244	69%	305	75%
15 to 17	159	65%	157	66%	180	65%	198	64%	210	72%	223	71%	226	65%
African American	1,820	79%	1,639	79%	1,501	78%	1,636	80%	1,352	79%	1,271	78%	1,427	75%
Hispanic	218	72%	134	68%	150	82%	184	77%	122	71%	145	76%	158	73%
Other	84	75%	95	78%	47	84%	70	70%	64	85%	72	83%	85	81%
White	1,143	78%	1,196	80%	1,318	82%	1,320	82%	1,293	80%	1,336	81%	1,581	83%

Youth Who Do Not Run Away from Substitute Care

Indicator 2.C	Of all children entering care at the age of 12 or older, what percentage did not run away from a foster care placement during the year?													
	2002		2003		2004		2005		2006		2007		2008	
						Illinois								
Entered Substitute Care at 12 or Older	1,216		1,142		1,163		1,199		1,084		1,034		1,168	
Did Not Run Away During the Year	925		871		906		927		855		831		946	
Percent	76%		76%		78%		77%		79%		80%		81%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	925	76%	871	76%	906	78%	927	77%	855	79%	831	80%	946	81%
Central	233	78%	249	79%	244	82%	232	83%	251	87%	217	83%	239	84%
Cook	294	69%	227	65%	221	68%	277	67%	184	64%	214	72%	253	72%
Northern	175	81%	150	79%	155	76%	181	83%	154	77%	134	83%	156	81%
Southern	114	81%	117	84%	146	85%	142	84%	124	86%	133	83%	146	83%
Female	484	76%	428	74%	495	78%	490	76%	430	77%	429	78%	484	82%
Male	441	77%	443	78%	411	78%	437	79%	425	81%	402	83%	461	80%
12 to 14*	606	82%	571	84%	574	83%	557	84%	538	87%	468	87%	526	91%
15 or older*	319	66%	300	65%	332	71%	370	69%	317	68%	363	73%	420	71%
African American	438	73%	413	72%	440	73%	481	72%	434	75%	429	76%	517	80%
Hispanic	52	74%	35	73%	31	66%	47	72%	41	66%	39	76%	49	83%
Other	30	75%	17	71%	6	55%	17	85%	16	89%	12	80%	18	86%
White	405	80%	406	82%	429	85%	382	85%	364	85%	351	86%	362	82%

* Age at case opening

Least Restrictive Setting

Indicator 3.A	Of all the children in out-of-home care at the end of the fiscal year who were under the age of 12 at the start of the placement, what percentage were not placed in a group home or institution?													
	2003		2004		2005		2006		2007		2008		2009	
	Illinois													
Children under 12	13,392		12,409		11,935		11,418		10,767		11,018		10,962	
Not Placed in Institution or Group Home	12,999		12,082		11,663		11,159		10,491		10,698		10,668	
Percent	97%		97%		98%		98%		97%		97%		97%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	12,999	97%	12,082	97%	11,663	98%	11,159	98%	10,491	97%	10,698	97%	10,668	97%
Central	2,376	99%	2,486	99%	2,567	99%	2,681	99%	2,790	98%	2,931	98%	3,016	98%
Cook	7,412	96%	6,334	97%	5,719	97%	4,972	97%	4,270	96%	4,161	96%	3,747	97%
Northern	1,388	98%	1,434	98%	1,534	98%	1,683	99%	1,643	98%	1,825	98%	2,019	98%
Southern	997	98%	1,075	99%	1,156	98%	1,206	99%	1,232	99%	1,297	98%	1,459	98%
Female	6,266	98%	5,650	98%	5,453	99%	5,231	98%	4,935	98%	5,026	98%	5,090	98%
Male	6,727	96%	6,424	97%	6,196	97%	5,904	97%	5,534	97%	5,648	96%	5,562	96%
Under 3	5,202	99%	4,984	99%	5,018	99%	4,931	99%	4,700	100%	4,869	99%	4,874	99%
3 to 5	2,716	99%	2,578	99%	2,450	99%	2,422	99%	2,276	99%	2,333	99%	2,400	99%
6 to 8	2,597	97%	2,357	98%	2,202	97%	2,029	97%	1,927	97%	1,915	96%	1,888	96%
9 to 11	2,484	91%	2,163	92%	1,993	93%	1,777	92%	1,588	91%	1,581	90%	1,506	90%
African American	8,718	97%	7,675	97%	7,096	97%	6,543	97%	5,918	97%	5,883	97%	5,572	97%
Hispanic	766	97%	725	97%	706	98%	668	97%	656	97%	648	97%	620	96%
Other	334	98%	295	98%	291	98%	287	98%	269	99%	271	97%	312	98%
White	3,181	97%	3,387	98%	3,570	98%	3,661	98%	3,648	98%	3,896	98%	4,164	98%

Placing Children with Relatives-First Placements

Indicator 3.B.1	Of all children entering substitute care, what percentage is placed with kin in their first placement?													
	2003		2004		2005		2006		2007		2008		2009	
	Illinois													
Entering Substitute Care	5,300		5,039		5,299		4,773		4,503		5,211		4,804	
Placed with Kin	1,977		2,099		2,294		2,051		2,143		2,594		2,466	
Percent	37%		42%		43%		43%		48%		50%		51%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	1,977	37%	2,099	42%	2,294	43%	2,051	43%	2,143	48%	2,594	50%	2,466	51%
Central	610	40%	634	42%	713	47%	711	47%	917	56%	1,028	59%	877	55%
Cook	687	36%	622	41%	742	42%	458	36%	418	41%	542	39%	409	37%
Northern	340	45%	362	44%	406	45%	470	52%	393	52%	557	57%	681	63%
Southern	244	38%	361	49%	347	44%	342	42%	351	46%	397	49%	459	57%
Female	983	39%	982	41%	1,155	44%	1,043	44%	1,041	47%	1,279	51%	1,286	54%
Male	994	36%	1,115	42%	1,133	42%	1,002	42%	1,099	48%	1,306	49%	1,178	49%
Under 3	797	39%	799	42%	949	46%	851	45%	896	51%	1,069	52%	1,014	53%
3 to 5	343	43%	367	48%	410	51%	387	50%	398	58%	526	62%	467	62%
6 to 8	289	43%	304	48%	313	48%	294	51%	309	55%	363	58%	358	61%
9 to 11	235	36%	251	43%	262	44%	203	46%	239	52%	263	52%	267	56%
12 to 14	195	29%	246	36%	216	32%	193	31%	178	33%	222	38%	202	37%
15 to 17	118	26%	132	28%	144	27%	123	26%	123	25%	151	26%	158	31%
African American	1,028	36%	1,000	40%	1,113	42%	923	40%	957	45%	1,071	44%	993	47%
Hispanic	94	33%	100	42%	119	39%	86	36%	94	39%	136	46%	124	48%
Other	59	35%	41	48%	55	43%	50	50%	55	56%	54	41%	69	47%
White	796	39%	958	44%	1,007	46%	992	47%	1,037	51%	1,333	56%	1,280	56%

Placing Children With Relatives in Substitute Care

Indicator 3.B.2	Of all children in substitute care at the end of the year, what percentage is living with kin?													
	2003		2004		2005		2006		2007		2008		2009	
	Illinois													
In Substitute Care	20,144		18,458		17,596		16,709		15,551		15,675		15,499	
Living with Kin	7,278		6,833		6,734		6,303		5,958		6,297		6,074	
Percent	36%		37%		38%		38%		38%		40%		39%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	7,278	36%	6,833	37%	6,734	38%	6,303	38%	5,958	38%	6,297	40%	6,074	39%
Central	1,076	31%	1,192	34%	1,313	37%	1,460	39%	1,669	45%	1,867	48%	1,783	44%
Cook	4,457	39%	3,773	38%	3,474	39%	2,796	36%	2,330	34%	2,303	35%	1,972	32%
Northern	794	37%	846	39%	922	41%	1,054	44%	1,011	44%	1,182	47%	1,300	48%
Southern	471	32%	586	38%	648	40%	662	40%	654	39%	695	39%	809	42%
Female	3,701	39%	3,395	40%	3,298	41%	3,021	39%	2,918	41%	3,088	43%	3,021	42%
Male	3,572	33%	3,433	34%	3,428	36%	3,267	36%	3,025	36%	3,139	38%	3,045	37%
Under 3	1,389	41%	1,375	43%	1,476	45%	1,473	46%	1,439	47%	1,603	50%	1,562	50%
3 to 5	1,311	42%	1,292	43%	1,360	46%	1,374	47%	1,306	48%	1,416	50%	1,420	49%
6 to 8	1,075	40%	1,022	42%	980	43%	949	43%	955	44%	1,017	46%	980	45%
9 to 11	1,003	37%	924	38%	879	40%	794	41%	709	40%	753	42%	725	41%
12 to 14	911	29%	825	30%	835	32%	682	30%	627	30%	615	32%	553	31%
15 to 17	1,589	31%	1,395	30%	1,204	28%	1,031	25%	922	25%	893	24%	834	22%
African American	5,322	39%	4,677	39%	4,322	39%	3,754	37%	3,394	37%	3,464	38%	3,165	37%
Hispanic	336	30%	336	32%	359	36%	353	37%	374	40%	363	40%	315	36%
Other	140	31%	127	34%	128	34%	144	39%	128	36%	144	41%	158	40%
White	1,480	30%	1,703	34%	1,925	37%	2,052	39%	2,062	41%	2,326	44%	2,436	43%

In-State Placements

Indicator 3.C	Of all children placed in a group home or institution as of June 30th, what percentage is placed in Illinois?													
	2003		2004		2005		2006		2007		2008		2009	
	Illinois													
Placed in a Group Home or Institution	2,396		2,112		2,030		1,901		1,774		1,868		1,854	
Placed in Illinois	2,386		2,102		2,090		1,888		1,763		1,849		1,837	
Percent	99.6%		99.5%		99.0%		99.3%		99.4%		99.0%		99.1%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	2,386	99.6%	2,102	99.5%	2,090	99.0%	1,888	99.3%	1,763	99.4%	1,849	99.0%	1,837	99.1%
Central	284	100.0%	274	100.0%	271	99.6%	314	99.7%	318	100.0%	376	99.7%	369	99.2%
Cook	1,471	99.5%	1,242	99.4%	1,184	99.0%	1,041	99.3%	945	99.3%	922	98.6%	898	99.1%
Northern	233	99.6%	232	99.6%	232	98.7%	231	99.1%	229	99.6%	260	98.5%	278	98.2%
Southern	150	100.0%	139	99.3%	146	99.3%	135	99.3%	118	99.2%	145	100.0%	160	99.4%
Female	711	99.2%	639	99.4%	623	98.9%	581	99.3%	562	99.6%	620	99.8%	624	99.5%
Male	1,674	99.8%	1,462	99.6%	1,385	99.0%	1,306	99.3%	1,201	99.3%	1,229	98.6%	1,213	98.9%
Under 3	50	100.0%	44	97.8%	33	100.0%	28	100.0%	20	95.2%	44	100.0%	28	100.0%
3 to 5	28	100.0%	24	100.0%	22	100.0%	23	100.0%	27	100.0%	27	100.0%	20	100.0%
6 to 8	72	98.6%	59	98.3%	60	98.4%	62	98.4%	61	98.4%	76	98.7%	69	98.6%
9 to 11	240	99.2%	196	99.0%	159	98.8%	143	98.6%	164	98.8%	171	99.4%	171	100.0%
12 to 14	702	99.9%	579	99.7%	516	98.9%	495	99.4%	475	99.6%	447	99.3%	431	98.4%
15 to 17	1,292	99.5%	1,200	99.7%	1,219	99.0%	1,137	99.4%	1,016	99.5%	1,084	98.7%	1,118	99.2%
African American	1,642	99.6%	1,412	99.6%	1,353	98.8%	1,224	99.2%	1,132	99.1%	1,171	98.7%	1,141	99.2%
Hispanic	131	100.0%	106	98.1%	107	100.0%	106	100.0%	92	100.0%	96	99.0%	95	97.9%
Other	43	100.0%	30	100.0%	30	100.0%	27	100.0%	24	100.0%	30	100.0%	22	100.0%
White	570	99.5%	554	99.6%	519	99.2%	531	99.4%	515	99.8%	552	99.5%	579	99.0%

Placing Children Close to Home

Indicator 3.D	Of all children entering substitute care, what is the median distance from their home of origin?						
	2003	2004	2005	2006	2007	2008	2009
Illinois Traditional Foster Care							
Entered Substitute Care	2,363	2,109	1,971	1,864	1,677	1,749	1,623
Median Miles from Home	9.6	10.0	9.6	9.3	8.5	9.6	10.4
Illinois Kinship Foster Care							
Entered Substitute Care	2,031	2,092	2,402	2,042	2,088	2,609	2,419
Median Miles from Home	4.2	3.7	3.8	3.7	3.2	3.5	3.4
Central Region: Illinois Traditional Foster Care							
Entered Substitute Care	715	651	586	569	601	566	593
Median Miles from Home	9.4	10.6	9.9	6.9	5.2	8.6	12.3
Central Region: Illinois Kinship Foster Care							
Entered Substitute Care	602	638	731	719	861	985	849
Median Miles from Home	3.3	3.8	3.0	2.7	2.4	2.8	2.7
Cook County: Illinois Traditional Foster Care							
Entered Substitute Care	736	537	483	379	290	365	293
Median Miles from Home	8.8	9.8	9.7	9.9	8.5	8.5	7.5
Cook County: Illinois Kinship Foster Care							
Entered Substitute Care	736	623	811	461	426	616	452
Median Miles from Home	4.7	3.9	4.4	4.9	5.0	5.1	4.3
Northern Region: Illinois Traditional Foster Care							
Entered Substitute Care	332	366	376	321	274	310	310
Median Miles from Home	11.2	9.8	8.8	8.9	8.7	15.4	11.4
Northern Region: Illinois Kinship Foster Care							
Entered Substitute Care	322	360	403	454	378	543	640
Median Miles from Home	4.9	2.6	2.9	3.8	3.2	3.6	3.4
Southern Region: Illinois Traditional Foster Care							
Entered Substitute Care	324	314	344	372	318	312	295
Median Miles from Home	12.2	8.4	8.9	15.0	12.3	10.4	16.2
Southern Region: Illinois Kinship Foster Care							
Entered Substitute Care	266	355	368	339	359	397	431
Median Miles from Home	2.1	4.4	4.6	3.4	5.6	2.9	1.6

Preserving Sibling Bonds

Indicator 3.E	Of all children placed into foster care at the end of the year, what percentage is placed with their siblings? (Children with no siblings in foster care are excluded from the analysis.)						
	2003	2004	2005	2006	2007	2008	2009
				Illinois			
Traditional Foster Care				**2-3 Siblings**			
Children with 2-3 Siblings	3,339	3,115	2,837	2,568	2,508	2,344	2,287
Placed with All Siblings	1,726	1,711	1,632	1,475	1,477	1,411	1,357
Percent	52%	55%	58%	57%	59%	60%	59%
Kinship Foster Care				**2-3 Siblings**			
Children with 2-3 Siblings	3,202	3,040	3,151	3,102	2,947	3,180	3,016
Placed with All Siblings	2,045	2,000	2,194	2,180	2,039	2,237	2,127
Percent	64%	66%	70%	70%	69%	70%	71%
Traditional Foster Care				**4 or More Siblings**			
Children with 4 or More Siblings	1,719	1,591	1,557	1,363	1,201	1,134	1,192
Placed with All Siblings	228	238	227	202	181	218	200
Percent	13%	15%	15%	15%	15%	19%	17%
Kinship Foster Care				**4 or More Siblings**			
Children with 4 or More Siblings	1,746	1,631	1,561	1,450	1,315	1,426	1,368
Placed with All Siblings	474	500	502	573	536	604	569
Percent	27%	31%	32%	40%	41%	42%	42%

Permanence at 12 Months: Reunification

Indicator 4.A	Of all children who entered substitute care during the year and stayed for longer than 7 days, what percentage was reunified with their parents within 12 months from the date of entry into foster care?													
	2002		2003		2004		2005		2006		2007		2008	
	Illinois													
Entering Substitute Care	5,637		5,300		5,039		5,299		4,773		4,503		5,211	
In a Permanent Home at 12 Months	1,179		1,139		1,025		1,022		888		914		963	
Percent	21%		21%		20%		19%		19%		20%		18%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	1,179	21%	1,139	21%	1,025	20%	1,022	19%	888	19%	914	20%	963	18%
Central	431	31%	447	29%	407	27%	389	26%	316	21%	429	26%	373	22%
Cook	195	8%	229	12%	115	8%	115	7%	111	9%	79	8%	113	8%
Northern	238	28%	194	26%	175	21%	194	22%	172	19%	136	18%	213	22%
Southern	254	40%	220	34%	279	38%	297	37%	245	30%	249	33%	228	28%
Female	563	20%	523	21%	499	21%	521	20%	419	18%	431	20%	473	19%
Male	616	22%	615	22%	526	20%	500	19%	469	19%	482	21%	486	18%
Under 3	378	18%	368	18%	311	16%	319	16%	301	16%	322	18%	359	17%
3 to 5	201	23%	208	26%	171	22%	203	25%	173	22%	174	25%	176	21%
6 to 8	163	23%	158	23%	165	26%	132	20%	132	23%	142	25%	145	23%
9 to 11	160	23%	147	23%	142	24%	147	25%	97	22%	104	23%	99	19%
12 to 14	160	22%	156	23%	163	23%	117	18%	124	20%	91	17%	98	17%
15 to 17	117	24%	102	22%	73	16%	104	20%	61	13%	81	16%	86	15%
African American	417	14%	427	15%	334	13%	335	13%	326	14%	317	15%	302	12%
Hispanic	74	20%	73	26%	30	13%	60	19%	26	11%	50	21%	67	23%
Other	61	34%	49	29%	25	29%	18	14%	13	13%	28	28%	29	22%
White	627	30%	590	29%	636	29%	609	28%	523	25%	519	26%	565	24%

Permanence at 24 Months: Reunification + Adoption

Indicator 4.B	What percentage attained permanency (through reunification or adoption) within 24 months from the date of entry into foster care?													
	2001		2002		2003		2004		2005		2006		2007	
	Illinois													
Entering Substitute Care	5,828		5,637		5,300		5,039		5,299		4,773		4,503	
In a Permanent Home at 24 Months	2,197		2,137		1,989		1,780		1,884		1,730		1,685	
Percent	38%		38%		38%		35%		36%		36%		37%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	2,197	38%	2,137	38%	1,989	38%	1,780	35%	1,884	36%	1,730	36%	1,685	37%
Central	797	54%	713	51%	751	49%	691	46%	724	48%	674	45%	794	48%
Cook	519	22%	499	22%	458	24%	267	17%	286	16%	215	18%	187	18%
Northern	427	49%	413	48%	331	44%	302	36%	363	40%	327	36%	272	36%
Southern	316	48%	350	55%	319	49%	389	52%	412	52%	385	48%	352	47%
Female	1,047	37%	1,046	38%	939	37%	851	36%	955	37%	825	35%	797	36%
Male	1,150	38%	1,091	38%	1,049	38%	928	35%	926	34%	904	37%	886	38%
Under 3	800	37%	819	38%	780	38%	645	34%	728	36%	690	36%	680	39%
3 to 5	354	39%	353	41%	338	42%	304	40%	323	40%	318	41%	293	42%
6 to 8	310	41%	277	39%	260	39%	256	40%	259	40%	235	41%	245	44%
9 to 11	294	40%	281	41%	235	37%	234	40%	238	40%	171	39%	185	41%
12 to 14	268	35%	256	35%	244	36%	238	34%	199	30%	214	35%	170	31%
15 to 17	171	35%	151	31%	132	29%	103	22%	137	26%	102	22%	112	23%
African American	959	29%	903	30%	854	30%	668	26%	709	26%	681	29%	658	31%
Hispanic	108	33%	132	35%	114	40%	56	24%	105	34%	59	25%	85	35%
Other	84	40%	83	46%	71	43%	38	44%	32	25%	33	33%	40	40%
White	1,046	52%	1,019	49%	950	47%	1,018	46%	1,038	47%	957	45%	902	44%

Permanence at 36 Months: Reunification + Adoption + Guardianship

Indicator 4.C	What percentage attained permanency (through reunification, adoption, or subsidized guardianship) within 36 months from the date of entry into foster Care?													
	2000		2001		2002		2003		2004		2005		2006	
						Illinois								
Entering Substitute Care	5,970		5,828		5,637		5,300		5,039		5,299		4,773	
In a Permanent Home at 36 Months	3,296		3,273		3,167		2,859		2,732		2,799		2,539	
Percent	55%		56%		56%		54%		54%		53%		53%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	3,296	55%	3,273	56%	3,167	56%	2,859	54%	2,732	54%	2,799	53%	2,539	53%
Central	1,159	68%	1,030	69%	974	70%	1,034	67%	1,020	68%	1,028	67%	968	65%
Cook	1,024	44%	1,027	43%	979	42%	742	39%	549	36%	592	34%	409	34%
Northern	589	63%	581	67%	569	67%	458	61%	470	57%	507	56%	487	54%
Southern	345	60%	434	65%	425	66%	425	65%	504	68%	527	66%	495	61%
Female	1,685	56%	1,589	57%	1,567	57%	1,355	53%	1,292	54%	1,391	53%	1,225	52%
Male	1,610	54%	1,684	56%	1,599	56%	1,503	54%	1,437	54%	1,401	52%	1,308	54%
Under 3	1,411	61%	1,295	60%	1,321	62%	1,200	59%	1,087	57%	1,190	58%	1,094	58%
3 to 5	533	58%	551	60%	513	59%	469	59%	468	61%	481	59%	461	60%
6 to 8	452	57%	448	59%	409	57%	381	57%	390	61%	380	58%	330	57%
9 to 11	351	50%	423	58%	391	57%	339	53%	340	58%	328	55%	252	57%
12 to 14	376	50%	372	49%	353	48%	325	48%	327	47%	264	40%	285	46%
15 to 17	173	36%	184	37%	180	38%	145	32%	120	26%	156	29%	117	25%
African American	1,706	49%	1,606	49%	1,475	49%	1,293	46%	1,134	45%	1,165	44%	1,047	45%
Hispanic	161	56%	162	49%	185	49%	159	56%	107	45%	148	48%	102	43%
Other	110	64%	141	68%	117	65%	93	56%	49	57%	63	50%	53	53%
White	1,319	64%	1,364	68%	1,390	67%	1,314	65%	1,442	66%	1,423	65%	1,337	63%

Stability of Permanence at Two Years

Indicator 4.D	Of all children who attained permanence during the year (excluding placements of less than 8 days), what percentage remain with their families after two years?													
	2001		**2002**		**2003**		**2004**		**2005**		**2006**		**2007**	
						Illinois								
Attained Permanence	8,391		7,421		6,422		5,159		4,845		4,399		4,415	
Stable Placements (two years)	7,781		6,841		5,896		4,711		4,406		4,037		3,996	
Percent	93%		92%		92%		91%		91%		92%		91%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	7,781	93%	6,841	92%	5,896	92%	4,711	91%	4,406	91%	4,037	92%	3,996	91%
Central	1,360	87%	1,386	88%	1,202	86%	1,070	86%	1,116	87%	1,048	89%	1,209	88%
Cook	4,431	96%	3,641	96%	2,926	96%	2,119	97%	1,830	95%	1,496	95%	1,286	94%
Northern	887	89%	845	89%	803	90%	597	86%	564	87%	531	88%	638	89%
Southern	473	84%	442	86%	498	85%	509	88%	547	86%	597	90%	573	89%
Female	3,801	93%	3,327	93%	2,823	92%	2,342	92%	2,137	91%	1,979	92%	1,931	91%
Male	3,979	93%	3,514	91%	3,071	92%	2,368	91%	2,264	90%	2,056	91%	2,065	90%
Under 3	870	90%	967	89%	877	89%	771	89%	733	89%	699	90%	720	89%
3 to 5	1,793	94%	1,493	94%	1,362	94%	1,051	91%	1,036	91%	996	92%	1,082	93%
6 to 8	1,655	94%	1,299	94%	1,133	93%	830	93%	826	93%	743	94%	695	91%
9 to 11	1,556	95%	1,329	94%	1,075	94%	779	94%	724	94%	668	94%	581	92%
12 to 14	1,173	92%	1,046	91%	885	90%	766	91%	646	91%	560	89%	484	88%
15 to 17	734	87%	707	88%	564	87%	514	89%	441	86%	371	88%	434	88%
African American	5,493	95%	4,536	94%	3,745	94%	2,856	94%	2,488	92%	2,188	93%	2,118	92%
Hispanic	394	97%	410	96%	353	93%	209	91%	263	92%	198	93%	186	91%
Other	172	90%	186	91%	165	90%	114	93%	109	95%	69	85%	78	90%
White	1,722	87%	1,709	88%	1,633	87%	1,532	87%	1,546	88%	1,582	90%	1,614	89%

Stability of Permanence at Five Years

Indicator 4.E	Of all children who attained permanence during the year (excluding placements of less than 8 days), what percentage remain with their families after five years?													
	1998		1999		2000		2001		2002		2003		2004	
	Illinois													
Attained Permanence	10,415		13,430		11,301		8,391		7,421		6,422		5,159	
Stable Placements (five years)	9,084		12,013		10,107		7,447		6,512		5,586		4,454	
Percent	87%		89%		89%		89%		88%		87%		86%	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	9,084	87%	12,013	89%	10,107	89%	7,447	89%	6,512	88%	5,586	87%	4,454	86%
Central	1,174	75%	1,344	81%	1,376	83%	1,306	83%	1,299	82%	1,132	81%	1,015	81%
Cook	5,532	92%	7,815	93%	6,349	93%	4,245	92%	3,494	92%	2,789	91%	2,012	92%
Northern	879	81%	1,021	83%	929	82%	835	84%	799	84%	756	85%	562	81%
Southern	502	81%	605	83%	485	78%	460	82%	409	79%	473	80%	469	81%
Female	4,620	88%	6,087	90%	5,107	90%	3,634	89%	3,165	89%	2,670	87%	2,218	87%
Male	4,459	87%	5,924	89%	4,991	89%	3,812	89%	3,347	87%	2,914	87%	2,235	86%
Under 3	910	82%	1,043	84%	939	84%	832	86%	931	86%	843	86%	741	86%
3 to 5	2,297	90%	2,957	93%	2,493	92%	1,742	91%	1,440	91%	1,314	91%	1,019	89%
6 to 8	2,184	90%	2,928	92%	2,430	92%	1,588	90%	1,258	91%	1,083	89%	789	88%
9 to 11	1,755	89%	2,424	89%	2,055	90%	1,478	90%	1,250	89%	997	87%	717	86%
12 to 14	1,137	80%	1,622	85%	1,375	85%	1,088	85%	944	82%	801	82%	690	82%
15 to 17	801	85%	1,039	88%	815	88%	719	85%	689	86%	548	84%	498	86%
African American	6,606	89%	9,066	91%	7,560	91%	5,245	90%	4,317	89%	3,538	89%	2,701	89%
Hispanic	518	92%	582	90%	530	94%	382	94%	392	92%	330	87%	201	87%
Other	125	80%	151	81%	152	82%	168	88%	181	89%	154	84%	110	89%
White	1,835	80%	2,214	83%	1,865	83%	1,652	83%	1,622	83%	1,564	83%	1,442	82%

Stability of Permanence at Ten Years

Indicator 4.F	Of all children who attained permanence during the year (excluding placements of less than 8 days), what percentage remain with their families after ten years?											
	1994		1995		1996		1997		1998		1999	
	Illinois											
Attained Permanence	4,493		5,773		6,075		6,562		10,415		13,430	
Stable Placements (ten years)	3,194		4,333		4,656		5,120		8,801		11,703	
Percent	71%		75%		77%		78%		85%		87%	
	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	3,193	71%	4,333	75%	4,656	77%	5,120	78%	8,801	85%	11,703	87%
Central	930	67%	998	66%	973	67%	971	69%	1,106	71%	1,270	77%
Cook	1,041	75%	1,805	81%	2,205	84%	2,726	84%	5,884	89%	8,246	90%
Northern	510	70%	619	75%	627	70%	639	72%	850	78%	1,014	83%
Southern	338	66%	433	70%	435	71%	411	70%	471	76%	578	79%
Female	1,588	72%	2,176	76%	2,355	78%	2,604	79%	4,472	85%	5,890	87%
Male	1,605	71%	2,154	74%	2,299	76%	2,515	77%	4,324	84%	5,811	87%
Under 3	581	68%	714	71%	631	71%	614	72%	859	77%	1,007	81%
3 to 5	808	76%	967	78%	1,129	79%	1,264	80%	2,200	86%	2,814	88%
6 to 8	581	74%	842	78%	965	78%	1,118	81%	2,064	85%	2,787	87%
9 to 11	420	72%	678	79%	689	76%	800	79%	1,696	86%	2,377	88%
12 to 14	380	62%	522	66%	601	74%	649	75%	1,171	82%	1,666	87%
15 to 17	424	73%	609	75%	641	79%	675	78%	811	86%	1,052	89%
African American	1,528	70%	2,366	77%	2,791	80%	3,197	81%	6,408	87%	8,847	89%
Hispanic	208	79%	230	82%	269	82%	310	85%	501	89%	575	89%
Other	52	70%	75	76%	75	74%	80	71%	120	76%	141	75%
White	1,406	71%	1,662	72%	1,521	71%	1,533	72%	1,772	77%	2,140	80%

Median Length of Stay In Substitute Care

Indicator 4.G	Of children entering care for the first time during that fisal year, what is the median length of stay in substitute care?						
	2001	2002	2003	2004	2005	2006	2007
				Illinois			
	Months	Months	Months	Months	Months	Months	Months
Median Length of Stay	26	28	23	25	26	25	24
Region							
Central	18	16	21	21	20	23	22
Cook	31	37	24	28	34	25	18
Northern	18	19	23	27	24	28	27
Southern	12	11	14	13	13	16	15
Female	27	27	22	24	25	25	25
Male	26	28	24	26	27	25	23
Under 3	28	29	27	29	29	27	26
3 to 5	26	28	21	22	23	23	20
6 to 8	26	25	18	23	23	22	18
9 to 11	25	25	20	18	22	18	22
12 to 14	25	28	13	22	30	22	25
15 to 17	13	15	15	16	21	18	23
African American	31	31	27	30	32	30	26
Hispanic	24	32	15	31	31	29	20
Other	19	20	21	15	31	21	28
White	16	18	19	18	19	21	22

APPENDIX B

Child Well-Being Indicators

Data provided in the following pages come from the Illinois Survey of Child and Adolescent Well-Being (ISCAW), which utilized caseworker, child, caregiver and teacher interviews conducted approximately 3 to 4 months following the end of a substantiated investigation. ISCAW is a component of the National Survey of Child and Adolescent Well-Being (NSCAW), a longitudinal probability study of well-being and service delivery for children who become involved with child welfare services.

Table B.1 Caregiver Risk Factors Data Reported by Caseworkers

	N	Alcohol Percent/SE	Substance Use Percent/SE	Domestic Violence Percent/SE	Mental Health Percent/SE	History of Arrest Percent/SE
Total	616	31% (3.7)	15% (2.9)	28% (2.7)	18% (3.7)	16% (2.6)
Child Setting			*		*	**
Traditional Foster	96	31% (6.0)	25% (4.8)	22% (5.2)	31% (6.6)	30% (5.2)
Kinship Care	124	31% (9.3)	25% (5.3)	19% (7.6)	32% (9.6)	40% (5.4)
In-Home	308	30% (3.7)	14% (3.0)	30% (3.0)	16% (3.5)	13% (2.7)
Region						
Cook	287	28% (1.7)	26% (.1)	20% (3.8)	26% (2.2)	26% (.1)
Central	170	35% (10.2)	11% (5.8)	33% (6.3)	19% (9.0)	15% (7.1)
Northern	111	29% (3.5)	13% (4.6)	34% 1.9)	10% (5.2)	10% (1.2)
Southern	48	28% (6.0)	15% (10.8)	13% 12.52)	21% (9.1)	19% (1.0)
Population Density				*		
Non-Rural	461	32% (2.5)	16% (3.6)	24% (3.4)	17% (2.6)	16% (2.9)
Rural	33	29% (9.4)	15% (3.6)	35% (2.7)	20% (8.0)	17% (4.4)
Sex			*			
Male	314	26% (2.9)	11% (4.5)	27% (3.1)	20% (3.9)	17% (2.9)
Female	302	35% (5.5)	20% (2.3)	29% (4.0)	16% (4.4)	16% (3.9)
Race/Ethnicity		[a]				[a]
African American	328	29% (4.9)	20% (3.2)	27% (4.9)	17% (2.9)	20% (3.7)
White	147	37% (6.9)	10% (2.1)	24% (3.0)	18% (6.0)	14% (2.7)
Hispanic	121	30% (4.6)	14% (5.4)	35% (4.3)	23% (8.0)	8% (3.2)
Other	20	1% (.8)	26% (20.2)	37% (14.2)	1% (1.0)	40% (16.6)
Child Age		**	*		[a]	
Under 3	368	0% (0)	26% (3.5)	28% (3.0)	24% (5.3)	20% (2.6)
3 to 5	95	18% (3.0)	14% (5.5)	29% (7.1)	23% (5.1)	16% (5.0)
6 to 8	54	78% (5.7)	9% (2.1)	28% (6.8)	9% (3.5)	12% (4.3)
9 to 11	56	57% (6.1)	10% (4.1)	26% (4.9)	6% (3.3)	14% (7.5)
12 to 17	43	46% (9.3)	5% (3.7)	29% (13.4)	16% (9.7)	17% (8.5)

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

Table B.2 Risk Factor Data Reported by Caregivers

	N	Average Family Income Mean/SE	Below Average Social Support Percent/SE	Poor Caregiver Physical Health Percent/SE	Poor Caregiver Mental Health Percent/SE
Total	571	28,445 (2395)	23% (2.4)	16% (1.6)	13% (2.8)
Child Setting		*[1]			*[2]
Traditional Foster Care	20	55,916 (6640)	0% (0)	5% (1.3)	1% (.6)
Kinship Care	69	38,834 (3314)	26% (11.7)	19% (5.0)	9% (4.2)
In-Home	467	24,533 (2635)	24% (2.8)	15% (2.2)	15% (3.1)
Region					
Cook	296	27,307 (4256)	28% (6.6)	11% (.20)	13% (2.3)
Central	127	26,992 (1092)	27% (.7)	18% (3.1)	10% (4.7)
Northern	87	29,829 (6101)	20% (5.0)	17% (1.3)	18% (6.8)
Southern	61	31,246 (8801)	11% (3.5)	19% (9.7)	12% (8.5)
Population Density		[a]			
Non-Rural	447	31,560 (2932)	19% (6.1)	15% (1.4)	12% (1.6)
Rural	124	23,469 (1448)	28% (2.5)	18% (2.6)	16% (6.2)
Sex					
Male	285	25,594 (3221)	25% (1.7)	14% (2.0)	17% (3.4)
Female	286	31,162 (2932)	22% (3.6)	17% (3.4)	10% (3.3)
Race/Ethnicity			*		
African American	285	28,003 (4156)	21% (4.7)	14% (2.5)	11% (3.3)
White	138	30,697 (5270)	17% (2.8)	19% (2.6)	16% (5.3)
Hispanic	132	24,824 (941)	32% (4.0)	15% (2.1)	13% (3.2)
Other	16	31,509 (7793)	48% (10.6)	12% (11.0)	14% (8.9)
Child Age					
Under 3	320	29,390 (2919)	18% (4.4)	10% (1.8)	12% (4.1)
3 to 5	93	26,166 (5116)	29% (7.4)	18% (5.8)	16% (5.1)
6 to 8	51	22,941 (3405)	15% (4.3)	20% (6.1)	12% (5.4)
9 to 11	51	33,469 (3292)	21% (8.0)	18% (6.6)	11% (5.0)
12 to 17	56	31,883 (7493)	33% (5.3)	18% (5.4)	17% (5.2)

Note: From various measures in the Caregiver Interview. Cells included means or percentages and standard errors. All analyses used weighted data. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result ([a]p< .10 *p < .05). [1] in-home < traditional foster, kin[2] traditional foster < in-home, kin

Table B.3 Percent of Youth 7 to 17 who Witnessed or were Exposed to Severe Violence

	N	Witnessed Percent/SE	Experienced Percent/SE
Total	**135**	**66% (4.1)**	**6% (2.3)**
Child Setting			**
Out-of-Home	**27**	**86% (8.5)**	**27% (8.8)**
In-Home	**103**	**64% (4.5)**	**3% (1.6)**
Region			
Cook	**59**	**59% (9.7)**	**3% (2.9)**
Central	**38**	**72% (2.9)**	**7% (4.8)**
Northern	**27**	**63% (10.6)**	**4% (2.5)**
Southern	**11**	-	-
Population Density		[a]	
Non-Rural	**103**	**62% (5.6)**	**8% (2.5)**
Rural	**32**	**74% (3.2)**	**2% (1.5)**
Sex			
Male	**68**	**66% (6.6)**	**9% (5.2)**
Female	**67**	**66% (4.6)**	**3% (2.3)**
Race/Ethnicity			
African American	**57**	**69% (10.8)**	**5% (3.5)**
White	**32**	**57% (11.5)**	**2% (2.3)**
Hispanic	**37**	**68% (5.8)**	**6% (3.1)**
Other	**9**	-	-
Child Age		[a]	
7 to 8	**22**	**77% (7.2)**	**0% (0)**
9 to 11	**51**	**52% (7.0)**	**5% (3.5)**
12 to 17	**62**	**74% (8.3)**	**9% (3.7)**

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

Table B.4 Health of Children

	N	Percent in Good Health[1] Percent/SE	Percent with a Well-Child Visit in Past Year Percent/SE	Caregiver Reports Special Healthcare Need[2] Percent/SE	Risk for Physical Disability[3] Percent/SE
Total	**225**	**95% (1.3)**	**88% (2.2)**	**40% (1.7)**	**2.2% (1.2)**
Child Setting					
Traditional Foster Care	**21**	**89% (6.9)**	**99% (.3)**	**48% (9.5)**	**1.2% (1.5)**
Kinship Care	**40**	**94% (2.3)**	**93% (4.2)**	**35% (4.8)**	**.4% (.4)**
In-Home	**157**	**96% (1.1)**	**87% (2.4)**	**40% (1.7)**	**2.6% (1.4)**
Region				[a]	
Cook	**95**	**92% (1.6)**	**89% (2.1)**	**36% (4.3)**	**2.7% (2.7)**
Central	**65**	**95% (2.4)**	**83% (6.5)**	**37% (2.4)**	**2.1% (1.9)**
Northern	**44**	**98% (1.3)**	**90% (1.6)**	**48% (4.2)**	**0% (0)**
Southern	**21**	**95% (1.8)**	**95% (.4)**	**33% (.7)**	**8.8% (4.4)**
Population Density					
Non-Rural	**164**	**94% (1.2)**	**89% (2.0)**	**38% (2.8)**	**3.5% (1.5)**
Rural	**61**	**96% (2.0)**	**88% (5.7)**	**42% (2.6)**	**0% (0)**
Sex				*	
Male	**107**	**94% (1.5)**	**87% (1.7)**	**48% (3.0)**	**2.0% (1.4)**
Female	**118**	**96% (1.3)**	**90% (2.9)**	**31% (4.7)**	**2.6% (1.8)**
Race/Ethnicity					
African American	**98**	**93% (2.4)**	**91% (1.1)**	**40% (3.4)**	**4.2% (2.3)**
White	**60**	**98% (1.3)**	**84% (4.6)**	**44% (3.8)**	**0% (0)**
Hispanic	**55**	**94% (3.0)**	**89% (4.4)**	**30% (5.1)**	**2.8% (2.6)**
Other	**12**	**95% (1.2)**	**9% (9.7)**	**51% (15.9)**	-
Child Age			*	**	
Under 3		**97% (1.9)**	**94% (1.5)**	**30% (3.3)**	-
3 to 5	**29**	**95% (3.0)**	**92% (2.2)**	**34% (4.8)**	**0% (0)**
6 to 8	**69**	**96% (3.3)**	**88% (4.8)**	**57% (4.6)**	**3.8% (2.9)**
9 to 11	**64**	**93% (3.0)**	**74% (8.6)**	**45% (6.6)**	**2.8% (2.6)**
12 to 17	**63**	**92% (3.4)**	**81% (5.0)**	**46% (4.9)**	**1.1% (1.2)**

Note: From various measures in the Caregiver Interview. All analyses used weighted data. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result ([a]p< .10 *p < .05, **p < .01). [1] "Good health" was defined as those children whose caregivers reported that they were in "good, very good, or excellent" health. [2] "Special Health Care need" was defined here using 2 overall sections of the caregiver reported child health and health services interview: chronic health and disability. For the first section, caregivers were asked about specific health problems, such as asthma, diabetes, etc., as well as specific questions about conditions that are expected to last at least one year (life-threatening allergic reaction, reduced effort, vision and hearing problems). The second section (disability) asks caregiver if a professional has ever told them that their child has a learning problem or special need. Some children have both chronic health conditions and disabilities, but were counted only once for special health care needs. [3] A physical disability is defined as a condition that substantially limits one or more basic physical activities, such as walking, climbing stairs, reaching, lifting, or carrying. This was measured for children 5-17 years of age and included cystic fibrosis, cerebral palsy, muscular dystrophy, blindness, deafness, traumatic brain injury, and orthopedic impairment.

Table B.5 Body Mass Index[1] (BMI) of Children Over the Age of 2

	N	Underweight Percent/SE	Healthy Weight Percent/SE	Overweight Percent/SE	Obese Percent/SE
Total	**267**	**11% (1.5)**	**42% (6.0)**	**14% (3.3)**	**33% (4.1)**
Child Setting					
Traditional Foster Care	**25**	**15% (7.0)**	**59% (17.1)**	**7% (4.6)**	**19% (7.7)**
Kinship Care	**58**	**15% (5.9)**	**31% (6.7)**	**26% (8.2)**	**28% (8.0)**
In-Home	**174**	**11% (2.0)**	**42% (7.3)**	**12% (3.2)**	**35% (4.1)**
Region					
Cook	**91**	**9% (5.0)**	**25% (5.6)**	**23% (4.4)**	**43% (3.7)**
Central	**94**	**13% (1.2)**	**42% (13.5)**	**13% (7.5)**	**32% (6.0)**
Northern	**57**	**11% (2.2)**	**54% (8.4)**	**5% (1.6)**	**30% (9.9)**
Southern	**25**	**8% (6.8)**	**42% (12.4)**	**27% (13.4)**	**23% (7.8)**
Population Density					
Non-Rural	**170**	**11% (2.0)**	**43% (5.7)**	**15% (3.4)**	**31% (4.7)**
Rural	**95**	**11% (1.9)**	**42% (11.8)**	**12% (6.7)**	**35% (5.9)**
Sex					
Male	**135**	**15% (2.5)**	**38% (6.1)**	**11% (1.5)**	**36% (4.5)**
Female	**132**	**8% (2.5)**	**45% (7.8)**	**17% (5.4)**	**30% (5.6)**
Race/Ethnicity					
African American	**104**	**9% (2.9)**	**40% (9.3)**	**13% (2.7)**	**38% (6.2)**
White	**87**	**14% (3.1)**	**50% (4.8)**	**10% (3.8)**	**26% (6.1)**
Hispanic	**59**	**13% (5.9)**	**30% (5.2)**	**26% (9.9)**	**31% (5.3)**
Other	**15**	**1% (.9)**	**46% (19.1)**	**0% (0)**	**53% (18.5)**
Child Age					
2 to 5	**110**	**12% (4.5)**	**42% (5.3)**	**10% (3.3)**	**35% (2.9)**
6 to 8	**52**	**17% (4.2)**	**37% (9.7)**	**9% (3.6)**	**37% (7.4)**
9 to 11	**47**	**11% (6.8**	**42% (7.1)**	**16% (4.1)**	**31% (8.5)**
12 to 17	**58**	**4% (2.9)**	**47% (12.8)**	**23% (9.1)**	**26% (8.5)**

Note: From the Child Health Questionnaire in the Caregiver Interview. All analyses used weighted data. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result. [1] Following Center for Disease Control methods, Body Mass Index (BMI) was calculated by age and gender of child with this equation: [weight/(height^2)] x 703. "Underweight" was lowest 5th percentile of BMI, "healthy weight" was between 5th percentile and 85th percentile, "overweight" was between 85th percentile and 95th percentile, and "obese" was above the 95th percentile.

Table B.6 Infant Development

	N	BINS average score Mean/SE	Percent at Risk for Developmental Delay Percent/SE
Total	**258**	**6.0 (.2)**	**64% (5.5)**
Child Setting			
Traditional Foster Care	**20**	**7.2 (.8)**	**55% (5.2)**
Kinship Care	**46**	**7.5 (.5)**	**44% (15.6)**
In-Home	**188**	**5.8 (.3)**	**66% (5.2)**
Region			
Cook	**163**	**5.3 (.1)**	**66% (4.3)**
Central	**49**	**5.8 (.8)**	**71% (14.9)**
Northern	**29**	**6.8 (.2)**	**57% (12.6)**
Southern	**17**	**7.0 (.8)**	**55% (11.9)**
Population Density			
Non-Rural	**217**	**6.0 (.2)**	**61% (3.6)**
Rural	**41**	**6.0 (.7)**	**70% (12.0)**
Sex			
Male	**129**	**5.6 (.3)**	**64% (7.5)**
Female	**129**	**6.4 (.3)**	**65% (5.0)**
Race/Ethnicity			
African American	**140**	**5.8 (.5)**	**69% (8.9)**
White	**55**	**6.3 (.3)**	**65% (17.2)**
Hispanic	**59**	**6.0 (.5)**	**55% (12.3)**
Other	**3**	**--**	**--**

Note: Children age 0 to 2. From the Bayley Infant Neurodevelopment Screener (BINS) in the Child Interview. All analyses used weighted data. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result.

Table B.7 Intellectual and Language Development

	N	K-BIT Composite Mean/SE	K-BIT Vocabulary Mean/SE	K-BIT Matrices Mean/SE	PLS Total Mean/SE	PLS Auditory Compre-hension. Mean/SE	PLS Expressive Communi-cation Mean/SE
Total	337	93.0 (1.2)	91.6 (1.3)	95.9 (1.1)	84.0 (2.0)	88.1 (1.5)	82.5 (2.2)
Child Setting							
Out-of-Home	75	89.5 (2.7)	84.0 (2.9)	97.2 (2.5)	84.9 (4.4)	86.9 (4.4)	83.1 (5.1)
In-Home	256	93.6 (1.3)	92.7 (1.4)	95.9 (1.2)	83.5 (1.9)	88.0 (1.5)	82.2 (2.2)
Region							
Cook	193	93.4 (1.0)	89.4 (.61)	98.8 (1.5)	81.9 (3.8)	87.7 (1.9)	78.8 (4.8)
Central	56	92.0 (2.9)	90.9 (2.8)	95.1 (2.1)	82.9 (2.6)	87.7 (.56)	80.3 (3.3)
Northern	47	94.4 (2.0)	95.1 (2.2)	94.7 (2.3)	87.4 (5.6)	89.8 (4.8)	87.4 (4.6)
Southern	41	91.3 (2.6)	88.4 (.6)	95.1 (4.5)	83.9 (.7)	86.9 (3.3)	84.0 (4.6)
Population Density							
Non-Rural	61	92.7 (1.2)	90.2 (1.0)	96.5 (1.3)	84.8 (2.3)	89.7 (1.6)	82.5 (2.7)
Rural	276	93.6 (2.5)	94.1 (2.5)	94.9 (1.9)	82.1 (2.4)	84.6 (1.1)	82.5 (3.0)
Sex				*			
Male	177	89.5 (1.4)	89.6 (2.0)	91.8 (1.0)	82.4 (2.9)	86.5 (2.8)	80.7 (2.6)
Female	160	96.0 (1.7)	93.3 (1.6)	99.5 (1.6)	85.8 (1.3)	90.1 (1.1)	84.7 (2.4)
Race/Ethnicity							
African American	186	93.3 (1.4)	89.5 (1.2)	98.4 (1.8)	82.0 (2.2)	86.9 (1.2)	80.1 (3.1)
White	88	94.7 (1.4)	97.0 (2.0)	93.5 (1.8)	86.4 (4.5)	88.8 (4.2)	87.0 (3.3)
Hispanic	57	88.3 (2.4)	84.8 (1.8)	94.2 (3.1)	82.7 (3.3)	86.7 (3.8)	79.7 (2.0)
Other	8	--	--	--	--	--	--
Child Age							
Under 3	(265-PLS)	N/A	N/A	N/A	84.5 (2.5)	88.0 (2.1)	84.5 (2.5)
3 to 5	45	90.1 (3.3)	94.1 (2.8)	89.0 (4.8)	83.3 (2.0)	88.3 (1.4)	80.0 (2.6)
6 to 8	47	95.0 (2.6)	94.4 (3.0)	96.6 (1.9)	N/A	N/A	N/A
9 to 11	48	96.4 (2.6)	90.8 (4.2)	102.6(1.9)	N/A	N/A	N/A
12 to 17	59	90.8 (3.3)	87.8 (2.5)	95.7 (3.9)	N/A	N/A	N/A

Note: From the Kaufman Brief Intelligence Test (K-BIT; children age 4 and older) and the Preschool Language Test (PLS; children age 0 to 6) in the Child Interview. "N/A" indicates that the measure is not applicable to a group. All analyses used weighted data. The sample sizes presented are unweighted. Cell results are omitted when cell n falls below 15. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result.

Table B.8 Daily Living Skills

	N	Low Percent/SE	Moderate Low Percent/SE	Adequate to High Percent/SE
Total	732	12% (1.4)	18% (1.7)	70% (1.2)
Child Setting				
Traditional Foster Care	142	22% (10.9)	25% (14.4)	52% (8.2)
Kinship Care	161	14% (8.6)	18% (2.8)	68% (9.6)
In-Home	412	11% (1.4)	18% (2.2)	71% (2.1)
Region				
Cook	377	15% (.4)	16% (1.5)	69% (2.0)
Central	171	7% (3.3)	18% (4.8)	75% (2.0)
Northern	118	13% (3.0)	19% (3.0)	67% (2.7)
Southern	66	11% (4.4)	22% (1.2)	67% (3.3)
Population Density[a]				
Non-Rural	564	15% (1.2)	17% (1.0)	69% (1.7)
Rural	168	7% (2.4)	21% (3.8)	72% (2.4)
Sex**				
Male	370	17% (2.0)	25% (3.5)	59% (2.4)
Female	362	7% (1.9)	12% (2.1)	81% (2.6)
Race/Ethnicity[a]				
African American	401	9% (3.3)	12% (2.8)	78% (2.3)
White	173	16% (4.3)	25% (3.6)	59% (4.7)
Hispanic	136	12% (5.8)	21% (2.4)	67% (6.4)
Other	20	1% (1.3)	0% (0)	99% (1.3)
Child Age**				
0 to 2	496	4% (1.4)	22% (3.2)	74% (2.3)
3 to 5	125	20% (2.7)	21% (3.8)	59% (2.9)
6 to 10	111	14% (3.3)	11% (2.1)	75% (3.9)

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

Table B.9 Percent of Children in Clinical/Borderline Clinical Range for Emotional and Behavior Problems

	Who Reported on Child/Youth's Problems?					
	Caregiver[1]		Teacher[2]		Youth[3]	
	N	Percent/SE	N	Percent/SE	N	Percent/SE
Total	401	29% (2.0)	96	34% (5.4)	85	27% (8.5)
Child Setting				[a]		
Out-of-Home	122	35% (7.9)	21	63% (16.8)	18	34% (15.0)
In-Home	266	29% (1.9)	70	28% (4.4)	63	27% (9.7)
Region		*				
Cook	164	30% (2.9)	37	45% (6.8)	40	21% (12.0)
Central	111	28% (2.1)	28	33% (7.8)	25	32% (16.9)
Northern	78	36% (2.5)	22	24% (7.8)	12	--
Southern	48	15% (4.8)	9	--	8	--
Population Density						
Non-Rural	282	29% (2.6)	66	38% (6.7)	67	25% (6.4)
Rural	119	30% (3.4)	30	29% (8.9)	18	31% (25.2)
Sex		[a]				
Male	215	37% (3.1)	50	38% (9.5)	45	31% (11.7)
Female	186	22% (4.3)	46	30% (7.1)	40	24% (8.2)
Race/Ethnicity						
African American	186	30% (5.1)	39	35% (10.2)	41	29% (7.6)
White	113	31% (4.0)	26	33% (9.7)	18	21% (14.8)
Hispanic	86	24% (3.6)	27	28% (5.8)	19	20% (5.8)
Other	16	34% (18.2)	4	--	7	--
Child Age		*				
1 ½ -4	**177**	**18% (1.6)**	**N/A**	**-**	**N/A**	**-**
5-7	**72**	**38% (5.2)**	**22**	**28% (9.9)**	**N/A**	**-**
8-10	**67**	**36% (5.3)**	**33**	**27% (7.9)**	**N/A**	**-**
11-13	**50**	**31% (8.4)**	**25**	**51% (12.3)**	**50**	**25% (8.6)**
14-17	**35**	**43% (5.8)**	**16**	**32% (13.8)**	**35**	**29% (9.3)**

Note: Total scale scores used. All analyses used weighted data. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result ([a]p< .10 *p < .05). [1] Child Behavior Checklist from the Caregiver Interview, children and youth age 1½ to 17. 2 Teacher Report Form, children and youth age 5 to 17. [3] Youth Self-Report, youth age 11 to 17.

Table B.10 Percent in Clinical Range on Children and Youth Report of Depression and Trauma Symptoms

	N	Depression Percent/SE	Trauma Percent/SE
Total	140	9% (2.7)	8% (4.0)
Child Setting			*
Out-of-Home	32	10% (7.0)	2% (2.2)
In-Home	105	8% (2.1)	9% (4.5)
Region			
Cook	56	2% (2.1)	2% (2.0)
Central	39	14% (6.7)	8% (4.3)
Northern	33	8% (2.8)	17% (10.6)
Southern	12	--	--
Population Density			
Non-Rural	102	9% (3.4)	9% (4.9)
Rural	38	11% (4.0)	6% (5.6)
Sex			
Male	71	6% (4.5)	7% (5.0)
Female	69	12% (3.9)	9% (3.7)
Race/Ethnicity			
African American	63	12% (4.5)	6% (2.9)
White	40	7% (3.2)	6% (5.4)
Hispanic	28	5% (4.8)	11% (7.7)
Other	9	--	--
Child Age			*
7 to 8	34	6% (4.2)	11% (10.8)
9 to 11	47	15% (5.0)	14% (5.2)
12 to 17	59	7% (3.3)	2% (1.3)

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

Table B.11 Percent of Children with *Fewer* Caregiver Reported Social Skills

	N	Fewer Percent/SE
Total	269	30% (5.1)
Child Setting		
Traditional Foster Care	21	61% (6.8)
Kinship Care	22	26% (7.3)
In-Home	190	30% (6.0)
Region		
Cook	108	39% (9.9)
Central	77	22% (4.9)
Northern	53	29% (13.3)
Southern	31	35% (4.6)
Population Density		**
Non-Rural	187	37% (6.0)
Rural	82	18% (1.8)
Sex		
Male	133	32% (6.7)
Female	136	28% (3.9)
Race/Ethnicity		
African American	121	34% (4.2)
White	76	27% (10.7)
Hispanic	59	33% (9.2)
Other	13	-
Child Age		
3 to 5	104	36% (5.7)
6 to 8	57	29% (4.5)
9 to 11	56	37% (12.3)
12 to 17	52	14% (6.2)

Note: Children and youth age 3 to 18. From the Social Skills Rating System in the Caregiver Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result (**p < .01).

Table B.12 Youth Report of Delinquent Acts within the Past 6 Months

	N	No Delinquent Act Percent/SE	Minor Delinquent Act[1] Percent/SE	Severe Delinquent Act[2] Percent/SE	Arrested Percent/SE
Total	83	72% (5.8)	14% (4.4)	14% (4.8)	8% (4.0)
Child Setting					
Out-of-Home	19	65% (13.4)	14% (12.2)	21% (10.0)	7% (5.6)
In-Home	62	73% (5.8)	14% (4.7)	13% (4.0)	8% (4.8)
Region					
Cook	40	70% (1.7)	21% (.5)	8% (2.2)	7% (1.1)
Downstate	43	73% (8.5)	11% (6.4)	16% (6.9)	8% (5.9)
Population Density					[a]
Non-Rural	66	71% (3.8)	13% (3.5)	16% (4.8)	10% (3.7)
Rural	17	75% (14.5)	17% (10.8)	8% (5.3)	2% (2.6)
Sex					[a]
Male	44	65% (9.8)	13% (9.7)	22% (7.0)	13% (4.4)
Female	39	78% (6.0)	15% (8.3)	7% (4.5)	4% (3.6)
Race/Ethnicity					
African American	40	80% (6.1)	12% (4.2)	8% (2.0)	5% (3.8)
White	17	70% (14.2)	22% (12.6)	8% (4.6)	4% (3.7)
Hispanic	19	66% (10.9)	13% (6.8)	21% (11.1)	8% (6.4)
Other	7	-	-	-	-
Child Age		[a]			
11 to 13	48	82% (4.7)	9% (3.2)	9% (3.1)	3% (2.6)
14 to 17	35	58% (4.7)	22% (10.6)	20% (9.0)	15% (9.4)

Note: Youth age 11 to 17. From the Modified Self Report of Delinquency Scale in the Child Interview. All analyses used weighted data. Cell results are omitted when cell n falls below 15. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result ([a]p<.10). [1]Minor delinquent acts represent such acts as being unruly in public, skipping school, shoplifting, damaging property, etc.[2] Severe delinquent acts represent such acts as gang fights, concealing a weapon, stealing, etc.

Table B.13 Youth Report of Substance Use

	N	Alcohol Percent/SE	Smoking Percent/SE	Marijuana Percent/SE	Hard Drugs[1] Percent/SE	Rode in car while driver was intoxicated Percent/SE
Total	84	41% (8.3)	10% (5.7)	15% (6.2)	21% (8.8)	23% (9.0)
Child Setting					[a]	
Out-of-Home	19	48% (11.8)	14% (11.1)	31% (14.4)	28% (16.0)	26% (14.5)
In-Home	63	42% (9.0)	9% (5.6)	12% (6.6)	17% (7.7)	23% (8.8)
Region		*		*	*	
Cook	40	22% (3.1)	3% (2.5)	3% (2.5)	8% (.4)	9% (6.7)
Downstate	44	51% (11.5)	13% (8.6)	20% (8.6)	27% (12.7)	30% (11.9)
Population Density			*	*	[a]	*
Non-Rural	66	47% (7.7)	14% (6.1)	20% (5.5)	27% (9.4)	29% (9.2)
Rural	18	28% (6.3)	0% (0)	2% (2.6)	6% (4.9)	11% (1.3)
Sex						
Male	44	38% (9.5)	9% (7.9)	13% (8.2)	15% (7.5)	17% (7.7)
Female	40	44% (11.7)	10% (5.3)	17% (7.2)	25% (12.4)	28% (11.3)
Race/Ethnicity						
African American	40	41% (7.9)	2% (2.2)	9% (2.6)	8% (4.5)	17% (7.0)
White	18	35% (10.2)	11% (8.9)	17% (13.6)	33% (20.0)	33% (13.6)
Hispanic	19	44% (19.4)	15% (12.0)	17% (12.3)	27% (18.2)	24% (19.1)
Other	7	-	-	-	-	-
Child Age			**	*		
11 to 13	49	34% (7.0)	3% (2.9)	7% (3.3)	19% (7.1)	18% (5.5)
14 to 17	35	53% (12.6)	20% (10.5)	27% (11.9)	24% (12.9)	32% (16.8)

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

Table B.14 Youth Report of Sexual Activity

		Ever Had Sex?		
	N	**No** Percent/SE	**Yes** –*Consensual* Percent/SE	**Yes** – *Forced* Percent/SE
Total	84	74% (8.2)	20% (5.2)	6% (3.2)
Child Setting				
Out-of-Home	19	79% (10.0)	19% (10.8)	2% (2.0)
In-Home	63	73% (8.3)	20% (4.8)	7% (4.0)
Region				
Cook	40	80% (.2)	20% (.2)	0% (0)
Downstate	44	72% (12.1)	20% (7.7)	8% (4.6)
Population Density				
Non-Rural	66	73% (7.8)	21% (4.0)	6% (4.2)
Rural	18	78% (12.4)	16% (9.7)	6% (4.8)
Sex				
Male	44	68% (7.8)	24% (5.7)	8% (4.0)
Female	40	80% (9.7)	16% (6.8)	4% (3.5)
Race/Ethnicity				
African American	40	81% (9.3)	14% (5.9)	5% (4.3)
White	18	70% (9.9)	22% (8.5)	8% (4.6)
Hispanic	19	72% (11.1)	28% (11.1)	0% (0)
Other	7	-	-	-
Child Age				
11 to 13	49	58% (12.7)	31% (5.6)	11% (9.1)
14 to 17	35	85% (7.0)	13% (6.3)	3% (2.8)

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

Table B.15 Teacher Ratings of Child Performance by Subject Type

		Math Percent/SE			Science Percent/SE			Language Percent/SE		
Percent/Error	**N**	**Below**	**Average**	**Above**	**Below**	**Average**	**Above**	**Below**	**Average**	**Above**
Total	94	46% (4.9)	37% (5.2)	18% (3.6)	43% (4.6)	43% (6.7)	13% (5.9)	56% (5.0)	23% (5.1)	21% (3.3)
Setting										
Out-of-Home	23	54% (10.0)	34% (12.8)	12% (8.3)	67% (14.4)	22% (14.1)	11% (8.4)	66% (14.3)	13% (8.4)	21% (11.5)
In-Home	69	45% (4.4)	35% (5.0)	20% (4.5)	41% (4.7)	45% (7.2)	14% (6.5)	52% (6.7)	26% (7.0)	22% (4.2)
Region										
Cook	37	42% (8.6)	54% (12.9)	4% (4.3)	51% (2.2)	42% (11.4)	7% (9.2)	68% (2.4)	21% (2.9)	11% (.6)
Central	27	45% (6.4)	38% (5.9)	17% (3.6)	46% (6.5)	37% (5.9)	17% (3.6)	61% (7.5)	21% (12.1)	18% (5.4)
Northern	20	49% (10.9)	24% (7.4)	27% (4.0)	37% (10.2)	46% (17.4)	17% (15.5)	45% (9.1)	21% (4.1)	34% (5.5)
Southern	10	-	-	-	-	-	-	-	-	-
Population Density										
Non-Rural	66	45% (5.6)	38% (7.7)	17% (4.3)	44% (5.6)	39% (5.5)	17% (7.9)	57% (7.4)	21% (5.6)	22% (4.9)
Rural	29	47% (5.9)	34% (5.7)	19% (6.1)	43% (6.6)	50% (9.9)	7% (3.4)	55% (6.0)	27% (8.0)	18% (5.7)
Sex										
Male	49	44% (8.8)	49% (10.0)	7% (5.2)	53% (4.7)	39% (9.3)	8% (5.9)	62% (8.6)	25% (9.2)	13% (4.3)
Female	46	47% (8.8)	25% (6.9)	28% (5.4)	34% (9.0)	48% (9.4)	18% (7.3)	51% (9.1)	22% (8.2)	27% (5.5)
Race										
African American	40	44% (8.5)	38% (13.4)	18% (9.1)	32% (7.0)	53% (9.1)	15% (9.6)	50% (10.7)	31% (9.3)	19% (6.7)
White	25	45% (8.6)	35% (5.7)	20% (7.0)	48% (12.4)	42% (17.9)	10% (7.6)	55% (4.8)	20% (2.6)	25% (3.4)
Hispanic	27	43% (15.6)	38% (7.5)	19% (7.0)	46% (16.0)	35% (8.4)	19% (10.2)	65% (8.6)	16% (7.0)	19% (10.2)
Other	3	-	-	-	-	-	-	-	-	-
Child Age										
5 to 10	55	48% (5.2)	37% (5.2)	15% (6.1)	42% (6.7)	47% (9.7)	11% (5.7)	54% (5.0)	25% (5.8)	21% (3.1)
11 to 17	40	41% (10.4)	36% (9.5)	23% (9.2)	45% (8.8)	38% (7.1)	17% (9.0)	59% (8.3)	21% (9.0)	20% (8.5)

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

Table B.16 Academic Achievement Test Scores

	N	WJ Letter Identificaion Mean/SE	WJ Passage Comprehension Mean/SE	WJ Applied Problems Mean/SE
Total	171	97.8 (1.3)	92.9 (1.4)	92.5 (1.5)
Child Setting				
Out-of-home	37	92.1 (3.5)	86.9 (5.0)	88.7 (2.8)
In Home	131	99.1 (1.1)	94.1 (1.2)	93.4 (1.2)
Region		*		*
Cook	68	95.3 (.9)	87.6 (.9)	87.6 (.8)
Central	45	97.4 (2.6)	90.3 (3.3)	92.7 (1.7)
Northern	40	101.4 (1.4)	98.1 (1.5)	95.4 (3.5)
Southern	18	93.0 (5.0)	91.6 (1.8)	95.2 (2.2)
Population Density				
Non-Rural	122	100.8 (1.7)	90.9 (2.0)	90.4 (1.7)
Rural	49	95.9 (1.5)	96.0 (2.1)	96.1 (1.7)
Sex				
Male	87	94.4 (2.4)	90.3 (2.0)	89.4 (2.1)
Female	84	100.5 (1.1)	95.0 (1.2)	95.1 (2.1)
Race/Ethnicity				
African American	77	94.7 (2.4)	90.8 (1.1)	89.2 (1.6)
White	53	101.8 (1.3)	97.1 (1.7)	95.3 (2.9)
Hispanic	32	97.0 (2.5)	84.2 (5.0)	93.9 (2.9)
Other	9	-	-	-
Child Age				*
5-7	46	97.8 (3.2)	96.3 (2.3)	89.7 (3.4)
8-10	45	100.3 (2.0)	92.0 (2.3)	98.5 (2.3)
11-13	49	96.1 (2.6)	86.2 (5.9)	90.8 (2.0)
14-17	31	96.2 (2.2)	-	90.2 (1.0)

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

Table B.17 Youth Report of Loneliness at School and School Engagement

	N	Loneliness Percent/SE	School Engagement Percent/SE
Total	164	31.1 (2.0)	34.8 (.6)
Child Setting			
Out-of-Home	32	31.0 (3.1)	34.6 (1.1)
In-Home	126	30.6 (2.1)	35.0 (.6)
Region			
Cook	69	29.8 (.1)	33.1 (.6)
Central	44	32.3 (4.0)	35.6 (1.3)
Northern	36	33.0 (3.1)	35.7 (1.2)
Southern	15	-	-
Population Density			
Non-Rural	120	32.4 (2.2)	33.6 (.4)
Rural	44	28.2 (3.9)	36.9 (.9)
Sex			
Male	80	32.1 (1.9)	33.8 (.8)
Female	84	30.3 (2.3)	35.5 (1.1)
Race/Ethnicity			
African American	69	29.0 (2.5)	33.6 (.4)
White	45	32.4 (3.2)	36.1 (.9)
Hispanic	41	33.7 (3.0)	34.6 (.8)
Other	9	-	-
Child Age			*
5 to 7	28	N/A	35.4 (1.5)
8 to10	52	32.6 (1.9)	36.1 (.4)
11 to 13	49	31.1 (3.2)	34.1 (1.3)
14 to 17	35	29.6 (3.0)	33.1 (.6)

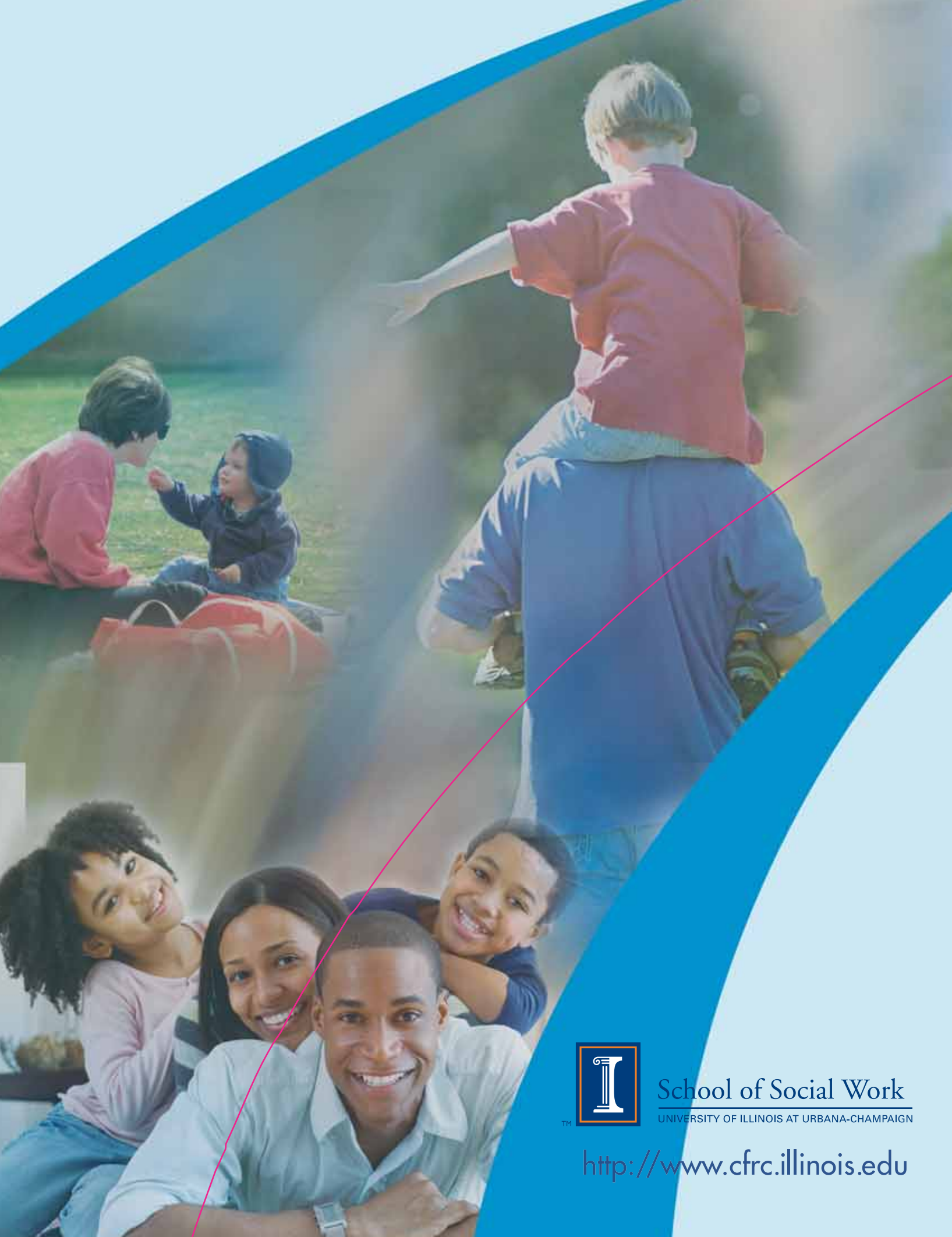
Note: From various measures in the Child Interview. All analyses used weighted data. The sample sizes presented are unweighted. Significance testing used Pearson χ 2 tests for cluster samples. Statistical significance is indicated by asterisks in the row above the statistically significant result (*p < .05). *Loneliness* scores assess children's feelings of loneliness and dissatisfaction with peer support at school using a self-report questionnaire. The children rate 16 items such as "Can you find a friend at school when you need one?" on a 3-point scale. Higher scores indicate greater loneliness. School engagement ranged from 20 to 44, with higher scores indicating greater engagement.

Table B.18 Percentage of School-age Children Resilient (ages 6 to 10)

Measures of Resilience by Domain	% Competent	% Competent on the number of indicators within each domain		
Behavior/Emotional		≥1, 91%	≥2, 69%	3, 49%
Average scores in the pro-social range of the Social Skills Rating system	65			
Scores in the nonclinical range on CBCL externalizing scale	58			
Scores in the nonclinical range on CBCL internalizing scale	83			
Education		≥2, 92%	≥3, 81%	4, 60%
Scores within average range on Woodcock-Johnson for letter identification	91			
Scores within average range on Woodcock-Johnson for applied problems	84			
Scores within average range on Woodcock-Johnson for passage comprehension	75			
Scores in the engaged/adaptive range on the school engagement items	79			

Table B.19 Percent of Adolescents Resilient (ages 11 to 17)

Measures of Resilience by Domain	% Competent	% Competent on the number of indicators within domain				
Behavior		≥2, 100%	≥3, 91%	≥4, 86%	≥5, 61%	6, 27%
Average scores in the pro-social range of the Social Skills Rating system	83					
Scores in the nonclinical range on CBCL externalizing scale	64					
Scores in the nonclinical range on Youth Self-Report CBCL scale	73					
Absence of substance abuse	77					
Absence of sexual history	77					
Absence of delinquency	72					
Emotional		≥1, 98%	≥2, 94%	3, 67%		
Scores in the nonclinical range on CBCL internalizing scale	77					
Scores in the nonclinical range on Children's Depression Inventory	87					
Scores in the nonclinical range on Trauma Symptoms Checklist	95					
Education		≥1, 90%	≥2, 73%	3, 50%		
Scores within average range on Woodcock-Johnson for letter identification	77					
Scores within average range on Woodcock-Johnson for applied problems	74					
Scores in the engaged/adaptive range on the school engagement items	63					



School of Social Work
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

http://www.cfrc.illinois.edu