



Conditions of Children in or at Risk of Foster Care in Illinois

2010 MONITORING REPORT
OF THE *B.H.* CONSENT DECREE



**CHILDREN AND FAMILY
| RESEARCH | CENTER**

UNIVERSITY OF ILLINOIS SCHOOL OF SOCIAL WORK



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A REPORT BY THE



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This year's report, perhaps more than any other in recent history, represents the culmination of the efforts of most of the staff at the Children and Family Research Center. I would like to take this opportunity to acknowledge these contributions.

Martin Nieto has been a data analyst at the Children and Family Research Center since 1998 and has worked on the *B.H.* monitoring report for over a decade. His expertise with the Integrated Database and countless hours of hard work form the foundation of this report, and he performed analyses that contributed to the Safety, Substitute Care, and Legal Permanence chapters.

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Jesse Helton and Theodore (Ted) Cross collaborated to write the Child Well-Being chapter. These two researchers have vast experience with and knowledge of the National Survey of Child and Adolescent Well-Being and the Illinois version of this study (the Illinois Study of Child and Adolescent Well-Being) upon which we derived all of the data for this chapter. It is not an over-exaggeration to say they know more about this unique dataset than anyone else in the nation. Dr. Cross also took the lead on writing the Legal Permanence chapter in this year's report, and his critical thinking and beautiful writing substantially improved what was already a well-written part of the report.

Jill Schreiber is another relatively new addition to the Children and Family Research Center, but she has quickly become an integral part of the *B.H.* team. She was given the daunting task of writing the Substitute Care chapter, which effectively combined two critical chapters from last year's report. She approached this task with care and thoughtfulness, and the end result is a comprehensive and clear chapter that presents a tremendous amount of information in a way that is not confusing or overwhelming. Jill also deserves thanks for always being willing to help with whatever task needed to be done to get the report complete.

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INTRODUCTION

The Evolution of Child Welfare Monitoring in Illinois

The Children and Family Research Center (CFRC, the Center) has been responsible for the annual report which monitors the performance of the Illinois child welfare system for thirteen years. The Center is an independent research organization whose mission is to support and conduct research which contributes to the safety, permanence and well-being of children and families. The *2010 Monitoring Report of the B.H. Consent Decree* is the culmination of the efforts of the center's researchers to provide the most clear and comprehensive data to a variety of stakeholders who are concerned with the outcomes of abused and neglected children in Illinois. 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 other human systems responsible for child protection and welfare. Rather, it is a monitoring report that examines specific performance indicators and identifies trends on selected outcomes of interest to the federal court, the Department, members of the *B.H.* class and their attorneys (see Box I-1 for further discussion of the differences between program monitoring and evaluation). It is our hope that this report will not sit on a shelf, but be used as a catalyst for dialogue between child welfare stakeholders at the state and local level about the meaning behind these reported

numbers and the strategies needed 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:

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.

Monitoring Versus Evaluation: Is There a Difference?

BOX I.1



The terms “monitoring” and “evaluation” are often used interchangeably, when in fact they each have different goals, standards, and criteria for meeting them. Both are important and necessary tools to ensure accountability.

Monitoring is the continuous and systematic process whereby data is tracked and performance assessed through analysis and comparison of a selected set of indicators over time from the initial benchmark to achievement of desired outcomes. Indicators can also be used to determine differences between population sub-groups, such as comparing outcomes based on gender, race or geographic location. Monitoring provides administrators and managers with necessary information at the practice level so that corrective action can be taken to improve performance in those areas where deficiencies are found in order to more effectively run a program. Monitoring of performance should be a critical ongoing task of all organizations to ensure the programs provided are operating as intended.

An evaluation is conducted once or periodically depending upon the specific set of research questions it is supposed to answer. Evaluations

determine if the objectives of a program have been accomplished. Evaluation entails rigorous research designs and detailed analysis of data to assess the relevance, effectiveness, efficiency, sustainability and/ or impact of a program, intervention or project. Evaluations provide policy makers, funders, and external stakeholders with necessary information to make decisions such as whether or not a program or project should be expanded or extended, replicated in another jurisdiction, or eliminated.

This report is not an evaluation but one which monitors the performance of outcome indicators determined to be of interest to the B.H. parties. Although its findings rest upon data analysis conducted by the CFRC in order to report on these selected indicators, this report does not assess or judge the relative performance of any specific program, practice or intervention, nor does it opine about the cause of some of the trends noted in the monitoring report. In many respects, this report may raise more questions than provide answers. Only a more in-depth evaluation designed and targeted to answer a specific research question could provide answers as to “why” some of the trends noted in this report are occurring.

- 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.
- 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.”

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;

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: permanence, 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:

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).

- 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's 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

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 The independence of the CFRC was an essential component of the settlement which was consistent with a growing national trend first identified by

Senator Orrin Hatch as a means by which the autonomy of research universities would ensure that governmental programs could be held accountable for ensuring that authorized work is actually being done and whether or not programs were successful in addressing the perceived needs of the clients the program served.⁷ The CFRC was also tasked, in consultation with the Department and counsel for the plaintiff class, with the development of outcome indicators to provide quantitative measures of progress toward meeting the goals set forth in the consent decree: “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.”⁸

The Joint Memorandum also 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...”⁹

The 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, permanence, and well-being. They also

⁵ Ibid, p. 2-4

⁶ Joint Memorandum, p. 2

⁷ Hatch, O. (1982). Evaluations of government programs. *Evaluation and Program Planning*, 5, 189-191.

⁸ Joint Memorandum, p. 4

⁹ Joint Memorandum, p. 4

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 in the first 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, region, child age, child race, and perpetrator). Indicators for permanence in the first report included: 1) rate of children who entered substitute care from intact cases; 2) percentage of children returned home from substitute care within 6, 12, 18, and 24 months; 3) percentage of reunified children who re-enter foster care; 4) percentage of children adopted from substitute care and median length of time to adoption, 5) adoption disruptions, and 6) percentage of children moved to legal guardianship from substitute care. Each of these indicators was examined by child age, race, gender, and region. No indicators of child well-being were included in the earliest *B.H.* monitoring reports because child welfare administrative data systems did not yet capture information on child physical and mental health, development, and education in ways that could be easily translated into outcome indicators.

In the decade since the first *B.H.* monitoring reports were filed, the State’s child welfare information management systems have become more comprehensive, which has facilitated the development of more sophisticated and reliable indicators of children’s safety and permanence. Although data on child well-being were not included in administrative data systems, separate studies were conducted by the Center to assess the well-being of children in substitute care beginning in FY2000. In FY2003, two additional chapters were added to the *B.H.* report to examine placement stability, the use of least restrictive settings (i.e. most family-like), and the continuity of family relationships while in care. In FY2009, data at the sub-regional level were included in order to more closely examine child welfare system functioning in light of the shifting of the overall substitute care

caseload toward the non-Cook County regions and worsening performance on indicators “downstate.” The sub-regional analyses allowed for a more comprehensive assessment of the differences between rural and urban settings.

The 2010 Monitoring Report of the *B.H.* Consent Decree

The continual evolution of child welfare monitoring in Illinois is manifested in this year’s *B.H.* report. The report has been reorganized into four chapters which attempt to capture the experience of a child as he or she travels through the child protection and child welfare systems. As in years past, “**Child Safety**” is the first chapter. Children’s first contact with the child welfare system is typically through a Child Protective Services (CPS) investigation. Investigators make several decisions related to child safety, including whether to remove the child from the home and take them into protective custody, whether the child is in immediate danger of a moderate to severe nature, whether there is credible evidence that maltreatment has occurred, and whether the family’s needs indicate that they would benefit from ongoing child welfare services. Regardless of whether or not additional child welfare services are provided, the child welfare system has a responsibility to keep the child safe from additional maltreatment once they have been investigated. The first chapter of the report examines the Department’s performance in fulfilling this obligation by examining indicators related to maltreatment recurrence that occurs within 12 months of an indicated child maltreatment investigation.

The second chapter of this report, “**Children in Substitute Care: Safety, Continuity, and Stability**,” examines the experiences of children from the time they are taken into substitute care until the time they exit the child welfare system. Once removed from their homes, the public child welfare system and its private agency partners have a responsibility to provide children with living arrangements that ensure that they are safe from additional harm, maintain connections with their family members (including other siblings in care) and community, and provide stability. In addition, substitute care should be a temporary solution and

children should live in substitute care settings for the shortest period possible to ameliorate the issues which brought the children into care. This chapter incorporates the separate “Stability” and “Continuity” chapters of previous years and examines how well the Illinois Department of Children and Family Services performs in providing substitute care living arrangements that meet these standards, and is organized into four sections: 1) Safety in Substitute Care, 2) Continuity with Family and Community, 3) Placement Stability, and 4) Length of Time in Substitute care.

The third chapter examines “**Legal Permanence: Reunification, Adoption and Guardianship**” with more in-depth analysis of each of these three exit types. Unlike previous *B.H.* reports, which combined the different types of permanency exits into overall permanency rates, the current chapter examines each separately, and examines the likelihood that a child will exit substitute care to reunification, adoption, or guardianship within 24 and 36 months of entry. For those children who achieve permanence, the stability of their permanent living arrangement at two, five, and ten years after exiting the child welfare system is assessed. This chapter also examines the residual population of children that remain in care longer than three years, as well as those that exit substitute care to other outcomes.

Finally, the fourth chapter takes a close look at the “**Child Well-Being**” of the children involved in substantiated reports of child maltreatment in Illinois. This chapter used data from a unique longitudinal study known as the Illinois Survey of Child and Adolescent Well-Being (ISCAW). Last year’s *B.H.* report was the first to use this comprehensive evaluation for analysis, which allows for comparison to the National Survey of Child and Adolescent Well-Being (NSCAW). This year’s Child Well-Being chapter focuses on mental health services for children and compares Illinois performance to that of the nation using the NSCAW sample.

Each chapter contains numerous figures or tables that allow the reader to easily visualize Illinois’ performance on each indicator over time. Some readers may be interested in examining the results of the analyses more closely. Additional information has been provided in the technical Appendices to this report: Appendix A

contains detailed **Indicator Definitions** for the majority of the indicators presented in the first three chapters of the report; Appendix B contains the **Outcome Data** for each indicator over the past seven years for the State as a whole, along with breakdowns for each by child age, race, gender, and geographical region; Appendix C contains a **Sub-regional Analysis** for a selected number of indicators (see Box I.2 for additional information on the Children and Family Research Center’s outcome data website).

Readers familiar with the content and structure of previous *B.H.* monitoring reports will notice numerous changes to the format and content of the report. These changes were made in the hopes that they would increase its clarity and comprehensiveness.

- The “At a Glance” summaries at the beginning of the chapters has been discontinued. These summaries were used in the past to provide a summary of each indicator in a chapter along with a graphic that specified whether performance was improving, declining, or level over the prior seven years. Since performance on most outcomes fluctuates in more than one direction over a seven year period, the circumstances under which an indicator should be seen as improving or declining were somewhat unclear. To avoid providing potentially misleading information, these summaries have been discontinued.
- The child safety indicators in the FY2005 through FY2009 reports were presented as rates of maltreatment *non-recurrence*, i.e., the proportions of children who had not experienced maltreatment recurrence during the period under review. Reader feedback consistently indicated that this reversal made the safety indicators counter-intuitive and difficult to interpret. For this report, the safety indicators have been changed to rates of maltreatment recurrence.
- Several chapters now contain “heat maps” to visually depict sub-regional performance. To create the heat map, the findings pertaining to the relevant indicator are compared to one

The CFRC Outcomes Website



The Children and Family Research Center maintains an Outcomes Website (www.cfr Illinois.edu/outcomeindicators.php) that can assist local child welfare stakeholders in accessing child welfare outcome data to enhance their understanding of local child welfare functioning, apply for grants, etc. The majority of the indicators in this report, not including those found in the Child Well-Being chapter, can be found on this interactive website. Visitors to the site can select from among a variety of indicators including:

Child Safety

- Of all children with a substantiated report, what percentage had another substantiated report within 12 months?
- Of all children served at home in intact family cases, what percentage had another substantiated report within 12 months?
- Of all children ever served in substitute care during the year, what percentage had a substantiated report during placement?

Stability of Family Life

- Of all children served in intact family cases, what percentage experienced a substitute care placement within a 12 month period?

- Of all children entering substitute care and staying for at least a year, what percentage had less than three placements within one year of removal?
- Of all children entering substitute care between the ages of 12 and 17, what percentage ran away from a foster care placement during the year?

Continuity of Social Ties

- Initial placement type for children entering substitute care;
- Children in substitute care at the end of the year by placement type;
- Of all children placed in a group home or institution as of June 30th, what percentage is placed in Illinois?
- Of all children entering substitute care during the fiscal year, the median miles from their home of origin to their initial placement;
- Of children in substitute care at the end of the fiscal year, the median miles from their home of origin to their end of year placement;
- Of children placed into substitute care, what percentage is placed with their siblings in their first placement?
- Of children in substitute care at the end of the year, what percentage is placed with their siblings?

The CFRC Outcomes Website CONT'D

Legal Permanence

- Of all children who entered substitute care during the year and stayed for longer than 7 days, what percentage attained permanence
 - Within 12 months?
 - Within 24 months?
 - Within 36 months?
- Of all children who attained permanency during the year (excluding placements of less than 8 days), what percent remain with their families
 - After 2 years
 - After 5 years
 - After 10 years

To demonstrate the ease of use of the Outcome Website, assume a child welfare supervisor in the

Peoria sub-region is interested in looking at placement stability outcomes in her sub-region in order to devise a local quality improvement plan. She can visit the CFRC Outcomes Web Site and click on the indicator which looks at what percentage of children entering substitute care had less than three placements within one year of their removal. After selecting the specific indicator she is interested in, a page will appear that provides the definition of the indicator and allows her to choose which subset of children she is interested in obtaining information about:

Outcome data can be obtained for all children in the entire state of Illinois, or can be filtered to examine a specific region, sub-region, Local Area Network (LAN), county or Chicago community. Additionally, the data can also be sorted demographically, by child age, gender, or race/ethnicity. Results are presented for the past seven years.

| [Illinois Total](#) | [Region](#) | [Sub-Region](#) | [LAN](#) | [County](#) | [Chicago](#) |

| [Cook North](#) | [Cook Central](#) | [Cook South](#) | [Aurora](#) | [Rockford](#) | [Champaign](#) | [Peoria](#) | [Springfield](#) | [East St Louis](#) | [Marion](#) |

| [Race](#) | [Age Group](#) | [Gender](#) |

		Entering and Staying One Year	Less Than Three Placements	
			N	%
FY	RACE			
2003	Black	222	165	74.3 %
	White	306	247	80.7 %
	Hispanic	6	3	50.0 %
	Other	32	25	78.1 %
	ALL CHILDREN	566	440	77.7 %
2004	Black	216	153	70.8 %
	White	291	243	83.5 %
	Hispanic	20	16	80.0 %
	Other	9	8	88.9 %
	ALL CHILDREN	536	420	78.4 %
2005	Black	225	175	77.8 %
	White	285	253	88.8 %
	Hispanic	22	18	81.8 %
	Other	12	11	91.7 %

another and ranked. The sub-regions and years in the top 25th percentile – those with the **best performance** in the selected indicator – are shown in the lightest shade. Those sub-regions and years in the bottom 25th percentile – those with the **worst performance** on this indicator – are shown in the darkest shade. Those that performed in the middle – between the 26th and 74th percentiles are shown in the medium shade. Each heat map provides a simple way to compare sub-regional performance over time and across the state. It is important to note that these “rankings” are relative only to performance with the ten sub-regions over the seven year time span depicted and not to any national or state benchmarks. Readers are cautioned that even though it may appear that a given sub-region may be performing well when compared to other sub-regions in the state, this does not necessarily mean that its performance should be considered “good” or “excellent” compared to a standard or benchmark.

- This year’s Substitute Care chapter examines both the initial placements of children and placement at the end of the fiscal year for several indicators including restrictiveness of placement, placement with siblings, and placement close to home. Readers are provided an opportunity to compare these results by presenting them side-by-side.
- Analyses in this year’s Substitute Care chapter are expanded beyond a comparison of children in kinship care to those in all other “non-kinship” settings. The effect of placement setting on substitute care outcomes is now examined for children in kinship foster homes, traditional foster homes, specialized foster homes, group homes, institutions, and independent/transitional living programs.
- The indicator that examines the percentage of children living in institutions or group homes outside Illinois has been dropped because there are so few children placed in congregate care out of state during the reporting period that this

indicator is no longer relevant.

Continued 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, when basic needs of children were not being met. In 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. 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. Through the use of innovative reforms such as the Subsidized Guardianship waiver, implementation of performance based contracting, and the development of the Child Endangerment Risk Assessment Protocol (CERAP), Illinois safely and effectively reduced the number of children in care from 51,596 in FY1997 to 15,287 as of September 30, 2011. Despite the impressive results of the past, the need for outcome monitoring has not ended. The findings of this year’s report indicate a need for heightened vigilance on the part of the Department, its private sector partners, the courts, and other child welfare stakeholders to ensure that the gains of the past are not lost. Although the reader is encouraged to read the corresponding chapters to understand the nuances of these findings, noteworthy findings that reflect the continued need for monitoring, discussion and potential action include:

Child Safety

- The rate of maltreatment recurrence within 12 months of an initial indicated report has remained relatively steady statewide at about 11.5% for the past several years. However, the statewide rate is an average of disparate rates at the regional and sub-regional level: children in the Cook sub-regions experience recurrence at much lower rates (8.4% in 2009) than those in the Central (12.8%) and Southern (14.5%) regions. The highest recurrence rates occur in the Marion (17.4%) Peoria (13.3%) and Champaign sub-regions (13.1%).

- A smaller segment of investigated families are receiving post-investigation services from the Department than before (46% in 2004 and 39% in 2010).
- Children served in intact families are slightly less safe than they were in the past: 12-month recurrence rates among children served in intact families have increased from about 10% to 12% in the past seven years.
- Children with indicated investigations served in intact family cases have recurrence rates that are approximately equal to those of children who do not receive any post-investigation services at all. However, these findings vary by child race. African American children served in intact families are *less likely* to experience recurrence of maltreatment than African American children that do not receive any services at all. The reverse is true for White children, who are much *more likely* to experience recurrence when served in intact families than when provided no services at all following an indicated report.

Children in Substitute Care: Safety, Continuity, and Stability

- Children in substitute care have increasing rates of indicated maltreatment over the past four years, from 1.1% in 2006 to 1.5% in 2010. Although the overall number of children maltreated in care remains small, the percentage reflects a 35% increase over a four year period.
- Young children in substitute care continue to have at the highest risk of additional maltreatment, with 1.8% of children 8 years of age or younger maltreated while in care compared to 1.3% of children between the ages of 9 and 11, 0.7% between the ages of 12 and 14, and 0.1% for youth 15 years or older in 2010.
- There has been an increase in maltreatment rates in kinship and traditional foster homes since 2006; the rate of maltreatment in kinship foster homes has risen from 1.1% in 2006 to

1.8% in 2010 (reflecting a 64% increase) and in traditional foster home from 0.9% in 2006 to 1.4% in 2010 (a 55% increase).

- There has been a 30% increase in initial placements in congregate care settings (group homes and institutions) from 14.3% in 2004 to 18.4% in 2010.
- Children living in institutions were placed a median distance of 21 miles from home in 2003 and this has nearly doubled to 40 miles in 2010. An analogous increase has occurred for children living in group homes – from 17 miles in 2003 to over 26 miles in 2010. Three sub-regions in the Central and Southern regions have a majority of their children in congregate care placed over 100 miles from home.
- The median length of stay in substitute care has been reduced for African American youth from a median of 35 months in 2002 to 29 months in 2008. However, during that same period of observation, median lengths of stay for White children have increased from 21 months to 25 months.
- The highest median lengths of stay have consistently occurred in the Cook regions, although a small decrease is noted in this year's report. The shortest median lengths of stay continue to be in the Southern region

Legal Permanence: Reunification, Adoption and Guardianship

- Reunification rates are lower in the three Cook County regions when compared to the balance of the state. Of potential concern is that several sub-regions have shown a drop in reunification rates for children over time.
- Children 15 years of age or older are significantly less likely to achieve any form of permanence than younger children.
- African-American children are much less likely to be reunified and slightly less likely to be

adopted than White children. Racial and ethnic differences in attaining permanence continue to be a contributing factor to the disproportionate percentage of children of color in the substitute care population.

- Wide regional differences also exist with the Cook regions lagging far behind the balance of the state on attaining each of the three types of permanence.
- The percentages of children exiting care to adoption at 24 and 36 months has declined since 2002. This decrease is not explained by changes in the age of children in care over time – the proportion of children under the age of three (the group most likely to be adopted), has actually increased slightly in recent years.

Child Well-Being

- The shortfall in out-patient mental health services for children following substantiated maltreatment investigations is of grave concern. Less than 15% of children across all settings (i.e. those in substitute care, those receiving intact family services, and those whose cases have been closed following investigation) receive specialty outpatient mental health services.
- For those children with identified serious mental health needs, approximately 40% of those who are in substitute care receive specialty outpatient services; 30% of children with open intact family services cases receive them. These percentages are consistently below the national comparison group.

Future Efforts to Monitor Child Welfare in Illinois

The indicators and outcomes included in the *B.H.* monitoring report will continue to evolve. The State's data management systems are becoming increasingly sophisticated, which will allow the CFRC to expand

the ways in which child safety and permanence are measured and tracked over time. Other statewide data collection activities, including the Illinois Survey of Child and Adolescent Well-Being (described in detail in Chapter 4), will provide reliable and valid data on the well-being of the children in or at risk of substitute care in Illinois. Future plans to link these two data sources will provide us with an unprecedented opportunity to examine the interplay between child welfare practice and child and family outcomes.

As new indicators are developed and old indicators are refined, new findings will be revealed that shed light on the performance of the Illinois child welfare system in providing for the safety, permanence, and well-being of the children that come to its attention. Findings uncovered from the monitoring report have been catalysts for important evaluations such as the “Multiple Move Study” conducted by the Children and Family Research Center, which was spurred by worsening Department performance on indicators of placement stability.¹⁰ Other studies that were prompted from findings from prior *B.H.* monitoring reports include an examination of the relationship between placement stability and the number of child placed in the same foster home,¹¹ the relationship between the license status of kinship foster parents and maltreatment recurrence in their homes,¹² and the status of enrollment of young children involved in the child welfare system in early childhood education programs.¹³ Several findings from this year's report warrant additional study; suggestions for such studies are included in the recommendations of each chapter (see Box I.3 for additional discussion of new federal legislation that will allow states to implement and evaluate emerging child welfare practices using Title IV-E waivers).

Our hope is that the *B.H.* monitoring report not only serves its intended purpose of informing the *B.H.* parties on the performance of the Illinois Department of Children and Family Services, but that it provides other child welfare stakeholders within the State with information that is useful to them and encourages further discussion on how to improve outcomes for children and families. We welcome feedback on the report, as well as suggestions for additional areas of study.¹⁴

¹⁰ http://www.cfr Illinois.edu/publications/rp_20091101_Multiple-MoveStudyUnderstandingReasonsForFosterCareInstability.pdf

¹¹ http://www.cfr Illinois.edu/publications/rp_20070101_PlacementStabilityAndNumberOfChildrenInAFosterHome.pdf

¹² http://www.cfr Illinois.edu/publications/rp_20090301_LicenseStatusOfKinshipFosterParentsAndTheSafetyOfChildrenInTheirCare.pdf

¹³ http://www.cfr Illinois.edu/publications/bf_20110405_EnrollmentInEarly-ChildhoodEducationProgramsForYoungChildrenInvolvedWithChildWelfare.pdf

¹⁴ Contact information for the Children and Family Research Center can be found on the Acknowledgements page.

Child and Family Services Improvement and Innovation Act Waivers

BOX 1.3

Child welfare policy and practice continues to evolve and respond to the ever changing needs of the nation's children and families. Monitoring and evaluation of those policies and practices must also change to provide timely and effective feedback to policy makers and practitioners. The successful partnership between the Department and the Children and Family Research Center in implementing and evaluating two federal waivers which in turn led to improved child welfare outcomes is an excellent example of how research can and should inform both policy and practice.

Federal legislation has recently been enacted which will allow states to test and evaluate emerging child welfare practices. The Child and Family Services Improvement and Innovation Act (P.L. 112-34) creates an opportunity for states to apply for a new round of demonstration waivers so that states could accomplish one or more of the following goals:

- To increase permanency by reducing time in foster care and promote successful transition to adulthood for older youth;
- To increase positive outcomes for infants, children and families in their homes and communities, and improve the safety and well-being of infants, children and youth; or
- To prevent child abuse and neglect and re-entry into care.

Waivers allow the state increased flexibility in the use of federal funds to support innovative policies, procedures or programs that would not otherwise be allowed under existing federal financing requirements. The Act also specifically allows states to establish demonstration projects designed to use Title IV-E foster care maintenance payments to be made on behalf of a child residing with a parent in a long-term therapeutic family treatment center that provides substance abuse treatment services, children's early intervention services, as well as other health, mental health and vocational training services; or to identify and address domestic violence that endangers children and results in their placement in foster care.

Waivers are demonstration projects to test and rigorously evaluate the approved program, practice or policy which is the subject of the waiver. The State of Illinois has successfully applied for and received three federal waiver demonstration projects. The findings from the Illinois Subsidized Guardianship Waiver were instrumental in the passage of the Fostering Connections to Success and Increasing Adoptions Act of 2009 (P.L. 110-351). The evaluation of the waiver, conducted by the Children and Family Research Center, found that giving the state the flexibility to use Title IV-E funds to support kinship placements for children and youth who would otherwise be placed in a traditional foster care setting led to improved outcomes, reduced the number of children and youth in care, and was cost effective. As a result, the Fostering Connections Act allowed states to create a new option under their Title IV-E plan to provide kinship guardianship assistance for youth who have been in foster care when a relative is taking legal guardianship. The Illinois Alcohol and Other Drug Abuse (AODA) Waiver, discussed in Chapter 3 of this report, is another example of an innovative child welfare strategy – the use of recovery coaches for substance abusing parents – which has demonstrated positive outcomes for both children and families.

To be eligible to receive a waiver, the state must apply for one from the Department of Health and Human Services (DHHS). The process is a competitive one. The Act authorizes DHHS to issue up to 10 waivers per year in federal fiscal years 2012, 2013 and 2014. For the new waivers, states must demonstrate their readiness to implement the proposed demonstration project within a specified period of time. In order to be approved to conduct a demonstration project, the state must implement at least two "child welfare program improvement policies" within three years of their application for a waiver. One of the program improvement policies may have been implemented prior to the submission of the application, but at least one policy must be new. The policies selected by Congress for implementation are:

- a) Establishing a bill of rights for children in foster care that outlines protections for them (e.g. visitation with parents and siblings) and procedures for ensuring those protections are provided.
- b) Developing and implementing a plan for meeting the health and mental needs of children in foster care that ensures their care is child-specific, comprehensive, and addresses the issue of trauma when appropriate.
- c) Including in the state plan an option allowing kinship guardianship assistance agreements.
- d) Electing to provide youth up to age 21.
- e) Ensuring that congregate care is being used appropriately and reduces the placement of youth in such care.
- f) Substantially increasing the number of cases of siblings placed together in out-of-home placements above the baseline of such cases in fiscal year 2008.
- g) Developing and implementing a plan to improve retention and recruitment of high quality foster family homes; supports may include increasing maintenance payments, expanding training, respite care and other support services.
- h) Establishing procedures designed to assist youth transitioning out of foster care, such as arranging for participation in age-appropriate extra-curricular activities, providing appropriate access to cell phones, computers, and opportunities to obtain a driver's license, providing notification of all sibling placements if siblings are in care and sibling location if they are out of care, and providing counseling and financial support for post-secondary education.
- i) Including in the state plan procedures for:
 1. Ensuring youth 16 or older are engaged in discussions that explore whether the youth wishes to reconnect with the youth's biological family, and if so, what skills and strategies the youth will need to successfully and safely reconnect;
 2. Providing appropriate guidance and services to youth who affirm an intent to reconnect with biological family members; and
 3. Making, when appropriate, efforts to include biological family members in such reconnection efforts.
- j) Establishing one or more of the following programs designed to prevent children from entering foster care or to provide permanency for them once they are in foster care:
 1. Intensive family finding.
 2. Kinship navigator.
 3. Family counseling, such as Family Group Decision Making or in-home peer support for families.
 4. Comprehensive family-based substance abuse treatment.
 5. Special efforts to identify and address domestic violence that puts children at risk of entering foster care
 6. Mentoring.

Some of the policies and programs allowed for in this new legislation have already been effectively implemented in Illinois, such as extending services to youth up to the age of 21. Others are worthy of consideration in light of the findings of this year's B.H. report findings. Illinois has long been a pioneer in child welfare reform efforts, yet much work remains to be done. The state is well-positioned to explore the option of a waiver by examining whether or not the proposed policy and program changes would enhance and improve outcomes for children and families in the child welfare system. Engaging in an inclusive and thoughtful planning process on the part of all child welfare stakeholders about a potential waiver is recommended.



CHAPTER 1

Child Safety

1

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 responsibility of public child welfare agencies is to ensure that children who have been found to be victims of abuse or neglect are protected from further harm, whether they remain in their own homes or are placed in out-of-home care” (p. 6).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.

There had been little change in Illinois law related to Child Protective Services (CPS) investigations over the past decade. However, on August 25, 2009, Illinois Governor Quinn signed into law the Differential Response Program Act (SB807), which amended the Children and Family Services Act and the Abused and Neglected Child Reporting Act in several important ways. 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; (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.

In December 2009, after a competitive application process, the State of Illinois was selected as one of three national research and demonstration sites (along with a consortium of 5 counties in Colorado and a consortium of 6 counties in Ohio) by the National Quality Improvement Center on Differential Response (QIC-DR) to implement and evaluate a Differential Response model. Led by principle investigator Dr. Tamara Fuller, the Children and Family Research Center is serving as the evaluator for the Illinois Differential Response project, formally known as *Pathways to Strengthening and Supporting Families*. Differential Response was implemented statewide in Illinois on November 1, 2010, and the evaluation period will continue through 2013 (see Box 1.1 for a detailed description of the Differential Response model and evaluation). Other jurisdictions

¹ U.S. Department of Health and Human Services, Administration on Children and Families, Children's Bureau. *Child Welfare Outcomes 2004 – 2007 Report to Congress: Safety, Permanency, Well-Being*. Washington, DC: Child Welfare

Information Gateway. Available online: <http://www.acf.hhs.gov/programs/cb/pubs/cwo04-07/cwo04-07.pdf>

that have rigorously evaluated Differential Response have found that children that receive an alternative or family assessment response to certain types of child maltreatment are either as safe as or marginally safer than children who receive a traditional investigation response.² The effects of the implementation of Differential Response on child safety in Illinois will be closely evaluated over the next several years.

Measuring Child Safety

In some ways, child safety is the most straightforward of all child welfare outcomes to define – 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 comparing or interpreting results. With that in mind, it is important to be clear about the ways that child safety is measured in this chapter (see Appendix A for detailed descriptions of the indicators used in this report).

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 or re-reports, take a broader view and include *all* subsequent reports following an initial report, regardless of whether or not the subsequent report was substantiated. Although recognizing the importance of all future contacts with child welfare, the current report follows the more commonly-used indicator of maltreatment recurrence that includes only additional *substantiated* 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 the immediate safety of children during the investigation typically use short recurrence follow-up periods, i.e., 60 – 120 days. The federal recurrence measure used in the Child and Family Services Review examines maltreatment recurrence within the 6 months following an initial indicated report. Advances in the quality and flexibility

of child welfare administrative data now allow us to extend the observation period for maltreatment recurrence for many years, even decades, if desired. However, the added benefit (and some would argue, the appropriateness) of monitoring recurrence for many years is negligible, since the risk of recurrence is greatest within several months after the first incident and decreases over time.³ The current report uses a 12-month recurrence period for the safety indicators.

The final consideration when selecting safety indicators is the population to be monitored. 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 whether post-investigation services are offered. Thus, the current chapter monitors child safety among three groups of children: 1) all children with an indicated report; 2) children served in intact families following an indicated report; and 3) children that do not receive services following an indicated report. Maltreatment that occurs while children are in substitute care placements is also of vital importance and is examined more closely in the next chapter. It is important to note that the child safety indicators in the 2005-2009 *B.H.* monitoring reports were reported as rates of maltreatment *non-recurrence*, i.e., the proportions of children who had NOT experienced maltreatment recurrence during the reporting period. Reader feedback indicated that this reversal made the safety indicators counter-intuitive and difficult to interpret. The safety indicators have therefore been changed in this chapter to rates of maltreatment recurrence.

Maltreatment Recurrence Among Children with Indicated Reports

Child protective services investigators have several important safety-related decisions to make during the investigation. Although practice varies from state to state,⁴ investigators must collect sufficient information to decide 1) whether or not abuse and/or neglect has occurred (investigation disposition); 2) whether or not the child is at imminent risk of serious harm (safety

² Loman, L.A., & Siegel, G.L. (2004). *Minnesota Alternative Response Evaluation Final Report*. St. Louis, MO: Institute for Applied Research. Loman, L.A., Filonow, C.S., & Siegel, G. (2010). *Ohio Alternative Response Evaluation: Final Report*. St. Louis, MO: Institute of Applied Research. Ruppel, J., Huang, Y., & Haulenbeek, G. (2011). *Differential Response in child protective services in New York State: Implementation, initial outcomes, and impacts of pilot project*. Albany, NY: New York State Office of Children and Families.

³ National Resource Center on Child Maltreatment. (2003). *Child maltreatment recurrence*. Duluth, GA: Author.

⁴ U.S. Department of Health and Human Services. (2003). *National study of child protective service systems and reform effort: Review of state CPS policy*. Retrieved from: <http://aspe.hhs.gov/hsp/cps-status03/state-policy03/index.htm>

Differential Response in Illinois: Pathways to Strengthening and Supporting Families

What is Differential Response?

Historically, there has been one response by the public child welfare system to accepted reports of alleged maltreatment—a child protective services 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 providing resources and services rather than conducting investigations. This approach is accompanied by greater efforts to identify, build, and coordinate formal and non-formal services and supports to address the issues that brought families to the attention of child welfare services.

Differential Response (DR) models have at least two pathways to serve families: an investigation pathway and a non-investigation pathway (sometimes called family assessment response, alternative response, or 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 Does Differential Response Look Like in Illinois?

In Illinois, the differential response model has been named Pathways to Strengthening and Supporting Families (PSSF). Under this new approach, calls made to the State Central Register (SCR, often referred to as the "hotline") are screened, as before, to determine if they meet the criteria for a child abuse or neglect report under Illinois statute. At the same time, case eligibility for DR services is determined, as not all reports are eligible. To be eligible for the DR pathway, accepted reports must meet all of the following criteria:

1. No prior family reports to the SCR; OR no prior *indicated* allegations of abuse and/or neglect; OR prior indicated reports have been expunged; 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:
 - Inadequate Food
 - Inadequate Shelter
 - Inadequate Clothing
 - Environmental Neglect
 - Mental Injury
 - Medical Neglect

Differential Response in Illinois: Pathways to Strengthening and Supporting Families CONT'D

- 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.

During the demonstration and evaluation period, cases will be randomly assigned to either a traditional child protective services investigation or DR assessment and services. Families assigned to the DR pathway will be served by a paired team consisting of one IDCFS Differential Response Specialist and one Strengthening and Supporting Families (SSF) caseworker employed by a community-based agency. The process for DR assessment and service provision is as follows:

- The workers contact the family via telephone (if possible) to arrange an in-home assessment within 3 days of case assignment.
- The DR Specialist and SSF caseworker make the initial home visit together.
- During the initial visit, the DR Specialist assesses the safety of all children and risk factors present in the home, using the Child Endangerment Risk Assessment Protocol.
- If the child(ren) is determined to be unsafe, or if the level is risk is high, DR supervisors have the authority to reassign a family to the investigation pathway.
- If there are no immediate safety concerns, the DR Specialist hands over all future services to the SSF caseworker.
- The SSF caseworker completes a family needs and strengths assessment, usually during the first visit.
- The SSF caseworker provides them with a wide array of services targeted to their specific concerns.
- The DR 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 based upon the family's needs and the availability of funds.

Differential Response was implemented throughout the entire state of Illinois on November 1, 2010. From this date through June 30, 2011, over 1,000 new cases were assigned to the DR pathway.

How Will We Know if Differential Response Works?

The program logic model for Differential Response assumes that eligible families served through the DR pathway will be more highly engaged in the assessment and service planning process and receive a wider variety of more appropriated matched services, which will lead to higher satisfaction with services, fewer repeat contacts with the child welfare system and less penetration into the system (e.g., child removal). The DR evaluation in Illinois will test these assumptions and attempt to answer three critical questions:

1. **Child Safety:** Are children whose families are served in the DR pathway as *safe* as or safer than children whose families receive the investigation pathway?
2. **Pathway Differences:** How is the non-investigation pathway different from the investigation pathway in terms of *family engagement, casework practice, and services provided?*
3. **Program Costs:** What are the *cost* and funding implications to the child welfare agency of the implementation and maintenance of a DR approach?

The evaluation consists of a randomized control trial (RCT) with qualitative elaboration and pre-test/post-test comparisons of worker and agency contextual factors. The RCT will compare outcomes

for children and families assigned to the treatment group (DR) and the control group (investigation) and will tell us *if DR works*. The process evaluation will document what DR looks like in Illinois and how DR practice differs from that in a traditional investigation and will tell us *how DR works*. Highlights of the comprehensive evaluation 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 implementation.
- A process evaluation will thoroughly document the steps taken to implement DR 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.
- Focus groups and structured interviews will be held with caseworkers, supervisors, administrators, and community providers to assess their perceptions regarding the DR 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.
- Interviews will be conducted with families to obtain their perceptions about differential response, service availability and IDCFS in general.
- 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.

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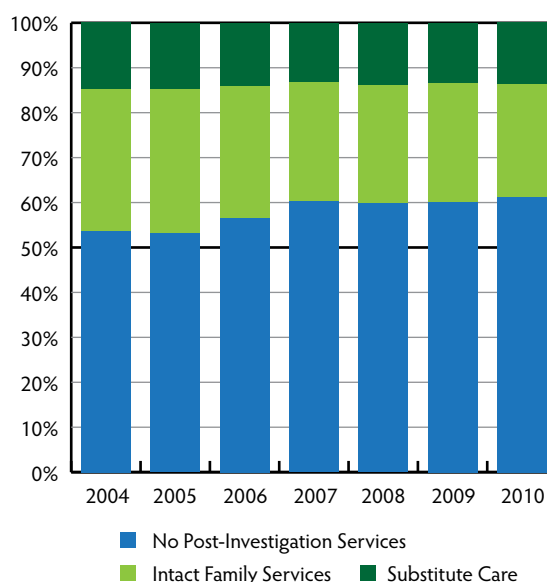
*Dr. Tamara Fuller, Principal Investigator
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assessment and decision); and 3) how to intervene to keep children safe by reducing longer-term risks in the home (case disposition). All formal investigations in Illinois receive a safety assessment within 24 hours after the investigator first sees the alleged victims, which allows the investigator to determine whether the children are in immediate danger of a moderate to severe nature. If it is determined that a child is unsafe, the investigator either a) works with the family to develop a safety plan that will either increase the parent's protective capacities or decrease the threats to child safety, or b) removes the children from the home. The effectiveness of the safety assessment process used in Illinois has been the subject of ongoing evaluation, and studies suggest that use of the safety assessment instrument (known as the Child Endangerment Risk Assessment Protocol) is associated with reduced maltreatment recurrence among investigated children.⁵ The safety assessment process in Illinois has recently been revised (see Box 1.2) and the enhanced safety model will be implemented throughout the state over the next year. Both the implementation of the enhanced safety model and its impact on child safety will need careful monitoring.

All formal investigations of maltreatment in Illinois receive a final determination (case disposition) of either indicated or unfounded, with the exception of those reports assigned to Differential Response (see Box 1.1). However, not all cases – even those where maltreatment is indicated – receive post-investigation 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. Figure 1.1 shows the service dispositions of children with indicated reports each year from 2004 to 2010. The majority of indicated children in Illinois do not receive post-investigation services, and this percentage has increased in the past several years from 54% in 2004 to 61% in 2010. About a quarter of children with indicated maltreatment reports are served in intact family cases, and this percentage has decreased

over time, from 32% in 2004 to 25% in 2010.⁶ A smaller portion of children are served in substitute care following an indicated investigation (around 14%), and this number has remained relatively level across the past seven years.⁷

Figure 1.1
Service Dispositions Among Children with Indicated Reports



The relationship between post-investigation service provision and risk of maltreatment recurrence is complex.⁸ Monitoring overall maltreatment recurrence rates without regard to service disposition ignores the fact that children served in one setting may be more or less safe than those served in another. In this chapter, separate indicators therefore examine maltreatment recurrence among 1) all children with indicated reports; 2) indicated children served in intact family cases; and 3) indicated children with no post-investigation service case (see Appendix B, Indicators 1.A, 1.B, and 1.C, respectively). Maltreatment that occurs while children are in substitute care placements is now discussed in Chapter 2 – Children in Substitute Care: Safety, Continuity, and Stability.

⁵ Numerous evaluations of the Child Endangerment Risk Assessment Protocol have been conducted by Dr. Tamara Fuller and Martin Nieto of the Children and Family Research Center since 1997. To download any of these reports, please visit the CFRC website at: www.cfrc.illinois.edu

⁶ This percentage includes those children with indicated reports that occurred while the child was already being served in an intact family case as well as children served in an intact family case within 60 days of the indicated report.

⁷ This percentage includes those children with indicated reports that occurred while the child was in substitute care as well as children placed in substitute care within 60 days of an indicated report.

⁸ Fluke, J.D., Shusterman, G.R., Hollinshead, D.M., & Yuan, Y.T. (2008). Longitudinal analysis of repeated child abuse reporting and victimization: Multistate analysis of associated factors. *Child Maltreatment*, 13, 76 – 88.

Assessing Safety: The DCFS Enhanced Safety Model⁹

The current safety assessment protocol used by the Illinois Department of Children and Family Services, the Child Endangerment Risk Assessment Protocol (CERAP), was implemented statewide in December 1996. In accordance with Public Act 88-614, the reliability and validity of the CERAP have been evaluated by the Children and Family Research Center each year since its implementation. The results of the evaluations indicate that maltreatment recurrence rates have dropped significantly since the implementation of the CERAP in 1996, but this decline cannot be attributed to the CERAP without a certain degree of uncertainty, since there was no control or comparison group utilized, and recurrence rates could have decreased even without CERAP implementation. Results of the annual CERAP evaluations from 1997 through 2010 are available on the Children and Family Research Center website (www.cfrc.illinois.edu).

The State of Illinois failed to meet the national standard for maltreatment recurrence in the first Child and Family Service Review (CFSR) in 2003. As part of the first Illinois Program Improvement Plan (PIP), the Department conducted a comprehensive analysis of the agency's current process for assessing safety and risk in families reported to or referred for services. This review resulted in the identification of several critical issues, including:

- There was conceptual confusion in the field regarding the differentiation of safety and risk as well as safety intervention versus safety management.
- Caregiver capacities were poorly assessed.
- No clear rational existed between information collected by staff and their decision-making around safety and risk.
- There was a lack of understanding about the relationship between safety intervention and service provision.
- Safety data collection was unfocused and imprecise.



- Safety plans were often limited in scope and not tailored to specific safety threats.
- Safety intervention and services were viewed by staff as the same; there was limited understanding that safety is not corrected by services.

Based on the results of this review, a Safety Workgroup comprised of DCFS staff and external stakeholders began a multi-year process of revising the safety assessment process used by the Department since 1996. The revised CERAP will be conducted at two phases during the investigation: within 24 hours of the hotline call and again within 25 days of the investigation initiation. A new risk assessment instrument which incorporates elements of the Child and Adolescent Needs and Strengths (CANS) instrument will also be completed by child protective services investigators. A new safety plan tool is also a critical part of the Enhanced Safety Model. The changes that are being made to the safety assessment process are anticipated by the Department to:

⁹ Information on the Enhanced Safety Model was taken from the Illinois Department of Children and Family Services Child and Family Service Review Second Round Program Improvement Plan.

Assessing Safety: The DCFS Enhanced Safety Model CONT'D

- **Strengthen the conceptual framework** by allowing staff to gather better information needed for decision-making. The definition of safe has been defined as one in which threats are managed by the parent's protective capacities or when such threats no longer exist. The model also clearly defines the terms safety, safety intervention, safety management, in-home and out of home safety plans, and provides a process that guides staff to gather comprehensive information on caregiver protective capacities.
- **Improve the structured decision-making process** by providing clearly defined criteria to guide decisions.
- **Expand the safety intervention system.**
- **Define information standards** so that staff will better understand the relationship of information to the decisions that are made.
- **Link the safety plan to safety outcomes.**

According to the Department's most recent Program Improvement Plan (PIP) filed with the Children's Bureau in January 2011, the Department plans to implement a new policy guide for workers and train child protection staff in three consecutive phases beginning in July 2011 and ending in November 2012. In addition, the impact of the enhanced safety model on specific safety indicators and overall safety outcomes will be measured through the Department's Outcome Enhancement Review (OER) process, as well as through "other quality improvement activities." Since a long-standing process for evaluating the reliability and validity of the CERAP safety assessment process already exists, it seems prudent to incorporate the evaluation of the Enhanced Safety Model into this established evaluative structure and process.

Figure 1.2
12-Month Maltreatment Recurrence
Among Children with Indicated Reports

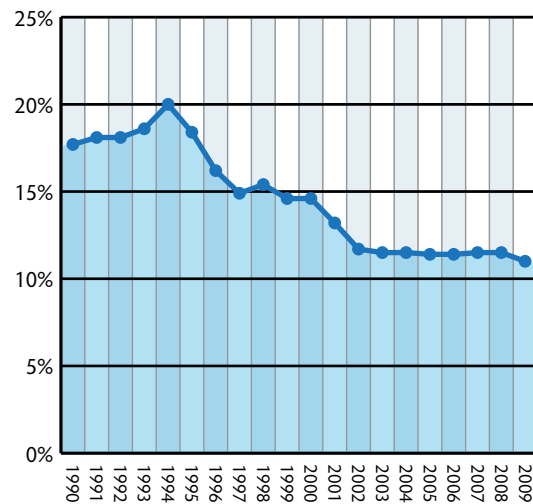


Figure 1.2 displays the 12 month maltreatment recurrence rate for all children with an indicated maltreatment report (see Appendix B, Indicator 1.A). When this indicator is examined over the past 20 years, it is evident that recurrence rates increased in the early 1990s to their peak of 20% in 1994, and then began a steady decline from 1995 to 2003, when the rate leveled off at about 11.5% and remained there through 2008. Recurrence decreased by .5 percentage points from 2008 to 2009.

A fair amount of research has examined the child, family, and case characteristics that are related to maltreatment recurrence. This research points to child age as an important predictor of recurrence – younger children are much more likely to experience maltreatment recurrence than older children.¹⁰ The recurrence rates in Illinois also show a consistent relationship to child age: as child age increases, maltreatment recurrence decreases (see Figure 1.3 and Appendix B, Indicator 1.A).

¹⁰ Bae, H., Solomon, P.L., & Gelles, R.J. (2009). Multiple child maltreatment recurrence relative to single recurrence and no recurrence. *Children and Youth Service Review*, 31, 617-624. Connell, C.M., Bergeron, N., Katz, K.H., Saunders, L., & Tebese, J.K. (2007). Re-referral to child protective services: The influence of child, family, and case characteristics on risk status. *Child Abuse & Neglect*, 31, 573-588. Kahn, J.M., & Schwalbe, C. (2010). The timing to and risk factors associated with child welfare system recidivism at two decision-making points. *Children and Youth Services Review*, 32, 1035-1044. Fluke, J.D., Shusterman, G.R., Hollinshead, D.M., & Yuan, Y.T. (2008). Longitudinal analysis of repeated child abuse reporting and victimization: Multistate analysis of associated factors. *Child Maltreatment*, 13, 76-88.

Figure 1.3
12-Month Maltreatment Recurrence
by Age

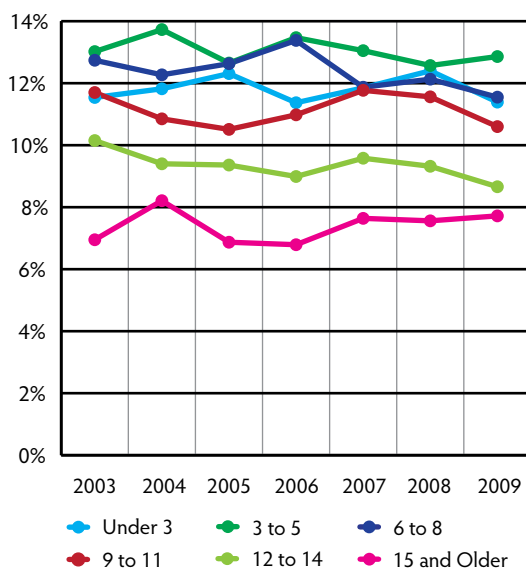
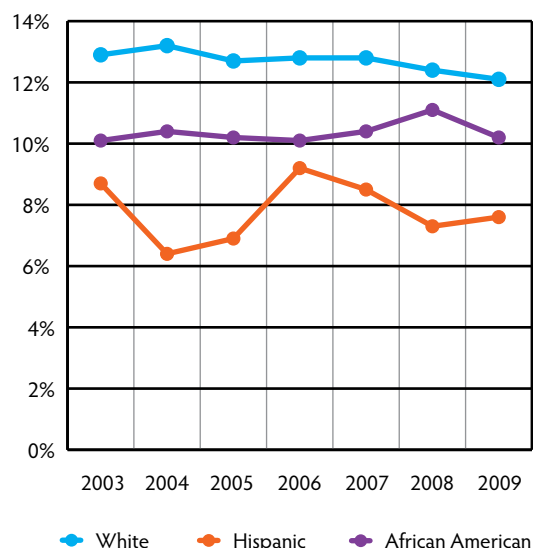


Figure 1.4
12-Month Maltreatment Recurrence
by Ethnicity



Although research from other locations shows mixed results, in Illinois there is a consistent relationship between child race/ethnicity and maltreatment recurrence (see Figure 1.4): rates among Hispanic children are the lowest (7.6% in 2009), followed by African American children (10.2%), with White children having the highest rate of recurrence (12.1%). Appendix B, Indicator 1.A shows the breakdowns for 12-month maltreatment recurrence rates by child gender, age, and race/ethnicity.

Previous *B.H.* monitoring reports have exposed consistent and modest differences in recurrence rates by region. These differences persist in 2010: the combined Cook regions have the lowest recurrence rate (8.4%), followed by the Northern region (9.8%), the Central region (12.8%) and Southern region (14.5%). Figure 1.5 displays a sub-regional “heat map” showing 12-month maltreatment recurrence rates among all children with an indicated report (see Appendix C, Indicator 1.A for corresponding data). To create the heat map, recurrence rates in each sub-region of Illinois between 2003 and 2009 are compared to one another and ranked. The sub-regions and years in the top 25th percentile – those with the *best performance* on this indicator – are shown in the lightest shade. Those sub-regions and years in the bottom 25th percentile – those with the

Figure 1.5
12-Month Maltreatment Recurrence
Sub-region Heat Map

	2003	2004	2005	2006	2007	2008	2009
Cook North							
Cook Central							
Cook South							
Aurora							
Rockford							
Champaign							
Peoria							
Springfield							
East St. Louis							
Marion							

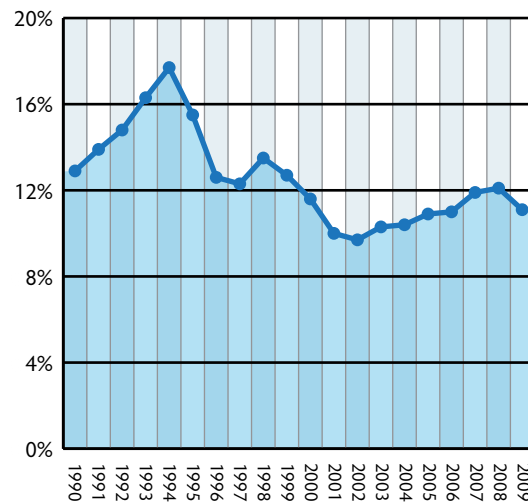
worst performance on this indicator – are shown in the darkest shade. Those that performed in the middle – between the 26th and 74th percentiles – are shown in the medium shade. The heat map therefore provides a visually simple way to compare a large amount of information on sub-regional performance both over time and across the state. It is possible to tell reasonably quickly if a region or sub-region is doing well (relative to the other regions in the state over the past 7 years) by looking for the areas in the lightest shade. It is important to note that these “rankings” are relative only to the performance within the ten sub-regions over the seven year time span and not to any national or state benchmarks. Thus, even though a given sub-region may be performing “well” compared to other sub-regions in the state (as indicated by a light shade on the heat map), this does not necessarily mean that its performance should be considered “good” or “excellent” compared to a standard or benchmark.

Examination of Figure 1.5 clearly reveals that the highest recurrence rates in the state are occurring in the Marion sub-region and the Springfield sub-region (see Appendix C, Indicator 1.A), and that performance in these two sub-regions is consistently poor throughout the entire observation period. Conversely, the best performing sub-regions are those in the Cook region, and this is also fairly consistent across the observation period.

Maltreatment Recurrence Among Indicated 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 compared to families with no history of maltreatment. Figure 1.6 displays the recurrence rates for these children (see Appendix B, Indicator 1.B).

Figure 1.6
12-Month Maltreatment Recurrence Among Children Served in Intact Families



Similar to overall recurrence, recurrence among children served in intact families climbed steeply during the early 1990s to its peak of 17.7% in 1994. Rates then declined, first steeply and then more gradually, over the next several years, before reaching their lowest point (9.7%) in 2002. Maltreatment recurrence has been slowly climbing from 2002 until 2008. Recurrence rates decreased by one percentage point in the past year – an encouraging sign if it persists.

The relationships between child age and race/ethnicity and recurrence among children served in intact families are very similar to those for overall maltreatment recurrence (see Appendix B, Indicator 1.B). Recurrence is much more likely to occur among younger children – children under three years are over four times more likely to experience recurrence than those 15 years and older. Also, White children served in intact families are much more likely to experience repeat maltreatment than African American children.

When recurrence in intact families is examined at the sub-region level (see Appendix C, Indicator 1.B), several trends are apparent (Figure 1.7). Once again, recurrence rates are lowest in the Cook sub-regions (lightest shade) and highest in the Marion and Springfield sub-regions (darkest shade). Recurrence in intact families appears to be getting worse in both the Rockford and Champaign sub-regions as well.

Figure 1.7
12-Month Maltreatment Recurrence
Among Children Served in Intact Families
Sub-region Heat Map

	2003	2004	2005	2006	2007	2008	2009
Cook North							
Cook Central							
Cook South							
Aurora							
Rockford							
Champaign							
Peoria							
Springfield							
East St. Louis							
Marion							

Maltreatment Recurrence Among Indicated Children Who Do Not Receive Services

Figure 1.8 displays the 12-month maltreatment recurrence rate for children with an indicated report who did not receive services (either intact family or substitute care) following the investigation (i.e., the case was indicated and closed; see Appendix B, Indicator 1.C). The trend is very similar to that for overall maltreatment recurrence: an increase in the early 1990s, followed by a decrease from 1994 until around 2002, and then a static pattern from 2002 until present.

Figure 1.9 compares the 12-month maltreatment recurrence rates between indicated children served in intact families and indicated children that receive no post-investigation services. Until around 2004, children served in intact families were slightly to moderately safer than those not provided services. However, since recurrence rates among intact families have been slowly increasing since 2002 while those among children not provided services have been level, rates among the two groups have been very similar for several years.

Figure 1.8
12-Month Maltreatment Recurrence
Among Indicated Children Who
Do Not Receive Services

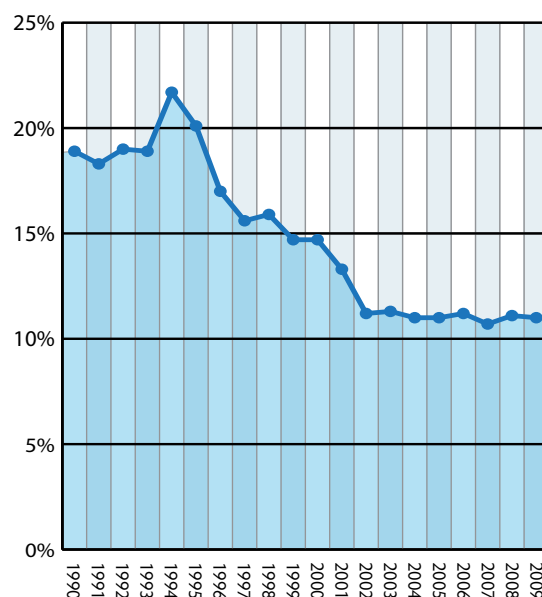
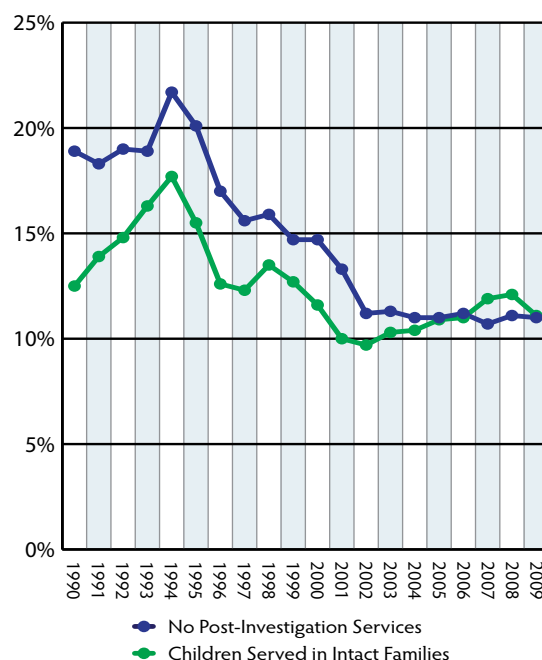


Figure 1.9
Comparison of Maltreatment Recurrence
Among Children Served in Intact Families
and Children Who Do Not Receive Services



An interesting discrepancy emerges when African American children (Figure 1.10) and White children (Figure 1.11) that received either no post-investigation services or intact family services are compared. The maltreatment recurrence rate among children not provided post-investigation services is similar for both African American and White children (11-12%) across the past several years. African American children provided with intact family services following an indicated investigation have much lower recurrence rates (8.7% among children investigated in 2009) compared to both White children provided with intact family services (14.7%) as well as African American children not provided with services following an investigation (11.1%). Thus, it appears as if intact family services are more effective in preventing maltreatment recurrence among African American families than White families. However, as with all findings related to racial differences in child welfare outcomes, the dynamics that underlie this discrepancy are no doubt complex, and likely related to differences in family characteristics such as poverty, length and number of prior contacts with the child welfare system, and the nature of the intact services provided. A more comprehensive analysis would further illuminate this interesting finding.

Conclusions and Recommendations: Child Safety

When examining child safety, the true litmus test of child welfare system performance is how well it protects children from additional maltreatment *after* they become known to the system. The primary indicator used to assess performance in this area is the rate of maltreatment recurrence, typically measured as the occurrence of a second indicated report of maltreatment that occurs within a certain time period following an initial indicated report. When maltreatment recurrence within 12 months is examined over time for all children in Illinois with an indicated report, rates have remained at a consistent level for the past several years. However, this overall rate masks fairly large differences in recurrence among various groups of children with indicated reports, and some of these difference warrant further attention.

There continue to be large regional differences in recurrence, with lower recurrence rates in the Cook region and higher recurrence in the Central and Southern regions of the state. An even closer examination of recurrence rates – at the sub-regional level

Figure 1.10

Maltreatment Recurrence Among African American Children by Service Disposition

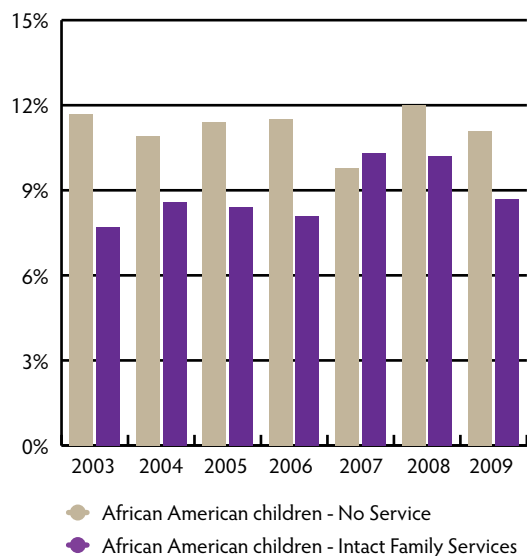
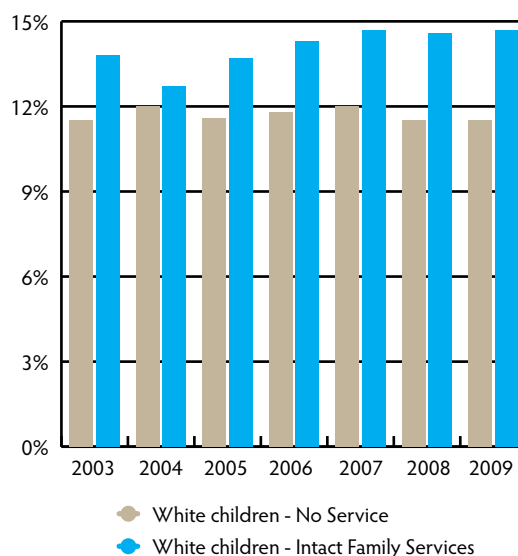


Figure 1.11

Maltreatment Recurrence Among White Children by Service Disposition



– reveals that the poor performance in the Southern region is being driven by the high recurrence rates in the Marion sub-region, while the poor performance in the Central region is due to the Springfield sub-region. Recurrence rates in these two sub-regions are over twice as high as those in the Cook sub-regions. Recurrence rates are influenced by a multitude of factors – including characteristics of the child (such as age and disability), the parent (substance abuse), the type of maltreatment (neglect is much more likely to recur than any other type of maltreatment), and the family’s history with child protective services. There is also some indication that recurrence is linked to differences in practice, such as the consistent use of safety assessment and the size of the investigation caseload.

Recent focus groups with investigators around the state conducted by the Children and Family Research Center revealed wide differences in child protective services practice from region to region, and even from office to office within each region. A much richer understanding of the factors related to maltreatment recurrence could be obtained by focusing on one or two sub-regions and collecting multiple types of data about the families and the ecological systems within which they are embedded (information about the children, their parents, their extended families, the neighborhoods and communities in which they live, the services that are available within those communities). This type of data collection goes well beyond the analysis of administrative data and involves qualitative methods such as case record reviews and focus groups with workers and supervisors. Although this type of data collection is more time-consuming and expensive, focusing on one or two sites would limit the effort and cost involved while still providing a better understanding of the reasons behind the large differences in recurrence around the state and allow the Department to target specific interventions to decrease the likelihood of recurrence.

One of the most complex decisions an investigator makes is whether or not to open an investigation for on-going services. Workers must weigh multiple factors at once, such as the immediate safety threats in the household, the long-term risk factors, the protective capacities and supports of the parents, the services that are available in the community, and the

parents’ ability to utilize those services, if provided. If there are no immediate safety concerns, best practice and DCFS policy indicate that children should be maintained safely in their own home, whenever possible and appropriate. However, Illinois was not in substantial conformity with this indicator on the most recent Child and Family Service Review (CFSR) conducted in 2009, with only 70.8% of cases achieving substantial conformity (compared to the 95% benchmark). The 2009 CFSR identified several concerns following a case review of 65 cases statewide: 1) children remaining in their own homes continued to be at risk either because services were not provided or because services that were provided did not target the key safety concerns, 2) there was a lack of ongoing safety and risk assessments, and 3) there were continued risk concerns in the home that were not addressed and/or monitored by the agency.¹¹

Findings in this year’s report suggest that smaller portions of investigated families are receiving intact family services and children served in these families are slightly less safe than they have been in the past. We need a better understanding of which families are most likely to be given intact family services (as opposed to no services or child removal from the home) and which families are most likely to benefit from intact family services. In Illinois, maltreatment recurrence rates are similar for those families that are provided intact family services and those provided with no post-investigation services at all. However, an interesting interaction was discovered when recurrence rates among African American and White children that received either intact family services or no post-investigation services were compared. African American children served in intact families are safer (e.g. are less likely to experience recurrence) than African American children that do not receive any services at all. The reverse is true for White children, who are much more likely to experience recurrence when served in intact families than when provided no services at all following an indicated report. It is likely that there are differences between the African American and White families that are provided intact family services and these differences may account for the discrepancies in recurrence. For example, it may be that White families that receive intact family services are more likely to have a higher number of previous reports than their African American counterparts, which makes

¹¹ U.S. Department of Health and Human Services. (2010). *Final report: Illinois Child and Family Services Review*. Retrieved from: http://www.state.il.us/dhhs/docs/Illinois_CFSR_Final_Report_ED_1_4_10.pdf

it more likely that they will experience recurrence. The first step in understanding the effectiveness of intact family services is understanding which families currently get them. Anecdotal evidence suggests that the types of families served through intact family cases has changed in the last several years, and that families now served have more serious and complex needs requiring a wider array of services, which are often not available. A file review of intact family cases, similar to the one done for the CFSR but tailored to answer different questions, could confirm this “practice wisdom” and aid the Department in its efforts to better serve families at home.

The Department is implementing two significant child protection reforms that are intended to increase child safety: Differential Response (DR) and the Enhanced Safety Model. Differential Response was implemented statewide on November 1, 2010, and over 1000 families have received DR services as of June 30, 2011. It is far too soon to tell if this initiative will have its intended effect on child safety, but a rigorous evaluation plan ensures that the answer to this question will be available by the end of the demonstration period. The second practice reform, the implementation of the enhanced safety model, is scheduled to begin sometime in FY2012. According to the most recent Illinois Program Improvement Plan, the Enhanced Safety Model “allows for the assessment of safety throughout the life of a case, from investigation to permanency, reduces confusion in the field, and provides clear definitions and links goals and objectives to safety planning” (p. 8).¹² It will be critical for the Department to document, with reliable and valid data, the actual impact of the Enhanced Safety Model. These evaluation efforts should build on the 15 years of research that has been conducted on the current safety model to document the impact on maltreatment recurrence. Previous research has shown that safety and risk assessment instruments are not always used as intended.¹³ Therefore, additional evaluation should also be done to explore how workers are using the revised tools and implementing the policy changes.

¹² Illinois Department of Children and Family Services. (2011). *Child and Family Services Review Program Improvement Plan*.

¹³ Lyle, C.G., & Graham, E. (2000). Looks can be deceiving: Using a risk assessment instrument to evaluate the outcomes of child protection services. *Children and Youth Services Review*, 22, 935-949. Schwalbe, C. (2004). Re-visioning risk assessment for human service decision-making. *Children and Youth Services Review*, 26, 561-576.



CHAPTER 2

Children in Substitute Care: Safety, Continuity, and Stability

Children should be removed from their parents and placed in substitute care only when it is necessary to ensure their safety and well-being. Once removed from their homes, the public child welfare system and its private agency partners have a responsibility to provide children with living arrangements that ensure that they are safe from additional harm, maintain connections with their family members (including other siblings in care) and community, and provide stability. In addition, substitute care should be a temporary solution and children should live in substitute care settings for the shortest period possible to ameliorate the issues which brought the children into care. This chapter examines how well the Illinois Department of Children and Family Services performs in providing substitute care living arrangements that meet these standards, and is organized into four sections: 1) Safety in Substitute Care, 2) Continuity with Family and Community, 3) Placement Stability, and 4) Length of Time in Substitute Care.

Measuring the Quality of Substitute Care

Several indicators have been developed to measure each of these “qualities” of the substitute care placements of children in Illinois. These indicators are described

more fully in the following sections, and technical definitions are provided in Appendix A. One of the difficulties encountered when considering the qualities of children’s substitute care placements is that children rarely stay in the same placement during their entire stay in care. Put another way, a child’s initial placement is often different from his or her placement at a later point in time during their substitute care stay. Rather than ignore these initial placements, even though they are often brief, the current chapter examines both initial placements and placement at the end of the year for several indicators (restrictiveness, placement with siblings, and placement close to home). It is important to keep in mind that the children in these two samples are not the same: “initial placement” includes all children who entered care within a given fiscal year and “end of year placement” includes all children in care on the last day of the fiscal year. Thus, the initial placement samples over-represent children who are in care for a short period of time and end-of-year samples over-represent children who have been in care for a long time. The other indicators examined in this chapter (e.g., safety, stability, length of time in care) do not differentiate between initial and end-of-year placements, but instead examine a child’s entire time in care during a particular fiscal year.

Placement setting has a significant impact on many aspects of a child's stay in substitute care, including safety, continuity, and stability. Indicators used in previous *B.H.* monitoring reports often compared children in kinship against all other “non-kinship” settings. The current chapter expands the analyses to include the full range of placement types that children may experience in Illinois, which are categorized as kinship foster homes, traditional foster homes, specialized foster homes, group homes, institutions, and independent living programs (see Box 2.1 for additional information). It is important to use these finer distinctions for several reasons. First, combining the outcomes of children in specialized foster homes, institutions and group homes with those of traditional foster homes into one larger group called “non-kin” masks true differences between kin foster homes and traditional foster homes. Second, while specialized foster care, institutions and group homes are less frequently used, they are more restrictive, less stable, and more expensive substitute care options than traditional foster care or kinship care. Finally, these placements are traditionally those of “last resort” and supposed to be reserved for the most troubled youth who require heightened structure in a therapeutic milieu, yet over 10% of youth in substitute care in Illinois reside in residential treatment facilities or group homes.

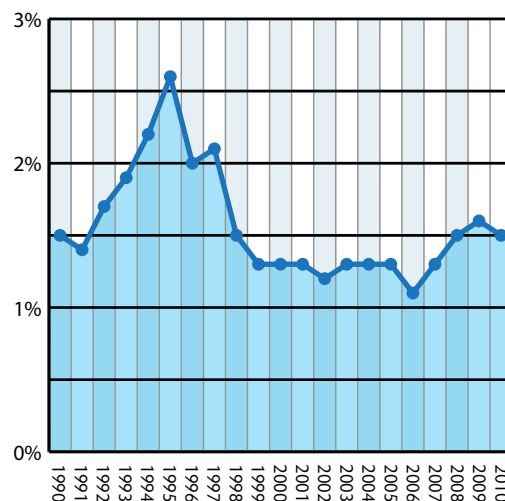
Safety in Substitute Care

First and foremost, children in substitute care should be safe from repeat maltreatment. This section examines the percentage of children in substitute care who had a substantiated report during their placement. Two things are important to keep in mind when interpreting the results based on this indicator. First, the analysis includes substantiated maltreatment from any source that occurs while children are in substitute care, unlike the federal outcome measure for maltreatment in foster care which only includes maltreatment perpetrated by a foster parent or facility staff member. Second, the indicator excludes substantiated reports of sexual abuse that occur during placement because 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 Children

and Family Research Center has revealed that the use of the report date rather than the incident date results in an overestimation of abuse and neglect in substitute care.¹ 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. Currently, DCFS administrative data does not distinguish between report date and incident date, so the effects of retrospective reporting errors must be estimated. Since the most common retrospective reports are of sexual abuse, sexual abuse has been excluded from this indicator.

Figure 2.1 shows the percentage of children served in substitute care that experienced an indicated maltreatment report while in placement each year from 1990 through 2010 (see Appendix B, Indicator 2.A). As with other indicators of maltreatment recurrence (see Chapter 1: Safety) rates of maltreatment in care were at their highest in the mid-1990s, declined fairly consistently through 1999, where they remained level at around 1.3% until 2006. Since 2006, the percentage of children maltreated while in care has increased from 1.1% to 1.5% in 2010.

Figure 2.1
Children Maltreated in Substitute Care



There are no substantial differences in maltreatment in substitute care when this indicator is examined by

¹ Tittle, G., Poertner, J., & Garnier, P. (2001) *Child Maltreatment in foster care: A study of retrospective reporting*. Urbana, IL: Children and Family Research Center.

Placement Type Terminology

Children in substitute care live in a number of different settings. At the simplest level of distinction, substitute care placement types can be categorized into those that can be considered “foster homes” versus “congregate care” settings. The former category includes placements where a child lives with a foster parent in their home, and includes kinship foster homes, traditional foster homes, and specialized or treatment foster homes.

Kinship foster care involves placement of children with relatives in the relatives’ homes. Relatives are the preferred placement for children who must be removed from their birth parents, as this kind of placement maintains the children’s connections with their families. In Illinois, kinship care providers may be licensed or unlicensed.

Traditional foster care involves placement of children with non-relatives in the non-relatives’ homes. These traditional foster parents have been trained, assessed, and licensed to provide shelter and care.

Specialized foster care (also called treatment or therapeutic foster care) involves placement of children with foster families who have been specially trained to care for children with certain medical or behavioral needs. Examples include medically fragile children, children with emotional or behavioral disorders, and HIV+ children. Treatment foster care programs generally require more training for foster parents, provide more support for children and caregivers than regular family foster care, and have lower limits on the number of children that can be cared for in the home.

While it is preferred that children in substitute care live in family settings, some children have physical or behavioral needs that require a congregate care facility – a non-family setting where a group of children receive specialized care and treatment. Congregate care settings include group homes, residential treatment centers, and several other types of specialized group settings.

Many states, including Illinois, use the term **group home** to refer to a non-family, community-based residence that houses more children than are permitted to reside in a foster family home, but fewer than reside in a residential treatment center (in Illinois, the number of children in a group home is limited to 10 or fewer). Group homes are operated by professional staff who work in rotating shifts.

All other congregate care settings are combined in the current chapter into a broad category called “**institutions**.” This broad category includes a variety of congregate care placements such as residential treatment centers (RTCs), detention centers, hospitals and other health facilities, and emergency shelters. Since the number of children placed in groups homes is relatively small, these children are sometimes combined with those in other congregate care settings in several of the analyses in this chapter. In these instances, the combined term “Institution/Group Home” is used.

Independent Living (ILO) and Transitional Living Programs (TLP) are distinct from substitute care placements. According to DCFS policy guides, Independent Living Services are defined as “casework and other supportive services provided by a licensed child welfare agency...to eligible youth who will be living in an apartment in the community and are intended to prepare the youth for transition to adulthood and self-sufficiency” and Transitional Living Services are defined as “caseworker and other supportive services to assist eligible youth to complete their secondary education (high school graduation or achievement of a GED), to assist a youth to develop basic self-sufficiency skills, and to prepare the youth for an ILO program. Services are most typically provided to a youth who is living in a group care or apartment setting that is owned or leased by the POS provider.”² Youth receiving ILO and TLP services are typically not included in the analyses in this chapter, unless otherwise specified.

² Retrieved from <http://dcfswebresource.dcf.illinois.gov/definitions/>

race or gender, but rates differ by child age. As with other indicators of maltreatment recurrence, young children are the most vulnerable and risk decreases with child age (see Figure 2.2 and Appendix B, Indicator 2.A). For example, in 2010, around 1.8% of children 8 years and younger were maltreated in care, compared to 1.0% of those between 9 and 14 years, and .1% of those 15 years and older.

Figure 2.2
Children Maltreated in Substitute Care by Age

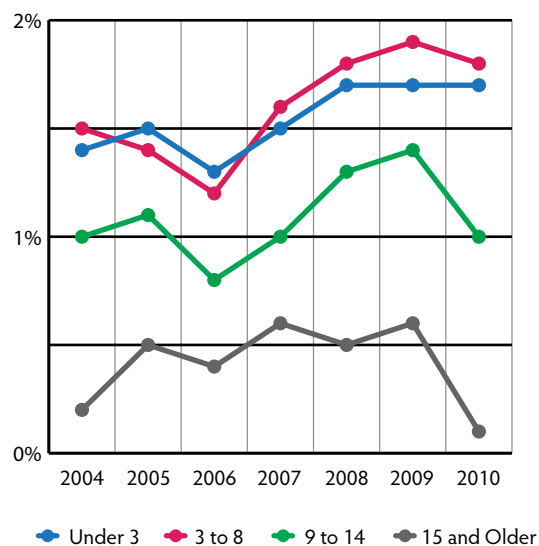


Figure 2.3 examines differences in maltreatment in care by placement type. Maltreatment is least likely to occur in congregate care settings (e.g., institutions and group homes) and most likely to occur in kinship foster homes. Of some concern is the increase in maltreatment rates in kinship and traditional foster homes since 2006: the rate of maltreatment in kinship foster homes has risen from 1.1% in 2006 to 1.8% in 2010 and in traditional foster homes from .9% in 2006 to 1.4% in 2010.

Maltreatment rates in substitute care vary by region of the state, with the Cook Region consistently having lower rates of maltreatment in care (see Appendix B, Indicator 2.A). There is even more variability in maltreatment rates at the sub-region level, as shown in the heat map in Figure 2.4 (see also Appendix C, Indicator 2.A).³ To

Figure 2.3
Children Maltreated in Substitute Care by Placement Type

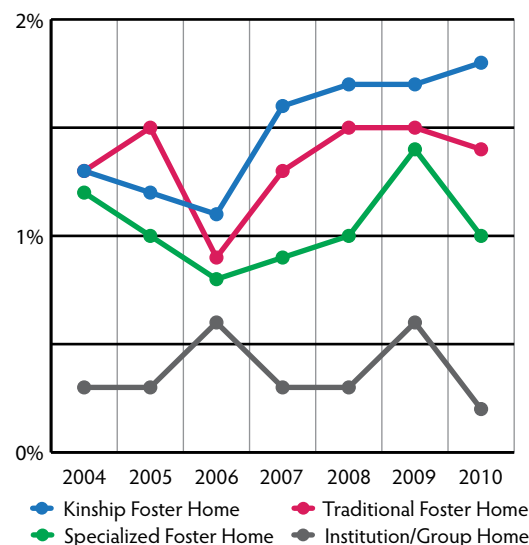


Figure 2.4
Children Maltreated in Substitute Care Sub-region Heat Map

	2004	2005	2006	2007	2008	2009	2010
Cook North							
Cook Central							
Cook South							
Aurora							
Rockford							
Champaign							
Peoria							
Springfield							
East St. Louis							
Marion							

³ The region of placement is determined by the region of the agency supervising the case.

create the heat map, recurrence rates in each sub-region of Illinois between 2004 and 2010 are compared to one another and ranked. The sub-regions and years in the top 25th percentile – those with the *best performance* on this indicator – are shown in the lightest shade. Those sub-regions and years in the bottom 25th percentile – those with the *worst performance* on this indicator – are shown in the darkest shade. Those that performed in the middle – between the 26th and 74th percentiles – are shown in the medium shade. The heat map therefore provides a visually simple way to compare a large amount of information on sub-regional performance both over time and across the state. It is possible to tell reasonably quickly if a region or sub-region is doing well (relative to the other sub-regions in the state over the past 7 years) by looking for the areas in the lightest shade. It is important to note that these “rankings” are relative only to the performance within the ten sub-regions over the seven year time span and not to any national or state benchmarks. Thus, even though a given sub-region may be performing “well” compared to other sub-regions in the state (as indicated by a light shade on the heat map), this does not necessarily mean that its performance should be considered “good” or “excellent” compared to a standard or benchmark.

The sub-regional heat map shows the lower maltreatment rates present in the Cook sub-regions (lighter shades) and the higher maltreatment rates that are clustered in the Central and Southern sub-regions, which also appear to be worsening over the past several years.

Continuity with Family and Community

Restrictiveness of Placement Settings

When it is in the best interest of a child to be placed in substitute care, it is both federal and state policy to place children in the least restrictive, most family-like setting possible. *The Adoption Assistance and Child Welfare Act of 1980* required states “to place a child in the least restrictive and most family-like setting that will meet the needs of the child.”⁴ In 1996, Congress required

states to include in their requisite Title IV-E state plans a provision which indicates that the State 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 child protection standards. Federal policies encourage placing children in the least restrictive (most family-like) setting that maintains the continuity of kinship and community ties.⁵ The importance of a family-like setting and the quality of care-giving relationship has been emphasized for over a century.⁶

One advantage of the least restrictive family-like setting is that it increases bonding capital. Bonding capital refers to strong social ties that exist between people who share a key attribute such as family, friendship, church membership, residence, etc. At the individual level, bonding capital is measured as a person’s primary source of social support.⁷ One advantage of placement with kin is that it builds on a child or youth’s existing bonding capital. However, research finds that youth in traditional foster care eventually develop bonds with foster parents comparable to those who are placed with kin.⁸ Even though less restrictive, home-like settings are generally preferred, there are situations where more restrictive placement types (e.g., institutions and group homes) better meet the needs of children, for example children with severe psychosocial problems.

Recent *B.H.* monitoring reports have measured the restrictiveness of children’s placement settings using four indicators: 1) the percentage of children under of the age of 12 who were living in group homes or institutions at the end of each year, 2) the percentage of children that were placed with kin as an initial placement and 3) at the end of the year, and 4) the percentage of children living in institutions or group homes outside Illinois. These indicators have been modified in several ways. The indicator that examined out-of-state residential placements has been dropped. While placement outside the state was a big concern in the early to mid-1990s, the number of children placed outside

⁴ Adoption Assistance and Child Welfare Act of 1980, Pub. L. 96-272.

⁵ Testa, M., Bruhn, C.M. & Helton, J. (2010) Comparative safety, stability, and continuity of children’s placements in formal and informal substitute care. In M.B. Webb, et al., *Child welfare and child wellbeing: New perspectives from the National Survey of Child and Adolescent Well-being*, (pp. 159-191). New York: Oxford.

⁶ Minton, S. E. (1893) Family Life versus Institution Life in *History of Child Saving in the United States, the Twentieth National Conference of Charities and Corrections*.

⁷ Putnam, Robert. (2000). *Bowling Alone: The Collapse and Revival of American Community*. New York: Simon & Schuster.

⁸ Testa, M., Bruhn, C.M. & Helton, J. (2010) Comparative safety, stability, and continuity of children’s placements in formal and informal substitute care. In M.B. Webb, et al., *Child welfare and child wellbeing: New perspectives from the National Survey of Child and Adolescent Well-being*, (pp. 159-191). New York: Oxford.

Illinois has decreased tremendously (e.g., 18 children were placed in residential care outside Illinois in 2008) and has not shown any real variance in the past decade.

Placement restrictiveness is now examined for children of all ages (i.e., not just those 12 and older in congregate care) and across all placement types (i.e., not

just with kin). In addition, placement restrictiveness is examined in two different groups of children: 1) initial placements of children entering care in a given year and 2) children in care at the end of the year. The first indicator (initial placements) over-represents children who are in care a short period of time, but provides important information about initial placements, which can influence a child's trajectory through substitute care. The second indicator (end of year placements) over-represents children who have been in care a long time but provides a better sense of the overall population of children in care than initial placements. Figures for the two indicators are presented side by side so readers can compare the patterns for initial and end-of-year placements.

Initial placement types for children entering care during fiscal years 2004 through 2010 are shown in Figure 2.5.⁹ Most children are initially placed in a kin foster home and that percentage has increased over time from 42.9% in 2004 to 53.9% in 2010 (see Figure 2.5 and Appendix B, Indicator 2.B.3). The percentage of children initially placed in traditional foster homes has steadily decreased, from 40.0% in 2004 to 25.2% in 2010 (Appendix B, Indicator 2.B.1). The percent of children initially placed in specialized foster homes has remained consistently low – around 2.5-3% (Appendix B, Indicator 2.B.2). There has been an increasing proportion of children initially placed in congregate care settings (group home and institutions) – from 14.3% in 2004 to 18.4% in 2010 (Appendix B, Indicator 2.B.4). Initial placement in a congregate care setting can occur for a variety of reasons: some children are placed in shelters and other congregate care settings because no other suitable placement can be found and some children are placed in residential centers based on an assessment of their physical, emotional, and mental health needs. However, the fact that nearly half these initial placements in institutions and group homes last 2 days or less suggests that they are being used as temporary placements fairly frequently. Additional inquiry and analysis is needed to understand the increasing percentage of children being initially placed in institutions (see Conclusions and Recommendations section).

Temporary Events That Precede Initial Placements

Initial placements are occasionally preceded by other types of “temporary events.” Of children entering substitute in 2010, 421(8.4%) had a temporary event prior to their initial placement. Hospitalization (including both medical and psychiatric hospitalization) accounted for 84% of temporary events in 2010. Other types of temporary events were infrequent and include abductions, runaways, and unauthorized placements (i.e. caseworker knows where the child is but the placement is not approved). Children with a temporary event before their initial placement were more likely to go into restrictive settings in their initial placement (specialized foster homes, group homes or institutions) than children who do not experience a temporary event. For example in 2010, 27.3% of children with a temporary event were initially placed in a group home or institution whereas 17.6 % of children without a temporary event preceding their first placement were placed in one. Additional research should evaluate the needs and trajectories of children who come into care from these temporary events, particularly hospitalization.

⁹ Only children who remain in substitute care for eight or more days are included in these analyses, i.e., children with very short stays (7 days or less) are excluded.

Figure 2.5
Initial Placement Types

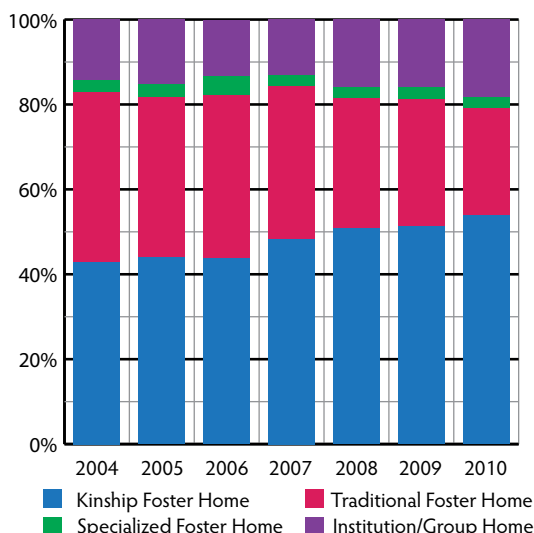
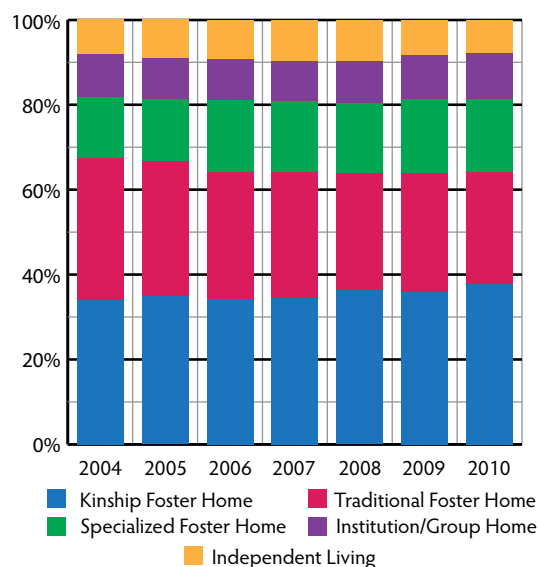


Figure 2.6
End of Year Placement Types



Among children in substitute care at the end of the year (Figure 2.6, Appendix B, Indicator 2.C.3), the proportion of children in kinship foster homes has increased from 34% in 2004 to 37.7% in 2010,¹⁰ and that in traditional foster homes has decreased from 33.3% in 2004 to 26.5% in 2010 (Appendix B, Indicator 2.C.1). The proportion of children in specialized foster homes at end of year has grown from 14.6% to 17.2% (Appendix B, Indicator 2.C.2). The proportion of children in congregate care (institutions and group homes) has remained around 10% (Appendix B, Indicators 2.C.4 and 2.C.5) and the proportion in independent/transitional living programs has fluctuated between 8.0% and 9.8% over the past 7 years (Appendix B, Indicator 2.C.6).

Comparison of Figures 2.5 and 2.6 reveals differences in the percentages of children placed in more restrictive placement types in their initial placements versus later placements (end of year). A higher proportion of children are initially placed in kinship foster homes than are in kinship foster homes at the end of the year. In addition, a higher portion of children have an initial placement in an institution than are placed there at the end of the year. Conversely, relatively few children are placed in specialized foster homes initially, compared to the percentage that are placed there at the end of the year. Finally, independent living programs are rarely, if

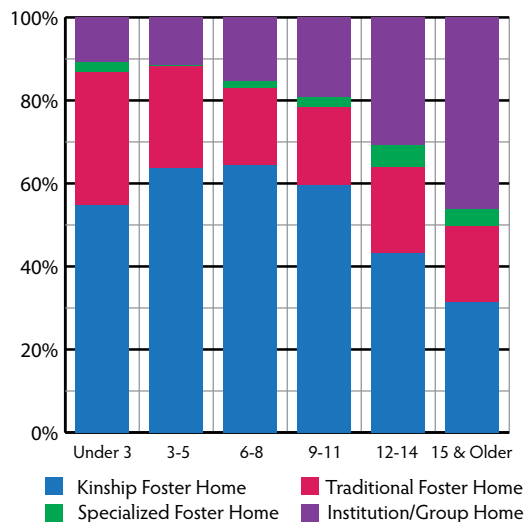
ever, used as initial placements, but constitute 8-10% of children's placements at the end of the year.

The use of different types of placements – both for initial placements and later placements – varies by child age, race, and geographical region. These relationships will be explored in more detail by examining the initial and end of year placements for Fiscal Year 2010 (FY2010). Most children, especially those 11 years and younger, are initially placed in family-like settings such as kin foster homes, traditional foster homes, or occasionally specialized foster homes (Figure 2.7). The portion of children initially placed in family-like settings decreases with age: in 2010, 89.2% of children under 3 years were placed in foster homes, compared to 88.6% of 3-5 year olds, 84.7% of 6-8 year olds, 80.8% of 9-11 year olds, 69.2% of 12-14 year olds, and 53.9% of those 15 years and older. The reverse is true for initial placement in an institution or group home – the portion of children placed in these settings increases with child age from 10.8% for children under 3 to 46.1% for children 15 and older. Even among the youngest children, however, initial placement in an institution is not uncommon.

There were a smaller proportion of children in institutions and group homes in all age categories at the end of FY2010 than at initial placement (Figure 2.8). There

¹⁰ This indicator has been updated since the last report, so the numbers in the figures and appendix tables will be slightly different than those in previous reports.

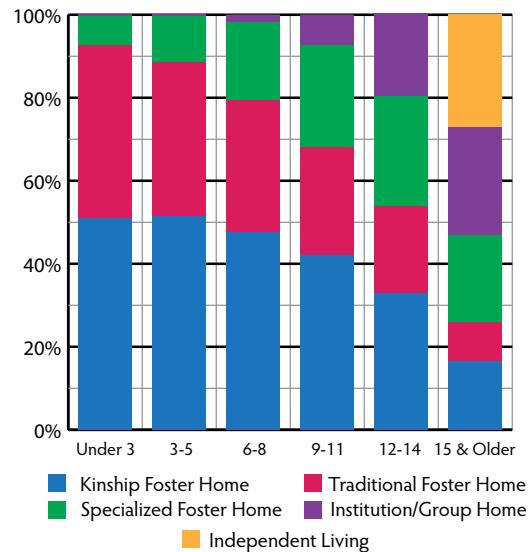
Figure 2.7
Initial Placement Types
by Age—FY 2010



were very few children under 9 years in congregate care at the end of FY2010. Most of these younger children are in kinship homes or traditional foster homes, with a smaller percentage in specialized foster homes. After age 9, the proportion of children in institutions and group homes increases with child age, with 7.2% of 9-11 year olds, 19.6% of 12-14 year olds, and 25.8% of youth 15 and older in congregate placements. Conversely, the proportion of youth in foster homes decreases significantly as child age increases. For youth age 15 and older, 16.4% were in kinship homes, 9.5% were in traditional foster homes, 21% were in specialized foster homes, 25.8% were in institutions or group homes, and 27.3% were in independent/transitional living programs. Recent anecdotal evidence contends that in some areas of the state, there is a desperate need for foster homes that are willing to accept teens,¹¹ suggesting that additional recruitment efforts for foster parents willing to foster teens may be needed.

Initial placement types also vary by child race (Figures 2.9 and 2.10). A greater portion of White children were initially placed in kin and traditional foster homes (83.5% in FY2010) compared to both African American children (75%) and Hispanic children (71.9%). Conversely, the percentage of White children initially placed

Figure 2.8
End of Year Placement Types
by Age—FY2010



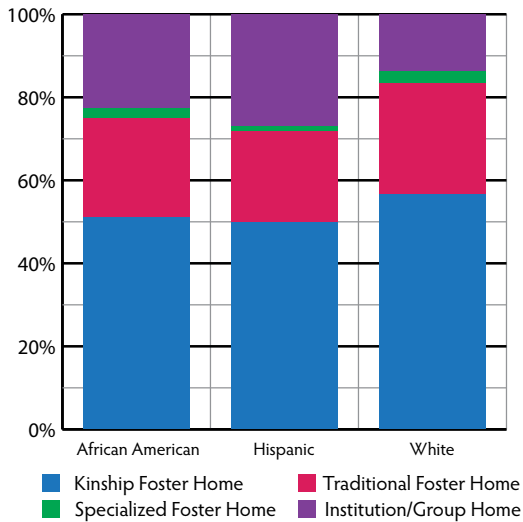
in group homes and institutions (13.7% in FY2010) was smaller than that for either African American (22.7%) or Hispanic children (26.9%).

At the end of FY2010 (see Figure 2.10), 72.6% of White children are in kin and traditional foster home placements, which is a higher percentage compared to both Hispanic (64.6%) and African American children (58.2%). Conversely, a smaller percentage of White children are in specialized foster homes (13.6%) at the end of the year, compared to both Hispanic (18.7%) and African American children (19.4%). While end of year placements in institution/group homes are fairly similar for children of different races/ethnicities (ranging from 9.6-11.5%) there is a larger variation in placement in independent living placements: 3.9% of White youth, 7.1% of Hispanic and 10.9% of African American youth are in independent or transitional living programs at the end of the fiscal year.

When initial placement settings are examined regionally (see Figure 2.11), the Cook region had a much lower proportion of children initially placed into kinship foster homes (39.5%) compared to the other regions (Northern = 61.8%, Central = 58.2%, Southern = 58.2%) and a much higher proportion of initial

¹¹ Towery, J. (August 6, 2011). Need increases for foster families to take in teens. *Peoria Journal Star*. Retrieved from <http://www.pjstar.com/features/x633532410/Need-increases-for-foster-families-to-take-in-teens>.

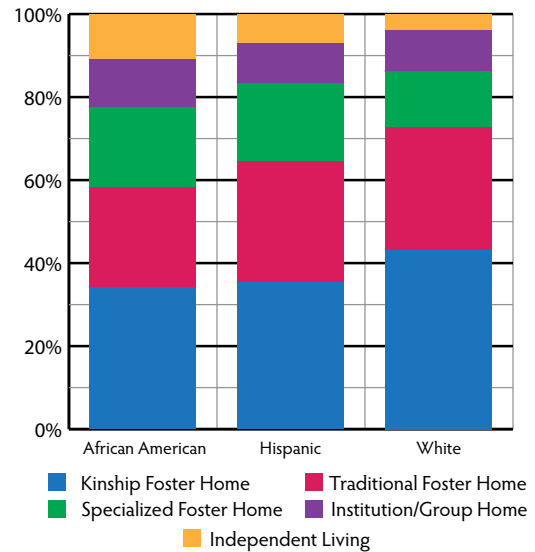
Figure 2.9
Initial Placement Types
by Race—FY2010



placements into institutions/group homes (41.7%) compared to other regions (Northern = 9.7%, Central = 5.6%, and Southern = 17.8%). This regional difference in initial placements in institutions was so striking that the analysis was expanded to examine the past seven years (see Figure 2.13). It is readily apparent that initial placement in an institution has been a much more common practice in Cook than in all other regions, and that the percentage of children initially placed in institutions in the Cook region is increasing. Also of note is the large increase from 2009 to 2010 in initial placements in institutions in the Southern region.

When placement settings at the end of year are examined regionally (see Figure 2.12), there are also differences in the use of more restrictive living arrangements such as institutions and group homes: 13.2% of children in the Cook region were living in such settings at the end of FY2010, compared to 10.6% in the Northern region, 8.2% in the Central region, and 7.9% in the Southern region. Conversely, the Cook region had the smallest percentage of children living in kinship foster homes at the end of FY2010: 30.5% compared to 43.6% in the Northern region, 41% in the Central region, and 44.8% in the Southern region.

Figure 2.10
End of Year Placement Types
by Race—FY2010



Placement with Siblings

Siblings provide one another emotional connections and cultural continuity. Foster youth often have siblings (e.g. in 2010, 45% of children entering care had one or two siblings and 20% of children had three or more siblings). States must make “reasonable efforts” to place siblings together according to section 206 of the 2008 Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-135). Recent research has shown the benefits of maintaining sibling relationships for youth in substitute care: foster children who are placed with siblings are less likely to experience placement disruptions,¹² more likely to be reunified with their parents,¹³ and report fewer internalizing problems such as depression.¹⁴ The benefit of being placed with siblings is stronger for the youth who have resided in their foster homes for shorter periods of time.¹⁵

Despite the strong preference for placing siblings together in substitute care, there are some instances in which it may be better to place siblings apart from one another. Sometimes siblings are not placed together to protect a vulnerable sibling from sibling abuse or bullying. Another reason why sibling groups are separated is due to availability of foster families. It is more

¹² Leathers, S. J. (2005). Separation from siblings: Associations with placement adaptation and outcomes among adolescents in long-term foster care. *Children & Youth Services Review*, 27, 793-819.

¹³ Albert, V. N., & King, W. C. (2008). Survival analyses of the dynamics of sibling experiences in foster care. *Families in Society*, 89, 533-541.

¹⁴ Hegar, R. L., & Rosenthal, J. A. (2009). Kinship care and sibling placement: Child behavior, family relationships, and school outcomes. *Children & Youth Services Review*, 31, 670-679.

¹⁵ Ibid.

Figure 2.11
Initial Placement Types
by Region—FY2010

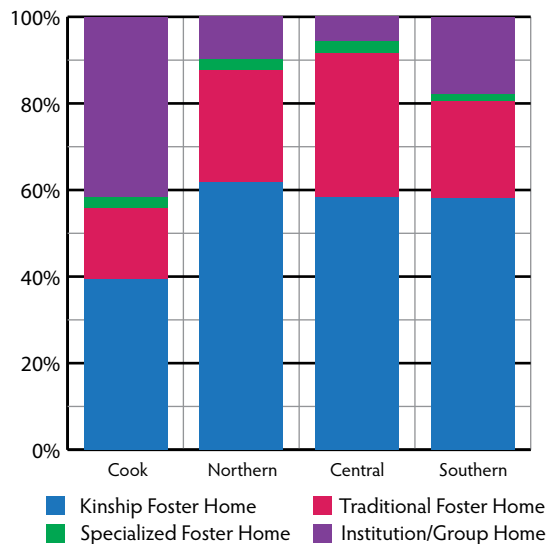


Figure 2.12
End of Year Placement Types
by Region—FY2010

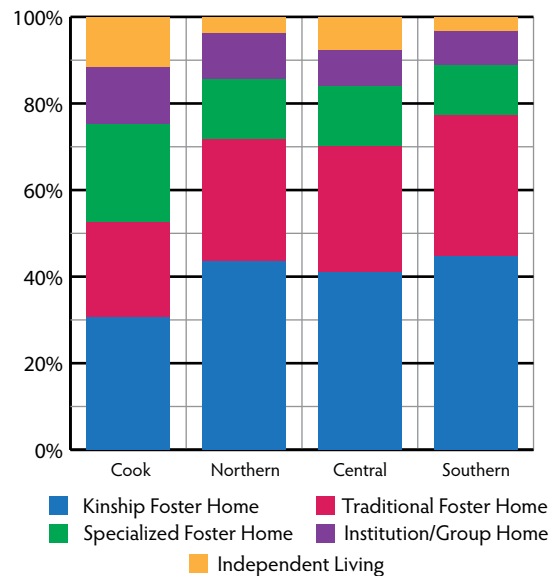
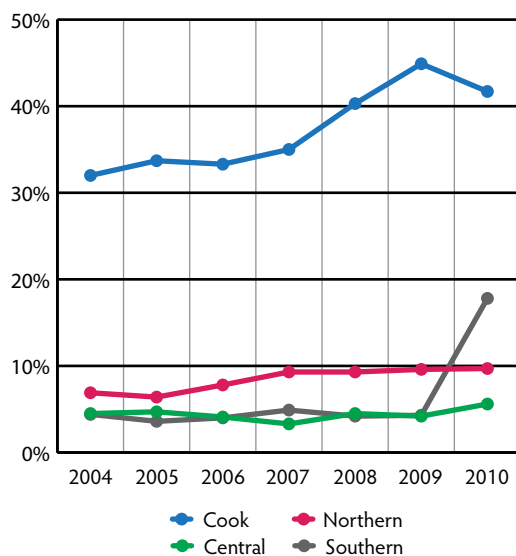


Figure 2.13
Initial Placement in Institutions
by Region—FY2010



difficult to find foster families who have the resources (physical, emotional, and financial) to provide for a sibling group. Some members of sibling groups may have physical or emotional disabilities that require specialized foster care. Additionally, some foster parents only prefer one gender or a specific age range of children.

The likelihood of a child being initially placed with all of his or her siblings is related to two factors: the size of the sibling group and the type of foster home (kin or traditional foster home). As might be expected, children with fewer siblings (1 or 2) were more likely to initially be placed with all their siblings than children with 3 or more siblings (see Figure 2.14 and Appendix B, Indicator 2.D). Additionally, children initially placed with kin are more likely to be placed with siblings than children in non-kin placements. In FY2010, the 84% percent of children with 1 or 2 siblings were placed together in kinship foster homes as compared to 71% of children with 1-2 siblings who were initially placed together in traditional foster homes. For children with 3 or more siblings, 55% were initially placed together in kinship foster homes as compared to only 15% of children with 3 or more siblings who were initially placed together in traditional foster homes.

Figure 2.14
Initial Placement with Siblings

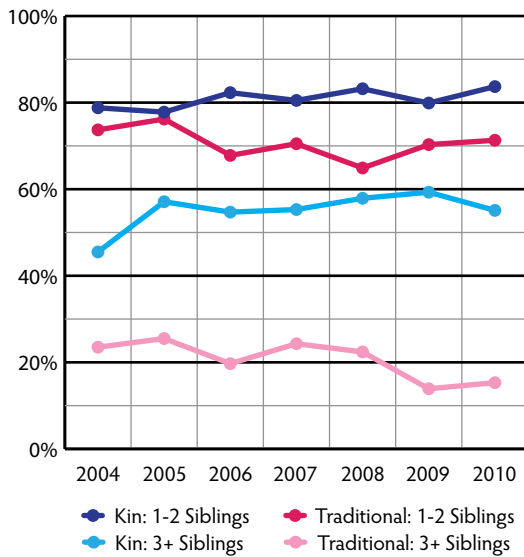
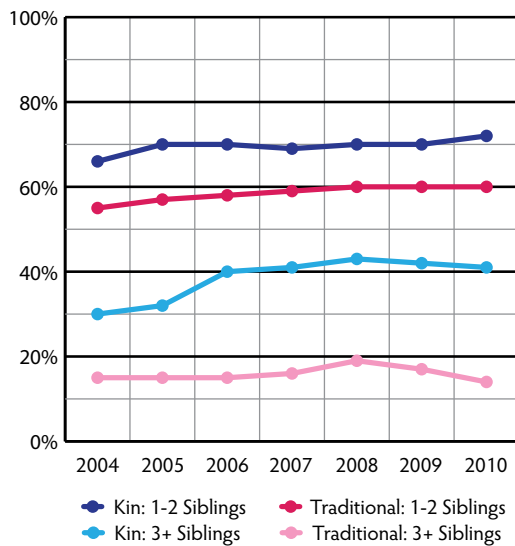


Figure 2.15
End of Year Placement with Siblings



When the percentage of children placed with all their siblings in care is examined at the end of each fiscal year for all children with siblings in care, the overall pattern is the same: smaller sibling groups and placement with kin increase the likelihood of siblings living together (Figure 2.15, Appendix B, Indicator 2.E). However, a smaller proportion of children are placed with all of their siblings at the end of the year than in initial placements and this is true for each of the four categories. In other words, more sibling groups who are initially placed together are eventually separated than those who are placed apart are subsequently reconnected.

Placement Close to Home

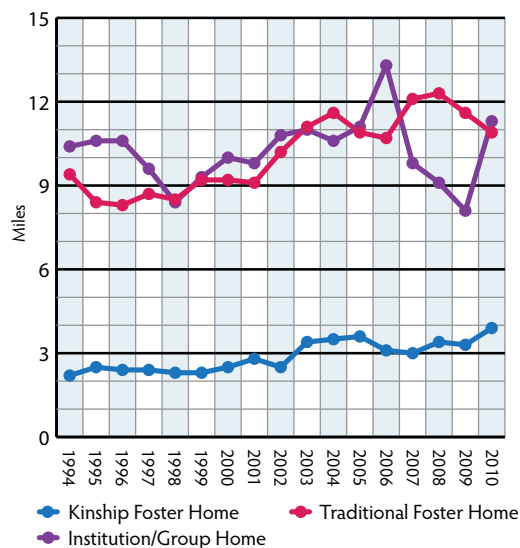
Another indicator of continuity is the distance between a child's home with their family of origin and a child's placement in substitute care. Close proximity to home and family of origin maintains the social and cultural capital that children receive from their neighborhood and schools. It also facilitates the possibility and frequency of visitation, which has been correlated with permanence for children in residential treatment.¹⁶ The Adoption Assistance and Child Welfare Act of 1980 requires the state to place a child in a setting that is close to their parent's home, if the child will benefit from this closer setting.¹⁷

Distance between a child's home of origin and his or her initial placement is influenced by the type of initial placement (Figure 2.16, Appendix B, 2.F.1- 2.F.4). Initial placements into kinship foster homes have had a median distance from home of 2.2-3.9 miles over the past 20 years. Median distances from home for children living in institutions and group homes have ranged between 8.1-13.3 miles. Children initially entering traditional foster homes have had a median distance from home between 8.3 and 12.3 miles. The median distance from home at initial placement has remained relatively stable over the past 20 years.

¹⁶ Lee, L.J. (2011) Adult visitation and permanency for children following residential treatment. *Children and Youth Services Review*, 33, 1288-1297

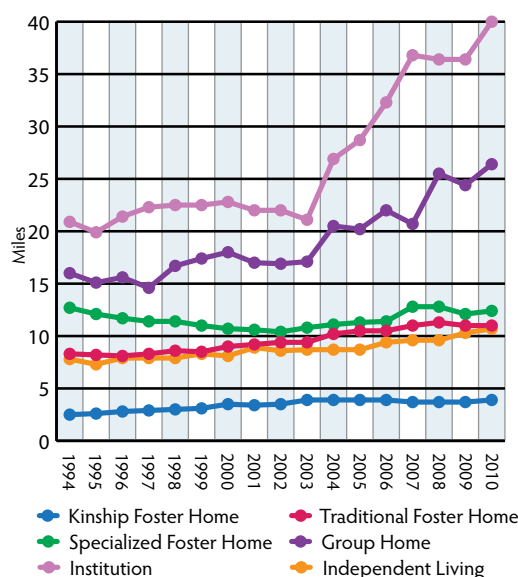
¹⁷ Adoption Assistance and Child Welfare Act of 1980, Pub. L. 96-272

Figure 2.16
Median Distance of Placement from Home at Initial Placement



Similarly, when placement settings at the end of the year are examined (see Figure 2.17 and Appendix B, 2.G.1 – 2.G.5), children living in kinship foster homes are much closer to their home of origin¹⁸ (median miles = 3.9 in 2010) than children living in other placement types (traditional foster home = 11.0 miles, specialized foster home = 12.4 miles, group home = 26.4 miles, institutions = 40 miles, and independent or transitional living programs = 10.7 miles). These median distances have been fairly steady since 1994, with the exception of the distance from home for those children living in group homes and institutions, which have increased from 17.1 miles in 2003 to 26.4 miles in 2010 for children placed in group homes and from 21.1 miles in 2003 to 40 miles in 2010 for children placed in institutions.

Figure 2.17
Median Distance of Placement from Home at End of Year



Another factor that strongly influences the proximity of a child's placement to his or her home of origin is geographical region (Appendix C, Indicator 2.G).¹⁹ The Rockford, Champaign, and Peoria sub-regions have the lowest end of year median distances from home, while the Aurora, Springfield, and Marion sub-regions have the highest end of year median distances (Figure 2.18).

There is an interesting interaction between placement type and geographic sub-region (see Figure 2.19). The Cook sub-regions have the largest median distance from home for kinship foster placements but the shortest median distance from home for all other placement types. There is a lot of variation by sub-region in the other three regions. There is a larger median distance for institutional placements in both the Central and Southern regions, with all sub-regions having a median distance of at least 80 miles from their family of origin. Independent/transitional living placements are quite varied at the sub-region level.

¹⁸ Note that distance is calculated by measuring the distance between the child's home of origin and his or her placement at the end of the year.

¹⁹ Note the region and sub-region are determined by where the case opened.

Figure 2.18
Median Distance of Placement from Home
Sub-region Heat Map

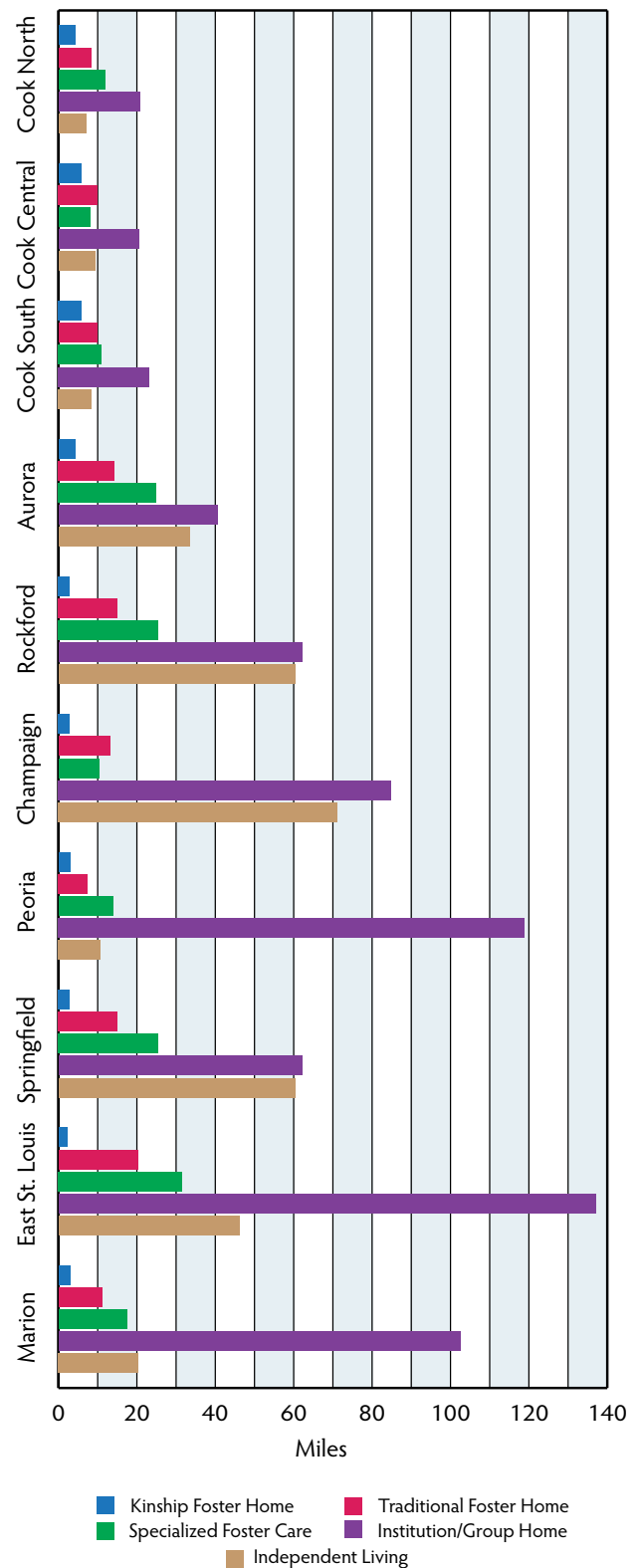
	2004	2005	2006	2007	2008	2009	2010
Cook North							
Cook Central							
Cook South							
Aurora							
Rockford							
Champaign							
Peoria							
Springfield							
East St. Louis							
Marion							

Placement Stability

Placement stability is important for children in substitute care, and placement instability has numerous negative consequences on a child's well-being and likelihood of achieving permanence. Despite the growing interest in this area, monitoring and evaluation of placement stability is hampered by the lack of a common set of measures. Measures vary widely in the length of time in care that is examined, the number of placement moves used to define "stability" and "instability" and the type of placement moves counted.²⁰

There are two measures of stability included in this monitoring report. The first measures stability – defined as two or fewer placements within the first year after removal – among children who entered care and stayed at least a year.²¹ The second measures the percentage of children between ages 12 and 17 that run away in the year after they entered care. Both measures look at stability

Figure 2.19
Median Distance of Placement from Home
by Placement Type and Sub-region—FY2010

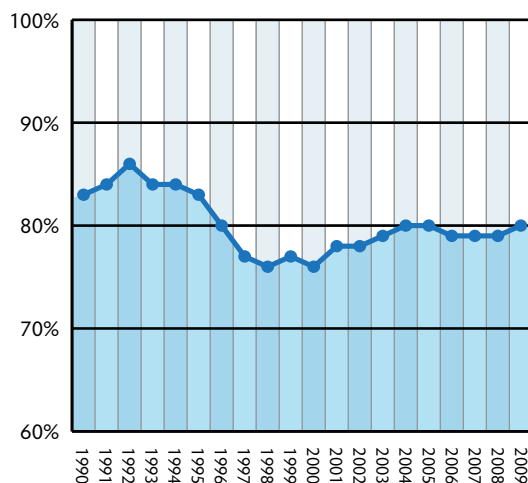


²⁰ U.S. Department of Health and Human Services (2009). *Child Welfare Outcomes 2004–2007: Report to Congress*. Retrieved July 27, 2011, from <http://www.acf.hhs.gov/programs/cb/pubs/cwo04-07/cwo04-07.pdf>. Barth, R.P., Lloyd, E.C., Green, R.L., James, S., Leslie, L.K., & Landsverk, J. (2007). Predictors of placement moves among children with and without emotional and behavioral disorders. *Journal of Emotional and Behavioral Disorders*, 15, 46-55. James, S., Landsverk, J., Slymen, D.J., & Leslie, L.K. (2004). Predictors of outpatient mental health service use – The role of foster care placement change. *Mental Health Services Research*, 6, 127-141.

²¹ Children who enter substitute care could be entering for the first time or they could be reentering.

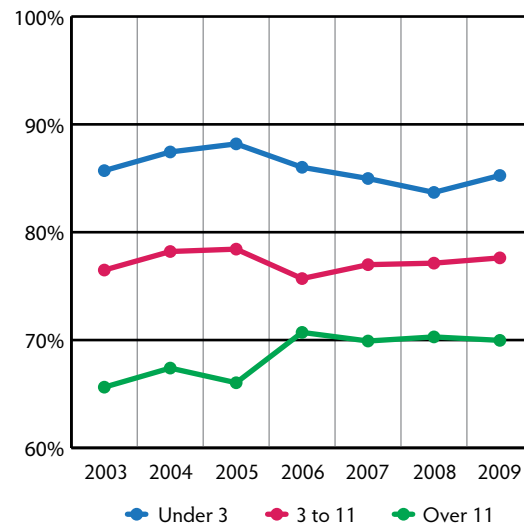
within the first year of entering care; the focus on stability in the first year is warranted for several reasons. First, 70% of disruptions occur with the first six months of a placement.²² Additionally, foster care instability in the first year has been tied to increased mental health costs²³ and increased ER visits.²⁴ The measure used in this report does not count the following types of placement moves in 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.” Using this definition, the percentage of children who experience stability in their first year in substitute care has remained level at 79-80% since 2003 (see Figure 2.20).

Figure 2.20
Children with Stable Placements in First Year in Care



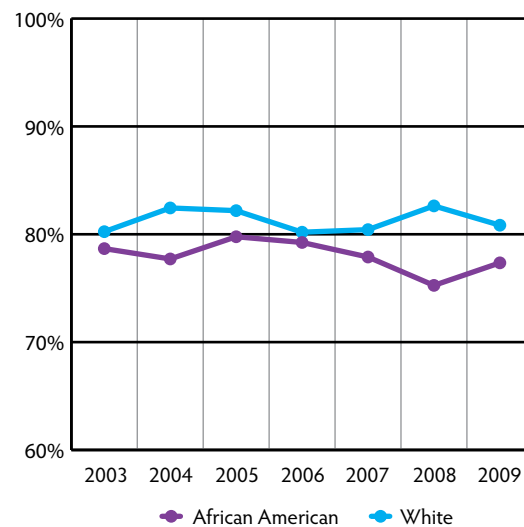
This measure of stability varies based on child age, race, and initial placement type. There are no clear or consistent differences in placement stability at the regional or sub-regional level. Consistent with other research,²⁵ placement stability in Illinois is related to child age, with older children experiencing less stability than younger children (Figure 2.21 and Appendix B, Indicator 2.H).

Figure 2.21
Placement Stability by Age



Over the past 7 years, White children have been slightly more stable than African American children (see Figure 2.22, Appendix B, Indicator 2.H). Of those children that entered care in 2009, 81% of White children experienced two or fewer moves during their first year in care, compared to 77% of African American children.

Figure 2.22
Placement Stability by Race



²² Jones, A. D., & Wells, S. J. (2008). *PATH/Wisconsin - Bremer Project: Preventing placement disruptions in foster care. Final report*. Saint Paul, MN: Center for Advanced Studies in Child Welfare, School of Social Work, University of Minnesota. Retrieved from http://www.cehd.umn.edu/ssw/g-s/media/Final_report.pdf.

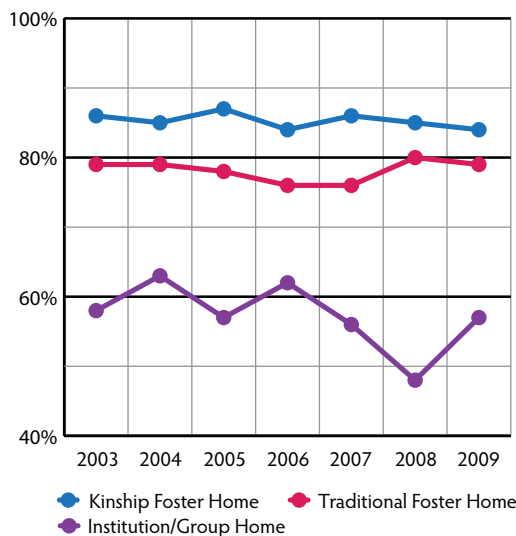
²³ Rubin, D.M., Alessandrini, E.A., Feudtner, C., Mandell, D.S., Localio, A.R., & Hadley, T. (2004) Placement stability and mental health costs for children in foster care. *Pediatrics*, 113, 1336-1341.

²⁴ Rubin, D.M., Alessandrini, E.A., Feudtner, C., Localio, A.R., & Hadley, T. (2004) Placement changes and emergency department visits in the first year of foster care. *Pediatrics*, 114, 354-360.

²⁵ Barth, R.P, Lloyd, E.C., Green, R.L., James, S., Leslie, L.K., & Landsverk, J. (2007). Predictors of placement moves among children with and without emotional and behavioral disorders. *Journal of Emotional and Behavioral Disorders*, 15, 46-55

Placement stability is also influenced by initial placement type (see Figure 2.23). Children who are initially placed in kinship foster homes have experienced the highest levels of stability (between 84% and 87% in the past 7 years), and those initially placed in traditional foster homes also experience high levels of stability (between 76% and 80%). Children who are initially placed in group homes or institutions are the least likely to experience stability during their first year in care, with rates as low as 48% in 2008. The percentages of children in specialized foster homes are not shown, since so few children are initially placed in this type of placement.

Figure 2.23
Placement Stability by Initial Placement Type



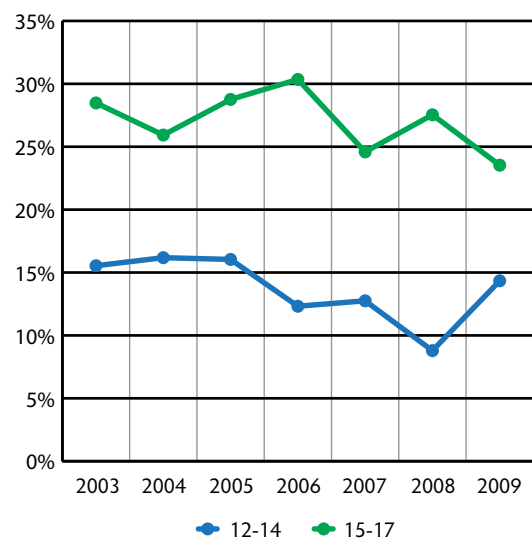
Youth Who Run Away from Substitute Care

Youth who run away from substitute care are different from typical runaways: “Unlike other runaways, youth who run away from foster care are generally not trying to escape from abuse or neglect.” Instead, youth who run away from foster care are often running to something (usually family or friends), although some youth state that they dislike their placement.²⁶ Running away puts youth at risk for victimization, sexual exploitation,

and substance use. It also limits youth’s access to school and services such as counseling, medication, and substance abuse treatment. Youth who run away are more likely to do so early in their placement, often in their first few months in care. Instability increases the likelihood of children running away from care. For example, youth who have two placements are 70% more likely to run away than those who are in their first placement.²⁷

The measure of running away used in the current chapter includes the percentage of children that run away within a year of entry to care. Since running away is an event that occurs most frequently among older children, this indicator includes children who are ages 12-17 when they enter care. The rate of youth over 12 running away from substitute care has remained steady at about approximately 20% for the past 7 years (see Appendix B, Indicator 2.I). Similar to other research on children who run away from substitute care,²⁸ older youth ages 15-17 are more likely to run away than youth ages 12-14 (Figure 2.24) and African American youth are more likely to run away than White youth (Figure 2.25).

Figure 2.24
Children Who Run Away from Substitute Care by Age

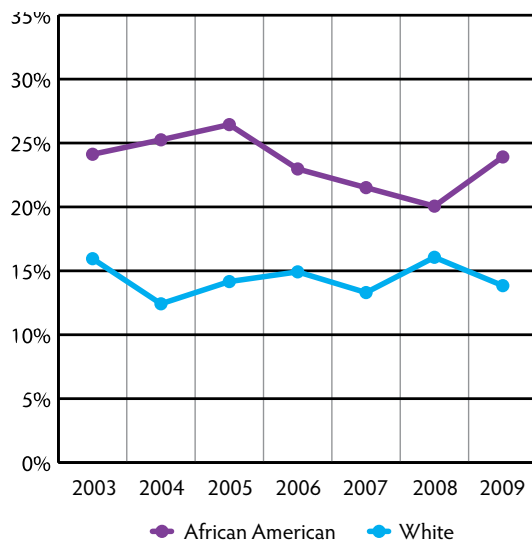


²⁶ National Runaway Switchboard Executive Summary (2010). Running away from foster care: Youths’ knowledge and access of services. Retrieved on April 20, 2011 from http://www.nrs crisisline.org/media/whytheyrun/report_files/042111_Part%20C%20Exec%20Summary.pdf

²⁷ Courtney, M.E. & Zinn, A. (2009) Predictors of running away from out-of-home care. *Children and Youth Services Review*, 31, 1298-1306.

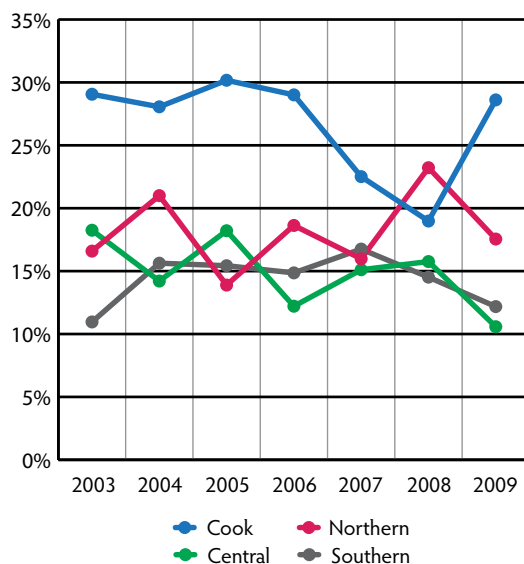
²⁸ Ibid.

Figure 2.25
Children Who Run Away from Substitute Care by Race



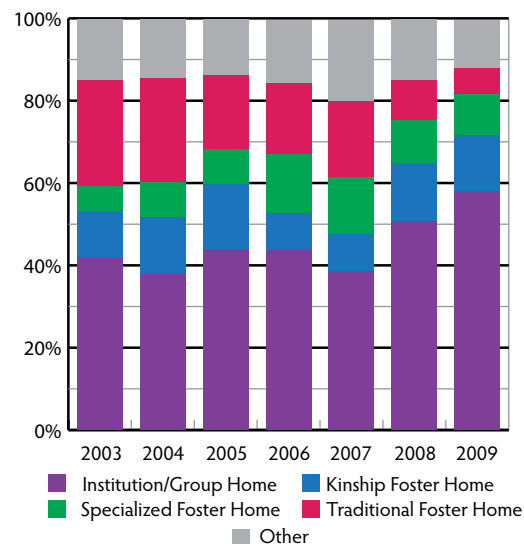
Youth have traditionally been more likely to run away from Cook than other administrative regions. The rate of runaways increased in 2009 for Cook, but all other region's rates improved from 2008 to 2009 (see Figure 2.26 and Appendix B, Indicator 2.I).

Figure 2.26
Children Who Run Away from Substitute Care by Region



Placement setting also influences the likelihood that a youth will run away from substitute care (see Figure 2.27). Children living in institutions are much more likely to run away than children in all other types of placement settings.

Figure 2.27²⁹
Children Who Run Away from Substitute Care by Placement Type



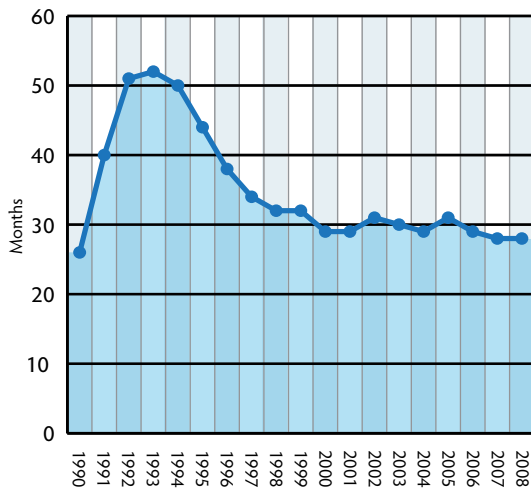
Length of Time in Substitute Care

There has been a long held value that children should not languish in foster care. Children may need to have the state take custody to keep them safe, but they should not be raised for long periods in a substitute care setting. Once a child is placed in substitute care, the goal is to move them out of care as quickly as it is safe and reasonable to do so. The length of time a child spends in substitute care is affected by a variety of factors, including their permanency goal, the type of placement in which they live, and the type of maltreatment that brought them into care. After peaking in the early 1990s at over 50 months, the median length of stay for children who enter substitute care and stay at least 8 days has been fairly stable at approximately 30 months since 1998 (Figure 2.28).³⁰

²⁹ Note Other Placement includes: Home of Parent, Hospital/Health Facility, Independent Living, Other, Transitional Living Program, Unauthorized Placement and Unknown

³⁰ The analysis used to determine this indicator was revised this year, so numbers are different from previous reports. The median length of stay is the amount of time when half of the children in care have achieved permanence.

Figure 2.28
Median Length of Time in Substitute Care



Although the median length of time in care for all children has been relatively stable for the last decade, it has been decreasing for African American children (from 35 months in 2002 to 29 months in 2008) and increasing for White children (from 21 months in 2002 to 25 months during the same time period), so that the difference between the two groups has diminished (see Figure 2.29 and Appendix B, Indicator 2.J). There is little variation in length of stay by age (see Appendix B, Indicator 2.J).

Figure 2.29
Median Length of Time in Substitute Care by Race

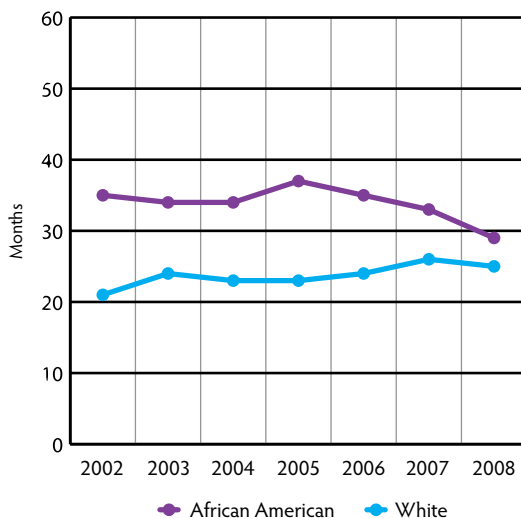


Figure 2.30 shows the sub-region heat map for median length of stay in care. The highest median lengths of stay have been in the Cook sub-regions, although stays have been decreasing in these sub-regions in recent years (Appendix C, Indicator 2.J). The shortest median lengths of stay have historically been in the Southern region.

Figure 2.30
Median Length of Time in Substitute Care Sub-region Heat Map

	2002	2003	2004	2005	2006	2007	2008
Cook North							
Cook Central							
Cook South							
Aurora							
Rockford							
Champaign							
Peoria							
Springfield							
East St. Louis							
Marion							

Conclusions and Recommendations: Children in Substitute Care

There are several challenges in monitoring and reporting child welfare system performance regarding the “quality” of substitute care placements. Many child welfare laws and accrediting standards set forth the basic principles of care that child welfare agencies should observe, such as keeping siblings together, placing children close to their home of origin and with family members when possible, and keeping placement moves to the minimum necessary for optimal care. However, placement decisions that increase the quality of care on one of these indicators may unintentionally decrease it on another indicator, and caseworkers and

other decision-makers working in the child welfare system must often balance competing priorities. For example, sometimes the safest placement is in a more restrictive setting. Similarly, a placement close to home may not be available for all siblings together; which is of higher value, keeping siblings together or placing them close to home? In each section in this chapter, indicators were presented independently, when the reality is that they are often interconnected. In spite of these limitations, there are some indicators that merit attention because they show signs of improvement or because they warrant concern.

Maltreatment in substitute care has increased by 35% over the past four years – from 1.1% in 2006 to 1.5% in 2010. The overall rate of maltreatment in care is so small (a good result) that it might mask the otherwise potentially important increase in maltreatment among children living in substitute care. Closer examination reveals that maltreatment rates are highest among children living in kinship foster homes, and have increased the most among this group, from 1.1% in 2006 to 1.8% in 2010 (a 64% increase). Prior research by the Children and Family Research Center suggests that unlicensed kin foster homes are significantly less safe than licensed kin foster homes,³¹ but changes in licensure rates among kin homes cannot account for the increases noted here. The preference for kin homes should not outweigh the need for safe placements for children, and additional examination of this decreasing safety is necessary and warranted.

This year, we took a much closer look at children's initial placements in substitute care – the restrictiveness of the placement type, the distance from their homes of origin, and the likelihood of initial placement with siblings. The rationale for this closer look is that initial placements can set a child on a certain trajectory, and that decisions about initial placement settings should be carefully made based on the needs of the individual child. The results were complex, and varied significantly depending on a child's age, race, and region. Some of the news is encouraging – initial placements with kin have increased from 42.9% in 2004 to 53.9% in 2010. The potentially less positive news is that initial placements in residential facilities (including shelters) have also increased from 14.3% in 2004

to 18.4% in 2010 – an almost 30% increase.³² Although there is some data to suggest that a small segment of children in substitute care may benefit from earlier placement into residential treatment centers to prevent multiple placement failures,³³ the increase in initial congregate care placements seen over the past six years do not appear to be among children that are being placed there for therapeutic reasons. Many of these placements – over half of those in residential facilities and almost all of those in shelters – are very brief (i.e., a week or less). In addition, 10.8% of children less than three years and 11.4% of children 3 to 5 years old were initially placed in an institution in 2010, yet no children in this age range were placed in these settings at the end of the year. Initial placement in institutions and group homes also varies significantly by both child race [it is more likely for African American (22.7%) and Hispanic children (26.9%) than White children (13.7%)] – and by region [it is much more likely in Cook (41.7%) than in Northern (9.7%), Central (5.6%) and Southern (17.8%) regions. Southern region had a particularly large jump in initial placements into congregate care facilities in 2010 – from 4% in 2009 to close to 18% in 2010.

Our concerns about initial placements in institutions and group homes are increased by the finding that children initially placed in these settings were substantially less likely to experience placement stability (defined as two or fewer placements) in the first year in care (around 50-60%) than those initially placed in kinship foster homes (around 85%) and traditional foster homes (around 80%). Also of concern is the fact that half of the children that ran away from placement during 2009 were running away from an institution or group home.

A related concern is the recent increase in the median distance of institutional placements from the child's home of origin – which has increased from 26.9 miles in 2004 to 40.0 miles in 2010. The large distances between home and institutional placements are especially striking for children who live in the Central and Southern regions of the state – including three sub-regions where the majority of children are placed over 100 miles away from home. While placement in residential facilities this far from their families of origin may be warranted for some youth with special therapeutic

³¹ Nieto, M., Fuller, T., & Testa, M. (2009). *License status of kinship foster parents and the safety of children in their care*. Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign. This study was completed based on a "warning" sign from a prior B.H. monitoring report showing decreasing safety among children living in kinship foster homes.

³² The percentage of children living in institutions and group homes at the end of the year has not significantly changed over the past several years.

³³ James, S., Landsverk, J., Leslie, L.K., Slymen, D.J., & Zhang, J. (2008). Entry into restrictive care settings: Placements of last resort? *Families in Society: The Journal of Contemporary Social Services*, 89, 348-359.

needs, such as youth exhibiting sexually problematic behaviors, it is also less likely they will be able to maintain social connections. Visitation with family and other significant adults may not be feasible. This can in turn lead to decreased likelihood that these youth will attain permanency.³⁴

Together, these findings raise questions about the use of institutions – both residential facilities and shelters -- as initial placements. Closer examination of the recent increases is warranted, as is a larger discussion about the appropriate use of initial or early placement in congregate care settings.

³⁴ Lee, L.J. (2011) Adult visitation and permanency for children following residential treatment. *Children and Youth Services Review*, 33, 1288-1297.



CHAPTER 3

Legal Permanence: Reunification, Adoption, and Guardianship

All children deserve permanent homes. Although abuse and neglect sometimes make it necessary to place children temporarily in “substitute” homes, federal and state child welfare policies mandate that permanency planning should begin at the time of placement and that children should be placed in a safe, nurturing, permanent home within a reasonable time frame. In Illinois, there are three processes through which children can exit substitute care and attain a permanent home: reunification with parents, adoption, and guardianship.

Reunification with parents is the preferred method for achieving permanence for children in substitute care and is the most common type of exit, accounting for 51% of foster care exits nationally in 2010.¹ Reunification is possible when parents are able to make changes in their lives, often with the benefit of child welfare and other services, to ensure that their children will be safe and adequately cared for when they return home. Sadly, in some cases parents cannot make the necessary changes to ameliorate the conditions which brought the children to the attention of the system. In these instances, child welfare systems are obligated to find alternative permanent homes for children as soon as

possible. A second permanency option is **adoption**, in which kin or non-kin adoptive parents legally commit to care for children, and have all the same rights and responsibilities in relation to their children as biological parents. Adoption accounted for 21% of foster care exits in the most recent national data, but it is difficult to find adoptive homes for many children – 37% of children waiting to be adopted had been waiting three years or more. **Guardianship** is a third permanency option developed in recent years, which involves caregivers, almost always kin, assuming legal custody and permanent care of children with financial support from the state. This form of permanence is advantageous for caregivers who want to commit to permanent care but do not wish to terminate the rights of the biological parent, who is typically a close relative of the guardian. Guardianship is a much less frequently used permanency option for children in substitute care, accounting for only 6% of all exits nationally in 2010.²

A fourth “permanency” option emerged in Illinois in 2009 when the Illinois General Assembly passed Public Law 96-600. This legislation allowed for a permanency goal of **continuing foster care** for a select group of

¹ U.S. Department of Health and Human Services. (2011). *The AFCARS report: Preliminary FY 2010 estimates*. Retrieved from http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report18.pdf. See also, e.g., Wildfire, J., Barth, R.P., & Green, R.L. (2007). Predictors of reunification. In R. Haskins, F. Wulczyn & M.B. Webb (Eds.), *Child protection: Using research to improve policy and practice* (pp. 155-170). Washington, DC: Brookings Institution Press.

² U.S. Department of Health and Human Services. (2011). *The AFCARS report: Preliminary FY 2010 estimates*. Retrieved from http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report18.pdf.

children. The court with responsibility for the child can set this permanency goal if it finds compelling reasons to do so, which can include: a) the child's wish not to be adopted or placed in guardianship, b) the child's extreme level of need that precludes removal from the current foster care placement, or c) the child's close and strong bonds with a sibling that would be interfered with by other forms of permanent placements. This legislation also gave the Department statutory authority to make reasonable efforts to locate parents of children over the age of 13 whose rights have been terminated for a minimum of three years under certain circumstances. Illinois also adopted a statutory scheme which allows for the reinstatement of parental rights under certain limited circumstances which would allow for a youth to be reunified with a parent or parents whose parental rights had been previously terminated. It is too soon to assess the impact of this legislation on permanence, but it will be important to monitor both the use of these new options over time, as well as their effects on other child outcomes.

Measuring Legal Permanence

Although the number of permanency options available to children in substitute care in Illinois is small, the number of potential indicators for measuring system performance related to the achievement of legal permanence is substantial. Good indicators are thoughtfully tied to the system's critical performance goals, which in this case involve moving children from impermanent placements in substitute care to permanent homes outside of substitute care and doing so in a timely manner. Thus, permanency indicators should measure both the *likelihood* of achieving permanence as well as the *timeliness* in which it is achieved. In addition, the *stability* of the permanent placement should be monitored to ensure that the children who exit substitute care do not re-enter care shortly thereafter.

Many child welfare performance monitoring efforts, including prior versions of the Illinois *B.H.* monitoring report, do not include separate outcome indicators for the three types of exits to permanent homes (e.g., reunification, adoption, and guardianship), instead relying on a combined or overall "permanency rate" that captures

all exits to permanent homes. However, more and more research demonstrates that children exit substitute care to different types of permanence at different rates and frequencies.³ In addition, policy and practice changes may affect one type of exit positively while adversely affecting another, but the overall effect on exits to permanence would be masked if only a combined indicator was utilized. This chapter therefore examines each type of permanency exit (reunification, adoption, and guardianship) separately, although the overall (e.g., combined) permanency rate is presented first to provide context and continuity with previous reports.

For each type of permanence, timeliness is monitored by showing the percentage of children in each yearly entry cohort that exit substitute care within 12 months (for reunification only), 24 months, and 36 months. In addition, for each type of permanence, the percentage of children exiting within 36 months is further examined by child age, race, and geographic region or sub-region, characteristics known to influence the likelihood of attaining permanence – although they exhibit different patterns depending on the exit type.

The stability of each type of legal permanence is monitored by examining the percentage of reunifications, adoptions, and guardianships that remain intact (i.e., the children do not re-enter substitute care) for 2 years, 5 years, and 10 years post-discharge.

Although child welfare systems strive to provide all children in substitute care with a permanent home in a timely manner, this goal is not achieved for all children. Some children exit substitute care to situations in which they do not have a legally permanent home – they run away, they are incarcerated, they emancipate or "age out." In addition, each year many children remain in care for periods much longer than 36 months. If exits to reunification, adoption, and guardianship are considered successes, then exits from care without attaining permanence and lengthy stays in care (longer than 3 years) should be considered system breakdowns. It is equally important to monitor negative as well as positive outcomes, so this chapter also examines "other exits" from care and children that remain in care longer than 36 months.

³ Akin, B.A. (2011). Predictors of foster care exits to permanency: A competing risks analysis of reunification, guardianship, and adoption. *Children and Youth Services Review*, 33, 999-1011. Connell, C.M., Katz, K.H., Saunders,

L., & Tebes, J.K. (2006). Leaving foster care – the influence of child and case characteristics on foster care exit rates. *Children and Youth Services Review*, 28, 780-798.

Children Achieving Legal Permanence

Figure 3.1 shows the overall permanency rate in Illinois – the percentage of children exiting substitute care to all three types of permanence combined – over a 20 year period. For comparison, the percentages of children exiting to permanence within 12 months, 24 months, and 36 months are shown. Permanency rates declined sharply during the 1990s, a time period coinciding with a major increase in the number of children entering care. There was a major turnaround between 1995 and 2001, with substantial increases in the percentage of children achieving permanent homes. The improvements in the permanency rates are seen most clearly in the 36-month permanency rate, to a lesser extent in the 24-month permanency rate, and much less in the 12-month permanency rate. There has been very little change in overall permanency rates since 2001, with rates around 21% at 12 months, 38% at 24 months, and 54% at 36 months.

Although Figure 3.1 provides a good picture of the overall pattern of exits to permanence over the last two

decades, it does not tell us anything about the relative frequencies of the three different types of permanence. Figure 3.2 examines separately the percentage of children who exit substitute care within 36 months for each of the three types of permanence: reunification, adoption, and guardianship (see Appendix B, Indicators 3.C.1, 3.C.2, and 3.C.3).

This figure shows that reunification has always been the most common type of exit from substitute care, and the decrease in permanence from 1990 to 1995 was attributable to a decrease in reunification. The decrease in reunification was part of a national trend toward lower reunification rates in the 1990s.⁴ Reunification rates rebounded somewhat in the late 1990s, though they were still substantially below levels of the 1980s. The biggest reason for the upsurge in overall permanency rates in the mid- to late-1990s was that the percentage of exits to adoption increased dramatically. The new subsidized guardianship option also contributed to increases in overall permanence seen in the late 1990s.

Figure 3.1
Children Exiting to Permanence
Within 12, 24 and 36 Months

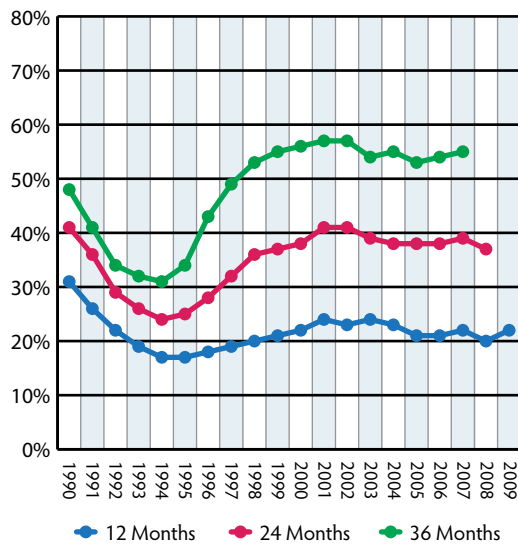
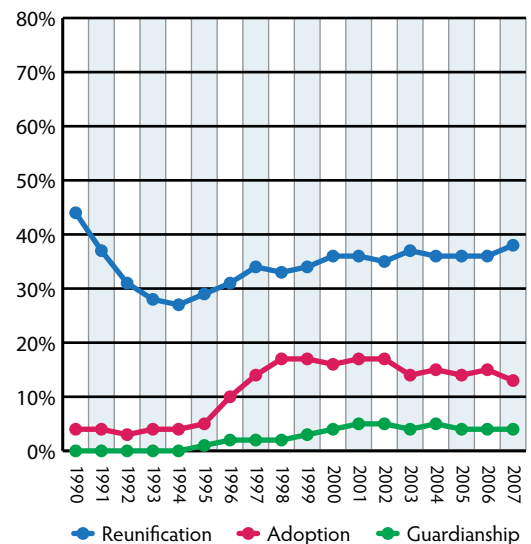


Figure 3.2
Children Exiting to Reunification,
Adoption and Guardianship Within 36 Months



⁴ Wulczyn, F. (2004). Reunification. *The Future of Children*, 14, 96-113.

Children Achieving Reunification

Figure 3.3 shows the percentage of children exiting substitute care to reunification within 12 months, 24 months, and 36 months of their entry into care (see Appendix B, Indicators 3.A.1, 3.B.1, and 3.C.1). All three indicators show a decrease in the early 1990s, an increase in the late 1990s, and stabilization since about 2001. Examination of the three lines provides an indication of the role that length of time in care has on the likelihood of an exit to reunification. About 20% of children that enter care in any given year since 1998 exit care to reunification within 12 months of entry. When the length of time to reunification is 24 months after entry, the percentage of children that exit care increases to over 30%. There is a smaller increase (about 5%) when the length of time to reunification is increased from 24 months to 36 months.

Child age is related to the likelihood that children will be reunified with parents within 36 months of entry (see Figure 3.4 and Appendix B, Indicator 3.C.1). Children between ages 3 and 11 years were the most likely to be reunified – about 46% of the children who entered care in 2007 were reunified within three years. Very young children (those less than 3 years) and youth between 12 and 14 years were reunified less often – about 34%. Youth ages 15 and older were the least likely to be reunified with their parents; only 24.5% of these youths who entered care in 2007 were reunified by 2010. The reunification rate for these older youth has decreased fairly dramatically in the past several years as well – 38.3% of youth 15 and older who entered care in 2001 were reunified within three years, as opposed to 24.5% of those of entered care in 2007.

A child's race and ethnicity also influenced the likelihood of being reunified with parents within 36 months of entry (see Figure 3.5, and Appendix B, Indicator 3.C.1). The clearest trend is that White children were consistently much more likely to be reunified than African American children. The high variability in reunification rates among Hispanic children is due to the small number of Hispanic children in substitute care. In general, however, Hispanic children were less likely to be reunified than White children.

Figure 3.3
Children Exiting to Reunification
Within 12, 24 and 36 Months

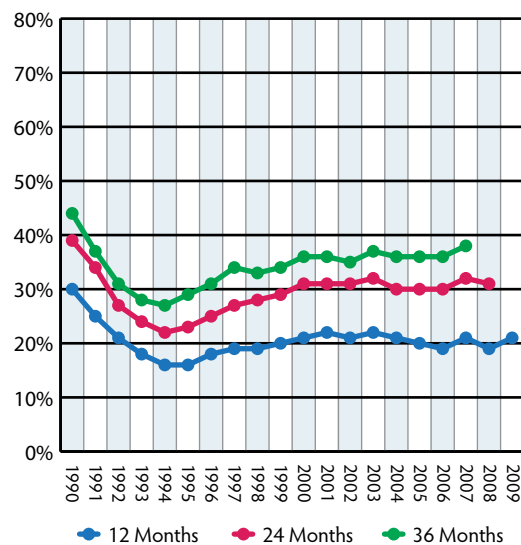


Figure 3.4
Children Exiting to Reunification
Within 36 Months by Age

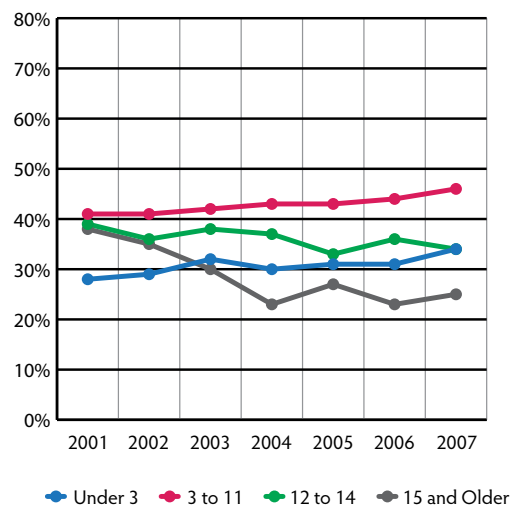


Figure 3.5
Children Exiting to Reunification
Within 36 Months by Race

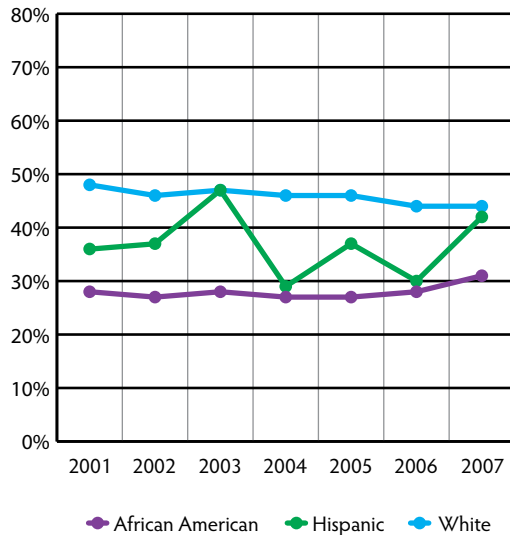


Figure 3.6
Children Exiting to Reunification
Within 36 Months Sub-region Heat Map

	2001	2002	2003	2004	2005	2006	2007
Cook North							
Cook Central							
Cook South							
Aurora							
Rockford							
Champaign							
Peoria							
Springfield							
East St. Louis							
Marion							

Figure 3.6 displays the sub-regional heat map showing reunification exits within 36 months of entry into substitute care (see Appendix C, Indicator 3.C.1 for corresponding data). To create the heat map, recurrence rates in each sub-region of Illinois for the past seven years were compared to one another and ranked. The sub-regions and years in the top 25th percentile – those with the *best performance* on this indicator – are shown in the lightest shade. Those sub-regions and years in the bottom 25th percentile – those with the *worst performance* on this indicator – are shown in the darkest shade. Those that performed in the middle – between the 26th and 74th percentiles – are shown in the medium shade. The heat map therefore provides a visually simple way to compare a large amount of information on sub-regional performance both over time and across the state. It is possible to tell reasonably quickly if a region or sub-region is doing well (relative to the other sub-regions in the state over the past 7 years) by looking for the areas in the lightest shade. It is important to note that these “rankings” are relative only

to the performance within the ten sub-regions over the seven year time span and not to any national or state benchmarks. Thus, even though a given sub-region may be performing “well” compared to other sub-regions in the state (as indicated by a light shade on the heat map), this does not necessarily mean that its performance should be considered “good” or “excellent” compared to a standard or benchmark.

As can be seen in Figure 3.6, reunification rates in Cook sub-regions are the lowest in the state for the entire time period (darkly shaded areas). The Marion sub-region shows comparatively high reunification rates across most of the observation period (lightly shaded areas). Of potential concern is that several of the sub-regions (Springfield, East St. Louis, Cook South, Cook North) have shown a drop in reunification rates for children over time.

Increasing Reunification Among Substance-Affected Families: The Illinois Alcohol and Other Drug Abuse (AODA) Waiver Demonstration

BOX 3.1

A wealth of evidence indicates that parental substance abuse compromises appropriate parenting practices and creates problems in the parent–child relationship.⁵ It is not surprising that children in substance abusing families are at an increased risk of physical abuse and neglect even after controlling for a wide range of covariates.⁶ Once involved in the child welfare system, substance-abusing parents are more likely to experience subsequent allegations of maltreatment as compared with non-substance-abusing parents.⁷ In addition to the increased risk of maltreatment, access to and engagement with treatment providers is often limited.⁸ Consequently, children of substance-abusing parents remain in substitute care for significantly longer periods of time and experience significantly lower rates of family reunification relative to almost every other subgroup of families in the child welfare system.⁹ For these reasons, it is important for child welfare systems to develop, implement and rigorously evaluate innovative strategies with substance abusing families. The Illinois Department of Children and Family Services has been a leader in the development of interventions for substance abusing families in the child welfare system. Part of the Department's efforts focus on the Illinois AODA Waiver Demonstration – a project that employs recovery coaches as a specialized and intensive case manager.

The use of recovery coaches is intended to increase access to substance abuse services, improve substance use disorder treatment outcomes, shorten length of time in substitute care, and bolster positive child welfare outcomes, including increasing rates of family reunification. To achieve these stated goals, recovery coaches engage in a variety of activities including comprehensive clinical assessments, advocacy, service planning, outreach, and case

management. The clinical assessments focus on a variety of problem areas, such as housing, domestic violence, parenting, mental health, and family support needs. Recovery coaches visit the family home and the AODA treatment provider agencies. Recovery coaches also make joint home visits with child welfare caseworkers, AODA agency staff, or both. Recovery coach services are provided for the duration of the case, and such services may also be continued for a period of time subsequent to case closing.

Summary of Key Findings to Date

As of December 2010, 2,893 parents and 4,216 children have been enrolled in the demonstration project. Beginning in 2000, parents suspected of alcohol and drug use were referred to the Juvenile Court Assessment Project (JCAP) and screened for substance abuse or dependence at the temporary custody hearing. A key finding of this project, not really related to child or family outcomes, is an accurate estimate of substance abusing parents associated with foster care placement. As of December 2009, 64% of screened parents were identified as either substance abusing or substance dependent (using DSM criteria) (see Figure 3.7). This estimate is only for those parents referred for screening. If all parents were included, that is every parent associated with a temporary custody hearing, whether or not they were referred for screening, approximately 43% would be identified as either substance abusing or substance dependent. These are the most accurate estimates to date in Illinois.

With regard to permanency outcomes, the families assigned to the recovery coach group were significantly more likely to achieve reunification (27% vs. 21.5%) and significantly more likely to achieve

⁵ Famularo, R., Kinscherff, R., & Fenton, T. (1992). Parental substance abuse and the nature of child maltreatment. *Child Abuse and Neglect*, 16, 475-483. Jaudes, P. K., Ekwo, E., & Van Voorhis, J. (1995). Association of drug abuse and child abuse. *Child Abuse & Neglect*, 19, 1065-1075. Kelleher, K., Chaffin, M., Hollenberg, J., & Fischer, E. (1994). Alcohol and drug disorders among physically abusive and neglectful parents in a community-based sample. *American Journal of Public Health*, 84(10), 1586-1590. Nurco, D.N., Blatchley, R.J., Hanlon, T.E., O'Grady, K.E., and McCarren, M. (1998). The family experiences of narcotic addicts and their subsequent parenting practices. *American Journal of Drug and Alcohol Abuse*, 24(1), 37-60.

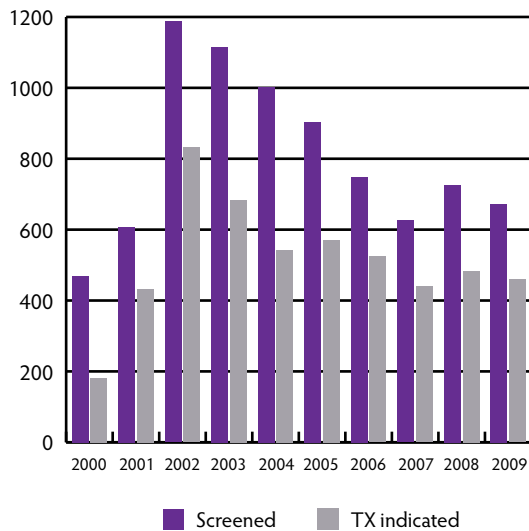
⁶ Chaffin, M., Kelleher, K., & Hollenberg, J. (1996). Onset of physical abuse and neglect: Psychiatric, substance abuse, and social risk factors from prospective community data. *Child Abuse & Neglect*, 20, 191-203.

⁷ Smith, B. D., & Testa, M. F. (2002). The risk of subsequent maltreatment allegations in families with substance-exposed infants. *Child Abuse & Neglect*, 26, 97-114.

⁸ Maluccio, A.N. & Ainsworth, F. (2003). Drug use by parents: A challenge for family reunification practice. *Children and Youth Services Review*, 25, 511-533.

⁹ General Accounting Office. (1998). *Report to the Chairman, Committee on Finance, U.S. Senate: Foster care agencies face challenges securing stable homes for children of substance abusers* (GAO/HEHS-98-182). Washington, DC: Author.

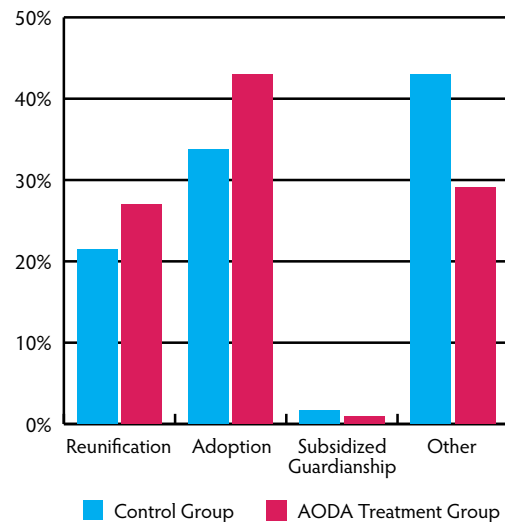
Figure 3.7
Referrals to JCAP and Cases Indicated for Substance Abuse Treatment



adoption as a secondary option for permanency (43% vs. 33.8%) five years post assignment (see Figure 3.8). Moreover, the parents associated with recovery coach services were significantly less likely to be associated with a subsequent substance exposed infant (15% vs. 21%). It is important to note that the rates of subsequent maltreatment are identical when comparing the control and experimental groups. That is, although children in the recovery coach group were more likely to be reunified with their biological parents, their safety was not compromised.

From a practice perspective, it is critical to recognize that problems with substance abuse often do not occur in isolation. The comorbidity rates with other health and social problems for substance abusing adults are high. In part, the problem of comorbidity makes working with substance abusing clients in child welfare particularly challenging. The National Institute of Mental Health Epidemiological Catchment Area Program reports that 37% of adults with an alcohol disorder and 53% of adults with a drug disorder also report a comorbid mental disorder. These estimates represent the general population. Within the child welfare system, co-occurring mental health, domestic violence and inadequate housing are frequently documented. In a study of substance abuse and co-occurring problems in the Illinois AODA waiver sample, Marsh et al. (2006) report that 92% of substance abusing families report simultaneously struggling with mental health, domestic violence or housing

Figure 3.8
Living Arrangements of Children Five Years Subsequent to Enrollment



problems. Specifically, in Illinois between 2000 and 2010, substance abusing families involved with the child welfare system in Cook County report high rates of domestic violence (43%), mental health diagnoses (61%), unemployment (72%), and homelessness (8%). These estimates have important implications for practice and policy, as the presence of such problems increases the risk of continued maltreatment and decreases the likelihood of achieving family reunification. Given high rates of co-occurring problems, and the consequences associated with such problems, the state has modified the AODA waiver demonstration to place greater attention on the role of mental health and domestic violence.

Conclusions and Future Directions for the Illinois AODA Waiver Demonstration

So what have we learned from the data collected that might help us increase reunification? One suggestion to improve reunification is to focus serious efforts on early family engagement. This would require some initial assessments – to better understand the barriers to engagement – and to better understand what families expect from the child welfare system. Central to family engagement is the timing of contact between workers and parents. Within the context of the AODA waiver, only 50% of the parents were screened at JCAP within 10 days of Temporary Custody (TC). For 35% of the families, more than two months elapsed between the TC hearing and the substance abuse assessment at JCAP. Parents need to be present at the temporary custody hearing (or shortly thereafter) for at least two

Increasing Reunification Among Substance-Affected Families CONT'D

reasons (1) the more time that passes, the less likely we are to engage families and (2) the more time that passes the more likely caseworkers and judges are to establish negative opinions (e.g., non-compliance, lack of concern) about the parents that will undoubtedly influence subsequent decisions to reunify. Within the AODA waiver demonstration to date, the parents who got JCAP screenings within ten days of the TC hearing were significantly more likely to achieve reunification – and the recovery coach model is far more effective for families who are engaged early. The blue line represents the time to reunification for families in the demonstration group (assigned to a recovery coach). The red line represents the time to reunification for families in the control group. Figure 3.10 displays the reunification rates for families that were assessed at JCAP in two or more months (delayed engagement). If we intend to improve the effectiveness of the recovery model and improve outcomes for families, we need to close this gap and make serious efforts to engage families early.

So how might the State modify the AODA waiver demonstration to help facilitate and speed up engagement? Once a case has been screened and Temporary Custody (TC) has been declared, the Case Assignment unit would flag all cases assigned to a demonstration group agency and/or DCFS Team and would alert the new Engagement Outreach Worker of the date and time of the TC hearing (usually within 48 hours). This worker would do immediate outreach to the parent(s) and offer support and logistical assistance such as transportation to the upcoming TC hearing. In addition, the worker would ensure that the parent both attends the TC hearing and gets screened at JCAP on that day, allowing for engagement with JCAP and a Recovery Coach to occur expeditiously. This intervention would also increase the attendance rate of TC hearings in general, which currently remains at approximately 35%. If the Engagement Worker is unsuccessful at making contact and/or unable to get the parent to the TC hearing, additional outreach attempts can be made within the subsequent weeks to ensure participation in the JCAP assessment, referral to treatment and engagement with services before the family court conference and upcoming hearing.

Figure 3.9
Reunification Rates with Early Engagement (Less Than 1 Month)

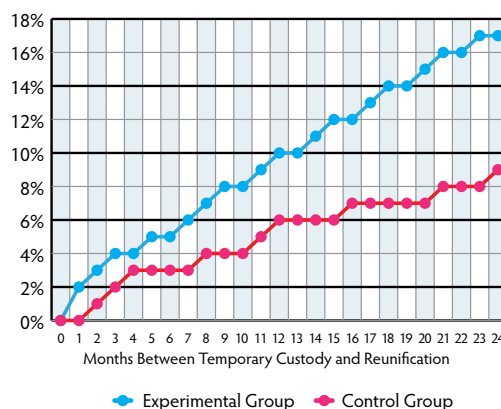
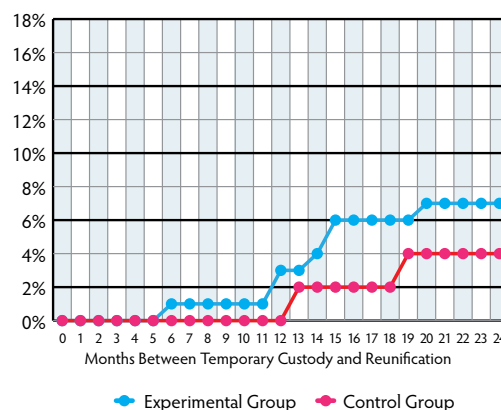


Figure 3.10
Reunification Rates with Delayed Engagement (Two or More Months)

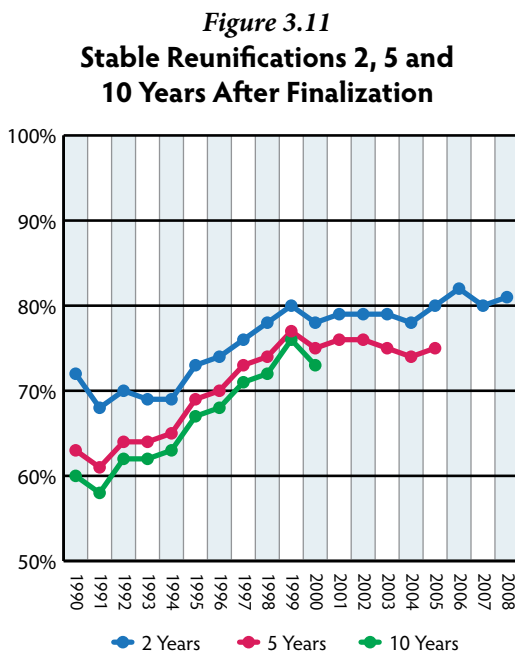


In closing, the Illinois AODA waiver demonstration is a great example of child welfare systems using evidence to implement and improve services to children and families. With a five year extension that will support modifications to the AODA waiver through 2017, the Illinois Department of Children and Family Services and the Children and Family Research Center at the University of Illinois, Urbana-Champaign will work to strengthen the recovery coach model so that parents are connected with service providers in a more timely fashion and thus more likely to achieve reunification.

Written by Joseph Ryan, Ph.D., Associate Professor and Faculty Fellow, Children and Family Research Center.

Stability of Reunification

Reunification is only truly permanent if children can remain safely in their homes and are not removed again. Figure 3.11 displays the percentage of children that remain stable in their homes (and do not re-enter care) within 2 years, 5 years, and 10 years following reunification with their parents (see Appendix B, Indicators 3.D.1, 3.E.1, and 3.F.1). The stability of reunification within the first two years post-discharge has remained steady at about 80% for the last decade. Post-reunification stability within five years has been similarly consistent, hovering at or around 75% among children who were reunified between 1999 and 2005. Family stability ten years post-reunification has improved over time – from around 60% among children reunified in 1990 to over 70% for children reunified in 2000.

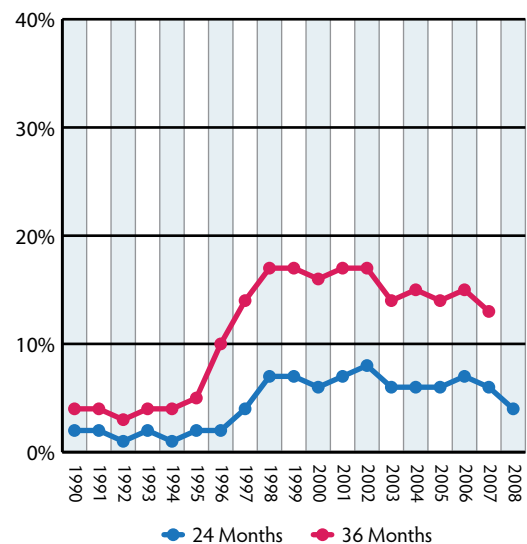


Children Achieving Adoption

Because adoption is typically considered only after it becomes clear that reunification is not achievable, adoptions rarely occur within 12 months. Figure 3.12 therefore shows the percentage of children who exit substitute care through adoption within 24 and 36 months after

entry. The overall pattern of the two lines is similar, but the likelihood of being adopted is much greater within 36 months of entry than within 24 months. The increase in adoptions that occurred in the late 1990s can be seen in both the percentage of children adopted within 24 months and 36 months, although the increase is more dramatic among adoptions within 36 months. After this dramatic increase, the percentages of children exiting to adoption within 36 months leveled off during the early 2000s and have since declined somewhat, from 16.5% of children that entered care in 2002 to 13.3% of those that entered care in 2007 (see Appendix B, Indicators 3.B.2 and 3.C.2).

Figure 3.12
Children Exiting to Adoption Within 24 and 36 Months

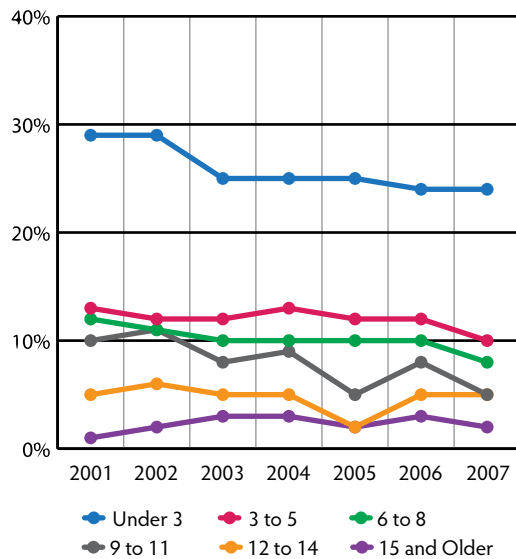


Illinois children less than 3 years of age are substantially more likely to be adopted than older children (see Figure 3.13), a finding that is consistent nationally.¹⁰ In fact, there is an inverse relationship between child age and the likelihood of adoption from substitute care, such that the older a child is when entering care, the less likely he or she is to be adopted within 36 months. The likelihood of youth ages 15 and older being adopted from substitute care within 36 months is very small – less than 2% (see Appendix B, Indicator 3.C.2).

¹⁰ U.S. Department of Health and Human Services. (2011). *The AFCARS report: Preliminary FY 2010 estimates*. Retrieved from http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report18.pdf

It should be noted that the decrease in overall exits to adoption mentioned earlier does not appear to be due to a decrease in the proportion of children in care who are under age three. There actually has been a slight trend toward the proportion of children under age 3 increasing from 2004 to 2010 from 17% to 21%, and a corresponding decrease in the proportion of children and youth over age three.

Figure 3.13
Children Exiting to Adoption
Within 36 Months by Age



There are only marginal differences in the percentages of African American and White children that exit substitute care to adoption (see Figure 3.14 and Appendix B, Indicator 3.C.2). The percentage of Hispanic children adopted was comparatively lower, although these results should be interpreted with some caution because the number of Hispanic children in the foster care population is small.

Trends in children exiting substitute care to adoption within 36 months at the sub-region level are shown in Figure 3.15 (see Appendix C, Indicator 3.C.2). The Champaign sub-region (located in the Central region) is in the top 25th percentile (when compared to all other regions) over the entire seven year observation period.

Figure 3.14
Children Exiting to Reunification
Within 36 Months by Race

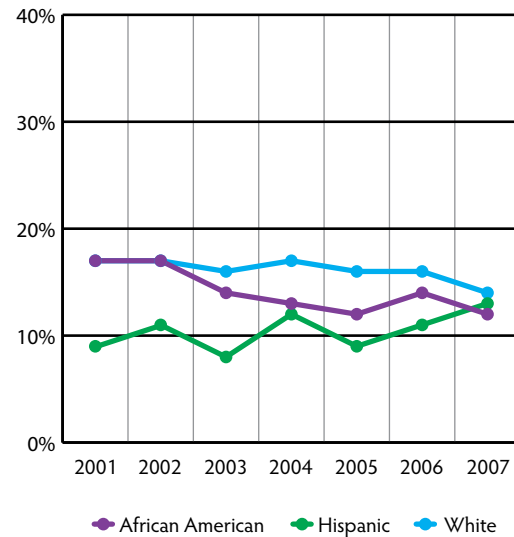


Figure 3.15
Children Exiting to Adoption
Within 36 Months Sub-region Heat Map

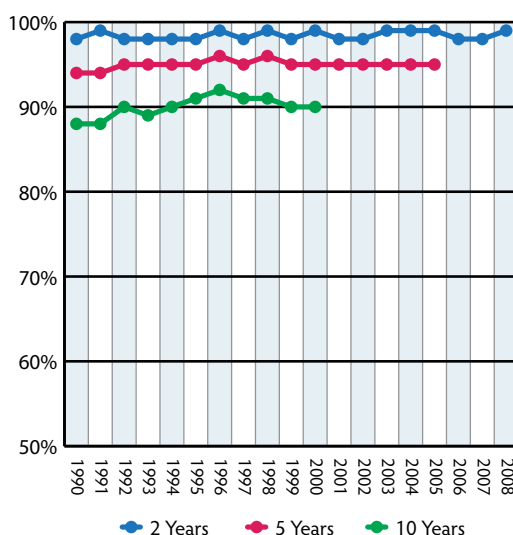
	2001	2002	2003	2004	2005	2006	2007
Cook North							
Cook Central							
Cook South							
Aurora							
Rockford							
Champaign							
Peoria							
Springfield							
East St. Louis							
Marion							

The Marion sub-region (in the Southern region) consistently performs in the lowest quartile on this indicator – unlike its performance on the reunification within 36 months indicator, where it was in the highest quartile. An interesting trend is apparent in the Cook sub-regions, in which performance steadily worsened; performance in the Cook North sub-region went from the highest quartile to the lowest.

Stability of Adoption

Children who exit substitute care to adoptive homes are highly likely to remain stable in those homes and usually do not re-enter substitute care (see Figure 3.16 and Appendix B, Indicators 3.D.2, 3.E.2, and 3.F.2). At two years post-adoption, 99% of children remained stable, a figure that has been remarkably consistent across the past 20 years. At five years post-adoption, 95% of children remain in their adoptive homes. Even ten years after adoption, around 90% of children remain in their adoptive homes. Despite anecdotal evidence to the contrary, these rates have been remarkably consistent over the past 20 years. Additional analyses show no differences in the stability of adoption by region, child age or race (see Appendix B, Indicators 3.D.2, 3.E.2, and 3.F.2).

Figure 3.16
Stable Adoptions 2, 5 and 10 Years
After Finalization

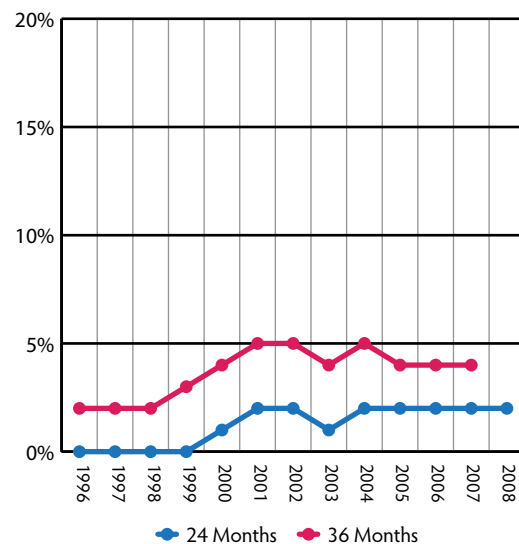


Children Achieving Guardianship

Subsidized guardianship began in Illinois in September 1996 when the state received federal IV-E waiver authority to extend subsidies to guardians. Interestingly, development of the subsidized guardianship program went hand-in-hand with a major increase in kin adoptions. As caseworkers explored permanency options with kin as part of the new subsidized guardianship program and other permanency initiatives, they discovered that more kin than anticipated chose adoption.

The percentage of children exiting substitute care to guardianship within 24 months and 36 months of entry into care is shown in Figure 3.17 (as with adoptions, very few children exit to guardianship within 12 months of entry, so those figures are not shown). The percentage of children exiting to guardianship increased steadily between 1996 and 2001 as the new subsidized guardianship program was implemented, but then leveled off and has remained consistent for the last several years at around 4% within 36 months (see Appendix B, Indicators 3.A.3, 3.B.3, and 3.C.3).

Figure 3.17
Children Exiting to Guardianship
Within 24 and 36 Months



Post-Adoption Service Needs and Use in Kin Adoptions

BOX 3.2



Although post-adoptive families express a wide variety of formal and informal service needs, their use of post-adoption services is lower than might be expected. Unfortunately, little is known about the factors that influence post-adoptive parents to seek out services. The Illinois Department of Children and Family Services invested in two surveys of post-adoption and guardianship families that assessed the families' service needs, service-seeking, and service receipt. These surveys revealed, among other findings, that most families who needed services following an adoption or guardianship in Illinois were able to seek them out and obtain them. Recent analysis using the data collected in the Children and Family Research Center's Post-Permanency Study 2 explored the differences between kin and non-kin adoptive parents' service needs and use.

The methodology for the Illinois Post-Permanency Study consisted of telephone interviews with parents and guardians who either adopted or assumed legal guardianship of a child in the Illinois substitute care system. Analyses for this study used the responses of 370 kin and 77 non-kin adoptive parents. A statistical technique called Propensity Score Matching (PSM) was used to balance mean differences in the characteristics of children and families in kin and non-kin adoptions. Prior to the matching, significant differences existed between these two types of

families on child age, caregiver age, and caregiver education; these differences disappeared once the PSM procedures were applied. The matched sample consisted of 114 families.

The results indicated that kin adoptive parents expressed a statistically significant lower number of service needs than non-kin adoptive parents. In particular, they expressed fewer clinical service needs, but showed no differences in needs for health and general services. Kin adoptive parents were less likely to inform their adoption agencies of any service needs that they did perceive than the non-kin group, and had a decreased likelihood of successfully obtaining those services they tried to get compared to the non-kin group. After controlling for marital status, level of education, and socioeconomic status, kin adoptive parents had a significantly lower amount of social support than non-kin adoptive parents. Kin adoptive parents' decreased perception of service needs, lack of reporting of service needs they did perceive, difficulty obtaining services, and decreased social support suggest that they need more aggressive outreach regarding post-adoption service availability. One possible source of coaching and support for these parents may be other parents who have adopted kin from the child welfare system.

This study was conducted by Minli Liao, graduate assistant at the Children and Family Research Center.

¹¹ Fuller, T., Bruhn, C., Cohen, L., Lis, M., Rolock, N., & Sheridan, K. (2006). *Supporting adoptions and guardianships in Illinois: An analysis of subsidies, services, and spending*. Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

Children five years and younger and youth 15 years and older are less likely to exit substitute care to guardianship than children ages 6 to 14 (see Figure 3.18 and Appendix B, Indicator 3.C.3). There were no meaningful differences in the likelihood of exits to guardianship by child race.

Sub-regional comparisons in exits to guardianship are displayed in Figure 3.19 (see Appendix C, Indicator 3.C.3).¹² Due to data coding issues in the administrative data used for this indicator, data from the three Cook sub-regions were combined into an overall Cook indicator in this figure. The Cook region, and the Peoria and Marion sub-regions perform relatively better in moving children from substitute care to permanent placements with guardians. The Springfield and East St. Louis sub-regions have performed in the bottom 25% of all the sub-regions for the majority of the past several years.

Stability of Guardianship

The percentage of children that exited substitute care to guardianships that remained stable at two years post-discharge was fairly consistent over the past several years, ranging from 93% to 97% (see Figure 3.20 and Appendix B, Indicator 3.D.3). The percent of children that remain in stable guardianships five years post-discharge has remained fairly consistent as well at around 90% (Appendix B, Indicator 3.E.3). Although post-guardianship stability decreased slightly in the past year, it is most likely that this decrease is just random fluctuation rather than the beginning of a downward trend. There are no meaningful differences in the stability of guardianships by child age, race, or region.

Children Who Exit Substitute Care Without Achieving Legal Permanence

Within three years of entering substitute care, most children exit the system through the planned permanency options of reunification, adoption or guardianship. However, some children exit the system without ever achieving a legally permanent relationship with a parent or guardian. There are several ways that this can happen: children and youth can run away from substitute care and not return, they can be incarcerated,

Figure 3.18
Children Exiting to Guardianship Within 36 Months by Age

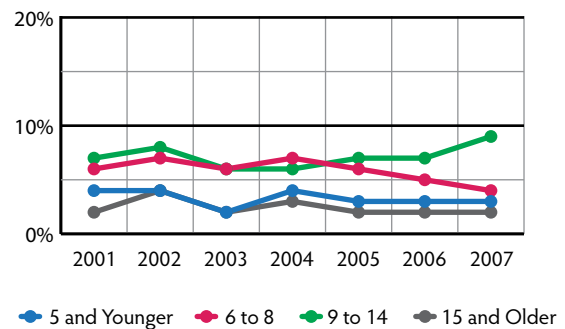
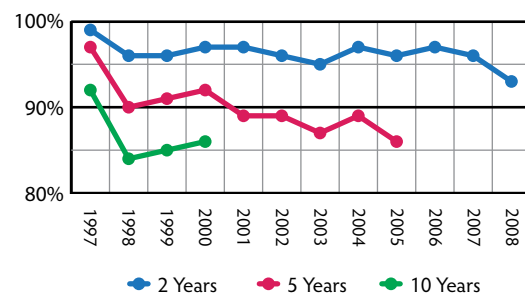


Figure 3.19
Children Exiting to Guardianship Within 36 Months Sub-region Heat Map

	2001	2002	2003	2004	2005	2006	2007
Cook Region							
Aurora							
Rockford							
Champaign							
Peoria							
Springfield							
East St. Louis							
Marion							

Figure 3.20
Stable Guardianships 2, 5 and 10 Years After Finalization

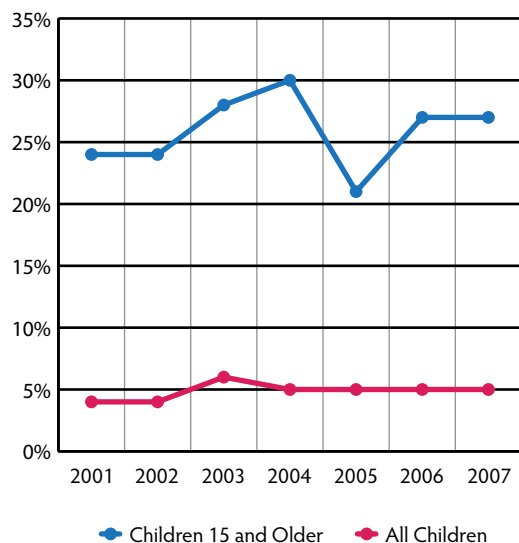


¹² In these analyses, child cases are categorized by the sub-region where the case originated or that has administrative responsibility for the case, as opposed to the sub-region associated with the family's address. The administrative data indicated that all of the guardianships in Cook County are administered in the

Cook Central region and none were located in the Cook North or Cook South regions for any of the years examined. For this reason, we combined the three Cook sub-regions (Cook North, Cook Central, and Cook South) into one Cook region for this analysis.

or they can simply reach the age of legal majority and no longer be a ward of the state. A very small portion of the children and youth entering substitute care in a given year exit without achieving any form of legal permanence within 36 months – around 4-6% (see Figure 3.21). Many of these non-permanency exits – such as incarceration, running away, and aging out – occur typically (or exclusively) among older youth. For instance, among the 494 youths who were 15 years and older when they entered substitute care in 2007, 131 of them (26.5%) exited care without achieving legal permanence (see Figure 3.21). In fact, children who enter care when they are 15 or older are about equally likely to exit care through a non-permanent exit type as they are to reunification, adoption, and guardianship combined.

Figure 3.21
Children Exiting Substitute Care Without Permanence



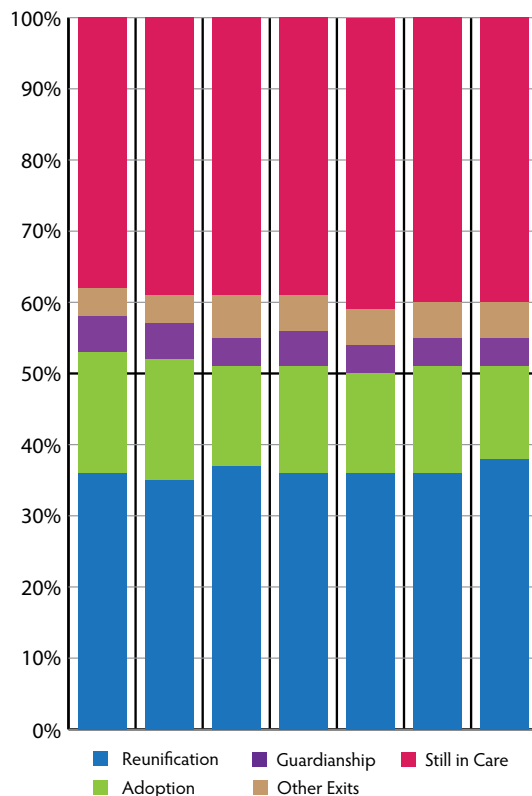
Children Remaining in Substitute Care

Although a little over half of all children who enter substitute care in a given year attain permanence through reunification, adoption, or guardianship within 36 months of entry, a significant portion of children remain in care longer than three years. For children entering care between 2001 and 2007, the portion that remains in care at 36 months after entry has been

consistent at approximately 40%. Youth 12 years and older are more likely than younger children to remain in care at 36 months. African American children are substantially more likely than White children to remain in care.

Figure 3.22 presents the overall picture of whether children entering substitute care achieve some form of legal permanence within 36 months, exit without permanence, or remain in care. For example, of the 4,504 children that entered substitute care in 2007, 38% were reunified within three years, 13% were adopted, 4% were taken into guardianship, 5% exited without permanence (2.3% aged out), and 39% remained in care longer than three years. This figure shows the remarkable consistency of the relative percentages of these outcomes over the past seven years. The one exception, as noted above, is the slight decrease in the percentage of children adopted.

Figure 3.22
Exits from Substitute Care Within 36 Months



Conclusions and Recommendations: Legal Permanence

The state of Illinois made nationally recognized gains in achieving permanence for children in substitute care during the 1990s. The latest data confirm that, for the most part, those gains have been sustained in recent years. The single most common form of permanence is reunification, which occurs at over twice the rate of adoption and subsidized guardianship combined. Adoption remains a fairly frequent permanency option, and kin are adopting children in care with some frequency. Subsidized guardianship remains an option that kin are using to give children permanence without the need to sever custodial ties with parents. The success of the Illinois subsidized guardianship waiver was instrumental in the passage of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351).

Much of the data on the stability of permanence is encouraging. Despite the persistent perception in the field that adoptions are failing, adoption continues to be the most stable form of permanence for children exiting substitute care. Only about 1% of children adopted from the child welfare system re-enter substitute care within two years of discharge. When the observation period is increased to a full decade, only 10% of adopted children have re-entered substitute care. In addition, these high levels of post-adoption stability have been consistent over the last 20 years – there has been no upsurge in failed adoptions since the permanency initiative of the 1990s. Post-guardianship stability rates are slightly lower than those of adoption, but have been consistent since this permanency option was made available in Illinois. By its very nature, reunification with parents is less stable than either adoption or guardianship, yet the five year reunification stability rates in Illinois are comparable to the 78% stability rate found in the Multi-state Foster Care Data Archive, a seminal research study about substitute care.¹³

Children 15 and older are significantly less likely to achieve any form of permanence than younger children.

For example, of the youth who were 15 and older when they entered care in 2007, only 24% were reunified within three years, 1.6% were adopted, and 1.8% were taken into guardianship. This age group has begun to be a special focus of efforts to improve permanence, especially since older youth in care are more likely to be in group homes and residential facilities and are at great risk for poor educational, behavioral and mental health outcomes.¹⁴ The new permanency option of continuing foster care established by Public Law 96-600 is relevant for this group of youths, who, being older and more inclined to independence, may well reject adoption and guardianship in favor of a connection to a foster parent that may represent the one adult relationship sustaining them. Note however that continuing foster care depends on having a nurturing relationship with a foster parent that the youth can count on over time, a resource that many older youth in care do not have. Future research needs to track all four permanency options for children of different ages and pay particular attention to permanency outcomes for older youth.

African American children are much less likely to be reunified and slightly less likely to be adopted than White children; therefore, the rate at which African American children remain in care is 1.4 to 1.7 times greater than that for White children. The rate of remaining in care has varied more for the smaller numbers of Hispanic children in care, but is also generally higher than the rate for White children. Racial/ethnic differences in attaining permanence are a contributing factor to the disproportionate percentage of children of color in the substitute care population. Racial disproportionality is a major issue in child welfare nationally¹⁵ as well as in Illinois, although progress has been made in Illinois as the number of African American children in substitute care was reduced substantially with the permanency initiative of the 1990s.¹⁶ Among the actions that have been identified to reduce disproportionality are 1) community development to address issues like poverty and neighborhood violence that disproportionately affect the capacity of minority communities to care for their children, 2) culturally appropriate prevention efforts that work with families in minority

¹³ Wulczyn, F.H., Chen, L., & Hislop, K.B. (2007). *Foster care dynamics 2000-2005: A report from the multistate foster care data archive*. Chicago, IL: Chapin Hall Center for Children.

¹⁴ Courtney, M. (2005). *Youth aging out of foster care*. Policy brief. MacArthur Foundation Research Network on Transitions to Adulthood. Retrieved from <http://www.transad.pop.upenn.edu/downloads/courtney--foster%20care.pdf>.

¹⁵ See, e.g., Child Welfare Information Gateway. (2011). *Addressing racial disproportionality in child welfare*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Courtney, M. & Skyles, A. (2003). Racial disproportionality in the child welfare system. *Children and Youth Services Review*, 25, 355-358.

¹⁶ Rolock, N. (2008). Child welfare in Illinois: From "Calcutta" to the "gold standard." *Illinois KidsCount 2008*. Retrieved from <http://www.voices4kids.org/library/files/kidscount08/kc08Chap5.pdf>.

communities, 3) training to improve the cultural competence of service agencies engaged with minority communities, 4) the development of different permanency options tailored to different cultures, and 5) culturally competent recruiting programs to increase the number of opportunities children have for permanent homes.¹⁷ The Alliance for Racial Equity in Child Welfare has recognized Illinois as one of 11 states that have enacted public policy measures to address disproportionality, including providing appropriate cultural competence training, implementing special foster and adoption recruiting efforts, and requiring regular monitoring of disproportionality using child welfare data systems.¹⁸

There are wide regional and sub-regional differences in permanency outcomes, with performance in the Cook region lagging far behind that in other regions of the state on each of the three types of permanence. The regional differences may be partially related to the racial differences discussed above, but there are clearly other factors at work as well. Additional information about the barriers to permanence that exist in the Cook regions – including those related to the legal proceedings required to move children to permanent homes – is needed to locate the “pressure points” in this process. An examination of performance data of the purchase of service (POS) agencies providing foster care case management services may be warranted to identify those agencies that are successful in attaining permanence to help identify best practices and share these with others who do not achieve such positive outcomes.

The data indicate a new warning sign regarding adoption, with a modest decrease in adoptions over the past several years. This decrease is not explained by changes in the age of children in care over time—the proportion of children under the age of three, the group most likely to be adopted, has actually increased slightly in recent years. Because this change threatens some of the considerable progress that has been made on permanence, we recommend focused attention on this topic in upcoming DCFS program evaluation. Intensive study of each component of the adoption process is indicated, including permanency planning on adoption, recruitment and preparation of adoptive parents, pre-adoptive placements, and moving adoptions through the court system. Interviews and focus groups with key

participants such as DCFS workers involved in adoption preparation and adoptive parents should supplement special analysis of administrative databases. We also recommend a special study of the new continuing foster care option to evaluate its impact upon attaining permanence. Little is known about who will make use of this option and under what circumstances or about its impact on providing both the residential consistency and emotional support that are both part of having a permanent home. This study should also examine the use of the legal mechanism to reinstate parental rights to determine under what circumstances petitions have been filed, the type and quality of assessment conducted to determine the appropriateness of the motion and the status of the youth following reinstatement and reunification.

This is an opportune time to learn more about how to enhance permanence. The consistency in most permanency indicators over a considerable period suggests that, while there is no crisis, new knowledge and new ideas would be especially valuable to give DCFS a chance at making progress in permanence for the first time in a number of years. Despite the considerable progress made in permanence in the 1990s, too many children and youth remain in substitute care.

¹⁷ Child Welfare Information Gateway. (2011). *Addressing racial disproportionality in child welfare*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

¹⁸ Alliance for Racial Equity in Child Welfare. (2009). *Policy actions to reduce racial disproportionality and disparities in child welfare: A scan of eleven states*. Washington, DC: Center for the Study of Social Policy



CHAPTER 4

Child Well-Being

Of all the child and family outcomes that child welfare systems are accountable for, child and family well-being are the hardest to define and measure. Unlike safety and permanence, well-being data are typically not included or readily available in state child welfare administrative data systems. The federal child welfare monitoring report (*Child Welfare Outcomes 2004 – 2007 Report to Congress: Safety Permanency Well-being*) does not include any well-being indicators,¹ nor are well-being data included in the two national child welfare-related data systems – the National Child Abuse and Neglect Data System (NCANDS) and the Adoption and Foster Care Analysis and Reporting System (AFCARS).

The Children and Family Research Center has taken a variety of approaches to monitoring the well-being of children in or at risk of foster care in Illinois. The earliest *B.H.* monitoring reports focused only on safety and permanence and did not include any information on child well-being. At the request of the federal court, the *B.H.* plaintiff attorneys, and DCFS for more information about the well-being of children in foster care, the Children and Family Research Center initiated a series of data collection activities collectively called the *Illinois Child Well-Being Studies*. In 2001, 2003, and 2005, random samples of Illinois children in substitute care were selected, and interviews with caseworkers, caregivers and children were conducted using an array of different child well-being measures. Data collected from the Illinois Child

Well-Being Studies were used to report on various aspects of child well-being in the 2005 – 2008 *B.H.* monitoring reports. These studies provided valuable data on the status of children in foster care and important information about the services they receive, but they had limitations. First, they sampled children in substitute care at a given point in time (a cross-section) rather than follow a cohort of children from initial contact with DCFS, and are therefore biased toward children with longer lengths of stay.² Second, and perhaps more importantly, they did not include information on children involved with DCFS who remained in their home – a group at risk for future child welfare involvement.

Beginning in 2008, DCFS made a serious commitment to collect data on child well-being by investing in the Illinois Survey of Child and Adolescent Well-Being (ISCAW), a comprehensive, longitudinal study of 818 children involved in substantiated child protective investigations in Illinois (see Box 4.1 for a detailed description of the ISCAW methodology). The ISCAW study was conducted as part of the larger National Survey of Child and Adolescent Well-Being (NSCAW), which includes 5,055 cases from 36 different states. Baseline data from the ISCAW sample, which were collected approximately four to five months following their Child Protective Services (CPS) investigations, were used in last year's *B.H.* monitoring report to provide a comprehensive description of children's well-being including indicators

¹ See <http://www.acf.hhs.gov/programs/cb/pubs/cwo04-07/cwo04-07.pdf>

² Wulczyn, F. (1996). A statistical and methodological framework for analyzing the foster care experiences of children. *Social Service Review*, 70, 318-329.

The Illinois Survey of Child and Adolescent Well-Being

BOX 4.1

The data in this chapter come from the Illinois Survey of Child and Adolescent Well-Being (ISCAW), a longitudinal probability study of well-being and service delivery for children who become involved with child welfare services. ISCAW, a component of the National Survey of Child and Adolescent Well-Being (NSCAW), 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 provides data on hundreds of variables covering a wide array of well-being domains (see Table 4.1 for a list of selected variables in ISCAW).

Unlike the previous Illinois Child Well-Being studies, which evaluated only children in out-of-home care, ISCAW evaluates children involved in substantiated investigations regardless of whether these children were placed into substitute care. The baseline ISCAW data collection took place 4-5 months following the investigation, meaning that a good portion of the cases included in the sample are closed following investigation and no longer involved with the child welfare system. However, children who are the subject of a substantiated investigation are at high risk for future DCFS investigations and removal. Information about the well-being of children that remain in the 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 – efforts meant to keep children out of substitute care.

Table 4.1 Illinois Survey of Child and Adolescent Well-Being Selected Variables

Child Variables

- Infant neuro-developmental impairment
- Physical health
- Adaptive behavior
- Temperament
- Cognitive skills
- IQ
- Language development
- Social skills
- Peer relationships
- Special educational needs
- Disability
- Trauma symptoms
- Depression
- Behavior problems
- School engagement
- Grade progression in school
- School achievement
- Disability status
- Exposure to violence
- Youth social competence
- Youth report of maltreatment
- Youth substance abuse
- Youth sexual activity
- Youth delinquency
- Youth relationship with and closeness to caregiver
- Youth report of future expectations
- Extracurricular activities
- Youth satisfaction with caseworker services
- Youth perceptions of out-of-home care
- Youth perceptions of their adoptive homes
- Youth report of parental monitoring

Caregiver Variables

- Quality of child's home environment
- Observations of caregiver cognitive/verbal responsiveness and stimulation of the child
- Quality of child's community environment
- Family income
- Social support
- Caregiver physical health
- Caregiver depression
- Caregiver alcohol dependence
- Caregiver drug dependence
- Caregiver criminal history
- Biological caregiver discipline and maltreatment of children
- Biological caregiver domestic violence in the home
- Caregiver satisfaction with caseworker

There is another important distinction between the previous Illinois Child Well-Being Studies and ISCAW samples. The former consisted of three cross-sectional (or point-in-time) samples of children in substitute care who had been in a placement at least three months at a given point in time. A point-in-time study has the advantage of profiling all children in substitute care in a given year, but it biases estimates of outcomes because children who have been in substitute care longer are overrepresented. ISCAW is a cohort study that follows an entire cohort of children, all of whom were in contact with DCFS at about the same time.

ISCAW gathers data from a number of informants who know the child, as well as from the children themselves, and also covers a number of well-being topics in much greater depth than other child welfare studies. Caregivers (biological parents or foster parents) complete measures about their own lives and about their children's health, development, and behavior. School-aged children complete standardized measures of academic achievement and self-report

measures of their feelings, opinions, and problems. Caregiver and child interviews are completed using audio computer-assisted self-interview (ACASI) that enhances their 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, which means that they have been developed by testing them on many different samples and that norms have been developed to provide information about average and non-average scores for the normed populations. Often a clinical range is established that indicates when a person's scores correspond to a level of difficulty in which professional intervention is needed (e.g., a physical or mental health need).

Table 4.2 presents the characteristics of the ISCAW sample as well as the national comparison sample (NSCAW). Some important differences between ISCAW and NSCAW must be discussed. First, ISCAW only sampled substantiated investigation reports, while other states taking part in NSCAW allowed the sampling of investigations regardless of the outcome. To correct for this sampling difference, Illinois/national comparisons will only be presented for substantiated cases. Second, important differences in child and case characteristics exist between Illinois and the nation. For example, more children in Illinois remain at home following a substantiated investigation compared to the nation, that is, fewer children in Illinois are placed into substitute care following a substantiated investigation. A larger proportion of African American children, a smaller proportion of Hispanic children, and a smaller proportion of adolescents are involved in substantiated investigations in Illinois compared to the nation.

In Illinois, 82% of the children live at home and were not removed following the investigation. Of the 18% that were removed from home and placed in substitute care, 5% were placed in traditional foster care and 13% in kinship foster care. The percentages of the sample from the Cook, Northern, and Central regions of the state are roughly the same (28% to 31%), with a smaller portion (12%) living in the Southern region. 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%) in the ISCAW sample as well. A majority of children

Investigation, Service, and Placement Variables

- Abuse and neglect details
- Case worker assessment of risk, harm and evidence of maltreatment
- Caseworker assessment of caregiver service needs
- Caseworker assessment of risk factors
- Caseworker report of caregiver service delivery and referral during intake
- Re-reports
- Re-victimization
- Child health services
- Child outpatient mental health services
- Child inpatient mental health services
- Special education services
- Caregiver report of mental health, alcohol, and drug services use
- Use of TANF
- Caseworker contact with caregivers
- Caregiver report of relationship with caseworker
- Type of out-of-home care
- Placement changes
- Adoption possibilities for the child
- Permanency planning options for child
- Permanency outcomes—reunification, adoption, guardianship

The Illinois Survey of Child and Adolescent Well-Being CONT'D

(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 4.2 Characteristics of ISCAW and NSCAW Samples

	ILLINOIS		NATION	
	PERCENT (SE)*	N	PERCENT (SE)	N
Total		818		2795
CHILD SETTING				
Traditional Foster Care	5% (.1)	145	9% (1.0)	779
Kinship Care	13% (1.6)	182	14% (1.4)	615
At Home	82% (1.8)	491	77% (1.8)	1337
IL REGION				
Cook	28% (1.6)	417		
Central	31% (1.9)	197		
Northern	29% (3.3)	130		
Southern	12% (2.5)	74		
SEX				
Male	49% (1.9)	416	47% (2.8)	1421
Female	51% (1.9)	402	53% (2.8)	1374
RACE/ETHNICITY				
African American	42% (5.3)	442	23% (2.9)	820
White	34% (6.1)	192	38% (4.3)	894
Hispanic	20% (3.1)	155	31% (3.7)	864
Other	4% (1.1)	27	8% (1.5)	205
CHILD AGE				
0 to 2	32% (2.7)	497	27% (1.7)	1582
3 to 5	25% (1.4)	125	22% (1.9)	336
6 to 8	15% (3.2)	69	14% (1.3)	270
9 to 11	14% (1.8)	6	12% (1.4)	208
12 to 17	14% (1.1)	63	25% (2.3)	399
MALTREATMENT				
Physical Abuse	15% (2.6)	100	13% (1.7)	312
Sexual Abuse	10% (2.6)	35	7% (1.2)	120
Neglect	26% (3.1)	143	31% (2.2)	664
Substance Exposure	13% (2.9)	155	12% (1.3)	345
Domestic Violence	18% (2.9)	83	13% (2.1)	260
Other	18% (3.6)	154	24% (2.1)	719

* 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.

such as environmental risk factors (caregiver alcohol and substance abuse, domestic violence, mental health problems, and household poverty levels), children's health, physical disabilities, developmental delays, intellectual functioning, emotional and behavioral functioning, depression and trauma symptoms, delinquent and high risk behaviors, and educational achievement.³ The second round of the ISCAW longitudinal data collection occurred approximately 18 months after the baseline data collection, and will allow us to monitor change in well-being indicators over time. Data from the 18-month follow-up were not available for analysis in time for inclusion in this chapter, but will be included in next year's *B.H.* monitoring report.

The last *B.H.* report provided a comprehensive look at the well-being status of children who had been investigated by the Illinois Department of Children and Family Services using the ISCAW sample. Areas of concern reported in the 2010 report included high rates of obesity, the prevalence of early childhood developmental delays, and the substantial proportion of children reported as functioning below grade level by teachers. This year's report provides an in-depth look at the mental health services being received by the children in the ISCAW sample, and compares the Illinois results to parallel data from the NSCAW.⁴ This focus on mental health services is warranted for several reasons. The *B.H.* Consent Decree requires that children shall receive mental health care adequate to address their serious mental health needs.⁵ Compared to children in the population at large, a disproportionate percentage of children involved with the public child welfare system have mental health conditions that require care (see Box 4.2 for a brief summary of the research on the mental health needs of these children).⁶ Unattended mental health problems can detract from children's emotional, physical, developmental, and social well-being, as well as negatively affect child welfare outcomes such as placement stability and permanence. Previous research both nationally and in Illinois indicates that child welfare system involvement can be a gateway to mental health services for many children, but that many children involved with child welfare do not receive

the mental health services they need (see Box 4.3 for a summary of this research).

Measuring Mental Health Service Use

ISCAW data on mental health service use were gathered through interviews with the caregivers of the children and youth in the sample. These interviews, like the rest of the baseline data collection activities, occurred about four to five months following the completion of the child's maltreatment investigation. If the child remained in his or her home following an investigation, the parents were asked about service receipt in the previous 12 months. This includes time before, during and after the investigation so it is not possible to tie mental health service delivery specifically to a period of DCFS involvement for children who remained in the home following the substantiated investigation. If the child was placed in substitute care following the investigation, foster caregivers were interviewed about services since the time of placement. At the baseline data collection, all of the children in the ISCAW sample placed in substitute care were living in either kinship or traditional foster homes. None of the children were placed in congregate care settings (i.e., group homes or institutions), so the results in this chapter are not applicable to children served in these settings.

Interview questions were adapted from the Child and Adolescent Services Assessment (CASA),⁷ which asks caregivers whether the child received a range of specific mental health services. Questions concerned both *specialty* and *non-specialty* mental health services. *Specialty mental health services* are those services provided by or overseen by mental health professionals like psychologists, psychiatrists or social workers. *Specialty outpatient* mental health services include treatment provided in an outpatient drug or alcohol clinic, mental health or community mental health center, in-home counseling, day treatment facility, or therapeutic foster care. *Specialty inpatient* mental health services included treatment provided in a psychiatric hospital, inpatient detoxification unit, hospital medical inpatient unit, or emergency room. By aggregating data on individual services, we

³ See http://www.cfr.illinois.edu/publications/rp_20090901_ConditionsOfChildrenBH2009.pdf

⁴ Comparisons were made using χ^2 tests for complex samples at an $\alpha=.05$

⁵ *B.H. et al. v. McDonald*, No. 88 cv 5599 (N.D. Ill. July 15, 1997).

⁶ 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.

⁷ Ascher, B.H., Farmer, E.M., Burns, B.J. & Angold, A. (1996). The Child and Adolescent Services Assessment (CASA): Description and psychometrics. *Journal of Emotional and Behavioral Disorders*, 4, 12-20.

Mental Health Needs of Children Involved with Child Welfare

BOX 4.2

It is not surprising that many children and youth involved with child welfare services have mental health needs at rates higher than children in the general population. All forms of child maltreatment negatively affect children's sense of safety, self-worth and confidence, as well as their ability to form healthy, loving attachments to others.⁸ Child abuse and neglect can impair brain development, leaving children with a reduced capacity for emotional self-control and cognitive functioning.⁹ Children who have been maltreated are at greater risk for aggression, difficulties with anger and impulse control, and problems with peer relationships. As they age, they are at greater risk for juvenile delinquency, substance abuse and partner violence.¹⁰ In addition, other family and environmental problems often accompany child maltreatment, including poverty, alcoholism and substance abuse, domestic violence and neighborhood violence. Moreover, in some cases youths with mental health problems can become involved with child welfare services because parents act abusively in response to children's behavior problems, or turn to child welfare agencies for help because they do not have the resources to provide care for their children with emotional disturbances.¹¹

A number of studies have examined the mental health of children in substitute care. Most studies find that between 30% and 50% of youth in foster care have serious emotional or behavioral problems in a range suggesting impairment,¹² although some found rates higher than 50%.¹³ Studies using structured psychiatric assessments of adolescents in substitute care have found that a number of psychiatric diagnoses were more common in the substitute care samples than in the general population, such as conduct disorder (which features delinquent behavior), major depressive disorder, anxiety disorders, post-traumatic stress disorder (PTSD), attention deficit hyperactivity disorder (ADHD) and mania.¹⁴ One study also examined alcohol and drug abuse, and found that 17% of adolescents in care met criteria for alcohol abuse or dependence and 7% for illicit substance abuse or dependence.

One might expect lower rates of mental health problems among children who remained in the home following a child protective services investigation, but these rates approximate those of children in substitute care. A study of a national sample of children involved in child maltreatment investigations showed that 47.9% had significant mental health problems that needed intervention.¹⁵ The leading

⁸ Sroufe, L.A., Egeland, B., Carlson, E.A., & Collins, A. (2005). *The development of the person: The Minnesota study of risk and adaptation from birth to adulthood*. New York: Guilford Press.

⁹ Child Welfare Information Gateway (2009). *Understanding the Effects of Maltreatment on Brain Development*. Issue Brief. http://www.childwelfare.gov/pubs/issue_briefs/brain_development/brain_development.pdf

¹⁰ See e.g., Mersky, J.P. & Reynolds, A.J. (2007). Child maltreatment and violent delinquency: Disentangling main effects and subgroup effects. *Child Maltreatment*, 12, 246-258.

¹¹ 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.

¹² Chemoff, R., Combs-Orme, T., Risley-Curtiss, C., & Heisler, A. (1994). Assessing the health status of children entering foster care. *Pediatrics*, 93, 594-601. Fanshel, D., & Shinn, E. (1978). *Children in foster care: A longitudinal investigation*. New York, NY: Columbia University Press. Farmer, E.M., Burns, B.J., Chapman, M.V., Phillips, S.D., Angold, A., & Costello, E. J. (2001). Use of mental health services by youth in contact with social services. *Social Service Review*, 75, 605-624. Garland, A.F., Landsverk, J.L., Hough, R.L., & Ellis-MacLeod, E. (1996). Type of maltreatment as a predictor of mental health service use for children in foster care. *Child Abuse & Neglect*, 20, 675-688.

¹³ Clausen, J.M., Landsverk, J., Ganger, W., Chadwick, D., & Litrownik, J. (1998). Mental health problems of children in foster care. *Journal of Child & Family Studies*, 7, 283-296. Swire, M.R., & Kavalier, F. (1977). The health status of foster children. *Child Welfare*, 56, 635-653. Tarren-Sweeney, M., & Hazell, P. (2006). Mental health of children in kinship and foster care in New South Wales Australia. *Journal of Pediatrics & Child Health*, 42, 89-97.

¹⁴ Keller, T.E., Salazar, A.M. & Courtney, M.E. (2010). Prevalence and timing of diagnosable mental health, alcohol, and substance use problems among older adolescents in the child welfare system. *Children and Youth Services Review*, 32, 626-634. McCann, J.B., James, A., Wilson, S., & Dunn, G. (1996). Prevalence of psychiatric disorders in young people in the care system. *British Medical Journal*, 313, 1529-1530. McMillen, J.C., Zima, B. T., Scott, L.D., Auslander, W.F., Munson, M.R., Ollie, M.T., et al. (2005). Prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child & Adolescent Psychiatry*, 44, 88-95.

¹⁵ See, e.g., Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43, 960-970.

researchers on mental health services for these children estimate that 40% to 60% may have a psychiatric diagnosis.¹⁶ Other studies of community samples have shown that as many as 80% of children involved with child welfare services have either emotional or behavioral problems, developmental delays or other problems that require a mental health intervention.¹⁷

ISCAW data, presented in last year's *B.H.* report, indicates that Illinois children investigated and substantiated by DCFS have substantial mental health needs. On a caregiver-reported measure of emotional and behavioral problems (the Child Behavior Checklist or CBCL), 29% of children age two and older had scores in the borderline clinical to clinical range, indicating a need for mental health treatment. On a parallel teacher measure, 34% scored in the borderline clinical to clinical range. Youths 12 and older completed a measure of their own emotional and behavioral problems, and 27% had scores in the borderline clinical to clinical range. Altogether, 37% of youth were identified with a mental health problem in the borderline clinical to clinical range by either the caregiver, a teacher or the youths themselves. The rate of emotional and behavioral problems was especially high among children in substitute care – 59% of these recently placed children were in the borderline clinical to clinical range on the CBCL. The rate among children who remained in their homes following a maltreatment investigation was also high – 29% had CBCL scores in the borderline clinical to clinical range.

were also able to determine whether children received any specialty outpatient or any specialty inpatient mental health service. *Non-specialty mental health services* were mental health services provided by other helping professionals who are not categorized as mental health specialists, such as guidance counselors, other school professionals, and family doctors.

The analyses examine mental health services among children in three groups: a) children placed in substitute care after investigation; b) children who remained in the home following an investigation but continued as open DCFS cases, known as intact family cases; and c) children who remained in the home whose cases were closed following the substantiated investigation. For each of these three groups, analyses were conducted to answer the following questions:

1. What percentage of Illinois children received specialty outpatient and inpatient mental health services, and how did it compare to children in the national comparison?
2. What specific mental health services did Illinois children receive and how did that compare to the national comparison?
3. How well did delivery of mental health services match need? Specifically, what percentage of Illinois children who had a demonstrated mental health need received mental health services?
4. Does receipt of mental health services for Illinois children vary by region, child gender, race and age?

¹⁶ Landsverk J, Garland AF, Leslie LK. (2002). Mental health services for children reported to Child Protective Services. In: J.E. Myers, L. Berliner, J. Briere, C.T. Hendrix, C. Jenny, T.A. Reid, (Eds.). *APSAC Handbook on Child Maltreatment*. Thousand Oaks, CA: Sage.

¹⁷ See e.g., Breland-Noble, A.M., Farmer, E.M., Dubs, M.S., Potter, E. & Burns, B.J. (2005). Health and other service use by youth in therapeutic foster care and group homes. *Journal of Child and Family Studies*, 14, 167–180. Farmer, E.M., Burns, B.J., Chapman, M.V., Phillips, S.D., Angold, A. & Costello, E.J. (2001). Use of mental health services by youth in contact with social services. *Social Service Review*, 7, 605–624. Landsverk, J. Garland, A.P., & Leslie, L. (2001). Mental health services for children reported to child protective services. In Myers, J.E., Hendrix, C.T., Berliner, L., Jenny, C. Briere, J. & Reid, T. (Eds.). *APSAC Handbook on Child Maltreatment*, Second Edition. (pp. 487–507) Thousand Oaks, CA: Sage.

The Challenge of Providing Children's Mental Health Services

BOX 4.3

A series of national analyses dating as far back as the 1960s have reported huge gaps in the availability of mental health services for children.¹⁸ For example, one national study found that only 20% of children age 6-17 who needed a mental health service received one.¹⁹ It is in this context of a generally insufficient public child mental health service system that DCFS must contend with mental health care for the children it serves.

In the last decade, several sources have reported a shortfall of mental health resources for children in Illinois. The MidAmerican Institute on Poverty of the Heartland Alliance (citing data from the National Survey of Children's Health) reported that 37% of Illinois children with behavioral, developmental or emotional problems did not receive any mental health service in the year previous to its survey.²⁰ This same report found that too few child psychiatrists and psychologists were available to treat children, and only 16% of the state's psychiatrists and psychologists accepted public insurance. This reinforced conclusions of the Illinois Children's Mental Health Task Force, a statewide multidisciplinary coalition of professionals who found that the system of mental health care for children in Illinois was "grossly underfunded."²¹ Medicaid funding for children's mental health services in Illinois is insufficient because of limited state funds to secure matching federal dollars, a lack of Medicaid-certified

providers, low reimbursement rates, difficulties with billing and significant delays in reimbursement.²²

The child welfare system has often been an avenue for underserved children to receive mental health services. Studies of mental health service use among this population of children have found a large increase in the probability of children receiving mental health services immediately after contact with child welfare; with children in substitute care receiving mental health services at a rate five to eight times higher than comparison groups of children in poverty.²³ A 1999 study found that Illinois children in substitute care were nearly four times more likely to receive a mental health service than a comparison group of children receiving AFDC.²⁴ Such findings have led some experts to call child welfare a "gateway" to mental health services.

A number of studies have examined mental health service use among children in substitute care, and report percentages ranging from 51% to 93%.²⁵ These rates varied because of research methodology, but also because of differences in service delivery across communities. Despite the high rates of mental health service use for children in substitute care, many children in need who are placed out of the home are nevertheless unserved.²⁶ The *B.H. Reports* for 2007 and 2008 reported data on mental health services from cross-sectional studies of Illinois

¹⁸ See, for example, Joint Commission on the Mental Health of Children (1969). *Crisis in child mental health: Challenge for the 1970's*. New York: Harper & Row. Leaf, P.J., Alegria, M., Cohen, P., Goodman, S.H., Horwitz, S.M., Hoven, C.W. et al. (1996). Mental health service use in the community and schools. Results from the four-community MACA Study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 889-897. Saxe, Dougherty, Cross & Silverman (1987). *Children's mental health: Problems and services*. Durham, NC: Duke University Press.

¹⁹ Kataoka, S.H., Zhang, L., & Wells, K.B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry*, 159, 1548-1555.

²⁰ MidAmerica Institute on Poverty of the Heartland Alliance. (2007). *Building on our success: Moving from health care coverage to improved access and comprehensive well being for Illinois children and youth*. Chicago: Author.

²¹ Illinois Children's Mental Health Task Force (April, 2003). *Children's mental health: An urgent priority for Illinois*. Final Report. Chicago, IL: Illinois Violence Prevention Authority.

²² Cross T.P. (2010). Obstacles and opportunities in accessing mental health services for children in foster care: Lessons from recent history in Illinois. *Illinois Child Welfare*, 5, 86-107.

²³ Leslie, L. K., Hurlburt, M. S., James, S., Landsverk, J., Slymen, D. J., & Zhang, J. (2005). Relationship between entry into child welfare and mental health service use. *Psychiatric Services*, 56, 981-987.

²⁴ Bilaver, L.A., Jaude P.K., Koepke, D., & Goerge, R.M. (1999). The health of children in foster care. *Social Services Review*, 73, 401-417.

²⁵ Dos Reis, S., Zito, J.M., Safer, D.J., & Soeken, K.L. (2001). Mental health services for youth in foster care and disabled youth. *American Journal of Public Health*, 91, 1094-1099. Halfon, N., Berkowitz, G., & Klee, L. (1992). Mental health services utilization by children in foster care in California. *Pediatrics*, 89, 1238-1244. Harman, J. S., Childs, G. E., & Kelleher, K. J. (2000). Mental health care utilization and expenditures by children in foster care. *Archives of Pediatric & Adolescent Medicine*, 154, 1114-1117. Takayama, J.I., Bergmann, A.B., & Connell, F.A. (1994). Children in foster care in the state of Washington: Health-care utilization and expenditures. *Journal of the American Medical Association*, 271, 1850-1855.

²⁶ United States Department of Health and Human Services, Administration for Children and Families. (2003). *National Survey of Child and Adolescent Well-Being (NSCAW). One year in foster care wave 1 data analysis report, November 2003*. Washington, DC: Author.

children in substitute care in 2003 and 2005. On one hand, they showed that DCFS was an important gateway to mental health services for Illinois children in need, since Illinois children in substitute care received mental health services at rates higher than children at risk in the general population. On the other hand, the data also showed a shortfall in mental health service delivery as well, since many Illinois children in substitute care in need of mental health services²⁷ did not receive them, and children in substitute care in other states were more likely to receive mental health services than children in substitute care in Illinois.

Much less research has examined services for children who are involved in child protective services investigations or for child victims who remain in their home following an investigation. One study using the 1999-2000 NSCAW cohort found that 15.8% of children and youth recently involved in a maltreatment investigation had received a mental health service within the previous year.²⁸ Of those children whose emotional and behavioral problem scores indicated they had a clinical need in the sample, 24.4% received mental health services. When children remained in the home following an investigation, 13.8% received mental health services. The exact percentage receiving a mental health service among children at home with a clinical need was not reported, but based on other results was no greater than 29.5%. A second study did a more comprehensive analysis utilizing three years of NSCAW follow-up data and found that 48.3% of investigated children were screened for mental health problems over three years, 34.5% were assessed for mental health need and 38.3% were

referred for mental health services.²⁹ Children were more likely to receive these services if they were older, had aggressive or disruptive behavior problems or were placed outside of the home. A third of children with clinically significant emotional or behavioral problems did not receive any of these three mental health interventions. The authors argued that these numbers demonstrated that child welfare agencies were failing to meet standards set by the Council on Accreditation³⁰ for service delivery.

A number of studies have shown that some children involved with child welfare are more likely to receive mental health services than others. Some, but not all, studies have found that children who have experienced sexual abuse and/or physical abuse are more likely to receive mental health services.³¹ Results on demographic variables vary. Several studies have found that children over age five are substantially more likely to receive mental health services than children under age five,³² though other age differences are inconsistent across studies. Girls were more likely to receive mental health services in some studies, boys in others, and some studies show no difference.³³

Examining racial-ethnic parity on mental health services for children involved in child welfare is important, given the ample data that show that children from minority populations are disproportionately represented in child welfare, are less likely to receive various child welfare services, and tend to have poorer child welfare outcomes than White children.³⁴ A number of studies have found that

²⁷ These reports are available on the Children and Family Research Center website: http://www.cfr.illinois.edu/publications/rp_20080901_ConditionsOfChildrenvH2007.pdf http://www.cfr.illinois.edu/publications/rp_20080901_ConditionsOfChildrenvH2008.pdf

²⁸ Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43, 960-970.

²⁹ Raghavan, R., Inoue, M., Ettner, S.L., Hamilton, B.H., & Landsverk, J. (2010). A preliminary analysis of the receipt of mental health services consistent with national standards among children in the child welfare system. *American Journal of Public Health*, 100,

³⁰ See <http://www.coastandards.org/standards.php?navView=public>

³¹ Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43, 960-970. Garland A.F., Landsverk, J.L., Hough, R.L., & Ellis-MacLeod, E. (1996). Type of maltreatment as a predictor of mental health service use for children in foster care. *Child Abuse and Neglect*, 20, 675-688. Leslie, L. K., Hurlburt, M. S., James, S., Landsverk, J., Slymen, D. J., & Zhang, J. (2005). Relationship between entry into child welfare and mental health service use. *Psychiatric Services*, 56, 981-987.

³² Burns et al., (2004); Leslie, et al., (2005); Leslie, L.K., Landsverk, J., Ezzet-Lofstrom, R., Tschann, J.M., Slymen, D.J., & Garland, A.I. (2000). Children in foster care: Factors influencing outpatient mental health service use. *Child Abuse and Neglect*, 24, 465-476.

³³ McMillen, J.C., Zima, B. T., Scott, L.D., Auslander, W.F., Munson, M.R., Ollie, M.T., et al. (2005). Prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child & Adolescent Psychiatry*, 44, 88-95. Courtney, M. E., Barth, R.P., Berrick, J.D., Brooks, D., Needell, B., & Park, L. (1996). Race and child welfare services: Past research and future directions. *Child Welfare*, 75, 99-135.

³⁴ Courtney, M.E., Barth, R.P., Berrick, J.D., Brooks, D., Needell, B., & Park, L. (1996). Race and child welfare services: Past research and future directions. *Child Welfare*, 75, 99-135.

The Challenge of Providing Children's Mental Health Services CONT'D

White children in substitute care were more likely to receive mental health services than African-American or Hispanic children. A study of youth aged 17 in substitute care found that youth minority populations were less likely to receive either outpatient or inpatient mental health services or psychotropic medication, but they were more likely than White children to receive residential treatment or group care.³⁵ Though previous research has focused on substitute care settings, more recent research has used the National Survey of Child and Adolescent Well-Being (1999-2000 cohort) to look at racial-ethnic disparities in mental health service receipt among all children involved in investigations. A study using baseline data found that White school age children involved with CPS were more likely to receive mental health services than African-American children,³⁶ while another study using an additional wave of NSCAW data found similar racial differences across all age groups.

³⁵ Garland, A.F., Hough, R.L., Landsverk, J.L., McCabe, K.M., Yeh, M., Ganger, W.C., & Reynolds, B.J. (2000). Racial and ethnic variations in mental health care utilization among children in foster care. *Children's Services: Social Policy, Research, and Practice*, 1, 133-146. Leslie, et al., (2000); McMillen, et al., (2005); Zima, B.T., Bussing, R., Yang, X., & Belin, T.R. (2000). Helpseeking steps and service use among children in foster care. *Journal of Behavioral Health Services and Research*, 27, 271-285.

³⁶ Burns et al., *ibid*, Leslie, et al., (2005), *ibid*.

Mental Health Services Among Children in Substitute Care

The following section examines mental health service use among the children in the ISCAW and NSCAW samples who were placed in substitute care following their substantiated child maltreatment investigation (see Table 4.3). This group comprises about 18% of the ISCAW sample and about 23% of the national (i.e., NSCAW) sample. The proportion of children in substitute care who received at least one specialty outpatient mental health service was 14.6% in Illinois and 25.2% in the national comparison, a statistically significant difference. The percentages receiving specialty inpatient services were low both in Illinois (1.3%) and the national comparison (3.3%), and this difference was not statistically significant. The very low rate of specialty inpatient mental health services is probably related to the particular circumstances of this sample at baseline: inpatient services, which are never frequent, are particularly unusual just a few months after a maltreatment investigation; they are more likely after outpatient services have been tried and found insufficient.

This analysis was expanded to compare Illinois and the nation on the use of several specific types of mental health services (see Table 4.3), including specialty outpatient and inpatient services as well as non-specialty mental health services from: a) guidance counselors, school social workers and school psychologists; and b) family doctors or other medical doctors. The most frequent specialty outpatient mental health service for Illinois children was treatment by mental health professionals in private practice (i.e., "private professional help"), though only 9.5% of children received this service. This was significantly less than the 18.8% of children in the national comparison sample of children in substitute care who received this type of mental health treatment. The percentages of Illinois children in substitute care that received mental health center services, in-home counseling or crisis services and day treatment were all below 8%, and not significantly different from the percentages for the national comparison. The analysis of specific inpatient services

reveals that the only inpatient services Illinois children in the sample used was emergency room visits, which only 1.3% of the children received. The most common mental health service received by Illinois children was visits with a school guidance counselor, school psychologist, or school social worker; which occurred among

13.2% of the children, comparable to the percentage in the national comparison. Only 2.7% of the sample saw a family doctor or medical doctor for mental health services, again comparable to the percentage in the national sample.

Table 4.3 Mental Health Services Among Children in Substitute Care

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

p < .05

Not all children in substitute care need mental health services, and the preceding analyses do not address to what extent children with mental health service needs are receiving them. This is an important question because an assessment of the adequacy of service delivery hinges first on whether those who need the service are receiving it. Because ISCAW provides data on child mental health problems, service delivery among a subgroup of children with clinically significant externalizing or internalizing problems can be examined. For this analysis, children with total scores in the clinical range on the Child Behavior Checklist (CBCL) completed by caregivers during the baseline data collection were identified. The CBCL is a frequently used, valid and reliable method of assessing child mental health problems. Research shows that CBCL scores correspond closely with psychiatric assessments by professionals,³⁷ and it has been used in numerous studies on mental health services in child welfare to measure the extent of mental health needs.³⁸ The clinical range on the CBCL is a commonly used threshold for determining those children with serious need for mental health services.

The number of children in the substitute care sample with a serious mental health need as measured by the CBCL was small; therefore results for this group should be interpreted cautiously. With that in mind, 39.6% of the children in this group received specialty outpatient mental health services, compared to 54.8% in the national comparison (see Table 4.3). Though this difference was not statistically significant because of the small sample, it does raise questions about the extent to which children in substitute care in Illinois who are in need of mental health services are receiving them. The percentage of children in substitute care with serious mental health needs who were receiving specialty inpatient services was slightly higher in Illinois (6.5%) than the national comparison (3%), although this difference was not statistically significant. In addition, children in Illinois were significantly more likely to receive mental health services in a hospital emergency room (6%) than were children in the national comparison (0.4%). Just over a quarter (26.4%) of the Illinois children in this subgroup saw a guidance counselor, school social worker, or school psychologist for non-specialty mental

health services, which was comparable to the national sample.

Mental Health Services Among Children in Intact Family Cases

Of the children in the ISCAW sample, 37% remained in their home following the investigation with an open child welfare service case (known as intact family cases in Illinois). Unlike children in substitute care, the Department does not have legal or physical custody of children in intact family cases, and therefore does not have the authority to make decisions about the services they receive. However, since these children have an open service case, the Department does have a responsibility to offer services that are responsive to their needs.

About 13% of Illinois children in intact family cases received outpatient services from a mental health specialist—slightly less than those in substitute care (see Table 4.4). This was a slightly smaller percentage than in the national sample (17.6%) although not significantly so. Specialty inpatient services were rare – 2.5% of the Illinois children served in intact family cases received them, and the national comparison was not significantly different. As with children in substitute care, the most common specialty outpatient service received was treatment from a private practitioner, which 7.5% of children in intact family cases received. The percentages of children in Illinois who received mental health center services and in-home counseling or crisis services were each less than 5% and no children in this subgroup received day treatment. The percentages receiving these services in the national comparison sample were slightly higher, but the differences were not statistically significant. The most common mental health service for children in intact family cases was seeing a guidance counselor, school social worker, or school psychologist—14% received this (non-specialty) service. Only a small percentage (3.1%) of Illinois children in intact cases received mental health care from a family doctor or other medical doctor – this was somewhat less than the national comparison but the difference was not statistically significant.

³⁷ Edelbrock, C., & Costello, A.J. (1988). Convergence between statistically derived behavior problem syndromes and child psychiatric diagnoses. *Journal of Abnormal Child Psychology*, 16, 219–231. Gould, M.S., Bird, H., & Jaramillo, B.S. (1993). Correspondence between statistically derived behavior problem syndromes and child psychiatric diagnoses in a community sample. *Journal of Abnormal Child Psychology*, 21, 287–313.

³⁸ See, e.g., Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43, 960–970. Garland, A.F., Landsverk, J., Hough, R.L., Ellis-MacLeod, F. (1996). Type of maltreatment as a predictor of mental health service use for children in foster care. *Child Abuse & Neglect*, 20, 675–688.

Table 4.4 Mental Health Services Among Children in Intact Family Cases

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

p < .05

If only the children in intact family cases with serious mental health needs (as measured by CBCL scores in the clinical range) are considered, 20.4% received a specialty outpatient mental health service compared to 38.6% in the national sample; this difference was not statistically significant given the small Illinois sample in this group (see Table 4.4). Of this same group of children, the percentage who received a specialty inpatient mental health service was 14.7%, compared to 12% in the national

comparison, a non-significant difference. About a third (31.3%) of children with a serious mental health need saw a guidance counselor or other school professional, which was comparable to the national percentage. Illinois children in intact family cases with a serious mental health need were significantly *less* likely to see a family doctor or other medical doctor for mental health care (6.5%) than were children in the national comparison (16.1%).

Mental Health Services Among Children Whose Cases Were Investigated and Closed³⁹

Almost half of the children in the ISCAW sample (45%) did not have an ongoing child welfare service case following the investigation; in other words, they were “investigated and closed.” Thus, these children were living at home and no longer involved with the Illinois child welfare system during the baseline ISCAW data collection that occurred four to five months after the investigation. Despite this fact, a sizable proportion of these children had mental health problems, and the decision to close the case following investigation does not necessarily mean that these children’s mental health service needs were met.

Less than ten percent (9.7%) of children in closed investigations received outpatient services from a mental health specialist in the months following the investigation, which is significantly lower than the children in the national comparison sample (15.9%, see Table 4.5). Less than 2% of children in closed investigations received specialty inpatient mental health services, similar to the national comparison sample. The most frequently used specialty outpatient service was treatment from a private practitioner, which was provided to 7% of children in Illinois and 12.3% of children in the national sample (not a statistically significant difference). Illinois children investigated and closed were significantly less likely to receive in-home counseling or crisis services (1.6%) than were children nationally (6.7%). The most common service for this group was the non-specialty service of seeing a guidance counselor, school social worker or school psychologist—18.8% received this service, which was somewhat higher than in the national comparison, although the difference was not statistically significant. Only a small percentage (3.2%) of children in this subgroup received mental health care from a family doctor or other medical doctor, and this was significantly smaller than that in the national sample (7.4%). There were too few cases of children in closed cases with evidence of mental health need to produce reasonable estimates, so results based on need are not presented.

Table 4.5 Mental Health Services Among Children Whose Cases Were Investigated and Closed

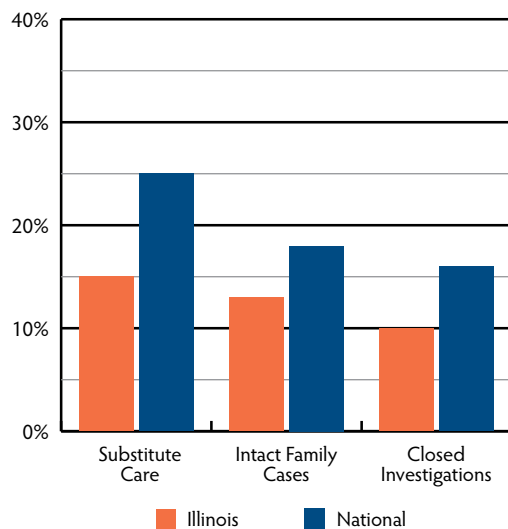
		All Children in Substantiated Cases	
		ILLINOIS (N=131)	NATION (N=433)
Specialty Outpatient Mental Health Services	<i>Any specialty outpatient mental health service</i>	9.7* (1.8)	15.9 (2.6)
	Private professional help	7.0 (1.9)	12.3 (2.7)
	Mental health or community mental health center	4.7 (2.4)	3.6 (1.6)
	In-home counseling or crisis services	1.6* (1.0)	6.7 (2.2)
	Day treatment	1.8* (1.7)	0 (0)
	Outpatient drug or alcohol clinic	0 (0)	2.4 (2.3)
Specialty Inpatient Mental Health Services	<i>Any specialty inpatient mental health service</i>	1.8 (1.7)	3.4 (1.3)
	Psychiatric hospital unit	.8 (.8)	2.0 (.9)
	Hospital medical inpatient unit	0 (0)	0 (0)
	Detox, drug or alcohol unit	0 (0)	1.2 (1.2)
	Hospital emergency room	1.0 (.9)	1.7 (.9)
Non-specialty Mental Health Services	Guidance counselor, school psychologist, or school social worker	18.8 (2.2)	13.3 (2.5)
	Family doctor or other medical doctor	3.2* (.5)	7.4 (2.1)

p < .05

³⁹ In this section, the phrase “closed investigation” will be used to denote those children who were involved in a substantiated maltreatment investigation but did not have an intact family case opened or substitute care placement resulting from that investigation.

Figure 4.1 graphically presents the proportion of children in Illinois and the nation receiving an outpatient mental health service by the above placement types. Two consistent trends are present: first, for both Illinois and the nation, receipt of outpatient mental health services decreased as child welfare involvement and oversight decreased; and second, fewer Illinois children received services compared to the nation regardless of placement type.

Figure 4.1
Outpatient Mental Health Services
by Child Placement Setting:
Illinois Versus National Comparison



Mental Health Services and Child Characteristics

In order to help identify gaps in mental health services in Illinois, it is important to know which children are most likely to receive such services. The following section examines differences in specialty outpatient mental health service receipt by geographic region, child gender, race, and age for those in substitute care,

intact family cases, or closed investigations (see Table 4.6). Differences in the receipt of specialty inpatient services are not presented because of the very small percentages of children receiving these services. In these analyses, geographic region is categorized into four groups: Cook, Northern, Central, and Southern. Similar to the other chapters in this report, analysis of race/ethnicity was limited to three groups – White, African American, and Hispanic – because only a small number of children and youth had other ethnicities and there were very large standard errors for this group.

Children in Substitute Care. A significantly higher percentage of older children in substitute care received a specialty outpatient service compared to younger children, with well over half of adolescents receiving an outpatient service (58%) but less than 12% for 0-5 year olds. The percentages of African-American (14%), White (14%) and Hispanic (13%) children in substitute care who received specialty outpatient services were almost identical. No regional or gender differences were present.

Children in Intact Family Cases. For children in intact family cases, a significantly greater proportion in the Central and Northern regions (18% and 24%) received a specialty outpatient service compared to the Cook (7%) and Southern (3%) regions. A significantly higher percentage of school-aged children (aged 6-17) received a specialty outpatient service compared to preschool-aged and younger (27% vs. 5%). Significantly smaller percentages of African American children (7%) and Hispanic children (9%) in intact family cases received an outpatient service compared to White children (26%). No gender differences were present.

Children in Closed Investigations. For children in closed investigations, only child age was significantly associated with receiving a specialty outpatient service in the past year: youth age 12 to 17 received a specialty outpatient mental health service in 19% of cases, but no child under the age of 6 received one.

**Table 4.6 Mental Health Services
and Child Characteristics**

	Percent Receiving a Specialty Outpatient Mental Health Service/SE		
	SUBSTITUTE CARE	INTACT FAMILY CASES	CLOSED INVESTIGATIONS
Total	14 (2.3)	13 (1.8)	10 (1.8)
REGION			
Cook	23 (2.1)	7 (1.3)*	2 (2.8)
Central	6 (3.4)	18 (2.4)	9 (3.9)
Northern	15 (7.4)	24 (8.8)	15 (2.4)
Southern	12 (7.0)	3 (3.3)	7 (4.6)
SEX			
Male	17 (4.4)	14 (4.4)	11 (3.3)
Female	11 (3.9)	12 (1.8)	9 (2.2)
RACE/ETHNICITY			
African American	14 (3.1)	7 (2.7)*	7 (4.6)
White	14 (5.1)	26 (5.9)	12 (5.0)
Hispanic	13 (10.4)	9 (5.1)	2 (2.3)
CHILD AGE			
Under 3	4 (2.9)**	3 (2.2)*	0 (0)*
3 to 5	12 (5.3)	8 (6.2)	0 (0)
6 to 11	31 (8.9)	28 (11.2)	17 (5.2)
12 to 17	58 (10.7)	26 (6.9)	19 (6.8)

* p<.05 ** p<.01

Conclusions and Recommendations: Child Well-Being

The most important finding is the shortfall in outpatient mental health services for Illinois children following substantiated maltreatment investigations. In every group of children – those in substitute care, intact family cases, and closed immediately after the investigation – less than 15% received specialty outpatient mental health services. Of the children with serious mental health needs, about 40% of children in substitute care received specialty outpatient services and 30% of children in intact family cases received them. The percentages for Illinois children receiving these services were consistently and significantly below the national comparison group. Children in substitute care in the national comparison were almost twice as likely to receive mental health services from a private practitioner as children in substitute care in Illinois.

Although we do not have data on the reasons children have not received mental health services in the ISCAW sample, it is likely that systemic factors contribute, many of which are beyond the control of DCFS and concern the public mental health system as a whole. These include the overall shortage of children's mental health professionals in the state, problems with Medicaid reimbursement for children's mental health care, and limitations in availability of funds for DCFS to support mental health services.⁴⁰ These results may assist DCFS in its advocacy for mental health services for children involved with the agency, and may inform efforts to identify children in need and connect them to services in the community. The gaps in mental health services for child victims found here should also help energize continued efforts by the Illinois Children's Mental Health Partnership and other groups to develop systems whereby every Illinois child in need of services has access to mental health care.

The most frequent children's service reported by care-givers was a mental health service provided by guidance counselors, school psychologists and school social workers. One question that cannot be addressed with

⁴⁰ Cross, T.P. (2010). Obstacles and opportunities in accessing mental health services for children in foster care: Lessons from recent history in Illinois. *Illinois Child Welfare*, 5, 65-85

ISCAW data is whether the services provided to troubled children in schools are sufficiently available and effective to make up for the shortfall in the availability of outpatient services from mental health specialists.

Regional differences in use of mental health services likely reflect local differences in the availability and capacity of children's mental health programs to provide these services. The lower rate of outpatient mental health services among African American and Hispanic children in intact family cases is consistent with other studies which have found racial-ethnic disparities in receipt of mental health services for children in the general population⁴¹ and children in substitute care,⁴² and is cause for concern and additional study. Analysis in an earlier NSCAW cohort also found a national trend for African-American and Hispanic children involved with child protective services to be less likely to receive mental health services.⁴³ There are many possible causal explanations that may contribute to these disparities, including socioeconomic differences, bias in referral patterns, differential access to mental health service providers, and cultural differences in attitudes toward mental health services. Clearly the needs of child victims with minority status deserve special attention and vigilance in mental health service planning at both the system and individual case level.

The very low rate of mental health services for children under the age of 6 also warrants attention. It is not simply a function of the lesser need of these children. To some degree, the gap for young children may be a result of limitations in our measurement of service delivery to them. It is possible that at least some of these children are receiving early intervention services that may help improve their mental health, but because they are not labeled as mental health services, they are not identified in the ISCAW results. We think it is likely, however, that the gap in services found here reflects a real deficit in response to very young children, because there is an insufficient supply of all psychosocial

interventions for young children, including early intervention. By interfering with their brain development and their attachment to parents, maltreatment at an early age can have widespread negative effects on children's relationships and can negatively affect learning. Many experts on early childhood development stress the need to intervene early with emotional and behavioral problems to prevent serious effects on development and emotional well-being.⁴⁴ DCFS and its partner agencies could explore further models of dealing with disturbed emotions and challenging behavior in young children and should work to broaden mental health service availability for these children.

⁴¹ Cuffe, S.P., Waller, J.L., Cuccaro, M.L., & Pumariega, A.J. (1995). Race and gender differences in the treatment of psychiatric disorders in young adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34, 1536-1543. McCabe, K.M., Yeh, M., Hough, R.L., Landsverk, J., Hurlburt, M.S., Culver, S.W., & Reynolds, B. (1999). Racial/ethnic representation across five public sectors of care for youth. *Journal of Emotional and Behavioral Disorders*, 7, 72-82. Zahner, G.E., & Daskalakis, C. (1997). Factors associated with mental health, general health, and school-based service use for child psychopathology. *American Journal of Public Health*, 87, 1440-1448.

⁴² Courtney, M.E., Barth, R.P., Berrick, J.D., Brooks, D., Needell, B., & Park, L. (1996). Race and child welfare services: Past research and future directions.

Child Welfare, 75, 99-135. Garland, A. F., Hough, R.L., Landsverk, J.A., McCabe, K.M., Yeh, M., Ganger, W.C., & Reynolds, B.J. (2000). Racial and ethnic variations in mental health care utilization among children in foster care. *Children's Services: Social Policy, Research & Practice*, 3, 133-146.

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

⁴⁴ Shonkoff, J. P., & Phillips, D. A. (Eds.). (2000). *From neurons to neighborhoods: The science of early development*. Washington, DC: National Academy Press.



APPENDIX A

Indicator Definitions

Appendix A provides definitions of the indicators used in the following chapters of this report: Chapter 1 - Child Safety; Chapter 2 - Children in Substitute Care: Safety, Continuity, and Stability; and Chapter 3 - Legal Permanence: Reunification, Adoption, and Guardianship. The data used in these indicators come from the September 30, 2010 data extract of the Illinois Department of Children and Family Services Integrated Database. Several acronyms are mentioned throughout the definitions. These acronyms come from the Illinois Department of Children and Family Services Integrated Database Codebook.¹

¹ Chapin Hall Center for Children. (2003). *Illinois Department of Children and Family Services Integrated Database Codebook (Version 10)*. Chicago, IL: Chapin Hall Center for Children at the University of Chicago.

Chapter 1: Child Safety

Indicator 1.A: Of all children with a substantiated report, what percentage had another substantiated report within 12 months?

Definition: For all children with a substantiated report of maltreatment during the fiscal year, this reports the percentage of those children that had another substantiated report of maltreatment within 12 months.

Indicator 1.B: Of all children served at home in intact family cases, what percentage had another substantiated report within 12 months?

Definition: All children who are served at home in an intact family case and the percentage of those children who experienced a substantiated report of maltreatment within a year. Intact family cases are cases where all children in a family are at home at the time the family case opens and they don't enter substitute care within 30 days after case opening.

Indicator 1.C: Of all children in an initial substantiated report that did not receive intact or substitute care services, what percentage had another substantiated report within 12 months?

Definition: All children with an initial substantiated report during the fiscal year who were not part of either a family case or placed in substitute care at the time of the initial report or within 60 days of the initial report, and the percentage of those children that had a second substantiated report within 12 months of the initial report.

Chapter 2: Children in Substitute Care: Safety, Continuity, and Stability

Indicator 2.A: Of all children ever served in substitute care during the year, what percentage had a substantiated report during placement?

Definition: All children ever served in substitute care during the fiscal year and the percentage that had a substantiated report during placement. Analyses for this indicator are based on administrative data that does not distinguish between the date the incident occurred and the date it was reported. A portion of maltreatment recorded while a child is in substitute care actually occurred prior to the child entering substitute care. Many of these retrospective reports are reports of sexual abuse. In an effort to remove the effects of this reporting error, this analysis excludes reports of sexual abuse after a child has entered care. This analysis excludes cases lasting less than 8 days, placements lasting less than 8 days and reports made less than 7 days into the placement.

Indicator 2.B.1: Of all children entering substitute care, what percentage is placed in a traditional foster home in their first placement?

Definition: Children entering substitute care during the fiscal year and the percentage initially placed in traditional foster homes. The Traditional Foster Home category is made up of Foster Home Boarding DCFS (FHB), Foster Home Indian (FHI), Foster Home Boarding Private Agency (FHP), and Foster Home Adoption (FHA) regardless of the duration of the placements. Cases lasting less than 8 days are excluded.

Indicator 2.B.2: Of all children entering substitute care, what percentage is placed in a specialized foster home in their first placement?

Definition: Children entering substitute care during the fiscal year and the percentage initially placed in

specialized foster homes. The Specialized Foster Home category is made up of Foster Home Specialized (FHS) and Foster Home Treatment (FHT) regardless of the duration of the placements. Cases lasting less than 8 days are excluded.

Indicator 2.B.3: Of all children entering substitute care, what percentage is placed in a kinship foster home in their first placement?

Definition: Children entering substitute care during the fiscal year and the percentage initially placed in kinship foster homes. The Kinship Foster Home category is made up of Delegated Relative Authority (DRA) and Home of Relative (HMR) regardless of the duration of the placements. Cases lasting less than 8 days are excluded.

Indicator 2.B.4: Of all children entering substitute care, what percentage is placed in a group home or institution in their first placement?

Definition: Children entering substitute care during the fiscal year and the percentage initially placed in a group home or institution. The Group Home or Institution category is made up of Group Home (GRH), Detention Facility/Jail (DET), Institution DCFS (ICF), Institution Department of Corrections (IDC), Institution Department of Mental Health (IMH), Institution Private Child Care Facility (IPA), Institution Rehabilitation Services (IRS), Nursing Care Facility (NCF), and Youth Emergency Shelters (YES) regardless of the duration of the placements. Cases lasting less than 8 days are excluded.

Indicator 2.C.1: Of all children in substitute care at the end of the year, what percentage is in traditional foster homes?

Definition: All children in substitute care at the end of the fiscal year and the percentage living in traditional foster homes. The Traditional Foster Home category is

made up of Foster Home Boarding (FHB), Foster Home Indian (FHI), Foster Home Boarding Private Agency (FHP), and Foster Home Adoption (FHA).

Indicator 2.C.2: Of all children in substitute care at the end of the year, what percentage is in specialized foster homes?

Definition: All children in substitute care at the end of the fiscal year and the percentage living in specialized foster homes. The Specialized Foster Home category is made up of Foster Home Specialized (FHS) and Foster Home Treatment (FHT).

Indicator 2.C.3: Of all children in substitute care at the end of the year, what percentage is in kinship foster homes?

Definition: All children in substitute care at the end of the fiscal year and the percentage living in kinship foster homes. The Kinship Foster Home category is made up of Delegated Relative Authority (DRA) and Home of Relative (HMR).

Indicator 2.C.4: Of all children in substitute care at the end of the year, what percentage is in group homes?

Definition: All children in substitute care at the end of the fiscal year and the percentage living in group homes. The Group Home category is made up of Group Home (GRH).

Indicator 2.C.5: Of all children in substitute care at the end of the year, what percentage is in institutions?

Definition: All children in substitute care at the end of the fiscal year and the percentage living in institutions. The Institution category is made up of Detention Facility/Jail (DET), Institution DCFS (ICF), Institution Department of Corrections (IDC), Institution Depart-

ment of Mental Health (IMH), Institution Private Child Care Facility (IPA), Institution Rehabilitation Services (IRS), Nursing Care Facility (NCF), and Youth Emergency Shelters (YES).

Indicator 2.C.6: Of all children in substitute care at the end of the year, what percentage is in independent living?

Definition: All children in substitute care at the end of the fiscal year and the percentage living in independent living. The Independent Living category is made up of Community Integrated Living Arrangement (CIL), Independent Living Only (ILO), and Transitional Living Program (TLP).

Indicator 2.D: Of children placed into substitute care, what percentage is placed with their siblings in the first placement?

Definition: The percentage of children placed in the same home as all of their siblings in substitute care in their initial placement. Children with no siblings in substitute care are excluded from this analysis. Siblings of children in substitute care who are not in substitute care are also excluded. Siblings are defined as children who belong to a common family based on the ID number of the family.

Indicator 2.E: Of children in substitute care at the end of the year, what percentage is placed with their siblings?

Definition: The percentage of children placed in the same home as all of their siblings in substitute care at the end of the fiscal year. Children with no siblings in substitute care are excluded from this analysis. Siblings of children in substitute care who are not in substitute care are also excluded. Siblings are defined as children who belong to a common family based on the ID number of the family.

Indicator 2.F.1: Of all children entering substitute care and initially placed in traditional foster homes, what is the median distance from their home of origin to their initial placement?

Definition: For all children initially placed in traditional foster homes, this reports the median distance (in miles) from the child's home of origin to the child's initial placement. The Traditional Foster Home category is made up of Foster Home Boarding (FHB), Foster Home Indian (FHI), Foster Home Boarding Private Agency (FHP), and Foster Home Adoption (FHA). Only children with valid address data are used in the calculation of the median. Region and sub-region categories are based on where the case opened.

Indicator 2.F.2: Of all children entering substitute care and initially placed in specialized foster homes, what is the median distance from their home of origin to their initial placement?

Definition: For all children initially placed in specialized foster homes, this reports the median distance (in miles) from the child's home of origin to the child's initial placement. The Specialized Foster Home category is made up of Foster Home Specialized (FHS) and Foster Home Treatment (FHT). Only children with valid address data are used in the calculation of the median. Region and sub-region categories are based on where the case opened.

Indicator 2.F.3: Of all children entering substitute care and initially placed in kinship foster homes, what is the median distance from their home of origin to their initial placement?

Definition: For all children initially placed in kinship foster homes, this reports the median distance (in miles) from the child's home of origin to the child's initial placement. The Kinship Foster Home category is made up of Delegated Relative Authority (DRA) and Home of Relative (HMR). Only children with valid address data are used in the calculation of the median. Region and sub-region categories are based on where the case opened.

Indicator 2.F.4: Of all children entering substitute care and initially placed in a group home or institution, what is the median distance from their home of origin to their initial placement?

Definition: For all children initially placed in a group home or institution, this reports the median distance (in miles) from the child's home of origin to the child's initial placement. The Group Home or Institution category is made up of Group Home (GRH), Detention Facility/Jail (DET), Institution DCFS (ICF), Institution Department of Corrections (IDC), Institution Department of Mental Health (IMH), Institution Private Child Care Facility (IPA), Institution Rehabilitation Services (IRS), Nursing Care Facility (NCF), and Youth Emergency Shelters (YES). Only children with valid address data are used in the calculation of the median. Region and sub-region categories are based on where the case opened.

Indicator 2.G.1: Of all children in traditional foster homes at the end of the fiscal year, what is the median distance from their home of origin?

Definition: For all children living in traditional foster homes at the end of the fiscal year, this reports the median distance (in miles) from the child's home of origin to the child's placement at the end of the fiscal year. The Traditional Foster Home category is made up of Foster Home Boarding (FHB), Foster Home Indian (FHI), Foster Home Boarding Private Agency (FHP), and Foster Home Adoption (FHA). Only children with valid address data are used in the calculation of the median. Region and sub-region categories are based on where the case opened.

Indicator 2.G.2: Of all children in specialized foster homes at the end of the fiscal year, what is the median distance from their home of origin?

Definition: For all children living in specialized foster homes at the end of the fiscal year, this reports the median distance (in miles) from the child's home of origin to the child's placement at the end of the fiscal year. The Specialized Foster Home category is made

up of Foster Home Specialized (FHS) and Foster Home Treatment (FHT). Only children with valid address data are used in the calculation of the median. Region and sub-region categories are based on where the case opened.

Indicator 2.G.3: Of all children in kinship foster homes at the end of the fiscal year, what is the median distance from their home of origin?

Definition: For all children living in kinship foster homes at the end of the fiscal year, this reports the median distance (in miles) from the child's home of origin to the child's placement at the end of the fiscal year. The Kinship Foster Home category is made up of Delegated Relative Authority (DRA) and Home of Relative (HMR). Only children with valid address data are used in the calculation of the median. Region and sub-region categories are based on where the case opened.

Indicator 2.G.4: Of all children in group homes at the end of the fiscal year, what is the median distance from their home of origin?

Definition: For all children living in group homes at the end of the fiscal year, this reports the median distance (in miles) from the child's home of origin to the child's placement at the end of the fiscal year. The Group Home category is made up of Group Home (GRH). Only children with valid address data are used in the calculation of the median. Region and sub-region categories are based on where the case opened.

Indicator 2.G.5: Of all children in institutions at the end of the fiscal year, what is the median distance from their home of origin?

Definition: For all children living in institutions at the end of the fiscal year, this reports the median distance (in miles) from the child's home of origin to the child's placement at the end of the fiscal year. The

Institution category is made up of Detention Facility/Jail (DET), Institution DCFS (ICF), Institution Department of Corrections (IDC), Institution Department of Mental Health (IMH), Institution Private Child Care Facility (IPA), Institution Rehabilitation Services (IRS), Nursing Care Facility (NCF), and Youth Emergency Shelters (YES). Only children with valid address data are used in the calculation of the median. Region and sub-region categories are based on where the case opened.

Indicator 2.G.6: Of all children in independent living at the end of the fiscal year, what is the median distance from their home of origin?

Definition: For all children living in independent living at the end of the fiscal year, this reports the median distance (in miles) from the child's home of origin to the child's placement at the end of the fiscal year. The Independent Living category is made up of Community Integrated Living Arrangement (CIL), Independent Living Only (ILO), and Transitional Living Program (TLP). Only children with valid address data are used in the calculation of the median. Region and sub-region categories are based on where the case opened.

Indicator 2.H: Of all children entering substitute care and staying for at least one year, what percentage had two or fewer placements within a year of removal?

Definition: The percentage of children entering substitute care and staying for at least one year that have two or fewer placements within their first year in substitute care. The following placement types were excluded from the calculation of placement stability: run away, detention, respite care (defined as a placement of less than 30 days where the child returns to the same placement), hospital stays and placements coded as 'unknown whereabouts'. Entry into substitute care is counted as one placement, and each time a child moves, an additional placement is counted.

Indicator 2.I: Of all children entering care between ages 12 and 17, what percentage ran away from a substitute care placement during the year?

Definition: Children entering substitute care between the ages of 12 and 17 and the percentage that ran away from their substitute care placement during the year (one year from the case opening date). Runaway includes Runaway, Abducted and Whereabouts Unknown.

Indicator 2.J: Of children entering substitute care for the first time during that fiscal year, what is the median length of stay in substitute care?

Definition: The median number of months children stay in substitute care. In other words, the amount of time that it took for half of the children who entered substitute care in a given fiscal year to exit care, either through permanence (reunification, adoption, or subsidized guardianship) or emancipation. This indicator looks only at first spells and excludes spells lasting less than 8 days.

Chapter 3: Legal Permanence: Reunification, Adoption, and Guardianship

Indicator 3.A.1: Of all children who entered substitute care during the year, what percentage was reunified with their parents within 12 months from the date of entry into substitute care?

Definition: Of children who entered substitute care during the fiscal year, the percentage that was reunified within 12 months of entering substitute care. Cases lasting less than 8 days are excluded.

Indicator 3.A.2: Of all children who entered substitute care during the year, what percentage was adopted within 12 months from the date of entry into substitute care?

Definition: Of children who entered substitute care during the fiscal year, the percentage that was adopted within 12 months of entering substitute care. Cases lasting less than 8 days are excluded.

Indicator 3.A.3: Of all children who entered substitute care during the year, what percentage attained subsidized guardianship within 12 months from the date of entry into substitute care?

Definition: Of children who entered substitute care during the fiscal year, the percentage that attained subsidized guardianship within 12 months of entering substitute care. Cases lasting less than 8 days are excluded.

Indicator 3.B.1: Of all children who entered substitute care during the year, what percentage was reunified with their parents within 24 months from the date of entry into substitute care?

Definition: Of children who entered substitute care during the fiscal year, the percentage that was reunified within 24 months of entering substitute care. Cases lasting less than 8 days are excluded.

Indicator 3.B.2: Of all children who entered substitute care during the year, what percentage was adopted within 24 months from the date of entry into substitute care?

Definition: Of children who entered substitute care during the fiscal year, the percentage that was adopted within 24 months of entering substitute care. Cases lasting less than 8 days are excluded.

Indicator 3.B.3: Of all children who entered substitute care during the year, what percentage attained subsidized guardianship within 24 months from the date of entry into substitute care?

Definition: Of children who entered substitute care during the fiscal year, the percentage that attained subsidized guardianship within 24 months of entering substitute care. Cases lasting less than 8 days are excluded.

Indicator 3.C.1: Of all children who entered substitute care during the year, what percentage was reunified with their parents within 36 months from the date of entry into substitute care?

Definition: Of children who entered substitute care during the fiscal year, the percentage that was reunified within 36 months of entering substitute care. Cases lasting less than 8 days are excluded.

Indicator 3.C.2: Of all children who entered substitute care during the year, what percentage was adopted within 36 months from the date of entry into substitute care?

Definition: Of children who entered substitute care during the fiscal year, the percentage that was adopted within 36 months of entering substitute care. Cases lasting less than 8 days are excluded.

Indicator 3.C.3: Of all children who entered substitute care during the year, what percentage attained subsidized guardianship within 36 months from the date of entry into substitute care?

Definition: Of children who entered substitute care during the fiscal year, the percentage that attained subsidized guardianship within 36 months of entering substitute care. Cases lasting less than 8 days are excluded.

Indicator 3.D.1: Of all children who were reunified during the year, what percentage remained with their families at two years?

Definition: All children who were reunified with their biological family during the fiscal year and the percentage who remain with those families at two years. This is tracked through administrative data that allow us to determine if children re-enter substitute care. Cases lasting less than 8 days are excluded.

Indicator 3.D.2: Of all children who were adopted during the year, what percentage remained with their families at two years?

Definition: All children who have been adopted during the fiscal year and the percentage who remain in those adoptive placements at two years. This is tracked through administrative data that allow us to determine if children re-enter substitute care. Cases lasting less than 8 days are excluded.

Indicator 3.D.3: Of all children who attained subsidized guardianship during the year, what percentage remained with their families at two years?

Definition: All children who have entered a subsidized guardianship arrangement and the percentage who remain in those homes at two years. This is tracked through administrative data that allow us to determine if children re-enter substitute care. Cases lasting less than 8 days are excluded.

Indicator 3.E.1: Of all children who were reunified during the year, what percentage remained with their families at five years?

Definition: All children who were reunified with their biological family during the fiscal year and the percentage who remain with those families at five years. This is tracked through administrative data that allow us to

determine if children re-enter substitute care. Cases lasting less than 8 days are excluded.

Indicator 3.E.2: Of all children who were adopted during the year, what percentage remained with their families at five years?

Definition: All children who have been adopted during the fiscal year and the percentage who remain in those adoptive placements at five years. This is tracked through administrative data that allow us to determine if children re-enter substitute care. Cases lasting less than 8 days are excluded.

Indicator 3.E.3: Of all children who attained subsidized guardianship during the year, what percentage remained with their families at five years?

Definition: All children who have entered a subsidized guardianship arrangement and the percentage who remain in those homes at five years. This is tracked through administrative data that allow us to determine if children re-enter substitute care. Cases lasting less than 8 days are excluded.

Indicator 3.F.1: Of all children who were reunified during the year, what percentage remained with their families at ten years?

Definition: All children who were reunified with their biological family during the fiscal year and the percentage who remain with those families at ten years. This is tracked through administrative data that allow us to determine if children re-enter substitute care. Cases lasting less than 8 days are excluded.

Indicator 3.F.2: Of all children who were adopted during the year, what percentage remained with their families at ten years?

Definition: All children who have been adopted during the fiscal year and the percentage who remain in those adoptive placements at ten years. This is tracked through administrative data that allow us to determine if children re-enter substitute care. Cases lasting less than 8 days are excluded.

Indicator 3.F.3: Of all children who attained subsidized guardianship during the year, what percentage remained with their families at ten years?

Definition: All children who have entered a subsidized guardianship arrangement and the percentage who remain in those homes at ten years. This is tracked through administrative data that allow us to determine if children re-enter substitute care. Cases lasting less than 8 days are excluded.



APPENDIX B

Outcome Data by Region, Gender, Age and Race

Appendix B provides a more comprehensive look at the outcome indicators used in the following chapters of this report: Chapter 1 - Child Safety; Chapter 2 - Children in Substitute Care: Safety, Continuity, and Stability; and Chapter 3 - Legal Permanence: Reunification, Adoption, and Guardianship. The data used in these indicators come from the September 30, 2010 data extract of the Illinois Department of Children and Family Services Integrated Database. The indicators show Illinois totals and breakdowns by region, gender, age and race over a seven year period. The State Fiscal Year is used throughout this data. All indicator data are available on-line at: <http://www.cfr Illinois.edu/outcomeindicators.php>.

Maltreatment Recurrence at 12 Months

Indicator 1.A	Of all children with a substantiated report, what percentage had another substantiated report within 12 months?						
IN ILLINOIS:	2003	2004	2005	2006	2007	2008	2009
Children with Substantiated Report	25,839	25,782	25,937	24,857	26,510	27,859	27,391
Children with Another Substantiated Recurrence within 12 months	2,976	2,976	2,952	2,842	3,043	3,214	3,012
Percent	11.5%	11.5%	11.4%	11.4%	11.5%	11.5%	11.0%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	2,976	11.5%	2,976	11.5%	2,952	11.4%	2,842	11.4%	3,043	11.5%	3,214	11.5%	3,012	11.0%
Central	1,092	14.7%	1,136	13.7%	1,082	13.2%	989	12.9%	1,146	13.9%	1,099	13.2%	1,074	12.8%
Cook	748	8.4%	680	8.7%	624	8.2%	641	8.7%	617	8.2%	660	8.5%	622	8.4%
Northern	549	9.6%	571	10.0%	620	10.3%	653	10.7%	687	10.1%	875	11.2%	771	9.8%
Southern	587	15.3%	587	15.0%	626	15.1%	559	14.9%	593	14.8%	580	14.5%	545	14.5%

Female	1,448	10.9%	1,466	11.2%	1,476	11.1%	1,328	10.5%	1,481	11.1%	1,608	11.4%	1,494	10.6%
Male	1,524	12.3%	1,504	12.0%	1,472	11.8%	1,507	12.5%	1,555	12.0%	1,598	11.8%	1,510	11.5%

Under 3	812	11.5%	844	11.8%	887	12.3%	816	11.4%	902	11.9%	1,024	12.4%	927	11.4%
3 to 5	646	13.0%	701	13.7%	667	12.7%	668	13.5%	705	13.0%	710	12.6%	717	12.9%
6 to 8	581	12.7%	542	12.3%	565	12.6%	579	13.4%	564	11.9%	577	12.1%	540	11.5%
9 to 11	467	11.7%	421	10.9%	382	10.5%	382	11.0%	418	11.8%	444	11.6%	392	10.6%
12 to 14	330	10.1%	314	9.4%	311	9.4%	264	9.0%	290	9.6%	298	9.3%	261	8.7%
15 and Older	139	7.0%	154	8.2%	138	6.9%	133	6.8%	164	7.6%	161	7.6%	175	7.7%

African American	937	10.1%	914	10.4%	891	10.2%	847	10.1%	917	10.4%	1,017	11.1%	908	10.2%
Hispanic	182	8.7%	135	6.4%	137	6.9%	188	9.2%	188	8.5%	166	7.3%	165	7.6%
Other	106	11.9%	75	8.4%	100	10.7%	77	8.6%	84	8.5%	135	11.5%	118	9.1%
White	1,751	12.9%	1,852	13.2%	1,824	12.7%	1,730	12.8%	1,854	12.8%	1,896	12.4%	1,821	12.1%

Maltreatment Recurrence Among Intact Family Cases

Indicator 1.B	Of all children served at home in intact family cases, what percentage had another substantiated report within 12 months?						
IN ILLINOIS:	2003	2004	2005	2006	2007	2008	2009
Number of Children in Intact Family Cases	20,011	20,033	19,317	17,197	16,502	15,520	15,793
Children with Substantiated Report	2,071	2,083	2,100	1,895	1,957	1,882	1,752
Percent	10.3%	10.4%	10.9%	11.0%	11.9%	12.1%	11.1%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	2,071	10.3%	2,083	10.4%	2,100	10.9%	1,895	11.0%	1,957	11.9%	1,882	12.1%	1,752	11.1%
Central	858	13.5%	855	12.4%	900	14.0%	809	13.8%	710	15.5%	535	13.9%	581	15.6%
Cook	573	6.8%	531	6.8%	495	6.5%	414	6.3%	531	7.4%	488	7.7%	454	6.8%
Northern	285	10.2%	321	11.3%	340	13.3%	340	14.0%	314	13.0%	468	15.5%	357	11.2%
Southern	355	15.0%	376	15.4%	365	13.6%	332	14.1%	402	17.2%	391	16.6%	360	16.1%

Female	1,035	10.3%	1,005	10.2%	1,006	10.6%	881	10.4%	947	11.6%	866	11.4%	868	11.1%
Male	1,034	10.3%	1,075	10.5%	1,091	11.1%	1,014	11.7%	1,007	12.2%	1,012	12.9%	882	11.1%

Under 3	687	14.7%	651	14.1%	738	15.8%	638	14.6%	669	16.0%	700	17.5%	622	15.5%
3 to 5	424	11.7%	495	13.3%	449	12.6%	443	13.2%	409	13.2%	413	13.8%	416	13.7%
6 to 8	369	10.5%	372	11.1%	382	11.7%	359	12.5%	358	12.6%	316	12.1%	299	11.5%
9 to 11	301	9.4%	279	8.8%	246	8.7%	240	9.9%	262	11.6%	228	10.7%	206	9.5%
12 to 14	218	8.0%	215	7.7%	212	8.0%	166	7.7%	188	9.0%	155	8.0%	139	7.4%
15 and Older	72	3.2%	71	2.9%	73	3.1%	49	2.4%	71	3.5%	70	3.8%	70	3.3%

African American	653	7.7%	721	8.6%	685	8.4%	589	8.1%	758	10.3%	655	10.2%	581	8.7%
Hispanic	139	6.4%	122	7.2%	121	7.3%	122	8.4%	131	8.3%	143	9.2%	96	6.3%
Other	45	10.4%	41	8.1%	59	12.0%	26	6.3%	29	6.1%	45	10.4%	50	8.0%
White	1,234	13.8%	1,199	12.7%	1,235	13.7%	1,158	14.3%	1,039	14.7%	1,039	14.6%	1,025	14.7%

Maltreatment Recurrence Among Families Receiving No Services

Indicator 1.C	Of all children in an initial substantiated report that did not receive intact or substitute care services, what percentage had another substantiated report within 12 months?						
IN ILLINOIS	2003	2004	2005	2006	2007	2008	2009
Number of Children not Receiving Services	14,146	13,848	13,785	14,058	15,982	16,677	16,464
Children with Substantiated Report	1,590	1,522	1,514	1,577	1,711	1,846	1,806
Percent	11.2%	11.0%	11.0%	11.2%	10.7%	11.1%	11.0%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	1,590	11.2%	1,522	11.0%	1,514	11.0%	1,577	11.2%	1,711	10.7%	1,846	11.1%	1,806	11.0%
Central	520	14.5%	518	12.7%	520	12.7%	537	13.6%	653	14.1%	682	13.7%	679	13.3%
Cook	431	9.2%	389	9.5%	311	8.6%	366	9.1%	340	7.7%	389	8.8%	351	8.4%
Northern	375	9.5%	347	9.3%	382	9.3%	407	9.6%	432	8.9%	510	9.7%	509	9.7%
Southern	263	13.6%	268	13.9%	301	15.3%	267	14.6%	286	13.7%	265	13.0%	267	13.8%

Female	795	10.7%	755	10.4%	752	10.5%	756	10.4%	847	10.4%	942	10.9%	920	10.8%
Male	795	11.8%	767	11.6%	762	11.5%	821	12.1%	864	11.1%	904	11.3%	886	11.1%

Under 3	476	14.7%	496	15.1%	472	15.0%	473	14.0%	559	14.0%	629	14.3%	625	14.4%
3 to 5	329	11.9%	333	11.8%	335	11.6%	369	13.3%	380	11.4%	400	11.8%	416	12.2%
6 to 8	305	11.9%	256	10.4%	275	11.1%	289	11.3%	290	9.9%	343	11.7%	281	9.9%
9 to 11	241	10.5%	206	9.6%	205	9.9%	224	10.4%	214	9.6%	233	9.8%	226	9.7%
12 to 14	176	9.0%	154	8.0%	164	8.3%	153	8.2%	176	8.8%	162	7.7%	177	8.7%
15 and Older	58	4.5%	73	6.3%	60	4.8%	69	5.3%	89	6.1%	78	5.3%	79	5.2%

African American	548	11.7%	466	10.9%	468	11.4%	488	11.5%	482	9.8%	599	12.0%	542	11.1%
Hispanic	116	8.6%	88	6.7%	82	6.8%	123	8.7%	118	7.7%	96	6.3%	100	7.5%
Other	52	10.3%	37	7.0%	42	8.1%	38	6.9%	44	7.0%	66	8.9%	72	9.7%
White	874	11.5%	931	12.0%	922	11.6%	928	11.8%	1,067	12.0%	1,085	11.5%	1,092	11.5%

Maltreatment Recurrence in Substitute Care

Indicator 2.A	Of all children ever served in substitute care during the year, what percentage had a substantiated report during placement?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
Children ever in Substitute Care	26,305	24,970	23,465	22,471	22,119	21,756	21,573
Children with Substantiated Reports	332	324	257	302	340	354	314
Percent	1.3%	1.3%	1.1%	1.3%	1.5%	1.6%	1.5%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	332	1.3%	324	1.3%	257	1.1%	302	1.3%	340	1.5%	354	1.6%	314	1.5%
Central	112	1.8%	124	2.0%	70	1.2%	100	1.6%	112	1.8%	131	2.2%	125	2.1%
Cook	132	0.9%	114	0.9%	91	0.8%	96	0.9%	80	0.8%	90	1.0%	68	0.8%
Northern	53	1.6%	53	1.6%	46	1.3%	51	1.5%	74	2.0%	85	2.1%	54	1.3%
Southern	35	1.5%	33	1.3%	50	1.9%	55	2.1%	74	2.8%	48	1.8%	67	2.2%

Female	148	1.2%	151	1.3%	105	1.0%	158	1.5%	168	1.6%	180	1.7%	136	1.3%
Male	184	1.3%	171	1.3%	152	1.2%	142	1.2%	170	1.5%	173	1.5%	178	1.6%

Under 3	131	1.4%	134	1.5%	117	1.3%	125	1.5%	141	1.7%	144	1.7%	144	1.7%
3 to 5	76	1.6%	72	1.6%	59	1.4%	72	1.8%	63	1.6%	73	1.9%	67	1.8%
6 to 8	58	1.4%	47	1.2%	33	0.9%	44	1.3%	61	1.9%	56	1.9%	52	1.8%
9 to 11	39	1.1%	39	1.2%	20	0.7%	30	1.1%	41	1.6%	37	1.5%	30	1.3%
12 to 14	26	0.9%	26	0.9%	23	0.9%	22	0.8%	27	1.1%	35	1.4%	19	0.7%
15 and Older	2	0.2%	6	0.5%	5	0.4%	9	0.6%	7	0.5%	9	0.6%	2	0.1%

African American	186	1.1%	156	1.0%	128	0.9%	152	1.1%	166	1.3%	179	1.5%	158	1.3%
Hispanic	18	1.3%	17	1.2%	12	0.9%	13	1.0%	23	1.7%	16	1.2%	17	1.4%
Other	8	1.6%	8	1.7%	6	1.4%	6	1.4%	7	1.8%	5	1.3%	5	1.3%
White	120	1.6%	143	1.9%	111	1.5%	131	1.8%	144	1.9%	154	2.0%	134	1.6%

Initial Placement - Traditional Foster Home

Indicator 2.B.1	Of all children entering substitute care, what percentage is placed in a traditional foster home in their first placement?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
Entering Substitute Care	5,034	5,299	4,771	4,504	5,211	4,817	4,987
Placed in Traditional Foster Home	2,016	2,002	1,843	1,621	1,605	1,438	1,256
Percent	40.0%	37.8%	38.6%	36.0%	30.8%	29.9%	25.2%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	2,016	40.0%	2,002	37.8%	1,843	38.6%	1,621	36.0%	1,605	30.8%	1,438	29.9%	1,256	25.2%
Central	763	47.6%	700	43.8%	664	43.1%	639	38.1%	598	33.5%	599	37.4%	567	33.4%
Cook	455	26.5%	458	24.1%	376	27.0%	305	25.7%	321	21.2%	216	17.7%	218	16.3%
Northern	437	47.7%	422	45.3%	371	37.8%	293	36.4%	332	31.3%	316	27.5%	266	25.9%
Southern	361	45.1%	422	48.6%	432	50.2%	384	46.1%	354	41.7%	307	36.3%	205	22.2%

Female	987	41.6%	1,015	39.0%	914	39.0%	828	37.7%	786	31.3%	726	30.3%	613	25.9%
Male	1,028	38.7%	984	36.6%	925	38.3%	793	34.4%	817	30.4%	711	29.4%	643	24.6%

Under 3	835	44.1%	852	41.7%	806	42.6%	713	40.4%	729	35.4%	695	36.1%	647	32.0%
3 to 5	288	37.7%	294	36.3%	299	38.7%	227	32.9%	225	26.6%	207	27.5%	196	24.4%
6 to 8	236	37.2%	233	35.7%	196	34.0%	202	36.1%	177	28.3%	165	27.9%	111	18.7%
9 to 11	226	38.4%	228	38.3%	161	36.2%	141	30.8%	144	28.3%	129	26.9%	85	18.8%
12 to 14	244	35.4%	221	33.2%	216	35.0%	161	29.9%	161	27.6%	124	22.3%	115	20.7%
15 and Older	187	40.0%	174	32.6%	164	35.2%	177	35.9%	169	28.8%	118	23.0%	102	18.2%

African American	908	36.0%	914	34.0%	885	38.0%	744	34.7%	711	29.2%	614	28.6%	512	24.0%
Hispanic	85	35.6%	102	32.7%	72	30.0%	78	32.1%	77	25.8%	61	22.8%	56	22.1%
Other	33	40.2%	33	29.7%	24	27.6%	27	33.8%	45	44.6%	33	29.2%	23	18.5%
White	990	45.2%	953	43.6%	862	40.8%	772	38.0%	772	32.5%	730	31.8%	665	26.9%

Initial Placement - Specialized Foster Home

Indicator 2.B.2	Of all children entering substitute care, what percentage is placed in a specialized foster home in their first placement?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
Entering Substitute Care	5,034	5,299	4,771	4,504	5,211	4,817	4,987
Placed in Specialized Foster Home	139	158	205	119	136	146	124
Percent	2.8%	3.0%	4.3%	2.6%	2.6%	3.0%	2.5%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	139	2.8%	158	3.0%	205	4.3%	119	2.6%	136	2.6%	146	3.0%	124	2.5%
Central	79	4.9%	77	4.8%	92	6.0%	34	2.0%	29	1.6%	44	2.8%	47	2.8%
Cook	37	2.2%	59	3.1%	71	5.1%	43	3.6%	58	3.8%	51	4.2%	34	2.5%
Northern	6	0.7%	13	1.4%	11	1.1%	12	1.5%	25	2.4%	22	1.9%	26	2.5%
Southern	17	2.1%	9	1.0%	31	3.6%	30	3.6%	24	2.8%	29	3.4%	17	1.8%

Female	80	3.4%	68	2.6%	116	4.9%	52	2.4%	65	2.6%	68	2.8%	57	2.4%
Male	59	2.2%	90	3.3%	89	3.7%	67	2.9%	71	2.6%	78	3.2%	67	2.6%

Under 3	61	3.2%	73	3.6%	91	4.8%	30	1.7%	44	2.1%	42	2.2%	46	2.3%
3 to 5	12	1.6%	16	2.0%	18	2.3%	7	1.0%	7	0.8%	8	1.1%	3	0.4%
6 to 8	9	1.4%	16	2.5%	19	3.3%	10	1.8%	9	1.4%	14	2.4%	10	1.7%
9 to 11	14	2.4%	16	2.7%	16	3.6%	13	2.8%	19	3.7%	21	4.4%	11	2.4%
12 to 14	28	4.1%	21	3.2%	30	4.9%	29	5.4%	30	5.1%	33	5.9%	30	5.4%
15 and Older	15	3.2%	16	3.0%	31	6.7%	30	6.1%	27	4.6%	28	5.4%	24	4.3%

African American	78	3.1%	88	3.3%	117	5.0%	55	2.6%	66	2.7%	67	3.1%	49	2.3%
Hispanic	3	1.3%	5	1.6%	4	1.7%	3	1.2%	13	4.4%	5	1.9%	3	1.2%
Other	1	1.2%	4	3.6%	4	4.6%	2	2.5%	2	2.0%	7	6.2%	3	2.4%
White	57	2.6%	61	2.8%	80	3.8%	59	2.9%	55	2.3%	67	2.9%	69	2.8%

Initial Placement - Kinship Foster Home

Indicator 2.B.3	Of all children entering substitute care, what percentage is placed in a kinship foster home in their first placement?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
Entering Substitute Care	5,034	5,299	4,771	4,504	5,211	4,817	4,987
Placed in Kinship Foster Home	2,160	2,332	2,086	2,176	2,643	2,472	2,689
Percent	42.9%	44.0%	43.7%	48.3%	50.7%	51.3%	53.9%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	2,160	42.9%	2,332	44.0%	2,086	43.7%	2,176	48.3%	2,643	50.7%	2,472	51.3%	2,689	53.9%
Central	689	43.0%	745	46.6%	720	46.8%	949	56.6%	1,078	60.4%	890	55.6%	988	58.2%
Cook	673	39.3%	745	39.1%	481	34.6%	425	35.7%	526	34.7%	405	33.2%	529	39.5%
Northern	411	44.8%	436	46.8%	522	53.2%	424	52.7%	604	57.0%	703	61.1%	635	61.8%
Southern	387	48.4%	406	46.8%	363	42.2%	378	45.4%	435	51.2%	474	56.0%	537	58.2%

Female	1,025	43.2%	1,173	45.1%	1,062	45.3%	1,056	48.1%	1,308	52.1%	1,282	53.5%	1,311	55.3%
Male	1,133	42.7%	1,153	42.9%	1,020	42.3%	1,117	48.4%	1,327	49.3%	1,188	49.1%	1,377	52.7%

Under 3	799	42.2%	932	45.6%	838	44.3%	893	50.7%	1,068	51.8%	1,011	52.6%	1,108	54.9%
3 to 5	382	50.1%	417	51.5%	391	50.6%	409	59.2%	538	63.5%	465	61.8%	513	63.8%
6 to 8	306	48.2%	320	49.0%	306	53.1%	310	55.4%	377	60.2%	361	61.1%	383	64.4%
9 to 11	271	46.1%	277	46.6%	203	45.6%	238	52.0%	268	52.8%	267	55.6%	269	59.5%
12 to 14	265	38.5%	230	34.5%	215	34.8%	192	35.6%	224	38.4%	212	38.1%	240	43.2%
15 and Older	137	29.3%	156	29.3%	133	28.5%	134	27.2%	168	28.6%	156	30.4%	176	31.4%

African American	1,042	41.3%	1,121	41.7%	925	39.7%	976	45.5%	1,106	45.4%	982	45.8%	1,090	51.0%
Hispanic	96	40.2%	131	42.0%	94	39.2%	92	37.9%	144	48.3%	130	48.5%	126	49.8%
Other	37	45.1%	51	45.9%	51	58.6%	51	63.8%	40	39.6%	59	52.2%	73	58.9%
White	985	44.9%	1,029	47.0%	1,016	48.1%	1,057	52.0%	1,353	56.9%	1,301	56.8%	1,400	56.6%

Initial Placement - Group Home/Institution

Indicator 2.B.4	Of all children entering substitute care, what percentage is placed in a group home or institution in their first placement?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
Entering Substitute Care	5,034	5,299	4,771	4,504	5,211	4,817	4,987
Placed in Group Home or Institution	719	807	637	588	827	761	918
Percent	14.3%	15.2%	13.4%	13.1%	15.9%	15.8%	18.4%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	719	14.3%	807	15.2%	637	13.4%	588	13.1%	827	15.9%	761	15.8%	918	18.4%
Central	72	4.5%	75	4.7%	63	4.1%	56	3.3%	80	4.5%	67	4.2%	95	5.6%
Cook	549	32.0%	641	33.7%	463	33.3%	416	35.0%	612	40.3%	548	44.9%	559	41.7%
Northern	63	6.9%	60	6.4%	77	7.8%	75	9.3%	99	9.3%	110	9.6%	100	9.7%
Southern	35	4.4%	31	3.6%	34	4.0%	41	4.9%	36	4.2%	36	4.3%	164	17.8%

Female	283	11.9%	347	13.3%	253	10.8%	259	11.8%	352	14.0%	319	13.3%	389	16.4%
Male	436	16.4%	460	17.1%	380	15.7%	329	14.3%	474	17.6%	441	18.2%	528	20.2%

Under 3	197	10.4%	185	9.1%	158	8.3%	127	7.2%	219	10.6%	175	9.1%	219	10.8%
3 to 5	81	10.6%	83	10.2%	65	8.4%	48	6.9%	77	9.1%	73	9.7%	92	11.4%
6 to 8	84	13.2%	84	12.9%	55	9.5%	38	6.8%	63	10.1%	51	8.6%	91	15.3%
9 to 11	77	13.1%	74	12.4%	65	14.6%	66	14.4%	77	15.2%	63	13.1%	87	19.2%
12 to 14	152	22.1%	194	29.1%	156	25.3%	157	29.1%	168	28.8%	187	33.6%	171	30.8%
15 and Older	128	27.4%	187	35.1%	138	29.6%	152	30.8%	223	38.0%	212	41.2%	258	46.1%

African American	493	19.6%	565	21.0%	405	17.4%	372	17.3%	552	22.7%	481	22.4%	486	22.7%
Hispanic	55	23.0%	74	23.7%	70	29.2%	70	28.8%	64	21.5%	72	26.9%	68	26.9%
Other	11	13.4%	23	20.7%	8	9.2%	0	0.0%	14	13.9%	14	12.4%	25	20.2%
White	160	7.3%	145	6.6%	154	7.3%	146	7.2%	197	8.3%	194	8.5%	339	13.7%

End of Year Placements - Traditional Foster Home

Indicator 2.C.1	Of all children in substitute care at the end of the year, what percentage is in traditional foster homes?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
In Substitute Care	20,089	19,317	18,430	17,246	17,373	16,906	16,533
Living in Traditional Foster Home	6,694	6,166	5,521	5,104	4,790	4,722	4,376
Percent	33.3%	31.9%	30.0%	29.6%	27.6%	27.9%	26.5%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	6,694	33.3%	6,166	31.9%	5,521	30.0%	5,104	29.6%	4,790	27.6%	4,722	27.9%	4,376	26.5%
Central	1,578	33.4%	1,503	31.7%	1,387	29.0%	1,332	28.6%	1,233	25.7%	1,336	28.9%	1,298	29.1%
Cook	3,383	30.1%	2,972	29.0%	2,484	27.2%	2,157	26.4%	1,972	25.3%	1,719	24.1%	1,487	22.0%
Northern	1,030	42.4%	1,007	39.5%	964	35.4%	877	34.0%	854	30.2%	906	29.7%	853	28.1%
Southern	703	41.4%	684	38.6%	686	38.3%	738	39.7%	731	37.7%	761	36.2%	738	32.5%

Female	3,285	34.4%	3,064	33.3%	2,784	31.8%	2,572	31.4%	2,383	28.8%	2,404	29.7%	2,242	28.4%
Male	3,407	32.3%	3,098	30.7%	2,728	28.3%	2,524	27.9%	2,397	26.4%	2,309	26.3%	2,129	24.7%

Under 3	1,574	49.2%	1,529	46.7%	1,461	45.1%	1,366	44.8%	1,340	42.1%	1,350	43.0%	1,325	41.8%
3 to 5	1,403	46.8%	1,302	44.2%	1,198	40.7%	1,127	41.3%	1,091	38.4%	1,141	39.2%	1,102	37.3%
6 to 8	1,065	43.8%	974	42.9%	861	39.0%	830	38.0%	723	33.0%	755	34.9%	683	32.0%
9 to 11	899	37.0%	811	37.1%	660	33.7%	565	32.1%	536	29.8%	487	27.5%	447	25.9%
12 to 14	816	29.5%	707	27.2%	619	27.1%	550	26.3%	481	24.8%	420	23.2%	358	21.1%
15 and Older	937	15.0%	843	14.0%	722	12.5%	666	12.2%	619	11.4%	569	11.1%	461	9.5%

African American	3,959	29.9%	3,597	28.9%	3,202	27.7%	2,865	27.2%	2,671	25.6%	2,520	25.9%	2,211	24.0%
Hispanic	479	42.2%	422	38.2%	369	35.0%	338	32.6%	314	30.8%	289	29.5%	273	29.2%
Other	146	40.6%	141	39.4%	125	36.7%	113	36.8%	92	34.2%	99	35.7%	89	33.0%
White	2,110	39.4%	2,006	37.0%	1,825	33.2%	1,788	33.2%	1,713	30.3%	1,814	30.7%	1,803	29.4%

End of Year Placements - Specialized Foster Home

Indicator 2.C.2	Of all children in substitute care at the end of the year, what percentage is in specialized foster homes?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
In Substitute Care	20,089	19,317	18,430	17,246	17,373	16,906	16,533
Living in Specialized Foster Home	2,931	2,813	3,112	2,850	2,882	2,973	2,840
Percent	14.6%	14.6%	16.9%	16.5%	16.6%	17.6%	17.2%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	2,931	14.6%	2,813	14.6%	3,112	16.9%	2,850	16.5%	2,882	16.6%	2,973	17.6%	2,840	17.2%
Central	832	17.6%	768	16.2%	807	16.9%	614	13.2%	600	12.5%	611	13.2%	622	13.9%
Cook	1,702	15.1%	1,611	15.7%	1,774	19.4%	1,663	20.4%	1,652	21.2%	1,669	23.4%	1,534	22.7%
Northern	230	9.5%	253	9.9%	307	11.3%	332	12.9%	359	12.7%	417	13.7%	422	13.9%
Southern	167	9.8%	181	10.2%	224	12.5%	241	13.0%	271	14.0%	276	13.1%	262	11.6%

Female	1,200	12.6%	1,159	12.6%	1,334	15.2%	1,178	14.4%	1,217	14.7%	1,272	15.7%	1,200	15.2%
Male	1,730	16.4%	1,652	16.4%	1,777	18.4%	1,672	18.5%	1,665	18.4%	1,699	19.3%	1,638	19.0%

Under 3	234	7.3%	259	7.9%	297	9.2%	237	7.8%	229	7.2%	218	6.9%	221	7.0%
3 to 5	290	9.7%	276	9.4%	362	12.3%	282	10.3%	323	11.4%	338	11.6%	327	11.1%
6 to 8	315	13.0%	286	12.6%	366	16.6%	358	16.4%	411	18.7%	395	18.3%	398	18.7%
9 to 11	485	19.9%	403	18.4%	421	21.5%	389	22.1%	392	21.8%	438	24.7%	429	24.8%
12 to 14	696	25.1%	653	25.1%	598	26.2%	561	26.8%	514	26.5%	498	27.6%	448	26.4%
15 and Older	911	14.6%	936	15.5%	1,068	18.4%	1,023	18.8%	1,013	18.7%	1,086	21.2%	1,017	21.0%

African American	2,006	15.1%	1,913	15.4%	2,090	18.1%	1,905	18.1%	1,904	18.3%	1,908	19.6%	1,785	19.4%
Hispanic	132	11.6%	124	11.2%	147	13.9%	141	13.6%	157	15.4%	187	19.1%	175	18.7%
Other	51	14.2%	50	14.0%	45	13.2%	39	12.7%	37	13.8%	44	15.9%	47	17.4%
White	742	13.9%	726	13.4%	830	15.1%	765	14.2%	784	13.8%	834	14.1%	833	13.6%

End of Year Placements - Kinship Foster Home

Indicator 2.C.3	Of all children in substitute care at the end of the year, what percentage is in kinship foster homes?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
In Substitute Care	20,089	19,317	18,430	17,246	17,373	16,906	16,533
Living in Kinship Foster Home	6,831	6,732	6,301	5,956	6,297	6,069	6,233
Percent	34.0%	34.9%	34.2%	34.5%	36.2%	35.9%	37.7%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	6,831	34.0%	6,732	34.9%	6,301	34.2%	5,956	34.5%	6,297	36.2%	6,069	35.9%	6,233	37.7%
Central	1,391	29.5%	1,483	31.3%	1,564	32.7%	1,724	37.1%	1,867	38.9%	1,782	38.5%	1,828	41.0%
Cook	3,918	34.9%	3,569	34.8%	2,928	32.0%	2,485	30.5%	2,450	31.4%	2,110	29.6%	2,063	30.5%
Northern	877	36.1%	968	37.9%	1,106	40.6%	1,049	40.7%	1,239	43.8%	1,326	43.5%	1,325	43.6%
Southern	645	37.9%	712	40.2%	703	39.3%	698	37.5%	741	38.3%	851	40.4%	1,017	44.8%

Female	3,390	35.5%	3,293	35.8%	3,019	34.5%	2,916	35.6%	3,085	37.3%	3,012	37.2%	3,063	38.8%
Male	3,436	32.6%	3,431	34.0%	3,268	33.9%	3,025	33.5%	3,197	35.3%	3,049	34.7%	3,166	36.7%

Under 3	1,375	43.0%	1,476	45.1%	1,473	45.5%	1,439	47.2%	1,604	50.4%	1,560	49.7%	1,616	51.0%
3 to 5	1,292	43.1%	1,360	46.1%	1,374	46.6%	1,306	47.9%	1,415	49.8%	1,419	48.8%	1,520	51.4%
6 to 8	1,022	42.1%	980	43.2%	949	42.9%	955	43.8%	1,019	46.4%	979	45.3%	1,014	47.5%
9 to 11	924	38.0%	878	40.2%	794	40.6%	709	40.3%	753	41.8%	726	41.0%	729	42.2%
12 to 14	825	29.8%	836	32.2%	683	29.9%	629	30.1%	616	31.8%	554	30.7%	558	32.9%
15 and Older	1,393	22.3%	1,202	19.9%	1,028	17.7%	918	16.9%	890	16.4%	831	16.2%	796	16.4%

African American	4,670	35.3%	4,327	34.8%	3,762	32.6%	3,404	32.4%	3,488	33.5%	3,187	32.7%	3,146	34.2%
Hispanic	336	29.6%	361	32.7%	356	33.8%	375	36.2%	368	36.1%	325	33.1%	331	35.4%
Other	124	34.4%	118	33.0%	132	38.7%	116	37.8%	107	39.8%	113	40.8%	112	41.5%
White	1,701	31.8%	1,926	35.5%	2,051	37.3%	2,061	38.3%	2,334	41.2%	2,444	41.4%	2,644	43.2%

End of Year Placements - Group Home

Indicator 2.C.4	Of all children in substitute care at the end of the year, what percentage is in group homes?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
In Substitute Care	20,089	19,317	18,430	17,246	17,373	16,906	16,533
Living in Group Home	359	354	311	278	275	266	253
Percent	1.8%	1.8%	1.7%	1.6%	1.6%	1.6%	1.5%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	359	1.8%	354	1.8%	311	1.7%	278	1.6%	275	1.6%	266	1.6%	253	1.5%
Central	59	1.2%	68	1.4%	48	1.0%	46	1.0%	48	1.0%	45	1.0%	41	0.9%
Cook	244	2.2%	226	2.2%	187	2.0%	177	2.2%	161	2.1%	166	2.3%	151	2.2%
Northern	50	2.1%	49	1.9%	55	2.0%	39	1.5%	47	1.7%	48	1.6%	59	1.9%
Southern	6	0.4%	11	0.6%	21	1.2%	16	0.9%	19	1.0%	7	0.3%	2	0.1%

Female	134	1.4%	111	1.2%	95	1.1%	84	1.0%	86	1.0%	92	1.1%	93	1.2%
Male	225	2.1%	243	2.4%	216	2.2%	194	2.1%	189	2.1%	174	2.0%	160	1.9%

Under 3	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
3 to 5	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
6 to 8	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
9 to 11	17	0.7%	14	0.6%	10	0.5%	13	0.7%	7	0.4%	10	0.6%	13	0.8%
12 to 14	66	2.4%	61	2.3%	55	2.4%	56	2.7%	42	2.2%	41	2.3%	31	1.8%
15 and Older	271	4.3%	269	4.5%	239	4.1%	200	3.7%	214	4.0%	204	4.0%	204	4.2%

African American	221	1.7%	231	1.9%	194	1.7%	184	1.7%	172	1.7%	175	1.8%	157	1.7%
Hispanic	32	2.8%	20	1.8%	20	1.9%	19	1.8%	16	1.6%	18	1.8%	16	1.7%
Other	1	0.3%	8	2.2%	1	0.3%	2	0.7%	1	0.4%	0	0.0%	0	0.0%
White	105	2.0%	95	1.8%	96	1.7%	73	1.4%	86	1.5%	73	1.2%	80	1.3%

Note: The youngest three age categories (8 years and younger) were replaced with NA because over the past 7 years there have been 12 or fewer children in these combined age categories in any given year.

End of Year Placements - Institution

Indicator 2.C.5	Of all children in substitute care at the end of the year, what percentage is in institutions?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
In Substitute Care	20,089	19,317	18,430	17,246	17,373	16,906	16,533
Living in Institution	1,640	1,521	1,457	1,360	1,422	1,456	1,509
Percent	8.2%	7.9%	7.9%	7.9%	8.2%	8.6%	9.1%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	1,640	8.2%	1,521	7.9%	1,457	7.9%	1,360	7.9%	1,422	8.2%	1,456	8.6%	1,509	9.1%
Central	335	7.1%	297	6.3%	311	6.5%	279	6.0%	316	6.6%	298	6.4%	327	7.3%
Cook	975	8.7%	897	8.7%	839	9.2%	781	9.6%	759	9.7%	754	10.6%	742	11.0%
Northern	190	7.8%	200	7.8%	206	7.6%	203	7.9%	242	8.6%	264	8.7%	264	8.7%
Southern	140	8.2%	127	7.2%	101	5.6%	97	5.2%	105	5.4%	140	6.7%	176	7.8%

Female	452	4.7%	451	4.9%	422	4.8%	409	5.0%	455	5.5%	469	5.8%	486	6.2%
Male	1,187	11.3%	1,069	10.6%	1,034	10.7%	951	10.5%	967	10.7%	987	11.2%	1,022	11.8%

Under 3	17	0.5%	7	0.2%	4	0.1%	4	0.1%	7	0.2%	7	0.2%	9	0.3%
3 to 5	15	0.5%	7	0.2%	13	0.4%	10	0.4%	10	0.4%	9	0.3%	9	0.3%
6 to 8	25	1.0%	27	1.2%	29	1.3%	33	1.5%	34	1.5%	27	1.2%	34	1.6%
9 to 11	108	4.4%	80	3.7%	73	3.7%	82	4.7%	113	6.3%	110	6.2%	111	6.4%
12 to 14	362	13.1%	340	13.1%	324	14.2%	292	14.0%	283	14.6%	293	16.2%	302	17.8%
15 and Older	1,113	17.8%	1,060	17.6%	1,014	17.5%	939	17.3%	975	18.0%	1,010	19.7%	1,044	21.6%

African American	1,121	8.5%	1,039	8.4%	958	8.3%	877	8.3%	910	8.7%	905	9.3%	903	9.8%
Hispanic	72	6.3%	81	7.3%	80	7.6%	72	6.9%	70	6.9%	72	7.3%	74	7.9%
Other	22	6.1%	16	4.5%	16	4.7%	13	4.2%	17	6.3%	8	2.9%	7	2.6%
White	425	7.9%	385	7.1%	403	7.3%	398	7.4%	425	7.5%	471	8.0%	525	8.6%

End of Year Placements - Independent Living

Indicator 2.C.6	Of all children in substitute care at the end of the year, what percentage is in independent living?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
In Substitute Care	20,089	19,317	18,430	17,246	17,373	16,906	16,533
Living in Independent Living	1,634	1,731	1,728	1,698	1,707	1,420	1,322
Percent	8.1%	9.0%	9.4%	9.8%	9.8%	8.4%	8.0%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	1,634	8.1%	1,731	9.0%	1,728	9.4%	1,698	9.8%	1,707	9.8%	1,420	8.4%	1,322	8.0%
Central	527	11.2%	619	13.1%	659	13.8%	657	14.1%	738	15.4%	552	11.9%	345	7.7%
Cook	1,013	9.0%	983	9.6%	927	10.1%	896	11.0%	811	10.4%	713	10.0%	787	11.6%
Northern	55	2.3%	74	2.9%	87	3.2%	76	3.0%	88	3.1%	85	2.8%	117	3.8%
Southern	39	2.3%	55	3.1%	55	3.1%	69	3.7%	70	3.6%	70	3.3%	73	3.2%

Female	1,082	11.3%	1,124	12.2%	1,101	12.6%	1,032	12.6%	1,052	12.7%	845	10.4%	806	10.2%
Male	552	5.2%	606	6.0%	627	6.5%	665	7.4%	654	7.2%	575	6.5%	516	6.0%

Under 3	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
3 to 5	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
6 to 8	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
9 to 11	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
12 to 14	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
15 and Older	1,631	26.1%	1,729	28.6%	1,726	29.8%	1,696	31.2%	1,706	31.5%	1,419	27.7%	1,322	27.3%

African American	1,264	9.5%	1,323	10.6%	1,335	11.6%	1,283	12.2%	1,278	12.3%	1,048	10.8%	999	10.9%
Hispanic	85	7.5%	97	8.8%	82	7.8%	92	8.9%	94	9.2%	90	9.2%	66	7.1%
Other	16	4.4%	25	7.0%	22	6.5%	24	7.8%	15	5.6%	13	4.7%	15	5.6%
White	269	5.0%	286	5.3%	289	5.3%	299	5.6%	320	5.7%	269	4.6%	242	3.9%

Note: The youngest five age categories (14 years and younger) were replaced with NA because over the past 7 years there have been 3 or fewer children in these combined age categories in any given year.

Preserving Sibling Bonds - Initial Placement

Indicator 2.D	Of children placed into substitute care, what percentage is placed with their siblings in their first placement? (Children with no siblings in substitute care are excluded from this analysis.)						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
Traditional Foster Home	1-2 SIBLINGS						
Children with 1-2 Siblings	817	816	748	695	635	580	502
Placed with All Siblings	602	622	507	490	412	408	358
Percent	74%	76%	68%	71%	65%	70%	71%
Kinship Foster Home	1-2 SIBLINGS						
Children with 1-2 Siblings	1,066	1,068	1,006	1,065	1,375	1,159	1,271
Placed with All Siblings	840	831	828	857	1,144	926	1,064
Percent	79%	78%	82%	80%	83%	80%	84%
Traditional Foster Home	3 OR MORE SIBLINGS						
Children with 3 or More Siblings	353	385	345	239	299	245	176
Placed with All Siblings	83	98	68	58	67	34	27
Percent	24%	25%	20%	24%	22%	14%	15%
Kinship Foster Home	3 OR MORE SIBLINGS						
Children with 3 or More Siblings	473	569	464	459	541	531	606
Placed with All Siblings	215	325	254	254	313	315	334
Percent	45%	57%	55%	55%	58%	59%	55%

Preserving Sibling Bonds - End of Year

Indicator 2.E	Of children in substitute care at the end of the year, what percentage is placed with their siblings? (Children with no siblings in substitute care are excluded from this analysis.)						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
Traditional Foster Home	1-2 SIBLINGS						
Children with 1-2 Siblings	3,098	2,828	2,559	2,503	2,338	2,276	2,155
Placed with All Siblings	1,709	1,625	1,474	1,472	1,405	1,356	1,295
Percent	55%	57%	58%	59%	60%	60%	60%
Kinship Foster Home	1-2 SIBLINGS						
Children with 1-2 Siblings	3,032	3,148	3,099	2,929	3,186	3,016	3,103
Placed with All Siblings	2,010	2,196	2,171	2,030	2,239	2,121	2,219
Percent	66%	70%	70%	69%	70%	70%	72%
Traditional Foster Home	3 OR MORE SIBLINGS						
Children with 3 or More Siblings	1,575	1,536	1,344	1,188	1,121	1,186	1,023
Placed with All Siblings	234	223	202	185	218	200	141
Percent	15%	15%	15%	16%	19%	17%	14%
Kinship Foster Home	3 OR MORE SIBLINGS						
Children with 3 or More Siblings	1,608	1,540	1,427	1,297	1,403	1,351	1,440
Placed with All Siblings	482	493	568	535	600	569	584
Percent	30%	32%	40%	41%	43%	42%	41%

Placing Children Close to Home - Initial Placement - Traditional Foster Home

Indicator 2.F.1	Of all children entering substitute care and initially placed in traditional foster homes, what is the median* distance from their home of origin to their initial placement?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
Entering Substitute Care - First Placement Traditional Foster Home	2,016	2,002	1,843	1,621	1,605	1,438	1,256
Median Miles from Home	11.6	10.9	10.7	12.1	12.3	11.6	10.9

Region	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES
Central	763	10.7	700	11.6	664	10.1	639	14.7	598	13.3	599	8.7	567	11.4
Cook	455	10.8	458	11.0	376	9.2	305	8.4	321	9.8	216	11.0	218	5.8
Northern	437	12.0	422	9.6	371	10.6	293	12.9	332	15.4	316	14.1	266	14.5
Southern	361	13.9	422	12.0	432	12.0	384	12.8	354	13.0	307	17.9	205	12.9

Female	987	12.1	1,015	10.3	914	11.2	828	12.3	786	13.9	726	11.5	613	10.0
Male	1,028	10.7	984	11.4	925	9.8	793	11.5	817	11.0	711	11.8	643	11.3

Under 3	835	10.5	852	9.9	806	11.1	713	10.3	729	10.6	695	10.8	647	9.0
3-5	288	11.8	294	11.7	299	9.2	227	13.4	225	15.2	207	12.3	196	8.3
6-8	236	13.6	233	10.9	196	9.3	202	14.2	177	12.1	165	18.6	111	8.2
9-11	226	11.3	228	11.5	161	16.4	141	14.7	144	14.7	129	8.0	85	16.0
12-14	244	14.6	221	13.1	216	8.7	161	14.6	161	19.1	124	14.2	115	25.1
15 and Older	187	15.4	174	10.0	164	9.0	177	15.4	169	15.5	118	15.7	102	27.5

African American	908	8.6	914	8.0	885	6.5	744	7.5	711	10.0	614	7.7	512	7.8
Hispanic	85	10.0	102	9.1	72	10.0	78	15.1	77	14.2	61	6.1	56	7.6
Other	33	9.3	33	11.1	24	4.4	27	4.9	45	25.6	33	5.7	23	17.3
White	990	15.1	953	15.9	862	14.5	772	15.1	772	14.1	730	16.9	665	14.2

*Median includes children with valid address information

Placing Children Close to Home - Initial Placement - Specialized Foster Home

Indicator 2.F.2	Of all children entering substitute care and initially placed in specialized foster homes, what is the median* distance from their home of origin to their initial placement?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
Entering Substitute Care - First Placement Specialized Foster Home	139	158	205	119	136	146	124
Median Miles from Home	9.4	5.1	12.3	21.6	18.1	13.0	17.2

Region	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES
Central	79	3.7	77	5.1	92	4.1	34	17.4	29	22.2	44	21.6	47	37.7
Cook	37	10.9	59	6.5	71	12.3	43	15.9	58	13.9	51	8.9	34	13.5
Northern	6	30.9	13	21.2	11	31.4	12	49.6	25	42.2	22	13.0	26	13.4
Southern	17	20.2	9	3.4	31	33.2	30	56.3	24	35.1	29	41.7	17	31.6

Female	80	10.6	68	3.8	116	13.3	52	14.4	65	18.1	68	12.6	57	18.0
Male	59	6.6	90	5.9	89	11.3	67	30.1	71	19.8	78	13.4	67	16.0

Under 3	61	7.4	73	5.2	91	10.7	30	16.1	44	11.0	42	8.7	46	13.5
3-5	12	10.6	16	3.3	18	6.2	7	30.1	7	13.2	8	12.3	3	7.7
6-8	9	29.5	16	13.2	19	7.6	10	21.6	9	21.6	14	8.3	10	13.4
9-11	14	8.5	16	3.3	16	47.9	13	34.1	19	22.0	21	24.4	11	30.4
12-14	28	11.0	21	4.1	30	22.6	29	5.2	30	28.8	33	18.8	30	39.8
15 and Older	15	15.6	16	12.8	31	31.1	30	20.2	27	18.1	28	13.7	24	14.2

African American	78	6.5	88	4.7	117	8.2	55	12.4	66	12.1	67	7.8	49	13.6
Hispanic	3	14.7	5	3.8	4	4.8	3	29.5	13	20.5	5	7.3	3	10.1
Other	1	2.1	4	30.2	4	24.6	2	63.8	2	-	7	4.8	3	-
White	57	17.2	61	7.6	80	24.1	59	43.1	55	36.9	67	27.6	69	30.8

*Median includes children with valid address information

Placing Children Close to Home - Initial Placement - Kinship Foster Home

Indicator 2.F.3	Of all children entering substitute care and initially placed in kinship foster homes, what is the median* distance from their home of origin to their initial placement?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
Entering Substitute Care - First Placement Kinship Foster Home	2,160	2,332	2,086	2,176	2,643	2,472	2,689
Median Miles from Home	3.5	3.6	3.1	3.0	3.4	3.3	3.9

Region	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES
Central	689	3.2	745	3.5	720	2.1	949	2.6	1,078	3.5	890	2.4	988	3.7
Cook	673	4.0	745	3.7	481	3.8	425	5.0	526	4.1	405	4.5	529	5.5
Northern	411	8.3	436	4.1	522	2.3	424	2.2	604	3.6	703	3.8	635	3.5
Southern	387	0.5	406	2.7	363	7.1	378	1.9	435	2.3	474	3.0	537	2.5

Female	1,025	3.2	1,173	3.5	1,062	2.5	1,056	2.4	1,308	3.5	1,282	2.9	1,311	4.0
Male	1,133	3.7	1,153	3.7	1,020	3.8	1,117	3.3	1,327	3.3	1,188	3.7	1,377	3.7

Under 3	799	2.6	932	3.4	838	2.6	893	2.4	1,068	3.0	1,011	3.3	1,108	3.1
3-5	382	2.8	417	3.6	391	2.3	409	3.2	538	2.9	465	2.5	513	4.0
6-8	306	1.8	320	3.5	306	2.5	310	3.4	377	3.4	361	3.5	383	3.7
9-11	271	5.2	277	4.4	203	8.9	238	2.6	268	4.1	267	2.4	269	5.7
12-14	265	6.7	230	3.7	215	4.3	192	5.0	224	5.9	212	5.1	240	3.6
15 and Older	137	4.1	156	3.8	133	5.2	134	3.7	168	4.1	156	5.0	176	4.4

African American	1,042	2.2	1,121	3.3	925	2.5	976	2.5	1,106	3.2	982	2.5	1,090	2.9
Hispanic	96	3.7	131	2.4	94	6.6	92	3.5	144	5.8	130	6.9	126	7.6
Other	37	7.4	51	3.9	51	2.4	51	2.4	40	1.8	59	1.5	73	2.7
White	985	9.1	1,029	10.7	1,016	6.2	1,057	5.3	1,353	3.7	1,301	6.4	1,400	5.4

*Median includes children with valid address information

Placing Children Close to Home - Initial Placement - Group Home/Institution

Indicator 2.F.4	Of all children entering substitute care and initially placed in a group home or institution, what is the median* distance from their home of origin to their initial placement?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
Entering Substitute Care - First Placement Group Home or Institution	719	807	637	588	827	761	918
Median Miles from Home	10.6	11.1	13.3	9.8	9.1	8.1	11.3

Region	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES
Central	72	34.5	75	19.3	63	17.9	56	97.3	80	41.4	67	74.8	95	74.0
Cook	549	9.5	641	10.5	463	12.1	416	8.3	612	8.0	548	7.3	559	7.8
Northern	63	28.6	60	18.2	77	25.9	75	24.6	99	25.5	110	30.3	100	31.4
Southern	35	21.9	31	38.5	34	26.0	41	23.1	36	62.5	36	25.9	164	23.8

Female	283	9.7	347	10.4	253	12.5	259	8.5	352	8.9	319	7.6	389	8.8
Male	436	10.8	460	11.5	380	13.4	329	10.5	474	9.1	441	8.7	528	12.8

Under 3	197	9.6	185	9.1	158	10.7	127	8.3	219	7.5	175	7.4	219	8.7
3-5	81	9.5	83	10.5	65	12.5	48	8.0	77	7.0	73	6.4	92	8.0
6-8	84	8.1	84	8.3	55	14.6	38	8.1	63	7.2	51	4.5	91	6.4
9-11	77	12.4	74	11.8	65	13.7	66	8.0	77	8.4	63	8.1	87	12.0
12-14	152	12.1	194	12.5	156	16.0	157	12.4	168	13.9	187	12.3	171	16.1
15 and Older	128	14.9	187	15.2	138	15.2	152	17.5	223	13.3	212	12.3	258	19.2

African American	493	10.2	565	11.3	405	12.5	372	8.5	552	7.4	481	7.3	486	7.5
Hispanic	55	6.0	74	8.7	70	8.3	70	5.8	64	8.9	72	5.0	68	8.6
Other	11	5.4	23	11.1	8	15.7	0	-	14	14.3	14	7.6	25	12.0
White	160	15.7	145	10.6	154	19.3	146	18.7	197	21.8	194	21.8	339	23.4

*Median includes children with valid address information

Placing Children Close to Home - End of Year Placement - Traditional Foster Home

Indicator 2.G.1	Of all children in traditional foster homes at the end of the fiscal year, what is the median* distance from their home of origin?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
In Traditional Foster Home at the End of the Year	6,694	6,166	5,521	5,104	4,790	4,722	4,376
Median Miles from Home	10.2	10.5	10.5	11.0	11.3	11.0	11.0

Region	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES
Central	1,578	10.6	1,503	11.1	1,387	11.1	1,332	11.5	1,233	11.3	1,336	11.4	1,298	10.0
Cook	3,383	9.6	2,972	9.7	2,484	10.0	2,157	10.0	1,972	10.6	1,719	9.9	1,487	9.4
Northern	1,030	12.6	1,007	11.4	964	11.5	877	13.6	854	15.5	906	14.1	853	14.4
Southern	703	12.6	684	14.5	686	14.9	738	15.1	731	13.0	761	12.8	738	13.8

Female	3,285	10.1	3,064	10.5	2,784	11.1	2,572	11.0	2,383	11.8	2,404	11.1	2,242	10.6
Male	3,407	10.3	3,098	10.6	2,728	10.1	2,524	11.0	2,397	11.0	2,309	10.9	2,129	11.2

Under 3	1,574	10.2	1,529	10.4	1,461	11.3	1,366	10.1	1,340	10.2	1,350	10.0	1,325	9.4
3-5	1,403	10.3	1,302	10.3	1,198	9.7	1,127	11.7	1,091	12.0	1,141	11.0	1,102	10.6
6-8	1,065	10.3	974	10.6	861	10.2	830	11.2	723	12.7	755	13.1	683	11.8
9-11	899	10.0	811	11.5	660	12.2	565	10.8	536	11.7	487	11.4	447	11.9
12-14	816	10.2	707	10.6	619	8.9	550	10.9	481	12.2	420	12.0	358	12.5
15 and Older	937	10.2	843	10.3	722	11.3	666	11.4	619	10.8	569	9.8	461	11.4

African American	3,959	8.8	3,597	8.9	3,202	9.3	2,865	9.3	2,671	10.1	2,520	9.4	2,211	9.5
Hispanic	479	8.1	422	8.5	369	8.7	338	9.6	314	10.2	289	10.0	273	9.8
Other	146	8.9	141	13.3	125	9.1	113	11.6	92	14.3	99	10.4	89	10.0
White	2,110	16.6	2,006	16.4	1,825	16.3	1,788	16.5	1,713	15.5	1,814	15.3	1,803	14.2

*Median includes children with valid address information

Placing Children Close to Home - End of Year Placement - Specialized Foster Home

Indicator 2.G.2	Of all children in specialized foster homes at the end of the fiscal year, what is the median* distance from their home of origin?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
In Specialized Foster Home at the End of the Year	2,931	2,813	3,112	2,850	2,882	2,973	2,840
Median Miles from Home	11.1	11.3	11.4	12.8	12.8	12.1	12.4

Region	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES
Central	832	9.8	768	8.6	807	10.4	614	15.0	600	20.6	611	14.3	622	18.0
Cook	1,702	10.6	1,611	11.0	1,774	10.7	1,663	11.7	1,652	11.3	1,669	10.9	1,534	10.9
Northern	230	23.7	253	25.1	307	25.5	332	23.5	359	23.7	417	23.1	422	24.9
Southern	167	15.9	181	19.0	224	15.6	241	21.1	271	22.9	276	20.6	262	20.6

Female	1,200	9.8	1,159	10.2	1,334	10.4	1,178	12.3	1,217	12.2	1,272	11.5	1,200	12.2
Male	1,730	11.9	1,652	12.2	1,777	12.3	1,672	13.1	1,665	13.2	1,699	12.5	1,638	12.7

Under 3	234	7.5	259	7.3	297	10.1	237	10.8	229	11.0	218	9.5	221	10.2
3-5	290	9.3	276	10.8	362	10.1	282	11.1	323	10.9	338	12.3	327	9.8
6-8	315	10.1	286	8.4	366	12.2	358	13.0	411	13.2	395	11.4	398	12.6
9-11	485	10.4	403	11.1	421	10.5	389	12.3	392	13.1	438	13.2	429	11.5
12-14	696	12.4	653	12.1	598	11.7	561	12.6	514	13.2	498	11.9	448	14.8
15 and Older	911	13.4	936	13.9	1,068	13.4	1,023	14.4	1,013	13.8	1,086	12.9	1,017	13.2

African American	2,006	10.0	1,913	10.2	2,090	10.3	1,905	11.4	1,904	11.3	1,908	10.8	1,785	10.9
Hispanic	132	11.0	124	14.3	147	11.1	141	14.3	157	12.9	187	11.2	175	10.2
Other	51	12.9	50	14.1	45	24.8	39	27.6	37	15.5	44	12.2	47	24.9
White	742	20.5	726	20.0	830	19.2	765	22.6	784	24.0	834	22.7	833	22.8

*Median includes children with valid address information

Placing Children Close to Home - End of Year Placement - Kinship Foster Home

Indicator 2.G.3	Of all children in kinship foster homes at the end of the fiscal year, what is the median* distance from their home of origin?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
In Kinship Foster Home at the End of the Year	6,831	6,732	6,301	5,956	6,297	6,069	6,233
Median Miles from Home	3.9	3.9	3.9	3.7	3.7	3.7	3.9

Region	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES
Central	1,391	3.1	1,483	3.1	1,564	2.8	1,724	2.4	1,867	2.7	1,782	2.6	1,828	2.9
Cook	3,918	4.4	3,569	4.4	2,928	4.7	2,485	4.7	2,450	5.1	2,110	5.2	2,063	5.4
Northern	877	3.3	968	3.0	1,106	3.6	1,049	3.1	1,239	3.2	1,326	3.4	1,325	3.3
Southern	645	2.7	712	3.2	703	2.5	698	3.4	741	2.8	851	2.0	1,017	2.9

Female	3,390	4.0	3,293	4.0	3,019	3.9	2,916	3.7	3,085	3.7	3,012	3.7	3,063	3.8
Male	3,436	3.9	3,431	3.8	3,268	4.0	3,025	3.7	3,197	3.7	3,049	3.8	3,166	3.9

Under 3	1,375	3.4	1,476	3.4	1,473	3.7	1,439	3.3	1,604	3.4	1,560	3.9	1,616	4.0
3-5	1,292	3.9	1,360	3.8	1,374	3.7	1,306	3.7	1,415	3.2	1,419	3.2	1,520	3.9
6-8	1,022	3.8	980	3.7	949	3.8	955	3.5	1,019	4.2	979	3.6	1,014	3.5
9-11	924	4.7	878	4.1	794	4.1	709	3.8	753	3.2	726	4.0	729	3.6
12-14	825	4.0	836	4.3	683	3.9	629	3.6	616	3.7	554	3.6	558	3.7
15 and Older	1,393	4.0	1,202	4.5	1,028	4.7	918	4.4	890	4.4	831	4.2	796	3.9

African American	4,670	3.7	4,327	3.7	3,762	3.7	3,404	3.5	3,488	3.6	3,187	3.7	3,146	3.7
Hispanic	336	2.4	361	2.8	356	3.2	375	3.6	368	3.6	325	2.9	331	3.9
Other	124	4.7	118	3.7	132	5.9	116	2.1	107	3.1	113	2.8	112	3.0
White	1,701	5.8	1,926	5.4	2,051	4.7	2,061	4.4	2,334	3.9	2,444	4.2	2,644	4.2

*Median includes children with valid address information

Placing Children Close to Home - End of Year Placement - Group Home

Indicator 2.G.4	Of all children in group homes at the end of the fiscal year, what is the median* distance from their home of origin?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
In Group Home at the End of the Year	359	354	311	278	275	266	253
Median Miles from Home	20.5	20.2	22.0	20.7	25.5	24.4	26.4

Region	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES
Central	59	39.8	68	31.1	48	33.4	46	69.6	48	93.4	45	104.4	41	106.7
Cook	244	19.3	226	15.8	187	16.3	177	15.1	161	16.1	166	15.2	151	17.3
Northern	50	23.9	49	35.8	55	38.3	39	32.8	47	34.3	48	45.1	59	45.1
Southern	6	127.0	11	148.1	21	70.9	16	65.6	19	68.2	7	93.3	2	93.3

Female	134	24.1	111	24.1	95	22.8	84	17.4	86	19.1	92	17.6	93	25.2
Male	225	19.6	243	19.2	216	21.4	194	22.0	189	29.7	174	26.2	160	27.8

Under 3	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
3-5	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
6-8	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
9-11	17	16.9	14	14.3	10	11.5	13	13.0	7	9.2	10	28.9	13	11.2
12-14	66	18.1	61	24.3	55	18.5	56	15.8	42	25.5	41	21.1	31	13.8
15 and Older	271	21.0	269	20.4	239	23.4	200	22.1	214	27.3	204	25.6	204	28.1

African American	221	19.5	231	17.4	194	18.9	184	16.7	172	19.8	175	17.3	157	21.4
Hispanic	32	22.7	20	22.5	20	24.1	19	14.0	16	18.2	18	25.9	16	10.6
Other	1	33.5	8	30.2	1	20.1	2	38.7	1	35.5	0	-	0	-
White	105	27.3	95	29.6	96	34.5	73	43.7	86	60.4	73	72.1	80	56.9

*Median includes children with valid address information

Placing Children Close to Home - End of Year Placement - Institution

Indicator 2.G.5	Of all children in institutions at the end of the fiscal year, what is the median* distance from their home of origin?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
In Institution at the End of the Year	1,640	1,521	1,457	1,360	1,422	1,456	1,509
Median Miles from Home	26.9	28.7	32.3	36.8	36.4	36.4	40.0

Region	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES
Central	335	62.7	297	68.8	311	79.6	279	99.0	316	96.7	298	113.8	327	113.8
Cook	975	18.0	897	20.2	839	20.6	781	24.2	759	23.5	754	21.9	742	22.7
Northern	190	42.1	200	39.4	206	44.6	203	46.4	242	52.0	264	50.0	264	52.1
Southern	140	49.2	127	62.9	101	97.4	97	91.6	105	71.3	140	91.3	176	97.9

Female	452	27.5	451	27.5	422	29.9	409	35.9	455	32.0	469	35.1	486	37.6
Male	1,187	26.0	1,069	29.5	1,034	32.8	951	37.2	967	39.2	987	37.9	1,022	42.9

Under 3	17	10.6	7	20.0	4	8.0	4	4.1	7	9.8	7	8.6	9	8.6
3-5	15	8.9	7	8.9	13	13.1	10	16.1	10	9.8	9	29.6	9	32.4
6-8	25	12.5	27	11.4	29	14.7	33	16.3	34	20.9	27	55.2	34	26.0
9-11	108	16.7	80	18.3	73	17.6	82	17.9	113	21.2	110	42.5	111	33.7
12-14	362	26.9	340	31.4	324	35.5	292	39.6	283	36.1	293	36.4	302	52.2
15 and Older	1,113	30.4	1,060	30.8	1,014	33.3	939	37.9	975	38.5	1,010	36.8	1,044	39.1

African American	1,121	19.5	1,039	23.1	958	24.9	877	31.3	910	29.5	905	29.3	903	32.8
Hispanic	72	23.6	81	17.0	80	16.4	72	22.8	70	23.2	72	24.7	74	12.9
Other	22	21.5	16	14.1	16	21.5	13	26.0	17	24.4	8	38.1	7	58.3
White	425	49.3	385	62.9	403	64.0	398	72.5	425	72.5	471	73.4	525	84.1

*Median includes children with valid address information

Placing Children Close to Home - End of Year Placement - Independent Living

Indicator 2.G.6	Of all children in independent living at the end of the fiscal year, what is the median* distance from their home of origin?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
In Independent Living at the End of the Year	1,634	1,731	1,728	1,698	1,707	1,420	1,322
Median Miles from Home	8.7	8.7	9.4	9.6	9.6	10.3	10.7

Region	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES
Central	527	8.8	619	9.1	659	10.4	657	10.2	738	9.3	552	10.4	345	14.6
Cook	1,013	8.0	983	7.7	927	8.4	896	8.6	811	8.8	713	8.7	787	8.4
Northern	55	23.8	74	23.4	87	22.7	76	26.2	88	33.5	85	33.6	117	34.6
Southern	39	50.9	55	51.9	55	36.9	69	22.0	70	19.2	70	60.7	73	67.7

Female	1,082	8.2	1,124	8.4	1,101	8.9	1,032	8.9	1,052	8.6	845	9.3	806	10.0
Male	552	9.7	606	9.4	627	11.0	665	11.3	654	11.9	575	13.0	516	13.0

Under 3	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
3-5	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
6-8	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
9-11	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
12-14	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
15 and Older	1,631	8.7	1,729	8.7	1,726	9.4	1,696	9.6	1,706	9.6	1,419	10.4	1,322	10.7

African American	1,264	8.2	1,323	8.1	1,335	9.0	1,283	9.1	1,278	9.0	1,048	9.7	999	9.7
Hispanic	85	4.1	97	5.2	82	6.3	92	5.1	94	5.8	90	7.8	66	8.0
Other	16	10.5	25	6.3	22	30.6	24	15.6	15	17.5	13	10.9	15	6.5
White	269	17.7	286	21.8	289	21.7	299	19.0	320	21.2	269	26.3	242	27.9

*Median includes children with valid address information

Stability in Substitute Care

Indicator 2.H	Of all children entering substitute care and staying for at least one year, what percentage had two or fewer placements within a year of removal?						
IN ILLINOIS	2003	2004	2005	2006	2007	2008	2009
Entering and Staying One Year	3,892	3,769	3,995	3,563	3,569	4,125	3,679
Two or Fewer Placements	3,064	3,016	3,210	2,831	2,824	3,246	2,927
Percent	79%	80%	80%	79%	79%	79%	80%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	3,064	79%	3,016	80%	3,210	80%	2,831	79%	2,824	79%	3,246	79%	2,927	80%
Central	966	77%	956	79%	1,018	83%	1,036	83%	1,180	84%	1,250	83%	1,078	82%
Cook	1,179	78%	1,025	80%	1,148	80%	712	77%	642	76%	795	70%	589	74%
Northern	508	82%	574	81%	606	81%	626	79%	501	79%	694	82%	730	81%
Southern	411	82%	461	82%	438	75%	457	77%	501	74%	507	79%	530	81%

Female	1,478	79%	1,420	80%	1,592	80%	1,409	79%	1,385	79%	1,569	77%	1,467	80%
Male	1,586	79%	1,595	80%	1,611	80%	1,412	80%	1,438	80%	1,668	80%	1,458	80%

Under 3	1,469	86%	1,392	87%	1,524	88%	1,378	86%	1,313	85%	1,478	84%	1,382	85%
3 to 5	451	76%	463	79%	487	80%	440	74%	439	79%	559	80%	459	79%
6 to 8	384	77%	362	78%	390	80%	335	77%	350	78%	387	77%	350	76%
9 to 11	336	77%	309	78%	319	74%	228	77%	255	73%	292	73%	256	78%
12 to 14	267	65%	310	69%	292	67%	239	70%	244	69%	304	75%	265	71%
15 and Older	157	66%	180	65%	198	64%	210	72%	223	71%	226	65%	215	69%

African American	1,641	79%	1,503	78%	1,644	80%	1,355	79%	1,279	78%	1,439	75%	1,216	77%
Hispanic	135	69%	150	82%	185	77%	122	71%	147	76%	160	73%	163	85%
Other	90	78%	44	83%	61	70%	59	88%	58	85%	63	82%	80	81%
White	1,198	80%	1,319	82%	1,320	82%	1,295	80%	1,340	80%	1,584	83%	1,468	81%

Youth Who Ran Away from Substitute Care

Indicator 2.1	Of all children entering care between ages 12 and 17, what percentage ran away from a substitute care placement during the year?						
IN ILLINOIS	2003	2004	2005	2006	2007	2008	2009
Entered Substitute Care Between 12 and 17	1,128	1,151	1,192	1,075	1,029	1,161	1,068
Ran Away During the Year	233	231	258	215	189	211	200
Percent	21%	20%	22%	20%	18%	18%	19%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	233	21%	231	20%	258	22%	215	20%	189	18%	211	18%	200	19%
Central	71	18%	54	14%	59	18%	37	12%	42	15%	49	16%	31	11%
Cook	111	29%	101	28%	140	30%	114	29%	88	23%	86	19%	107	29%
Northern	35	17%	46	21%	30	14%	38	19%	27	16%	49	23%	43	18%
Southern	16	11%	30	16%	29	15%	26	15%	32	17%	27	15%	19	12%

Female	134	24%	125	20%	144	22%	125	23%	115	21%	104	18%	94	18%
Male	99	18%	106	20%	114	21%	90	17%	74	15%	106	19%	106	20%

12 to 14	106	16%	112	16%	107	16%	76	12%	69	13%	51	9%	80	14%
15 to 17	127	28%	119	26%	151	29%	139	30%	120	25%	160	28%	120	24%

African American	137	24%	150	25%	174	26%	130	23%	120	22%	129	20%	131	24%
Hispanic	11	22%	14	30%	17	26%	20	32%	12	24%	9	16%	6	12%
Other	7	32%	5	45%	3	18%	1	6%	3	21%	2	11%	1	5%
White	78	16%	62	12%	64	14%	64	15%	54	13%	71	16%	62	14%

Median Length of Stay in Substitute Care

Indicator 2.J	Of children entering substitute care for the first time during that fiscal year, what is the median length of stay (in months) in substitute care?						
IN ILLINOIS	2002	2003	2004	2005	2006	2007	2008
Median Length of Stay (Months)	31	30	29	31	29	28	28

Region							
Central	22	24	25	24	24	25	26
Cook	39	41	41	45	42	40	30
Northern	22	26	28	28	31	31	28
Southern	16	19	17	18	20	21	24

Female	30	30	29	30	29	29	28
Male	31	30	30	31	29	28	28

Under 3	31	31	32	31	31	29	28
3 to 5	32	31	28	29	29	28	28
6 to 8	29	28	28	28	29	25	28
9 to 11	30	29	25	26	26	26	27
12 to 14	32	26	28	38	27	33	28
15 and Older	22	28	25	37	27	30	29

African American	35	34	34	37	35	33	29
Hispanic	38	27	36	40	37	28	28
Other	20	28	28	33	24	22	25
White	21	24	23	23	24	26	25

Permanence at 12 Months: Reunification

Indicator 3.A.1	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 substitute care?						
IN ILLINOIS	2003	2004	2005	2006	2007	2008	2009
Total Entering Substitute Care	5,296	5,034	5,299	4,771	4,504	5,211	4,817
Reunified at 12 Months	1,164	1,042	1,033	909	932	976	1,024
Percent	22.0%	20.7%	19.5%	19.1%	20.7%	18.7%	21.3%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	1,164	22.0%	1,042	20.7%	1,033	19.5%	909	19.1%	932	20.7%	976	18.7%	1,024	21.3%
Central	479	29.0%	410	25.6%	386	24.2%	325	21.1%	422	25.1%	385	21.5%	412	25.8%
Cook	230	10.9%	128	7.5%	115	6.0%	109	7.8%	90	7.6%	117	7.7%	102	8.4%
Northern	215	25.5%	200	21.8%	210	22.6%	197	20.1%	146	18.2%	222	20.9%	257	22.3%
Southern	240	34.2%	304	38.0%	322	37.1%	278	32.3%	274	32.9%	252	29.8%	253	29.9%

Female	539	21.0%	510	21.5%	529	20.3%	427	18.2%	440	20.0%	479	19.1%	510	21.3%
Male	624	22.6%	532	20.0%	503	18.7%	482	20.0%	491	21.3%	494	18.4%	512	21.2%

Under 3	368	18.0%	312	16.5%	319	15.6%	303	16.0%	327	18.5%	357	17.4%	356	18.5%
3-5	210	26.4%	171	22.4%	203	25.1%	173	22.4%	174	25.2%	177	20.8%	212	28.1%
6-8	160	23.7%	165	26.0%	133	20.4%	133	23.1%	142	25.4%	145	23.2%	147	24.9%
9-11	150	23.4%	143	24.5%	148	24.9%	99	22.2%	107	23.5%	100	19.6%	115	24.0%
12-14	163	23.9%	167	24.1%	119	17.8%	130	21.1%	94	17.4%	102	17.6%	110	19.7%
15 and Older	113	24.6%	84	17.9%	111	20.8%	71	15.2%	88	17.8%	95	16.1%	84	16.3%

African American	443	15.7%	343	13.6%	341	12.7%	338	14.5%	333	15.5%	311	12.8%	378	17.6%
Hispanic	75	26.0%	34	14.2%	61	19.6%	29	12.1%	53	21.8%	69	23.2%	41	15.3%
Other	49	30.6%	24	29.3%	18	16.2%	15	17.2%	26	32.5%	28	27.7%	27	23.9%
White	597	29.5%	641	29.2%	613	28.0%	527	25.0%	520	25.6%	568	23.9%	578	25.2%

Permanence at 12 Months: Adoption

Indicator 3.A.2	Of all children who entered substitute care during the year and stayed for longer than 7 days, what percentage was adopted within 12 months from the date of entry into substitute care?						
IN ILLINOIS	2003	2004	2005	2006	2007	2008	2009
Total Entering Substitute Care	5,296	5,034	5,299	4,771	4,504	5,211	4,817
Adopted at 12 Months	75	70	61	63	52	26	20
Percent	1.4%	1.4%	1.2%	1.3%	1.2%	0.5%	0.4%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	75	1.4%	70	1.4%	61	1.2%	63	1.3%	52	1.2%	26	0.5%	20	0.4%
Central	17	1.0%	17	1.1%	11	0.7%	12	0.8%	18	1.1%	8	0.4%	7	0.4%
Cook	52	2.5%	43	2.5%	39	2.0%	42	3.0%	27	2.3%	11	0.7%	12	1.0%
Northern	5	0.6%	7	0.8%	5	0.5%	4	0.4%	4	0.5%	3	0.3%	1	0.1%
Southern	1	0.1%	3	0.4%	6	0.7%	5	0.6%	3	0.4%	4	0.5%	0	0.0%

Female	29	1.1%	39	1.6%	28	1.1%	30	1.3%	30	1.4%	11	0.4%	10	0.4%
Male	46	1.7%	31	1.2%	33	1.2%	33	1.4%	22	1.0%	15	0.6%	10	0.4%

Under 3	26	1.3%	15	0.8%	18	0.9%	14	0.7%	19	1.1%	11	0.5%	6	0.3%
3-5	8	1.0%	8	1.0%	6	0.7%	2	0.3%	5	0.7%	2	0.2%	1	0.1%
6-8	9	1.3%	8	1.3%	11	1.7%	4	0.7%	4	0.7%	2	0.3%	3	0.5%
9-11	11	1.7%	16	2.7%	8	1.3%	13	2.9%	7	1.5%	2	0.4%	5	1.0%
12-14	12	1.8%	15	2.2%	8	1.2%	19	3.1%	9	1.7%	6	1.0%	2	0.4%
15 and Older	9	2.0%	8	1.7%	10	1.9%	11	2.4%	8	1.6%	3	0.5%	3	0.6%

African American	58	2.1%	53	2.1%	47	1.7%	49	2.1%	35	1.6%	15	0.6%	15	0.7%
Hispanic	1	0.3%	1	0.4%	3	1.0%	2	0.8%	1	0.4%	4	1.3%	0	0.0%
Other	0	0.0%	1	1.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.9%
White	16	0.8%	15	0.7%	11	0.5%	12	0.6%	16	0.8%	7	0.3%	4	0.2%

Permanence at 12 Months: Subsidized Guardianship

Indicator 3.A.3	Of all children who entered substitute care during the year and stayed for longer than 7 days, what percentage attained subsidized guardianship within 12 months from the date of entry into substitute care?						
IN ILLINOIS	2003	2004	2005	2006	2007	2008	2009
Total Entering Substitute Care	5,296	5,034	5,299	4,771	4,504	5,211	4,817
Attained Subsidized Guardianship at 12 Months	4	21	7	11	27	17	35
Percent	0.1%	0.4%	0.1%	0.2%	0.6%	0.3%	0.7%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	4	0.1%	21	0.4%	7	0.1%	11	0.2%	27	0.6%	17	0.3%	35	0.7%
Central	0	0.0%	3	0.2%	0	0.0%	1	0.1%	0	0.0%	0	0.0%	2	0.1%
Cook	1	0.0%	18	1.0%	7	0.4%	10	0.7%	23	1.9%	13	0.9%	28	2.3%
Northern	1	0.1%	0	0.0%	0	0.0%	0	0.0%	3	0.4%	0	0.0%	3	0.3%
Southern	2	0.3%	0	0.0%	0	0.0%	0	0.0%	1	0.1%	4	0.5%	2	0.2%

Female	1	0.0%	11	0.5%	4	0.2%	8	0.3%	14	0.6%	5	0.2%	16	0.7%
Male	3	0.1%	10	0.4%	3	0.1%	3	0.1%	13	0.6%	12	0.4%	19	0.8%

Under 3	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
3-5	0	0.0%	1	0.1%	1	0.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
6-8	1	0.1%	4	0.6%	0	0.0%	0	0.0%	1	0.2%	0	0.0%	1	0.2%
9-11	1	0.2%	6	1.0%	2	0.3%	2	0.4%	8	1.8%	2	0.4%	6	1.3%
12-14	1	0.1%	2	0.3%	2	0.3%	8	1.3%	12	2.2%	5	0.9%	13	2.3%
15 and Older	1	0.2%	8	1.7%	2	0.4%	1	0.2%	6	1.2%	10	1.7%	15	2.9%

African American	1	0.0%	12	0.5%	7	0.3%	11	0.5%	25	1.2%	16	0.7%	28	1.3%
Hispanic	1	0.3%	5	2.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	1.3%	0	0.0%	0	0.0%
White	2	0.1%	4	0.2%	0	0.0%	0	0.0%	1	0.0%	1	0.0%	7	0.3%

Permanence at 12 Months: Reunification + Adoption + Subsidized Guardianship

Indicator 3.A.4	Of all children who entered substitute care during the year and stayed for longer than 7 days, what percentage attained permanence (reunification + adoption + subsidized guardianship) within 12 months from the date of entry into substitute care?						
IN ILLINOIS	2003	2004	2005	2006	2007	2008	2009
Total Entering Substitute Care	5,296	5,034	5,299	4,771	4,504	5,211	4,817
In a Permanent Home at 12 Months (Reunification + Adoption + Subsidized Guardianship)	1,243	1,133	1,101	983	1,011	1,019	1,079
Percent	23.5%	22.5%	20.8%	20.6%	22.4%	19.6%	22.4%

Permanence at 24 Months: Reunification

Indicator 3.B.1	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 24 months from the date of entry into substitute care?						
IN ILLINOIS	2002	2003	2004	2005	2006	2007	2008
Total Entering Substitute Care	5,636	5,296	5,034	5,299	4,771	4,504	5,211
Reunified at 24 Months	1,734	1,669	1,509	1,609	1,433	1,451	1,591
Percent	30.8%	31.5%	30.0%	30.4%	30.0%	32.2%	30.5%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	1,734	30.8%	1,669	31.5%	1,509	30.0%	1,609	30.4%	1,433	30.0%	1,451	32.2%	1,591	30.5%
Central	622	41.5%	690	41.8%	592	36.9%	602	37.7%	559	36.3%	673	40.1%	643	36.0%
Cook	411	15.9%	338	16.1%	226	13.2%	241	12.7%	176	12.7%	180	15.1%	223	14.7%
Northern	352	41.4%	322	38.2%	292	31.8%	358	38.5%	318	32.4%	247	30.8%	372	35.1%
Southern	349	49.9%	319	45.5%	399	49.9%	408	47.0%	380	44.2%	351	42.1%	353	41.7%

Female	833	30.1%	783	30.9%	720	30.3%	835	32.1%	671	28.6%	680	31.0%	789	31.4%
Male	901	31.5%	885	32.0%	789	29.7%	772	28.7%	762	31.6%	769	33.3%	799	29.7%

Under 3	547	25.6%	568	27.8%	471	24.9%	524	25.7%	483	25.5%	514	29.2%	592	28.8%
3-5	314	36.1%	303	38.1%	280	36.7%	297	36.7%	294	38.1%	268	38.8%	300	35.3%
6-8	248	34.6%	232	34.4%	230	36.2%	236	36.1%	211	36.6%	227	40.5%	244	39.0%
9-11	232	33.5%	209	32.7%	203	34.8%	222	37.3%	152	34.2%	175	38.5%	179	35.2%
12-14	238	32.3%	227	33.3%	219	31.6%	194	29.1%	195	31.6%	155	28.7%	150	25.9%
15 and Older	155	32.3%	130	28.3%	106	22.6%	136	25.5%	98	21.0%	112	22.7%	126	21.4%

African American	672	22.3%	661	23.4%	528	20.9%	580	21.6%	529	22.7%	557	25.9%	522	21.4%
Hispanic	110	29.3%	109	37.8%	54	22.6%	96	30.8%	50	20.8%	83	34.2%	96	32.2%
Other	71	40.6%	65	40.6%	32	39.0%	29	26.1%	32	36.8%	31	38.8%	38	37.6%
White	881	42.6%	834	41.2%	895	40.8%	904	41.3%	822	38.9%	780	38.3%	935	39.3%

Permanence at 24 Months: Adoption

Indicator 3.B.2	Of all children who entered substitute care during the year and stayed for longer than 7 days, what percentage was adopted within 24 months from the date of entry into substitute care?						
IN ILLINOIS	2002	2003	2004	2005	2006	2007	2008
Total Entering Substitute Care	5,636	5,296	5,034	5,299	4,771	4,504	5,211
Adopted at 24 Months	432	338	288	291	317	253	225
Percent	7.7%	6.4%	5.7%	5.5%	6.6%	5.6%	4.3%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	432	7.7%	338	6.4%	288	5.7%	291	5.5%	317	6.6%	253	5.6%	225	4.3%
Central	123	8.2%	110	6.7%	110	6.9%	131	8.2%	140	9.1%	121	7.2%	125	7.0%
Cook	210	8.1%	151	7.2%	96	5.6%	80	4.2%	94	6.8%	57	4.8%	36	2.4%
Northern	69	8.1%	50	5.9%	48	5.2%	41	4.4%	41	4.2%	41	5.1%	38	3.6%
Southern	30	4.3%	27	3.9%	34	4.3%	39	4.5%	42	4.9%	34	4.1%	26	3.1%

Female	227	8.2%	171	6.8%	144	6.1%	131	5.0%	165	7.0%	126	5.7%	112	4.5%
Male	205	7.2%	167	6.0%	143	5.4%	159	5.9%	151	6.3%	127	5.5%	113	4.2%

Under 3	274	12.8%	213	10.4%	175	9.2%	204	10.0%	210	11.1%	171	9.7%	157	7.6%
3-5	40	4.6%	35	4.4%	24	3.1%	26	3.2%	25	3.2%	25	3.6%	21	2.5%
6-8	31	4.3%	28	4.2%	26	4.1%	24	3.7%	24	4.2%	18	3.2%	10	1.6%
9-11	49	7.1%	25	3.9%	29	5.0%	16	2.7%	19	4.3%	12	2.6%	16	3.1%
12-14	28	3.8%	25	3.7%	22	3.2%	10	1.5%	25	4.1%	19	3.5%	15	2.6%
15 and Older	10	2.1%	12	2.6%	12	2.6%	11	2.1%	14	3.0%	8	1.6%	6	1.0%

African American	245	8.1%	199	7.0%	146	5.8%	137	5.1%	159	6.8%	115	5.4%	93	3.8%
Hispanic	23	6.1%	8	2.8%	7	2.9%	10	3.2%	13	5.4%	5	2.1%	7	2.3%
Other	13	7.4%	6	3.8%	5	6.1%	2	1.8%	3	3.4%	7	8.8%	5	5.0%
White	151	7.3%	125	6.2%	130	5.9%	142	6.5%	142	6.7%	126	6.2%	120	5.0%

Permanence at 24 Months: Subsidized Guardianship

Indicator 3.B.3	Of all children who entered substitute care during the year and stayed for longer than 7 days, what percentage attained subsidized guardianship within 24 months from the date of entry into substitute care?						
IN ILLINOIS	2002	2003	2004	2005	2006	2007	2008
Total Entering Substitute Care	5,636	5,296	5,034	5,299	4,771	4,504	5,211
Attained Subsidized Guardianship at 24 Months	127	67	99	88	79	67	121
Percent	2.3%	1.3%	2.0%	1.7%	1.7%	1.5%	2.3%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	127	2.3%	67	1.3%	99	2.0%	88	1.7%	79	1.7%	67	1.5%	121	2.3%
Central	32	2.1%	9	0.5%	27	1.7%	35	2.2%	30	1.9%	14	0.8%	39	2.2%
Cook	33	1.3%	34	1.6%	44	2.6%	38	2.0%	30	2.2%	36	3.0%	54	3.6%
Northern	47	5.5%	15	1.8%	15	1.6%	7	0.8%	14	1.4%	11	1.4%	18	1.7%
Southern	15	2.1%	9	1.3%	13	1.6%	8	0.9%	5	0.6%	6	0.7%	10	1.2%

Female	71	2.6%	37	1.5%	54	2.3%	47	1.8%	37	1.6%	31	1.4%	65	2.6%
Male	56	2.0%	30	1.1%	45	1.7%	41	1.5%	42	1.7%	36	1.6%	56	2.1%

Under 3	27	1.3%	11	0.5%	16	0.8%	20	1.0%	15	0.8%	10	0.6%	17	0.8%
3-5	11	1.3%	4	0.5%	18	2.4%	12	1.5%	6	0.8%	6	0.9%	18	2.1%
6-8	14	2.0%	16	2.4%	16	2.5%	15	2.3%	15	2.6%	5	0.9%	15	2.4%
9-11	18	2.6%	10	1.6%	14	2.4%	14	2.4%	15	3.4%	16	3.5%	20	3.9%
12-14	37	5.0%	19	2.8%	24	3.5%	17	2.5%	21	3.4%	22	4.1%	30	5.2%
15 and Older	20	4.2%	7	1.5%	11	2.3%	10	1.9%	7	1.5%	8	1.6%	21	3.6%

African American	58	1.9%	39	1.4%	48	1.9%	42	1.6%	39	1.7%	44	2.0%	70	2.9%
Hispanic	5	1.3%	2	0.7%	7	2.9%	1	0.3%	3	1.3%	2	0.8%	5	1.7%
Other	3	1.7%	2	1.3%	0	0.0%	1	0.9%	0	0.0%	1	1.3%	6	5.9%
White	61	2.9%	24	1.2%	44	2.0%	44	2.0%	37	1.8%	20	1.0%	40	1.7%

Permanence at 24 Months: Reunification + Adoption + Subsidized Guardianship

Indicator 3.B.4	Of all children who entered substitute care during the year and stayed for longer than 7 days, what percentage attained permanence (reunification + adoption + subsidized guardianship) within 24 months from the date of entry into substitute care?						
IN ILLINOIS	2002	2003	2004	2005	2006	2007	2008
Total Entering Substitute Care	5,636	5,296	5,034	5,299	4,771	4,504	5,211
Total in a Permanent Home at 24 Months (Reunification + Adoption + Subsidized Guardianship)	2,293	2,074	1,896	1,988	1,829	1,771	1,937
Percent	40.7%	39.2%	37.7%	37.5%	38.3%	39.3%	37.2%

Permanence at 36 Months: Reunification

Indicator 3.C.1	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 36 months from the date of entry into substitute care?						
IN ILLINOIS	2001	2002	2003	2004	2005	2006	2007
Total Entering Substitute Care	5,827	5,636	5,296	5,034	5,299	4,771	4,504
Reunified at 36 Months	2,084	1,984	1,935	1,786	1,879	1,693	1,695
Percent	35.8%	35.2%	36.5%	35.5%	35.5%	35.5%	37.6%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	2,084	35.8%	1,984	35.2%	1,935	36.5%	1,786	35.5%	1,879	35.5%	1,693	35.5%	1,695	37.6%
Central	771	47.6%	682	45.5%	794	48.1%	680	42.4%	690	43.2%	637	41.4%	775	46.2%
Cook	567	22.0%	535	20.7%	437	20.8%	329	19.2%	346	18.2%	253	18.2%	230	19.3%
Northern	425	44.6%	399	46.9%	365	43.3%	346	37.7%	402	43.3%	391	39.9%	305	38.0%
Southern	321	47.3%	368	52.6%	339	48.4%	431	53.9%	441	50.8%	412	47.9%	385	46.2%

Female	998	35.6%	939	33.9%	906	35.8%	852	35.9%	952	36.6%	800	34.1%	800	36.4%
Male	1,086	35.9%	1,044	36.5%	1,028	37.2%	932	35.1%	921	34.3%	893	37.0%	893	38.7%

Under 3	603	27.8%	627	29.3%	659	32.2%	564	29.8%	632	31.0%	584	30.8%	603	34.2%
3-5	374	40.7%	371	42.6%	353	44.3%	329	43.2%	348	43.0%	352	45.6%	323	46.7%
6-8	323	42.7%	286	39.9%	275	40.8%	279	43.9%	280	42.9%	246	42.6%	264	47.1%
9-11	300	40.9%	266	38.4%	256	40.0%	252	43.2%	256	43.0%	182	40.9%	203	44.6%
12-14	295	38.8%	267	36.3%	256	37.5%	253	36.6%	218	32.7%	224	36.3%	181	33.5%
15 and Older	189	38.3%	167	34.8%	136	29.6%	109	23.2%	145	27.2%	105	22.5%	121	24.5%

African American	915	27.9%	808	26.8%	788	27.9%	679	26.9%	727	27.0%	654	28.0%	662	30.8%
Hispanic	121	36.3%	138	36.8%	134	46.5%	70	29.3%	116	37.2%	71	29.6%	101	41.6%
Other	84	42.0%	82	46.9%	68	42.5%	40	48.8%	41	36.9%	37	42.5%	33	41.3%
White	964	47.9%	956	46.2%	945	46.7%	997	45.5%	995	45.5%	931	44.1%	899	44.2%

Permanence at 36 Months: Adoption

Indicator 3.C.2	Of all children who entered substitute care during the year and stayed for longer than 7 days, what percentage was adopted within 36 months from the date of entry into substitute care?						
IN ILLINOIS	2001	2002	2003	2004	2005	2006	2007
Total Entering Substitute Care	5,827	5,636	5,296	5,034	5,299	4,771	4,504
Adopted at 24 Months	959	932	763	737	719	691	599
Percent	16.5%	16.5%	14.4%	14.6%	13.6%	14.5%	13.3%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	959	16.5%	932	16.5%	763	14.4%	737	14.6%	719	13.6%	691	14.5%	599	13.3%
Central	286	17.6%	266	17.7%	264	16.0%	294	18.3%	304	19.0%	296	19.2%	296	17.6%
Cook	418	16.2%	450	17.4%	273	13.0%	190	11.1%	179	9.4%	171	12.3%	115	9.7%
Northern	156	16.4%	131	15.4%	125	14.8%	164	17.9%	127	13.7%	118	12.0%	109	13.6%
Southern	99	14.6%	85	12.2%	101	14.4%	89	11.1%	109	12.6%	106	12.3%	79	9.5%

Female	461	16.5%	487	17.6%	373	14.7%	344	14.5%	341	13.1%	346	14.8%	310	14.1%
Male	498	16.5%	445	15.5%	390	14.1%	392	14.8%	377	14.0%	340	14.1%	289	12.5%

Under 3	633	29.2%	628	29.4%	503	24.6%	470	24.8%	503	24.6%	463	24.4%	420	23.8%
3-5	120	13.1%	104	11.9%	94	11.8%	101	13.3%	97	12.0%	90	11.7%	72	10.4%
6-8	88	11.6%	76	10.6%	69	10.2%	65	10.2%	63	9.6%	57	9.9%	46	8.2%
9-11	72	9.8%	73	10.5%	48	7.5%	50	8.6%	30	5.0%	34	7.6%	24	5.3%
12-14	40	5.3%	41	5.6%	37	5.4%	36	5.2%	15	2.2%	32	5.2%	29	5.4%
15 and Older	6	1.2%	10	2.1%	12	2.6%	15	3.2%	11	2.1%	15	3.2%	8	1.6%

African American	541	16.5%	504	16.7%	400	14.2%	338	13.4%	319	11.9%	318	13.6%	265	12.3%
Hispanic	29	8.7%	40	10.7%	22	7.6%	28	11.7%	29	9.3%	27	11.3%	31	12.8%
Other	46	23.0%	32	18.3%	20	12.5%	6	7.3%	17	15.3%	15	17.2%	14	17.5%
White	343	17.0%	356	17.2%	321	15.9%	365	16.7%	354	16.2%	331	15.7%	289	14.2%

Permanence at 36 Months: Subsidized Guardianship

Indicator 3.C.3	Of all children who entered substitute care during the year and stayed longer than 7 days, what percentage attained subsidized guardianship within 36 months from the date of entry into substitute care?						
IN ILLINOIS	2001	2002	2003	2004	2005	2006	2007
Total Entering Substitute Care	5,827	5,636	5,296	5,034	5,299	4,771	4,504
Attained Subsidized Guardianship at 36 Months	281	283	184	233	225	175	180
Percent	4.8%	5.0%	3.5%	4.6%	4.2%	3.7%	4.0%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	281	4.8%	283	5.0%	184	3.5%	233	4.6%	225	4.2%	175	3.7%	180	4.0%
Central	57	3.5%	60	4.0%	25	1.5%	63	3.9%	71	4.4%	63	4.1%	55	3.3%
Cook	153	5.9%	155	6.0%	97	4.6%	106	6.2%	114	6.0%	61	4.4%	71	6.0%
Northern	45	4.7%	50	5.9%	32	3.8%	32	3.5%	21	2.3%	33	3.4%	34	4.2%
Southern	26	3.8%	18	2.6%	30	4.3%	32	4.0%	19	2.2%	18	2.1%	20	2.4%

Female	158	5.6%	157	5.7%	94	3.7%	114	4.8%	114	4.4%	89	3.8%	89	4.1%
Male	123	4.1%	126	4.4%	90	3.3%	119	4.5%	111	4.1%	86	3.6%	91	3.9%

Under 3	61	2.8%	68	3.2%	39	1.9%	55	2.9%	56	2.7%	50	2.6%	44	2.5%
3-5	58	6.3%	37	4.2%	22	2.8%	39	5.1%	36	4.4%	20	2.6%	20	2.9%
6-8	43	5.7%	48	6.7%	37	5.5%	46	7.2%	38	5.8%	27	4.7%	22	3.9%
9-11	59	8.0%	53	7.6%	35	5.5%	36	6.2%	41	6.9%	36	8.1%	45	9.9%
12-14	52	6.8%	57	7.7%	43	6.3%	44	6.4%	41	6.1%	34	5.5%	40	7.4%
15 and Older	8	1.6%	20	4.2%	8	1.7%	13	2.8%	13	2.4%	8	1.7%	9	1.8%

African American	178	5.4%	180	6.0%	113	4.0%	128	5.1%	133	4.9%	82	3.5%	93	4.3%
Hispanic	16	4.8%	9	2.4%	7	2.4%	14	5.9%	4	1.3%	8	3.3%	12	4.9%
Other	9	4.5%	4	2.3%	5	3.1%	1	1.2%	4	3.6%	1	1.1%	1	1.3%
White	78	3.9%	90	4.4%	59	2.9%	90	4.1%	84	3.8%	84	4.0%	74	3.6%

Permanence at 36 Months: Reunification + Adoption + Subsidized Guardianship

Indicator 3.C.4	Of all children who entered substitute care during the year and stayed for longer than 7 days, what percentage attained permanence (reunification + adoption + subsidized guardianship) within 36 months from the date of entry into substitute care?						
IN ILLINOIS	2001	2002	2003	2004	2005	2006	2007
Total Entering Substitute Care	5,827	5,636	5,296	5,034	5,299	4,771	4,504
Total in a Permanent Home at 36 Months (Reunification + Adoption + Subsidized Guardianship)	3,324	3,199	2,882	2,756	2,823	2,559	2,474
Percent	57.0%	56.8%	54.4%	54.7%	53.3%	53.6%	54.9%

Stability of Permanence at Two Years: Reunification

Indicator 3.D.1	Of all children who were reunified during the year (excluding cases of less than 8 days), what percentage remain with their families at two years?						
IN ILLINOIS	2002	2003	2004	2005	2006	2007	2008
Reunified	2,747	2,431	2,077	2,147	2,013	1,995	1,995
Stable at Two Years	2,167	1,910	1,616	1,710	1,647	1,604	1,616
Percent	79%	79%	78%	80%	82%	80%	81%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	2,167	79%	1,910	79%	1,616	78%	1,710	80%	1,647	82%	1,604	80%	1,616	81%
Central	685	74%	619	74%	526	73%	586	77%	508	79%	582	79%	663	81%
Cook	794	85%	662	85%	514	84%	451	85%	440	86%	365	85%	302	85%
Northern	386	78%	338	79%	275	76%	315	78%	311	81%	329	80%	301	81%
Southern	302	77%	291	74%	301	78%	358	79%	388	83%	328	79%	350	78%

Female	1,037	82%	896	79%	764	78%	808	80%	820	83%	765	81%	766	80%
Male	1,130	77%	1,012	78%	851	78%	899	79%	826	80%	839	80%	846	82%

Under 3	405	77%	379	78%	343	78%	352	79%	349	82%	351	81%	370	79%
3-5	383	81%	368	80%	302	75%	358	79%	343	81%	359	82%	385	86%
6-8	389	82%	347	82%	263	80%	290	83%	317	89%	249	79%	282	81%
9-11	353	82%	305	82%	243	82%	270	87%	250	85%	245	83%	204	82%
12-14	290	71%	249	72%	242	73%	231	76%	211	74%	190	77%	178	78%
15 and Older	347	80%	262	77%	223	78%	209	74%	177	77%	210	79%	197	78%

African American	1,071	81%	944	81%	673	77%	719	78%	686	82%	728	81%	557	78%
Hispanic	160	84%	152	84%	95	81%	127	88%	94	86%	84	84%	125	91%
Other	78	80%	65	77%	52	88%	46	88%	29	78%	38	84%	55	90%
White	858	76%	749	75%	796	78%	818	80%	838	82%	754	79%	879	81%

Stability of Permanence at Two Years: Adoption

Indicator 3.D.2	Of all children who were adopted during the year (excluding cases of less than 8 days), what percentage remain with their families at two years?						
IN ILLINOIS	2002	2003	2004	2005	2006	2007	2008
Adopted	3,595	3,077	2,412	2,047	1,807	1,838	1,645
Stable at Two Years	3,523	3,040	2,378	2,020	1,775	1,800	1,621
Percent	98%	99%	99%	99%	98%	98%	99%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	3,523	98%	3,040	99%	2,378	99%	2,020	99%	1,775	98%	1,800	98%	1,621	99%
Central	618	98%	494	99%	491	98%	446	100%	464	99%	541	98%	502	99%
Cook	2,380	98%	1,971	99%	1,438	99%	1,118	98%	878	98%	760	98%	662	99%
Northern	366	98%	397	99%	270	99%	247	100%	236	96%	297	98%	278	99%
Southern	159	96%	178	99%	179	97%	209	100%	197	99%	202	99%	179	97%

Female	1,727	98%	1,497	99%	1,187	99%	971	98%	870	98%	878	98%	796	99%
Male	1,796	98%	1,543	99%	1,191	99%	1,047	99%	904	98%	922	98%	825	98%

Under 3	533	99%	465	99%	403	99%	354	99%	315	99%	339	99%	310	99%
3-5	965	99%	860	100%	652	99%	593	99%	570	99%	635	99%	521	100%
6-8	739	99%	634	99%	460	99%	431	99%	333	99%	355	98%	350	99%
9-11	712	97%	586	99%	416	99%	327	99%	277	97%	224	98%	214	97%
12-14	419	95%	374	97%	310	97%	218	98%	183	94%	159	94%	135	95%
15 and Older	155	96%	121	97%	137	96%	97	96%	97	98%	88	94%	91	95%

African American	2,600	98%	2,138	99%	1,665	99%	1,298	98%	1,072	98%	1,020	98%	896	98%
Hispanic	199	100%	160	99%	93	99%	103	98%	79	99%	91	97%	97	100%
Other	64	100%	60	100%	46	100%	39	100%	28	100%	18	95%	26	100%
White	660	99%	682	99%	574	97%	580	100%	596	99%	671	98%	602	98%

Stability of Permanence at Two Years: Subsidized Guardianship

Indicator 3.D.3	Of all children who attained subsidized guardianship during the year (excluding cases of less than 8 days), what percentage remain with their families at two years?						
IN ILLINOIS	2002	2003	2004	2005	2006	2007	2008
Attained Subsidized Guardianship	1,079	914	670	651	579	583	475
Stable at Two Years	1,041	868	647	622	564	562	444
Percent	96%	95%	97%	96%	97%	96%	93%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	1,041	96%	868	95%	647	97%	622	96%	564	97%	562	96%	444	93%
Central	146	95%	140	93%	87	94%	86	97%	78	91%	129	98%	77	94%
Cook	805	98%	572	97%	432	99%	449	96%	377	98%	310	95%	256	93%
Northern	80	86%	110	89%	89	93%	47	92%	56	98%	71	97%	64	90%
Southern	10	100%	46	94%	39	91%	40	98%	53	100%	52	98%	47	98%

Female	517	98%	398	93%	356	96%	330	96%	261	97%	269	97%	214	94%
Male	524	95%	470	97%	291	97%	292	95%	303	98%	293	96%	229	93%

Under 3	21	95%	25	100%	20	100%	22	100%	27	96%	27	100%	19	100%
3-5	130	96%	124	98%	92	100%	78	96%	79	98%	85	97%	63	97%
6-8	164	98%	146	96%	100	97%	104	97%	93	98%	88	97%	63	91%
9-11	240	98%	170	95%	111	98%	121	95%	132	99%	109	97%	86	92%
12-14	294	96%	237	95%	185	95%	175	95%	143	97%	124	95%	102	91%
15 and Older	192	95%	166	91%	139	94%	122	94%	90	95%	129	96%	111	95%

African American	837	97%	636	95%	482	97%	453	98%	415	98%	366	96%	312	94%
Hispanic	40	100%	35	92%	21	100%	34	83%	23	100%	11	100%	22	100%
Other	18	90%	20	91%	7	70%	5	100%	2	100%	10	100%	6	75%
White	146	94%	177	94%	137	97%	130	92%	124	95%	175	96%	104	93%

Stability of Permanence at Two Years: Reunification + Adoption + Subsidized Guardianship

Indicator 3.D.4	Of all children who attained permanence during the year (excluding cases of less than 8 days), what percentage remain with their families at two years?						
IN ILLINOIS	2002	2003	2004	2005	2006	2007	2008
Attained Permanence	7,421	6,422	5,159	4,845	4,399	4,416	4,115
Stable Placements at Two Years (Reunification + Adoption + Subsidized Guardianship)	6,731	5,818	4,641	4,352	3,986	3,966	3,681
Percent	91%	91%	90%	90%	91%	90%	89%

Stability of Permanence at Five Years: Reunification

Indicator 3.E.1	Of all children who were reunified during the year (excluding cases of less than 8 days), what percentage remain with their families at five years?						
IN ILLINOIS	1999	2000	2001	2002	2003	2004	2005
Reunified	4,186	3,463	2,858	2,747	2,431	2,077	2,147
Stable at Five Years	3,210	2,596	2,174	2,088	1,818	1,537	1,612
Percent	77%	75%	76%	76%	75%	74%	75%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	3,210	77%	2,596	75%	2,174	76%	2,088	76%	1,818	75%	1,537	74%	1,612	75%
Central	660	66%	618	68%	666	72%	654	71%	582	70%	499	69%	549	73%
Cook	1,823	85%	1,393	83%	898	85%	778	83%	639	82%	500	82%	435	82%
Northern	414	69%	359	68%	355	71%	368	74%	321	75%	262	72%	293	73%
Southern	313	72%	226	66%	255	68%	288	73%	276	70%	276	72%	335	74%

Female	1,580	76%	1,268	76%	1,063	77%	995	78%	858	76%	726	74%	766	76%
Male	1,628	77%	1,324	74%	1,110	75%	1,093	74%	958	74%	810	74%	843	74%

Under 3	471	71%	389	69%	378	75%	380	72%	357	73%	322	74%	326	73%
3-5	669	82%	511	76%	397	75%	364	77%	342	75%	283	71%	336	74%
6-8	626	80%	525	81%	376	78%	376	79%	334	79%	246	75%	265	76%
9-11	557	78%	446	76%	363	78%	338	78%	287	77%	228	77%	254	82%
12-14	411	68%	365	70%	310	74%	284	69%	237	68%	236	71%	223	73%
15 and Older	476	80%	360	78%	350	76%	346	79%	261	76%	222	78%	208	73%

African American	1,836	80%	1,532	77%	1,131	78%	1,039	78%	900	77%	647	74%	672	73%
Hispanic	277	86%	200	86%	144	88%	153	81%	144	80%	91	77%	124	86%
Other	85	69%	57	67%	61	71%	76	78%	60	71%	52	88%	45	87%
White	1,012	70%	807	70%	838	73%	820	72%	714	71%	747	73%	771	75%

Stability of Permanence at Five Years: Adoption

Indicator 3.E.2	Of all children who were adopted during the year (excluding cases of less than 8 days), what percentage remain with their families at five years?						
IN ILLINOIS	1999	2000	2001	2002	2003	2004	2005
Adopted	7,186	6,204	4,398	3,595	3,077	2,412	2,047
Stable at Five Years	6,830	5,923	4,195	3,410	2,937	2,302	1,949
Percent	95%	95%	95%	95%	95%	95%	95%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	6,830	95%	5,923	95%	4,195	95%	3,410	95%	2,937	95%	2,302	95%	1,949	95%
Central	635	95%	701	96%	583	97%	601	96%	482	97%	476	95%	427	95%
Cook	5,483	95%	4,577	96%	2,962	95%	2,302	95%	1,892	95%	1,389	95%	1,077	94%
Northern	434	95%	386	93%	454	95%	356	96%	388	97%	262	96%	240	97%
Southern	278	95%	259	95%	196	97%	151	91%	175	97%	175	95%	205	98%

Female	3,491	96%	3,013	95%	2,052	95%	1,670	95%	1,446	96%	1,154	96%	933	95%
Male	3,339	95%	2,907	95%	2,143	96%	1,740	95%	1,491	95%	1,148	95%	1,014	96%

Under 3	540	97%	518	96%	435	97%	530	99%	460	98%	398	98%	349	98%
3-5	2,027	96%	1,807	97%	1,219	97%	943	96%	846	98%	645	98%	578	96%
6-8	1,856	95%	1,580	95%	1,023	95%	719	96%	617	96%	448	97%	420	96%
9-11	1,359	92%	1,211	94%	862	94%	677	92%	549	93%	388	92%	303	92%
12-14	766	94%	596	92%	473	93%	388	88%	345	90%	286	89%	203	91%
15 and Older	282	97%	211	100%	183	97%	153	95%	120	96%	137	96%	96	95%

African American	5,530	95%	4,715	95%	3,305	95%	2,504	94%	2,050	95%	1,606	95%	1,243	94%
Hispanic	275	95%	289	98%	197	95%	195	98%	154	95%	91	97%	103	98%
Other	54	98%	76	96%	65	98%	64	100%	59	98%	45	98%	37	95%
White	971	96%	843	95%	628	96%	647	97%	674	98%	560	95%	566	97%

Stability of Permanence at Five Years: Subsidized Guardianship

Indicator 3.E.3	Of all children who attained subsidized guardianship during the year (excluding cases of less than 8 days), what percentage remain with their families at five years?						
IN ILLINOIS	1999	2000	2001	2002	2003	2004	2005
Attained Subsidized Guardianship	2,059	1,634	1,135	1,079	914	670	651
Stable at Five Years	1,867	1,499	1,015	965	798	598	563
Percent	91%	92%	89%	89%	87%	89%	86%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	1,867	91%	1,499	92%	1,015	89%	965	89%	798	87%	598	89%	563	86%
Central	122	89%	135	89%	112	90%	126	82%	130	86%	82	88%	83	93%
Cook	1,506	91%	1,146	92%	773	89%	756	92%	523	89%	401	92%	402	86%
Northern	200	87%	180	92%	93	87%	74	80%	102	82%	80	83%	39	76%
Southern	39	85%	38	88%	37	93%	9	90%	43	88%	35	81%	39	95%

Female	944	92%	788	91%	491	89%	477	90%	356	83%	329	89%	302	88%
Male	923	90%	709	93%	524	89%	488	89%	442	91%	269	89%	261	85%

Under 3	18	95%	21	100%	12	92%	19	86%	24	96%	20	100%	22	100%
3-5	252	94%	165	95%	116	91%	125	93%	119	94%	90	98%	71	88%
6-8	423	93%	306	91%	177	90%	156	93%	130	86%	94	91%	96	90%
9-11	467	88%	371	92%	230	88%	215	87%	148	83%	96	85%	102	80%
12-14	425	87%	392	89%	294	85%	260	85%	211	84%	159	82%	151	82%
15 and Older	282	96%	244	95%	186	96%	190	94%	166	91%	139	94%	121	93%

African American	1,645	91%	1,255	92%	802	89%	770	89%	583	88%	442	89%	404	87%
Hispanic	24	71%	34	87%	38	95%	39	98%	31	82%	20	95%	31	76%
Other	2	100%	11	85%	10	83%	18	90%	19	86%	7	70%	5	100%
White	196	88%	199	90%	165	92%	138	88%	165	88%	129	91%	123	87%

Stability of Permanence at Five Years: Reunification + Adoption + Subsidized Guardianship

Indicator 3.E.4	Of all children who attained permanence during the year (excluding cases of less than 8 days), what percentage remain with their families at five years?						
IN ILLINOIS	1999	2000	2001	2002	2003	2004	2005
Attained Permanence	13,431	11,301	8,391	7,421	6,422	5,159	4,845
Stable Placements at Five Years (Reunification + Adoption + Subsidized Guardianship)	11,907	10,018	7,384	6,463	5,553	4,437	4,124
Percent	89%	89%	88%	87%	86%	86%	85%

Stability of Permanence at Ten Years: Reunification

Indicator 3.F.1	Of all children who were reunified during the year (excluding cases of less than 8 days), what percentage remain with their families at ten years?						
IN ILLINOIS	1994	1995	1996	1997	1998	1999	2000
Reunified	3,241	4,124	4,060	4,473	4,263	4,186	3,463
Stable at Ten Years	2,026	2,766	2,758	3,158	3,067	3,163	2,512
Percent	63%	67%	68%	71%	72%	76%	73%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	2,026	63%	2,766	67%	2,758	68%	3,158	71%	3,067	72%	3,163	76%	2,512	73%
Central	807	63%	886	62%	788	61%	773	62%	667	59%	650	65%	589	64%
Cook	524	62%	1,020	72%	1,168	77%	1,544	79%	1,694	82%	1,801	83%	1,368	81%
Northern	412	64%	502	69%	491	64%	517	66%	427	66%	410	68%	337	64%
Southern	283	59%	358	65%	311	63%	324	65%	279	68%	302	70%	218	63%

Female	997	63%	1,392	68%	1,411	70%	1,607	72%	1,572	73%	1,559	75%	1,212	73%
Male	1,028	62%	1,371	66%	1,345	66%	1,550	69%	1,492	71%	1,602	76%	1,296	72%

Under 3	401	59%	553	66%	463	65%	485	67%	503	69%	461	70%	371	66%
3-5	440	65%	509	67%	539	67%	641	69%	609	70%	648	79%	483	72%
6-8	293	61%	405	67%	473	67%	579	73%	580	74%	615	78%	497	76%
9-11	247	64%	400	72%	343	66%	435	71%	521	75%	552	77%	436	74%
12-14	270	55%	363	59%	381	65%	428	68%	393	65%	411	68%	365	70%
15 and Older	375	71%	535	72%	559	76%	590	75%	461	78%	476	80%	360	78%

African American	862	59%	1,333	67%	1,445	70%	1,786	73%	1,802	74%	1,813	79%	1,480	74%
Hispanic	132	74%	168	77%	169	78%	204	81%	232	83%	274	85%	194	83%
Other	43	66%	53	68%	64	72%	61	68%	69	65%	84	68%	57	67%
White	989	64%	1,212	66%	1,080	64%	1,107	66%	964	67%	992	69%	781	68%

Stability of Permanence at Ten Years: Adoption

Indicator 3.F.2	Of all children who were adopted during the year (excluding cases of less than 8 days), what percentage remain with their families at ten years?						
IN ILLINOIS	1994	1995	1996	1997	1998	1999	2000
Adopted	1,253	1,649	2,015	2,089	4,874	7,186	6,204
Stable at Ten Years	1,124	1,503	1,847	1,901	4,432	6,462	5,597
Percent	90%	91%	92%	91%	91%	90%	90%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	1,124	90%	1,503	91%	1,847	92%	1,901	91%	4,432	91%	6,462	90%	5,597	90%
Central	254	92%	303	91%	322	90%	345	92%	458	91%	587	88%	667	91%
Cook	654	90%	906	92%	1,179	93%	1,220	91%	3,457	91%	5,194	90%	4,322	90%
Northern	131	85%	181	92%	185	86%	194	91%	323	91%	416	91%	369	89%
Southern	85	88%	113	88%	161	95%	142	87%	194	89%	265	90%	239	88%

Female	573	90%	750	91%	923	91%	960	91%	2,246	91%	3,292	90%	2,848	90%
Male	551	90%	753	92%	924	92%	941	91%	2,186	91%	3,170	90%	2,746	90%

Under 3	172	95%	148	93%	157	92%	118	96%	336	92%	524	95%	493	92%
3-5	348	90%	430	92%	570	93%	602	92%	1,410	93%	1,897	90%	1,717	92%
6-8	274	88%	415	89%	474	90%	514	88%	1,214	88%	1,703	87%	1,437	87%
9-11	171	86%	277	92%	344	88%	361	90%	852	89%	1,291	88%	1,143	89%
12-14	110	88%	159	90%	220	96%	221	93%	461	91%	765	94%	596	92%
15 and Older	49	98%	74	99%	82	98%	85	98%	159	99%	282	97%	211	100%

African American	644	89%	989	90%	1,308	92%	1,367	91%	3,435	90%	5,223	90%	4,439	90%
Hispanic	75	89%	59	95%	100	89%	104	92%	257	93%	265	91%	279	95%
Other	7	88%	20	100%	8	100%	18	86%	41	100%	49	89%	76	96%
White	398	91%	435	93%	431	92%	412	92%	699	93%	925	91%	803	91%

Stability of Permanence at Ten Years: Subsidized Guardianship

Indicator 3.F.3	Of all children who attained subsidized guardianship during the year (excluding cases of less than 8 days), what percentage remain with their families at ten years?						
IN ILLINOIS	1994	1995	1996	1997	1998	1999	2000
Attained Subsidized Guardianship	0	0	0	185	1,279	2,059	1,634
Stable at Ten Years	0	0	0	171	1,070	1,747	1,406
Percent	-	-	-	92%	84%	85%	86%

	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Illinois	0	-	0	-	0	-	171	92%	1,070	84%	1,747	85%	1,406	86%
Central	0	-	0	-	0	-	2	100%	57	74%	117	85%	130	86%
Cook	0	-	0	-	0	-	160	93%	865	85%	1,416	86%	1,075	86%
Northern	0	-	0	-	0	-	2	100%	118	76%	177	77%	164	84%
Southern	0	-	0	-	0	-	7	78%	30	86%	37	80%	37	86%

Female	0	-	0	-	0	-	69	95%	535	83%	880	85%	743	86%
Male	0	-	0	-	0	-	102	91%	533	84%	867	84%	661	86%

Under 3	0	-	0	-	0	-	2	100%	14	78%	16	84%	21	100%
3-5	0	-	0	-	0	-	18	86%	141	82%	226	84%	145	84%
6-8	0	-	0	-	0	-	41	89%	208	79%	369	81%	265	79%
9-11	0	-	0	-	0	-	42	93%	260	82%	429	81%	339	84%
12-14	0	-	0	-	0	-	40	93%	266	84%	425	87%	392	89%
15 and Older	0	-	0	-	0	-	28	100%	181	95%	282	96%	244	95%

African American	0	-	0	-	0	-	150	92%	970	84%	1,537	85%	1,179	87%
Hispanic	0	-	0	-	0	-	1	100%	7	70%	22	65%	32	82%
Other	0	-	0	-	0	-	1	50%	6	75%	2	100%	11	85%
White	0	-	0	-	0	-	19	100%	87	83%	186	84%	184	84%

Stability of Permanence at Ten Years: Reunification + Adoption + Subsidized Guardianship

Indicator 3.F.4	Of all children who attained permanence during the year (excluding cases of less than 8 days), what percentage remain with their families at ten years?						
IN ILLINOIS	1994	1995	1996	1997	1998	1999	2000
Attained Permanence	4,494	5,773	6,075	6,747	10,416	13,431	11,301
Stable Placements at Ten Years (Reunification + Adoption + Subsidized Guardianship)	3,150	4,269	4,605	5,230	8,569	11,372	9,515
Percent	70%	74%	76%	78%	82%	85%	84%



APPENDIX C

Outcome Data by Sub-Region

Appendix C provides a more comprehensive look at select outcome indicators used in the following chapters in this report: Chapter 1 - Child Safety; Chapter 2 - Children in Substitute Care: Safety, Continuity, and Stability; and Chapter 3 - Legal Permanence: Reunification, Adoption, and Guardianship. The data used in these indicators come from the September 30, 2010 data extract of the Illinois Department of Children and Family Services Integrated Database. The indicators show Illinois totals and breakdowns by sub-regions over a seven year period and only indicators that were analyzed by sub-region are included in this appendix. The State Fiscal Year is used throughout this data. All indicator data are available on-line at: <http://www.cfrc.illinois.edu/outcomeindicators.php>.

Maltreatment Recurrence at 12 Months

Indicator 1.A	Of all children with a substantiated report, what percentage had another substantiated report within 12 months?						
IN ILLINOIS:	2003	2004	2005	2006	2007	2008	2009
Children with Substantiated Report	25,839	25,782	25,937	24,857	26,510	27,859	27,391
Children with Another Substantiated Recurrence within 12 months	2,976	2,976	2,952	2,842	3,043	3,214	3,012
Percent	11.5%	11.5%	11.4%	11.4%	11.5%	11.5%	11.0%

SUB-REGION	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Cook North	255	7.5%	211	10.1%	163	7.8%	155	7.8%	151	7.7%	195	9.5%	211	9.7%
Cook Central	156	9.6%	221	7.9%	215	8.1%	286	10.0%	251	8.0%	229	8.1%	175	6.8%
Cook South	337	8.8%	248	8.5%	246	8.7%	200	8.0%	215	8.9%	236	8.3%	236	8.9%
Aurora	327	8.7%	317	8.6%	343	8.8%	387	9.4%	408	9.0%	500	9.3%	438	8.4%
Rockford	222	11.4%	254	12.7%	277	13.1%	266	13.3%	279	12.4%	375	15.2%	333	12.7%
Champaign	353	14.2%	365	12.2%	312	11.4%	321	12.2%	360	12.1%	371	12.5%	387	13.1%
Peoria	394	13.6%	411	13.3%	400	12.8%	386	12.6%	415	13.1%	394	12.5%	430	13.3%
Springfield	345	17.0%	360	16.1%	370	15.8%	282	14.4%	371	17.9%	334	15.3%	257	11.8%
East St Louis	221	12.8%	199	12.6%	197	11.4%	196	13.3%	232	13.1%	173	10.1%	169	10.5%
Marion	366	17.3%	388	16.6%	429	17.7%	363	16.0%	361	16.2%	407	17.7%	376	17.4%

Maltreatment Recurrence Among Intact Family Cases

Indicator 1.B	Of all children served at home in intact family cases, what percentage had another substantiated report within 12 months?						
IN ILLINOIS	2003	2004	2005	2006	2007	2008	2009
Number of Children in Intact Family Cases	20,011	20,033	19,317	17,197	16,502	15,520	15,793
Children with Substantiated Report	2,071	2,083	2,100	1,895	1,957	1,882	1,752
Percent	10.3%	10.4%	10.9%	11.0%	11.9%	12.1%	11.1%

SUB-REGION	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Cook North	206	7.5%	133	7.9%	131	9.2%	87	7.4%	118	9.1%	120	9.8%	119	8.5%
Cook Central	181	5.7%	242	6.1%	238	5.7%	207	6.2%	221	6.0%	198	6.4%	159	5.2%
Cook South	186	7.3%	156	7.1%	126	6.2%	120	5.9%	192	8.7%	170	8.6%	176	7.9%
Aurora	172	9.3%	187	11.1%	183	12.3%	178	12.9%	197	12.5%	247	13.4%	227	10.5%
Rockford	113	12.0%	134	11.7%	157	14.7%	162	15.4%	117	14.0%	221	18.9%	130	12.6%
Champaign	245	13.4%	284	12.6%	292	13.3%	264	13.8%	257	15.6%	189	13.8%	213	15.8%
Peoria	373	12.4%	342	11.0%	343	12.5%	340	12.6%	251	13.8%	222	13.6%	207	14.2%
Springfield	240	15.6%	229	14.9%	265	17.8%	205	16.5%	202	18.1%	124	14.7%	161	17.8%
East St Louis	132	11.7%	122	11.3%	174	12.0%	134	11.4%	188	15.4%	162	13.2%	141	12.5%
Marion	223	18.1%	254	18.8%	191	15.6%	198	16.8%	214	19.3%	229	20.4%	219	19.9%

Maltreatment Recurrence in Substitute Care

Indicator 2.A	Of all children ever served in substitute care during the year, what percentage had a substantiated report during placement?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
Children ever in Substitute Care	26,305	24,970	23,465	22,471	22,119	21,756	21,573
Children with Substantiated Reports	332	324	257	302	340	354	314
Percent	1.3%	1.3%	1.1%	1.3%	1.5%	1.6%	1.5%

SUB-REGION	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Cook North	45	1.0%	40	1.1%	31	1.0%	19	0.7%	21	0.8%	29	1.1%	22	0.9%
Cook Central	48	0.9%	49	1.0%	30	0.7%	41	1.0%	36	1.0%	18	0.6%	22	0.8%
Cook South	39	0.9%	25	0.6%	30	0.8%	36	1.1%	23	0.7%	43	1.3%	24	0.8%
Aurora	28	1.4%	28	1.3%	21	1.0%	24	1.1%	34	1.4%	35	1.4%	20	0.8%
Rockford	25	2.1%	25	2.0%	25	1.9%	27	2.1%	40	3.1%	50	3.4%	34	2.2%
Champaign	43	2.4%	26	1.5%	17	0.9%	35	1.8%	45	2.2%	53	2.5%	45	2.1%
Peoria	61	1.7%	72	2.1%	37	1.2%	39	1.3%	47	1.6%	57	2.2%	51	1.9%
Springfield	8	0.8%	26	2.4%	16	1.4%	26	2.3%	20	1.7%	21	1.8%	29	2.4%
East St Louis	15	1.1%	22	1.6%	27	1.9%	37	2.5%	36	2.5%	30	2.0%	25	1.5%
Marion	20	1.9%	11	1.0%	23	1.9%	18	1.5%	38	3.1%	18	1.5%	42	3.2%

Placing Children Close to Home - End of Year Placement

Indicator 2.G.7	Of all children in substitute care at the end of the fiscal year, what is the median* distance from their home of origin?						
IN ILLINOIS	2004	2005	2006	2007	2008	2009	2010
In Substitute Care at the End of the Year	20,089	19,317	18,430	17,246	17,373	16,906	16,533
Median Miles from Home	8.4	8.5	8.7	9.1	9.1	8.9	9.1

SUB-REGION	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES	N	MILES
Cook North	3,406	8.9	3,053	9.1	2,625	9.1	2,307	9.8	2,281	9.6	2,172	8.8	2,092	8.9
Cook Central	4,299	7.8	3,901	7.9	3,506	8.5	3,094	8.9	2,813	9.5	2,394	9.7	2,120	9.4
Cook South	3,530	7.8	3,304	8.0	3,008	8.7	2,758	8.8	2,711	8.8	2,565	9.2	2,552	8.9
Aurora	1,565	13.3	1,628	13.7	1,730	14.5	1,677	13.6	1,839	15.5	1,945	15.0	1,864	15.4
Rockford	867	6.2	923	5.5	995	5.2	899	4.9	990	5.1	1,101	5.4	1,176	5.4
Champaign	1,278	10.1	1,273	12.8	1,347	10.2	1,399	4.9	1,505	4.8	1,489	4.8	1,525	5.8
Peoria	2,724	6.9	2,685	6.5	2,591	6.8	2,415	6.4	2,436	6.5	2,229	5.8	1,980	6.1
Springfield	720	20.6	780	15.0	838	9.9	838	15.3	861	15.0	906	19.2	956	17.2
East St Louis	974	8.9	994	8.4	971	7.6	1,040	8.8	1,105	8.0	1,203	8.1	1,357	8.4
Marion	726	15.5	776	19.1	819	19.1	819	21.0	832	18.4	902	15.8	911	13.3

*Median includes children with valid address information

Median Length of Stay in Substitute Care

Indicator 2.J	Of children entering substitute care for the first time during that fiscal year, what is the median length of stay in substitute care?						
IN ILLINOIS	2002	2003	2004	2005	2006	2007	2008
Median Length of Stay (in months)	31	30	29	31	29	28	28

SUB-REGION							
Cook North	37	41	41	49	51	41	30
Cook Central	40	39	37	42	35	30	28
Cook South	39	48	46	46	45	41	31
Aurora	24	26	31	31	35	31	28
Rockford	18	25	27	25	26	32	28
Champaign	18	23	22	23	22	23	22
Peoria	24	28	28	27	26	28	28
Springfield	22	23	23	20	24	24	27
East St Louis	19	22	20	22	21	23	28
Marion	13	17	15	13	20	19	20

Permanence at 36 Months: Reunification

Indicator 3.C.1	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 36 months from the date of entry into substitute care?						
IN ILLINOIS	2001	2002	2003	2004	2005	2006	2007
Total Entering Substitute Care	5,827	5,636	5,296	5,034	5,299	4,771	4,504
Reunified at 36 Months	2,084	1,984	1,935	1,786	1,879	1,693	1,695
Percent	35.8%	35.2%	36.5%	35.5%	35.5%	35.5%	37.6%

SUB-REGION	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Cook North	163	24.1%	207	27.4%	164	26.9%	113	24.8%	105	21.4%	71	21.9%	53	18.3%
Cook Central	150	14.8%	146	13.8%	119	13.4%	98	12.8%	115	13.7%	86	13.8%	71	14.8%
Cook South	254	28.7%	182	23.7%	154	25.5%	118	23.8%	126	22.0%	96	21.6%	106	25.2%
Aurora	259	42.8%	214	43.5%	218	41.8%	190	36.3%	235	43.1%	211	36.6%	193	38.4%
Rockford	166	47.7%	185	51.5%	147	45.9%	156	39.6%	167	43.5%	180	44.6%	112	37.5%
Champaign	278	50.9%	255	51.5%	339	54.0%	282	47.2%	241	43.0%	250	44.8%	337	49.8%
Peoria	337	42.4%	274	39.0%	318	42.7%	251	38.1%	258	39.0%	242	37.6%	293	43.3%
Springfield	156	55.5%	153	50.5%	137	49.5%	147	42.4%	191	50.9%	145	42.9%	145	44.6%
East St Louis	158	44.6%	197	51.4%	149	44.1%	204	50.6%	194	46.6%	202	45.6%	209	44.1%
Marion	163	50.2%	171	54.1%	190	52.3%	227	57.3%	247	54.6%	210	50.4%	176	49.0%

Permanence at 36 Months: Adoption

Indicator 3.C.2	Of all children who entered substitute care during the year and stayed for longer than 7 days, what percentage was adopted within 36 months from the date of entry into substitute care?						
IN ILLINOIS	2001	2002	2003	2004	2005	2006	2007
Total Entering Substitute Care	5,827	5,636	5,296	5,034	5,299	4,771	4,504
Adopted at 24 Months	959	932	763	737	719	691	599
Percent	16.5%	16.5%	14.4%	14.6%	13.6%	14.5%	13.3%

SUB-REGION	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Cook North	143	21.2%	151	20.0%	87	14.3%	52	11.4%	51	10.4%	24	7.4%	22	7.6%
Cook Central	121	12.0%	136	12.8%	115	12.9%	92	12.1%	71	8.5%	104	16.7%	67	14.0%
Cook South	154	17.4%	163	21.2%	71	11.8%	46	9.3%	57	9.9%	43	9.7%	26	6.2%
Aurora	100	16.5%	68	13.8%	69	13.2%	71	13.6%	49	9.0%	63	10.9%	68	13.5%
Rockford	56	16.1%	63	17.5%	56	17.5%	93	23.6%	78	20.3%	55	13.6%	41	13.7%
Champaign	118	21.6%	110	22.2%	117	18.6%	111	18.6%	135	24.1%	129	23.1%	162	23.9%
Peoria	128	16.1%	101	14.4%	104	14.0%	112	17.0%	97	14.7%	108	16.8%	83	12.3%
Springfield	40	14.2%	55	18.2%	43	15.5%	71	20.5%	72	19.2%	59	17.5%	51	15.7%
East St Louis	42	11.9%	54	14.1%	60	17.8%	54	13.4%	68	16.3%	48	10.8%	42	8.9%
Marion	57	17.5%	31	9.8%	41	11.3%	35	8.8%	41	9.1%	58	13.9%	37	10.3%

Permanence at 36 Months: Subsidized Guardianship

Indicator 3.C.3	Of all children who entered substitute care during the year and stayed longer than 7 days, what percentage attained subsidized guardianship within 36 months from the date of entry into substitute care?						
IN ILLINOIS	2001	2002	2003	2004	2005	2006	2007
Total Entering Substitute Care	5,827	5,636	5,296	5,034	5,299	4,771	4,504
Attained Subsidized Guardianship at 36 Months	281	283	184	233	225	175	180
Percent	4.8%	5.0%	3.5%	4.6%	4.2%	3.7%	4.0%

Sub-Region	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Cook	153	5.9%	155	6.0%	97	4.6%	106	6.2%	114	6.0%	61	4.4%	71	6.0%
Aurora	33	5.5%	33	6.7%	20	3.8%	18	3.4%	14	2.6%	25	4.3%	20	4.0%
Rockford	12	3.4%	17	4.7%	12	3.8%	14	3.6%	7	1.8%	8	2.0%	14	4.7%
Champaign	14	2.6%	8	1.6%	5	0.8%	16	2.7%	15	2.7%	29	5.2%	13	1.9%
Peoria	42	5.3%	51	7.3%	18	2.4%	44	6.7%	46	7.0%	31	4.8%	37	5.5%
Springfield	1	0.4%	1	0.3%	2	0.7%	3	0.9%	10	2.7%	3	0.9%	5	1.5%
East St Louis	7	2.0%	4	1.0%	5	1.5%	5	1.2%	1	0.2%	0	0.0%	6	1.3%
Marion	19	5.8%	14	4.4%	25	6.9%	27	6.8%	18	4.0%	18	4.3%	14	3.9%



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