ILLINOIS
CFRC | Children & Family Research Center
SCHOOL OF SOCIAL WORK

The 2017 Illinois Child Well-Being Study Final Report

April 2019

Theodore P. Cross
Steve P. Tran
Aide Hernandez
Emily Rhodes

with the assistance of
Jennifer Parsons
Karen Retzer
Linda Owens

2017 Illinois Child Well-Being Study
Final Report

April 2019

Theodore P. Cross
Steve P. Tran
Aide Hernandez
Emily Rhodes

with the assistance of
Jennifer Parsons
Karen Retzer
Linda Owens

Submitted to:
Illinois Department of Children and Family Services
Kimberly Mann,
Deputy Director,
DCFS- Office of Child Well-Being

Table of Contents

List of Tables

Acknowledgements

This study would not have been possible without the assistance of many people. First and foremost is Dr. Kimberly Mann, Deputy Director, DCFS- Office of Child Well-Being. Her vision, encouragement, support and problem solving were indispensable and much appreciated. The steady hand of the study Steering Committee helped us stay on course and maximized the study's usefulness. The DCFS Guardian's Office put tireless effort into protecting the children in this study, as did psychologists at DCFS who responded to incidents that arose in the course of the conducting the study. Several Children and Family Research Center had critical roles in the study: Martin Nieto, Tamara Fuller, and Heidi Meyer. The many interviewers who made numerous telephone calls and trudged to children's homes, and patiently worked through long, careful interviews with caseworkers, caregivers, and children are the unsung heroes of this study.

This report is a publication of the Children and Family Research Center and is available on our website at: www.cfrc.illinois.edu. The recommended citation for the report is:

Cross, T.P., Tran, S., Hernandez, A., & Rhodes, E. (2019). *The 2017 Illinois Child Well-Being Study Final Report*. Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign

Key Findings

This report presents results from the 2017 Illinois Study of Child Well-Being, a study of the well-being of children and youths in the care of the Illinois Department of Children and Family Services (DCFS) in 2017. The study sampled 700 children who were listed as in care in DCFS' SACWIS client information system on October 23, 2017 and interviewed caseworkers, caregivers and children (age seven and older) themselves. Key findings from the study are listed below.

Child Development

- Most children age 0 to 5 did not show signs of developmental difficulties on the Ages and Stages Questionnaire (ASQ), a standardized caregiver measure of children's capabilities
- On the Communications, Gross Motor, and Fine Motor domains of the ASQ, more than one-fifth of children either showed signs of a possible developmental delay or had scores that suggested the child could benefit from monitoring.
- 26.5% of caregivers of children age 0 to 5 reported having been told their child has a learning problem.
- 18.5% of children aged 0 to 5 had an Individualized Family Services Plan (IFSP), a comprehensive plan to provide services to address children's special needs
- 25.8% of caregivers reported that their child aged 3 to 5 had been classified as needing special education
- 24.9% of caregivers of children aged 0 to 5 reported their child received educational services or therapies in their home
- 48.4% of children aged 0 to 5 received a developmental intervention
- Children aged 0 to 3 were more likely to receive a developmental intervention (56.8%) than children aged 4 and 5 (34.8%)
- Many children with developmental need on the ASQ did not receive a developmental intervention.
- Children in kinship care were less likely to receive an IFSP (9.4%)
- Children aged 0 to 5 were more likely to receive a developmental intervention if they were in specialized foster care (71.4% of 7 children) or in traditional foster care (55.6%) than if they were in kinship care (37.5%)
- Children aged 0 to 5 were more likely to receive a developmental intervention in Cook County (73.8%) and the Northern region (58.3%) than in the Southern region (38.5%) and Central region (25.0%).
- 80.8% of caregivers of children aged 3 to 5 reported that their child received some form of preschool or Head Start
- Caseworkers identified one or more special needs for 29.2% of children in the sample
- Special needs were more likely in specialized foster care (57.8%) and group homes and residential treatment (52.0%) than in kinship care (26.9%) or traditional foster care (21.0%)

Physical Health

- 94.1% of caregivers said their child was in good to excellent health
- 98.0% of caregivers said their child was up-to-date on their immunizations
- Caregiver responses indicated that 46.8% of children had a serious or chronic health problem

- 32.3% of youths reported that they had an illness, disability, handicap and/or recurring health problem
- Out of 12 LGBTQ+ youths, 7 were reported to have a serious or chronic health problem by caregivers and 7 self-reported this (each 58.3%)
- 46.9% of youths reported suffering an injury in the previous 12 months and 27.7% had seen a doctor or nurse for an injury during that time
- 9.3% of children reported a broken bone or dislocated joint in the previous 12 months and 8.3% a head injury or concussion

Emotional and Behavioral Health

- Caregiver ratings on the Child Behavior Checklist (CBCL) indicated that 17.8% of children aged 3 to 5 had emotional or behavioral problems in the clinical or borderline clinical range, indicating a need for intervention
- 41.5% of children and youth age 6 to 18 scored in the clinical or borderline clinical range on the CBCL, indicating need for intervention
- The most common child emotional and behavioral problems identified by caregivers were extreme stress from abuse and neglect (31.4%), attention deficit disorder (29.4%), oppositional or defiant behavior (29.1%), conduct or behavior problems (29.0%), and attachment problems (21.2%)
- According to caregivers, the most common child behavioral health problems diagnosed by doctors were attention deficit disorder (19.8%), oppositional or defiant behavior (13.3%), and extreme stress from abuse/neglect (12.4%)
- 36.9% of youths age 11 and older scored in the clinical or borderline clinical range on the Youth Self Report measure of emotional and behavioral health problems
- Only small percentages of youths self-reported having depressive symptoms (8.7%) and trauma symptoms (9.5%) in the clinical range.
- Out of 12 LGBTQ+ youths, majorities scored highly on self-report scales of somatic complaints, thought problems, and negative mood
- Substantial proportions of youths aged 15 to 17 have used alcohol (55.8%), cigarettes (45.1%), and marijuana (47.2%)
- 20.4% of youths aged 15 to 17 have used hard drugs
- 32.2% of youths aged 15 to 17 have used prescription drugs illicitly
- 66.6% of youths aged 15 to 17 and 11.9% of youths aged 11 to 14 have had sexual intercourse
- 26.9% of youths who had had sexual intercourse reported that their first time was not consensual
- 33.8% of youths aged 15 to 17 who were having sex always use protection
- 5 out of 15 girls age 15 to 17 (33.3%) reported having been pregnant, but no boy reported having gotten someone pregnant
- 22.3% of youths aged 11 to 17 had committed one to three delinquent acts in the last six months and 18.1% had committed four or more delinquent acts
- Children in specialized foster care, group homes and residential had especially high rates of emotional and behavioral health problems Children and youth in kinship care had the lowest rates of emotional and behavioral health problems, but these rates were still higher than among children in general

- 60.0% of children were currently receiving a mental health service and 85.9% of those with mental health need were
- The most common mental health services currently being received were counseling (44.7% of all children), in school counseling (22.8%), and outpatient psychiatry (19.0%)
- 25.5% of children with a mental health need had been psychiatrically hospitalized
- Children in kinship care and traditional foster care were less likely to have had intensive mental health services than children in specialized foster care, group homes and residential treatment, but it was still much more common for them than for children in general

Education

- Just about every child was enrolled in school (99.4% according to caseworkers and 100% according to youth themselves)
- 10.7% of children and youth had been retained for one or more grades
- A majority of children (62.2%) had attended two or more schools in the past two years, and 18.1% had attended three or more schools.
- 45.3% of children had been absent from school at least one day in the prior 30 and 3.9% for 10 days or more, mostly excused absences
- 15.9% of students had detentions in the previous year, 11.5% in-school suspensions, 8.5% out-of-school suspensions, and 11.3% other disciplinary actions
- 7.4% of youths aged 12 to 17 had missed 10 or more days of school in the last 30
- According to both caregivers and children themselves, almost one quarter of children had report cards with grades lower than C
- Each of the following difficulties applied to about a third of school age children, according to caregivers:
    - Reading below grade level (30.2%)
    - Doing math below grade level (33.4%)
    - Caregiver being told the child has a learning problem (33.0%)
    - Child being classified as needing special education. (39.7%)
- Large majorities of children and youth reported being average to above average in language arts, history, math, and science
- Large majorities of children reported positive behaviors and experiences in school often or almost always (e.g., enjoyed being in school, listened carefully in school)
- Majorities of children reported at least sometimes hating going to school, finding schoolwork too hard, and not completing assignment.
- White students were significantly more likely to get a grade below C (39.5%) than Black students (17.0%) or Other Race students (13.2%).
- Black students were significantly more likely to have been held back a grade (30.0%) than White students (9.5%)
- White students had a higher average score on a school engagement measure than African-American students
- It is a significant limitation that our data on education come only from caseworker, caregiver, and child interviews and not from school records

Child Safety

- 32.6% of children reported being physically hurt deliberately by someone in the past year
    - 53.3% of youths aged 15 to 17 reported this
    - 66.7% of youths in group homes or residential treatment reported this
- Three children reported being physically hurt in the last year by someone who had responsibility for taking care of them, which was 4.7% of the sample answering this question.
- 10.2% of youths reported experiencing a physical attack in the past year that caused injury
- The percentages of children who witnessed the following acts during their lifetime ranged from 19.1% to 44.9%: someone being slapped hard, someone stealing, someone being beaten, drug dealing, and someone being arrested
- 21.8% of youths reported personally being slapped hard by an adult at home during their lifetime and 14.5% being beaten up at home by an adult
- Among 13 LGBQT+ youth, 5 (38.5%) report having been beaten up by an adult at home in their life
- 44.7% of children and youth had witnessed someone being arrested during their lifetime
- The percentages of children witnessing or experiencing different forms of violence in their current home were generally small.
- 20.0% of children aged 9 to 11 reported being spanked in their current placement; children in kinship care were most likely to be spanked
- 8.9% of children reported witnessing someone being arrested in their current home and 8.0% reported witnessing someone stealing stuff from another person in their current home

Children's Experience of Out of-Home Care

- Large majorities of children felt good when they were with their caregiver and felt close to them.
- Large majorities felt their caregiver cared about them, trusted them, helped them, thought they were capable, and enjoyed spending time with them
- However, 42.7% said it was "sort of true" or "very true" that their caregiver did not know how the child felt about things.
- Almost all youths liked living with their foster family and felt like part of the family.
- 86.1% of children in kinship care or traditional foster care felt that they could stay in their placement until they grow up.
- 69.2% of children missed someone from where they used to live
- About one-third of children would choose to live with their birth mother right now, about a third with their current foster parent, and smaller percentages with a variety of other relatives or friends
- 37.5% of children never saw their birth mother, 34.2% saw their birth mother at least once a week, and 28.4% saw their mother less than once a week
- Youths were more likely to see their birth mother at least once a month if they were in kinship care (63.5%) or in a group home or residential treatment (64.6%) than if they were in traditional foster care (37.3%) or specialized foster care (22.2%).
- 68.4% of children wanted to see their birth mother more

- 53.6% of children and youth never saw their birth father, 2.7% saw him at least once a week, and 23.7% saw him less often
- Most children in kinship care saw their father at least occasionally (64.3%) and so did most youth in group homes and residential treatment (57.1%), but only 25% of children in traditional foster care saw their father and 12.5% of those in specialized foster care.
- Majorities of children reported that their caregivers monitored them in a variety of ways
- Majorities of caregivers used non-violent disciplinary methods such as grounding the child
- Most children felt that their caseworker listened to them all the time and understood their situation very well
- Caseworkers reported that 69.4% of the children in the study had siblings in care. Almost two-thirds of these children (64.1%) lived with their siblings, but 35.9% of them had siblings in another placement
- No more than half of children saw their siblings at least once a month, and the majority wanted to see their siblings more
- Caseworkers reported that 86.3% of caregivers had expressed interest in adopting the child

Resilience

- Across a range of questions, 88.7% or more of youths reported that they had a parent, another relative, and /or a non-relative adult who supported them
- 76.0% of youths reported average to above average involvement in sports
- 91.0% of youths reported spending as much time or more on hobbies compared to their peers
- 78.7% of youths reported that they had a job or assigned chores
- 37.9% of youths said they were in clubs, teams or other organized groups
- Almost all youths reported that they had at least one close friend and almost half had four or more close friends
- Large majorities of youths reported that they had skills for using the Internet and other technology
- Large majorities reported that they had adults that were checking in on them, and that they could call in an emergency
- On a measure of life skills, most youths reported that they could evaluate nutritional value using food labels, could think about the impact of different foods on their health, could cook for themselves, and could use cleaning products and a fire extinguisher
- Majorities of children and adolescents gave high or very high ratings on questions asking about life satisfaction
- However:
    - 35.8% of children reported always to sometimes wishing they had a different kind of life
    - 32.8% of reported that they had none of what they wanted in life to only some of what they wanted
    - 39.4% of adolescents rated their life as very poor to fair
    - 47.0% of adolescents rated their life situation as very poor to fair
- 91.3% of youths thought it was pretty likely that they would graduate from high school
- 49.1% of youths thought there was some chance to about a 50-50 chance of being married by age 25, and 21.3% thought it was pretty likely it will happen

- 84.6% of youths thought it was pretty likely they would live to age 35
- 84.1% thought they had chances of a good job by age 30
- 57.8% thought it was pretty likely they would have a family when they got older
- 76.9% thought there was no chance they would have a child before age 18

Executive Summary

This report presents initial results from the 2017 Illinois Study of Child Well-Being, a study of the well-being of children and youths in the care of the Illinois Department of Children and Family Services (DCFS) in 2017. The study provides an overview of children's development, physical health, mental health, and other domains of well-being for children in traditional foster care, specialized foster care, kinship care, and residential treatment and group homes. The study responds to an order to conduct a well-being study from Judge Jorge L. Alonso, the presiding judge in the B.H. consent decree that governs child welfare services in Illinois[1]. The judge's order was based on recommendations of an expert panel that he appointed in 2015 to study how to improve DCFS services. The strategy is to utilize data to make the system more responsive to children's needs[2]

Methodology

The Children and Family Research Center drew a stratified random sample for the study from the population of children and youth in DCFS care in October 2017. The Survey Research Laboratory of the University of Illinois at Chicago conducted the interviews for this study from December 2017 to July 2018.

The 2017 Illinois Child Well-Being Study is in most ways a replication of the Second Illinois Child Well-Being Study (IL-CWB) conducted in 2004[3] and the Third Illinois Child Well-Being Study conducted in 2005.[4] This enabled the research team, which had limited time and funds, to field the study more quickly by adapting interview protocols and other methods from the previous studies. It also makes it easier to compare results from the current study to results from the previous studies.

The current study sampled 700 children who were listed as in care in DCFS' SACWIS client information system on October 23, 2017 and interviewed caseworkers, caregivers and children (age 7 and older) themselves to produce the data analyzed here. When it emerged that some children in the original sample were ineligible, an additional 97 cases were sampled. Additional data on the 797 cases were downloaded from DCFS client information systems. Stratified random sampling was used to insure that enough cases of children in different age groups and with different lengths of care were adequately represented. Half the children in the sample had been in care less than three years and half more than three years, and additional stratification by child age was done within the length of care categories.

---

[1] Alonso, J.L. (2015) Order. B.H., et al., Plaintiffs, v. George H. Sheldon, Acting Director, Illinois Department of Children and Family Services, Defendant. Case: 1:88-cv-05599 Document #: 507

[2] Testa, M.F., Naylor, M.W., Vincent, P. & White, M. (July 2015). *Report of the Expert Panel: B.H. vs. Sheldon Consent Decree.* Retrieved from https://www.aclu-il.org/sites/default/files/field_documents/report_of_the_expert_panel.pdf

[3] (2017). Hartnett, M.A., Bruhn, C., Helton, J., Fuller, T. & Steiner, L. (2009). *Illinois Child Well-Being Study: Year Two Final Report*. Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

[4] Bruhn, C., Helton, J., Cross, T.P., Shumow, L. & Testa, M. (2008) Well-being. In Rolock, N. & Testa, M. (Eds.) *Conditions of children in or at risk of foster care in Illinois 2007: An assessment of their safety, stability, continuity, permanence, and well-being*. Children and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign. Urbana, IL: Children and Family Research Center

Child Development

Data were collected from caregivers and caseworkers on the development of children aged 0 to 5. Most children did not show signs of developmental difficulties on the Ages and Stages Questionnaire (ASQ), a standardized caregiver measure of children's capabilities. However, on the Communications, Gross Motor, and Fine Motor domains of the ASQ, more than one-fifth of children either showed signs of a possible developmental delay or had scores that suggested the child could benefit from monitoring. More than a quarter of caregivers were told their child had a learning problem and more than a quarter reported that their child had been classified as needing special education. Developmental issues could also affect older children as well. Caseworkers identified one or more special needs for 29.2% of children across the entire sample

Just under half (48.4%) of caregivers of 0 to 5 year olds said their child was receiving a developmental intervention, and 24.9% said their child received education or therapeutic services in the home. Surprisingly, there was only a modest relationship between ASQ scores and receiving a developmental intervention. Many children who scored in the delay/monitoring range on the ASQ were not receiving a developmental intervention. Children aged 0 to 3 were more likely to receive a developmental intervention (56.8%) than children aged 4 and 5 (34.8%). Children aged 0 to 5 were more likely to receive a developmental intervention if they were in specialized foster care (71.4% of 7 children) or in traditional foster care (55.6%) than if they were in kinship care (37.5%). Children aged 0 to 5 were more likely to receive a developmental intervention in Cook County (73.8%) and the Northern region (58.3%) than in the Southern region (38.5%) and Central region (25.0%). A large majority of caregivers of children aged 3 to 5 (80.8%) reported that their child received some form of preschool or Head Start.

Caseworkers identified one or more special needs for 29.2% of children in the sample. Special needs were more likely in specialized foster care (57.8%) and group homes and residential treatment (52.0%) than in kinship care (26.9%) or traditional foster care (21.0%).

Thus, a substantial proportion of young children in out-of-home care appear to have developmental issues and many children across the age range have special needs. These are likely to be underestimates of developmental issues because the study has no formal assessments. The positive news is that slightly almost half of caregivers of children aged 0 to 5 reported that their child received some form of developmental intervention, and a large majority for children aged 0 to 3. . However, some children who were rated by the ASQ as needing intervention were not receiving it. Despite the large percentage of children receiving early childhood education, there is room for improvement, as it is DCFS policy for *all* children in care aged 3 to 5 to receive early childhood education.

Physical Health

Almost all caregivers (94.1%) said their child was in good to excellent health, and almost all (98%) said that their child was up-to-date on their immunizations. Yet caregivers' responses suggested that 46.8% of children had a serious or chronic health problem, and 32.3% of youths interviewed reported that they had an illness, disability, handicap and/or recurring health problem. Almost half of youths (48.4%) reported suffering an injury in the previous 12 months and 27.7% said that they had seen a doctor or

nurse for an injury during that time period. Clearly, health issues are a concern for a large proportion of children in out-of-home care.

The results for injuries are worrisome, though somewhat difficult to interpret because we do not know how severe a child's injuries were. Nevertheless, the finding that over a quarter of children saw a doctor or a nurse for an injury in the previous year suggests that children in out-of-home care are at significant risk for injuries that require medical attention. This raises questions about whether children were in safe environments and are provided appropriate monitoring and safety practices.

Caseworkers reported making referrals in a majority of cases for routine check-ups or immunization and for routine or preventative dental care, and occasionally for other health services as needed. The vast majority of children received the health service they were identified by caseworkers as needing. Health issues are significant among children in out-of-home care and they will need more medical care than other children. The risk due to injuries suggests that this area needs more study.

Emotional and Behavioral Health

The study included a range of different measures of child emotional and behavioral problems from the interviews with caseworkers, caregivers, and children themselves. Caregiver ratings on the Child Behavior Checklist (CBCL) indicated that 17.8% of children age 3 to 5 had emotional or behavioral problems in the clinical or borderline clinical range, a range typically requiring intervention. On the CBCL for children and youth age 6 to 18, 41.5% scored in the clinical or borderline clinical range and were likely to need intervention. The most common child emotional and behavioral problems identified by caregivers were extreme stress from abuse and neglect (31.4%), attention deficit disorder (29.4%), oppositional or defiant behavior (29.1%), conduct or behavior problems (29.0%), and attachment problems (21.2%). According to caregivers, the most common child problems diagnosed by doctors were attention deficit disorder (19.8%), oppositional or defiant behavior (13.3%), and extreme stress from abuse/neglect (12.4%). On the Youth Self-Report measure completed by youths age 11 or older, 36.9% of youth fell in the clinical to borderline clinical range. Out of 12 LGBTQ+ youths, majorities scored highly on self-report scales of somatic complaints, thought problems, and negative mood.

Substantial proportions of youths aged 15 to 17 had used alcohol (55.8%), cigarettes (45.1%), and marijuana (47.2%). More than a fifth (20.4%) of youths aged 15 to 17 had used hard drugs and 32.2% in that age group had used prescription drugs illicitly. Two third of youths aged 15 to 17 and 11.9% of youths aged 11 to 14 had had sexual intercourse. Out of 26 youths who had had sex, 26.9% reported that the first time they had sex, it was not consensual. Only 33.8% of youths aged 15 to 17 always used protection when having sex. Five out of 15 girls aged 15 to 17 (33.3%) reported having been pregnant, but no boy reported having gotten someone pregnant. Over one fifth of youths aged 11 to 17 (22.2%) had committed one to three delinquent acts in the last six months and 18.1% had committed four or more delinquent acts. Children and youth in specialized foster care and groups and residential treatment had the highest rates of emotional and behavioral problems. Children and youth in kinship care had the lowest rates of emotional and behavioral problems, though still significantly higher than children in general.

A majority of children in the sample (60.0%) was currently receiving a behavioral health service and 85.3% of those with mental health need (as measured in the study) were receiving one. The most common mental health service currently being received was counseling (44.7% of all children and 69.5% of those with mental health need), in school therapeutic services (22.8% of all children), and outpatient psychiatry (19.0% of all children).

Caregivers were also presented a second list of emotional and behavioral health services and asked which ones their child had ever received. The second list, drawn from the National Survey of Child and Adolescent Well-Being (NSCAW), did not capture private mental health services or mental health services in certain community agencies. The most common mental health services *ever* received were in-school counseling services (39.0%) and in-home counseling and crisis services (16.7%). It is noteworthy that 12.8% of children 25.5% of children with a mental health need had been psychiatrically hospitalized. Youth in group homes and residential treatment center had a much more extensive history of mental health treatment than other youth.

The 41.6% of youths aged 6 to 17 scoring in the borderline clinical to clinical range on the CBCL was strikingly similar to the result on this variable for the CBCL from the Round One IL-CWB (45%), the Round Two IL-CWB (41.4%) and the Round Three IL-CWB (44.0%). This suggests that there has been a consistently high rate of emotional and behavioral problems among children in out-of-home care for at least the past 17 years.

The vast majority of children with a mental health need were currently receiving some form of mental health service. The 85% in need currently receiving mental health services is somewhat larger than the 77% reported in the Round Two IL-CWB. This suggests a slight improvement in the percentage of children with mental health need receiving mental health services. However, it is important to acknowledge limitations in analyzing mental health services in this study. The most common mental health services such as counseling and in-school services can involve widely varying types and amounts of therapeutic work with children, and we have little or no understanding of how the service was delivered, what issues were addressed, and what the quality of the service was. Future research could assess more thoroughly whether children are receiving the services they need.

Education

Almost all children were currently in school and the vast majority were expected to advance to the next grade. However, a majority of children (62.2%) had attended two or more schools in the past two years, and 18.1% had attended three or more schools. By far the most common reason for changing schools was the geographic location of a new foster care placement. A large majority of children had no school disciplinary actions against them in the previous year, but 15.9% had detentions, 25.1% in-school suspensions, 8.5% out of school suspensions, and 11.4% other disciplinary actions. Many children (41.3%) had missed 1 to 9 days of school in the last 30 and 3.9% had missed 10 days or more.

Caregiver reports suggest that most children were performing adequately in school: the majority of children reportedly had no grades lower than C and were at grade level or higher in reading and math. But more than one-fifth had report cards with grades lower than C (caregivers reported 21.1% and children themselves 23.1%). Each of the following difficulties applied to about a third of the sample:

reading below grade level, doing math below grade level, caregiver being told the child has a learning problem, and child being classified as needing special education. White students were significantly more likely to get a grade below C (39.5%) than African-American students (17.0%) or Other Race students (13.2%).

On average, students scored 3.23 (se=.05) which is between "often" engaged and "almost always" engaged on a 4-point school engagement scale. White students were significantly more engaged (mean=3.38) than African-American students (mean=3.02). Out of 13 LGBTQ+ youth, 6 reported often or always hating to go to school (46.2%), a significantly higher percentage than heterosexual youth (13.2%).

A majority of the sample was performing adequately or better in school and was positively engaged with school, according to caregivers and youth themselves, though we cannot necessarily vouch for the accuracy of their reports. On the other hand, the results also showed that many children faced obstacles to school success. Having to change schools because of foster care placements remains a problem. School disciplinary issues, poor academic performance and grade retention were problems for a substantial minority of students. The finding that half of the small sample of LGBTQ+ youths often or always hated going to school raises questions about whether they are treated badly there.

It is noteworthy that results from our interviews with caregivers, children and caseworkers tended to be more positive for several variables than the results gathered from school records in the previous IL-CWB studies. It would be a very human response for caregivers and children to recall information more positively than school records indicate. Educational progress need to be explored more with school records.

Increased efforts are needed to reduce frequent school changes due to foster care placements, to increase school attendance, to deal with behavior problems at school, and to improve academic performance. The National Working Group on Foster Care and Education has described 25 promising programs from around the country to help improve educational outcomes for children in out of home care[5].

Child Safety

Analyses were conducted on variables measuring children's being deliberately hurt by others and children's exposure to violence. Almost one-third of children (32.6%) reported being physically hurt by someone in the past year--53.3% of youths aged 15 to 17 reported this as did 66.7% of youths in group homes or residential treatment. Three children reported being physically hurt in the last year by someone who was responsible for taking care of them, which was 4.7% of the sample answering this question. Just over one-tenth of youths (10.2%) reported experiencing a physical attack from someone in the past year that caused injury

[5] National Working Group on Foster Care and Education (2018). *Fostering success in education: National Factsheet on the Educational Outcomes of Children in Foster Care*. Chicago, IL: The Legal Center for Foster Care and Education. Retrieved from http://fosteringchamps.org/wp-content/uploads/2018/04/NationalEducationDatasheet2018-2.pdf

Many children had witnessed or experienced violence in their lives. The percentages of children who witnessed the following acts by an adult in the home during their lifetime ranged from 19.1% to 44.9%: someone being slapped hard, someone stealing, someone being beaten, drug dealing, and someone being arrested. Over one-fifth of youths reported personally being slapped hard by an adult in their home during their lifetime and 14.5% being beaten up by an adult in the home. Almost half of youths reported being spanked during their lifetime. Among 13 LGBQT+ youth, 5 (38.5%) report having been beaten up by an adult at home in their life, significantly more than heterosexual youth (13.0%). Children in group homes and residential treatment have experienced violence at especially high rates.

The rates at which children in out-of-home care witnessed or experienced violence in their current home were generally low. However, about one in seven children (14.6%) reported witnessing spanking in their current foster home. Among children age 9 to 11, 20.0% reported being spanked in their current placement; children in kinship care were at higher risk of being spanked (15.6%) than children in traditional foster care (2.2%).

Overall, these findings suggest that placement in out-of-home care leads to greater safety. But over half of older adolescents had been physically hurt by someone in the past year, and two-thirds of those in group homes and residential treatment. This threat of injury by attack needs to be studied more and actions taken to reduce this threat. The use of spanking by caregivers needs to be explored more, as DCFS licensing standards prohibit corporal punishments and considerable research indicates that it is harmful to children's well-being. Substantial attention is needed on the safety of youths in group homes and residential treatment, and the risk for LGBTQ+ youth needs to be explored more.

Children's Experience of Out-of-Home Care

How children experience their life is an important perspective on well-being in out-of-home care. Numerous questions in the child interview asked children and youths about their experience of out-of-home care, and the caseworker interview provided relevant information as well.

Large majorities of children felt good when they were with their caregiver and felt close to them. Large majorities felt their caregiver cared about them, trusted them, helped them, thought they were capable, and enjoyed spending time with them. Almost all youths liked living with the foster family and felt like part of the family. Most children felt that they could stay in their placement until they grow up. Caseworkers reported that 86.3% of caregivers had expressed interest in adopting the child. Yet more than two-thirds of children and youths missed someone from where they used to live.

About one-third of children would choose to live with their birth mother right now, about a third with their current foster parent, and smaller percentages with a variety of other relatives or friends. More than a third of children (37.5%) never saw their birth mother, 34.2% saw their birth mother at least once a week, and 28.4% saw their mother less than once a week. About a third of youths saw their birth mother at least once a week, and about a quarter less often, but more than a third never saw her. More than two-thirds of children wanted to see their birth mother more. More than half of children and youth (53.6%) never saw their birth father, 2.7% saw him at least once a week, and 23.7% saw him less often Majorities of children reported that their out-of-home caregivers monitored them in a variety of ways.

Majorities of caregivers used non-violent disciplinary methods such as grounding the child. Most children felt that their caseworker listened to them all the time and understood their situation very well.

Caseworkers reported that 69.4% of the children in the study had siblings in care. Almost two-thirds of these children (64.1%) lived with their siblings, but 35.9% of them had siblings in another placement. No more than half of children saw their siblings at least once a month if they did not live with them, and the majority wanted to see their siblings more.

These results speak both to the positive caretaking mission of out-of-home care and to the sadness that children nevertheless experience. Most children reported positive experiences with their caregivers and caseworkers. But most of these children had to change neighborhoods and many missed people they had left behind. Many had limited or no contact with their birth mother and father or other family members. Children in traditional and specialized foster care were especially unlikely to have much contact.

A limitation of the current study is that it only assesses foster care at a single point in time, so it provides little information about the stability of foster care. One telling finding in the current study is that the majority of children had had at least one other out-of-home placement prior to the current one. It is encouraging that a majority of youths felt they could stay in their current placement until they grow up and that a majority of caregivers was serious about adoption. The data from other studies on the instability of substitute care should temper our conclusions about the positive experience of children in out-of-home care, and journalistic accounts that are critical of the foster care system need to be taken seriously as indicators of the need for constant vigilance to make the system work for children. Nevertheless, the biggest lesson of this chapter is that most children felt safe, supported and cared for in out-of-home care.

Resilience

Some children are resilient and do well despite the maltreatment they have suffered. Supporting children's resilience is an important part of the child protection response and has the potential to promote children's continued well-being into adulthood.

Across a range of questions, 88.7% or more of youths reported that they had a parent, another relative, and/or a non-relative adult who supported them. Large majorities reported that they had adults who were checking in on them and that they could call in an emergency. Large majorities of youths reported average to above average involvement in sports, and having a job or assigned chores. Over a third of youths said they were involved in clubs, teams or other organized groups. Almost all youths reported that they had at least one close friend and almost half said they had four or more close friends.

Large majorities of the youths reported that they had skills for using the Internet and other technology. Most youths reported that they could evaluate food labels to see how healthy food was, could think about the impact of different foods on their health, could cook for themselves, and could use cleaning products and a fire extinguisher.

Majorities of children and adolescents gave high or very high ratings on questions asking about life satisfaction. However, 35.8% of pre-adolescent children reported always to sometimes wishing they had a different kind of life, 32.8% reported that they had none of what they wanted in life to only some of what they wanted, 39.4% of adolescents rated their life as very poor to fair, and 47.0% of adolescents rated their life situation as very poor to fair

More than 90% of youths thought it was pretty likely they would graduate from high school. Almost half of youths thought there was some chance to about a 50-50 chance of being married by age 25, and 21.3% thought it was pretty likely it would happen. A large majority (84.6%) of youths thought it was pretty likely they would live to age 35, and 84.1% thought they had chances of a good job by age 30. More than half (57.8%) thought it was pretty likely they would have a family when they got older. Just over three-quarters thought there was no chance they would have a child before age 18.

The results presented in this chapter provide encouraging news about these children's resilience. This suggests that children and youths have strengths to count on to deal with the stresses and difficulties of experiencing child maltreatment, being removed from their home, and not yet having a permanent home to return to. These results also suggest that their life in out-of-home care may support their resilience by facilitating their access to caring adults and to normal positive life experiences that could be out of reach if they lived in homes in which they were maltreated.

There are caveats however. First, not all children and adolescents reported life satisfaction: a substantial minority said their life was no better than fair. These youths deserve greater attention. Second, one may be skeptical about children's positive reports of resilience in this chapter. One may wonder about these results, given the difficulties they have been through, and the challenges to their physical health, emotional and behavioral health, education and safety that are detailed in other chapters. It is sobering to consider the contrast between the skills and positive expectations youths express in this study and the major challenges with daily functioning and difficulties with independence that many youths aging out of foster care experience.

Youths in this study may not have been entirely candid. One limitation of our study is the paucity of information from caregivers and caseworkers on children's resilience, which might corroborate children's reports. We think it is more likely that youths are providing honest information about their self-appraisal. Their history of living in a maltreating environment and being placed in foster care may lead them to have reduced expectations from their life. What they do have in potentially hostile environments is themselves and their belief in themselves. Having lower expectations from their environment and greater reliance on themselves may influence their report of their satisfaction and their ratings of the competence and skills. Their ability to think well of their life and themselves in the face of objectively limited functioning and challenged environments may be a strength.

Conclusion

The 2017 Illinois Child Well-Being Study identifies strengths shared by many children and youths in out-of-home care. Many children are doing well in their development, physical health, emotional and behavioral health, education, and experience of out-of-home care. Yet many of our findings should provoke concern. Many children and youth are struggling. Many are lagging in development, have

chronic health conditions or special needs, have serious emotional or behavioral challenges, struggle at school, have experienced threats to their safety, and report at least some substantial negative experiences during their time in out-of-home care.

It is good news that children often received services and supports. However, our knowledge about these services and supports is limited. We do not have much information on the nature of the interventions children received, what their quality is, whether they were well matched to children's needs, and whether they employed evidence-based methods. We know that most children report positive experiences in their substitute homes, but we lack corroboration from other data sources that would give us full confidence that their reports are valid. Ultimately, an omnibus study of well-being relying solely on data from caseworkers, caregivers, and children is limited. We recommend pursuing a well-being research program in the future with a suite of small studies that examine specific aspects of well-being in greater detail, and include data from systems as well as from caseworkers, caregivers and children.

We need to be aware of how children and youth's well-being differs depending on what placement setting they are in. One persistent theme is the substantially greater difficulties of children in group homes and residential treatment and specialized foster care. One positive finding is that these children were also more likely to receive a range of different mental health services, which is probably a function of their setting being organized to assess and respond to children's mental health problems. Our findings underscore the substantial need of children in these settings and should reinforce our determination to devote resources to these children and seek the best treatment possible for them.

A number of findings suggest that the well-being of children in kinship care was in some ways better and in some ways worse than the well-being of children in traditional foster care. Children in kinship care were more likely to have contact with their existing friends and to see their birth mother and birth father. However, they were more likely to be spanked, and less likely to receive developmental interventions. Though we need to be careful in drawing conclusions because of small sample sizes, these differences between kinship care and traditional foster care should be explored more. Another difference that needs to be explored further is the greater likelihood of developmental interventions in Cook County and the Northern region compared to the Central and Southern regions.

This was the first IL-CWB study to assess sexual orientation and attraction; 21.8% of the youth age 12 to 17 who were interviewed reported an LGBTQ+ sexual orientation. Despite the small size of this group, LGBTQ+ youths were significantly more likely to score high on self-report measures of negative mood, somatic (bodily) concerns, and thought problems, more likely to report often or always hating going to school, and more likely to report having been beat up by an adult at home at some point in their life. It is possible that these youths face negative reactions to their sexual orientation that make their life even more difficult than other youths in out-of-home care. We recommend more research specifically focused on exploring the well-being of LGBTQ+ youth in out-of-home care.

Limitations. Limitations of the study include the limited set of standardized instruments, the lack of data from systems, our inability to measure change over time, and the limited information we have about the nature and quality of services children received and about children's safety. We know that most children

report positive experiences in their substitute homes and positive expectations for their life, but we lack corroboration from other data sources that would give us full confidence that their reports are valid.

Similarity to Previous Illinois Child Well-Being Studies. We cannot yet point to one result in the current study that differs substantially from a parallel result in the previous Illinois Child Well-Being Studies. Does it make sense to do the same study repeatedly if we keep getting the same results? This repetition is perhaps a reason to consider a more focused suite of smaller well-being studies in the future.

We have several suggestions for ways to use the results from this and other well-being studies:

Advocacy for Children and Youths. Advocates for children could use many findings in this report to support arguments to improve the response to children in out-of-home care in the multiple systems that interact with children in care. These systems include early intervention, education, health, and mental health. Numbers help underline appeals based on case narratives, and lend greater credibility to advocates when seeking to improve services and secure more funding.

Reality Check on DCFS Policy. DCFS has developed numerous policies and practices to support the well-being of children in out-of-home care. Data from this study can be used to assess the implementation of these policies. This may help identify gaps in implementation, and may also provide evidence when DCFS is carrying out policies effectively.

Well-Being Impact Statements. We are coining a colloquial term – the "well-being impact statement". Well-being data could be useful to help shape new programs and policies developed for the population of children in out-of-home care. Practitioners and policy could collaborate with researchers to develop "well-being impact statements" in the process of developing new initiatives.

Guidepost to Future Research. The 2017 Illinois Child Well-Being study is well suited to help guide future research. It is very broad, covering many areas, but also very thin, exploring none of them in depth. Many smaller studies could be developed to pursue questions raised by the study. We recommend that DCFS professionals, policy stakeholders, researchers, and students study well-being findings from this and other well-being studies and craft plans for future research.

Chapter 1

Measuring Child Well-Being in the Illinois Department of Children and Family Services

This report presents initial results from the 2017 Illinois Child Well-Being (IL-CWB) Study, a study of the well-being of children and youth in the care of the Illinois Department of Children and Family Services (DCFS) in 2017. The study provides an overview of children's development, physical health, mental health, and other domains of well-being for children in traditional foster care, kinship care, specialized foster care, and residential treatment and group homes. The study and this report respond to an order to conduct a well-being study from Judge Jorge L. Alonso, the presiding judge in the *B.H.* consent decree that governs child welfare services in Illinois.[6] The judge's order was based on recommendations of an expert panel that he appointed in 2015 to study how to improve DCFS services. The expert panel's report recommended a well-being study as part of an overall strategy of utilizing data to make the system more responsive to children's needs.[7]

The Children and Family Research Center (CFRC) drew the stratified random sample for the study from the population of children and youth in DCFS care in October 2017. The Survey Research Laboratory of the University of Illinois at Chicago conducted the interviews for this study from November 2017 to July 2018, and produced the data files

We anticipate that the findings of this report will help DCFS and its partner agencies make decisions to better align child welfare policy and practice in Illinois to children's well-being needs. We also expect that the well-being study data will enable the CFRC to produce additional reports and research briefs as new questions emerge regarding particular areas of child well-being.

Keeping the Child in Mind

At the heart of a well-being study is an appreciation of who the children in DCFS care are. To begin our look at the well-being of children and youth in DCFS care in 2017, we would like you to put aside for now our research methods, our standardized measures, our statistics, and our data tables. For now think instead about an individual child in DCFS care, and imagine their similarity to a child you love: a daughter, a son, a sister or a brother, or a child you have served as a professional or a volunteer. We think that this helps remind us of the awe-inspiring responsibility and privilege we have of promoting and protecting the well-being of children and youth in care. Perhaps it helps remind us that they enter

---

[6] Alonso, J.L. (2015) Order. B.H., et al., Plaintiffs, v. George H. Sheldon, Acting Director, Illinois Department of Children and Family Services, Defendant. Case: 1:88-cv-05599 Document #: 507

[7] Testa, M.F., Naylor, M.W., Vincent, P. & White, M. (July 2015). *Report of the Expert Panel: B.H. vs. Sheldon Consent Decree.* Retrieved from https://www.aclu-il.org/sites/default/files/field_documents/report_of_the_expert_panel.pdf

care as individuals, with hopes, wishes, interests, strengths and people they love, as well as fear, anger, distrust, shortcomings and conflict with people in their lives. If they are infants, they no doubt inspire warm, protective feelings as well as dreams about their future. If they are older, they no doubt can make us laugh and admire their gifts and look forward to their adventures in the world.

Inescapably, they enter DCFS in crisis: they have been removed because of threats to their safety and failures in the caregiving environment. Many of them are subject to stresses and challenges in their family and environment. Removal itself is wrenching and disrupts the fabric of their lives. Throughout their stay in out-of-home, the hope of reunification with their family often remains or, if that is not possible, permanent placement in a loving home.

Like no other institution in children's lives, child welfare services provide a temporary home for hundreds of children. The question for many becomes if and when they can return to their parents. Most children eventually find a permanent placement, but for some, their time in care extends from the time of their initial placement to adulthood. Throughout, their value remains, and our responsibility is to protect and nurture that. Assessing children's well-being in order to be able to better address their needs is a response to that value. We would like readers to keep the experience of children and youth in mind as they read this report, and at times throughout this report we return with reminders.

Well-Being and Child Welfare Policy

Inarguably, child welfare services has the responsibility for supporting the well-being of children in its care, especially given the reality that many children remain in out of home care for years and some age out care.[8] Children in out-of-home care require special attention because of multiple threats to their well-being; in addition to maltreatment, many have experienced such adverse experiences as parental substance abuse and mental health problems, and domestic violence.[9]

From the federal government's earliest involvement in child welfare policy, federal actions have provided support for services to address the well-being needs of children involved in the child welfare system. For example, the federal Child Abuse Prevention and Treatment Act (CAPTA) has provided funding for treatment services since its inception in 1974.[10] Other efforts also make it clear that the

---

[8] Cross, T. P., & Hershkowitz, I. (2017). Psychology and child protection: Promoting widespread improvement in practice. *Psychology, Public Policy, and Law*, *4*, 503-518. DePanfilis, D., & Salus, M. K. (2003). *Child Protective Services: A guide for caseworkers*. Administration for Children and Families. Retrieved from https://www.childwelfare.gov/pubPDFs/cps.pdf

[9] See, e.g., De Bellis, M. D., Broussard, E. R., Herring, D. J., Wexler, S., Moritz, G., & Benitez, J. G. (2001). Psychiatric co-morbidity in caregivers and children involved in maltreatment: A pilot research study with policy implications. *Child Abuse & Neglect*, *25*, 923-944. Edleson, J. L. (1999). The overlap between child maltreatment and woman battering. *Violence Against Women*, *5*, 134–154. Merritt, D. (2009). Child abuse potential: Correlates with child maltreatment rates and structural measures of neighborhoods. *Children and Youth Services Review*, *31*, 927–934. Walsh, C., MacMillan, H. L., & Jamieson, E. (2003). The relationship between parental substance abuse and child maltreatment: Findings from the Ontario Health Supplement. *Child Abuse & Neglect*, *27*, 1409–1425.

[10] Courtney, M.E. (2013) Child welfare: History and policy framework. *Encyclopedia of Social Work.* Retrieved from http://socialwork.oxfordre.com/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-530.

government sought to support the well-being of children in care; for instance, the federal government produced user manuals in the 1970s and 1980s that provided guidance for responding to children's service needs.[11] But well-being did not achieve the status as an outcome for which child welfare services would be held accountable until the Adoption and Safe Families Act of 1997.[12] Child welfare services focused on safety and permanency before that, and child well-being was not articulated as a goal expected of state child welfare agencies.

There are several challenges to establishing child well-being as an outcome for which child welfare services is held accountable. First, child well-being is broad, encompassing development, physical health, mental health, education and other domains, and therefore demands a wider range of services than the more focused outcomes of safety and permanency. Caregiving of children and its successes and failures is only one factor influencing children's well-being.[13] Addressing well-being issues demands a wider range of expertise than can be found in a child welfare agency and more resources than a child welfare agency can muster by itself. It requires the involvement of service providers from multiple disciplines and a major societal commitment to deal with the problems that afflict thousands of children.

In addition, monitoring safety and permanency is relatively straight forward compared to measuring well-being, because outcomes such as re-reports of maltreatment, reunification, placement disruption and adoption can be measured with DCFS administrative data. Measuring well-being requires the more difficult task of using valid and reliable measures to evaluate an array of well-being domains, measures that child welfare agencies do not often use.

National Survey of Child and Adolescent Well-Being

The federal Administration for Children and Families invested in developing knowledge on the well-being of children involved in child welfare services through the National Survey of Child and Adolescent Well-Being (NSCAW), a longitudinal national probability study of children involved in CPS investigations.[14] NSCAW sampled thousands of cases across the country randomly sampled to produce a nationally representative sample. Interviewers used project-developed questions and standardized measures to collect data from caseworkers, caregivers, and children themselves. Longitudinal data were collected through repeated waves of interviewing. The first NSCAW study was begun in 1999 (NSCAW I), and the second in 2008 (NSCAW II). As of this writing, preparation for the third NSCAW study is

---

[11] See Child Welfare Information Gateway (n.d.) *Child Abuse and Neglect User Manual Series pre-1990s.* Retrieved from https://www.childwelfare.gov/pubs/umprenineties/ .

[12] Wulczyn, F., Barth, R. P., Yuan, Y. T., Harden, B. J., & Landsverk, J. (2005). *Beyond common sense: Child welfare, child well-being, and the evidence for policy reform*. New Brunswick, NJ: Aldine Transaction.

[13] Wulczyn, et al. (2005) ibid

[14] Dolan, M., Smith, K., Casanueva, C., & Ringeisen, H. (2011). *NSCAW II Baseline Report: Introduction to NSCAW II. Administration for Children and Families*. Retrieved from https://www.acf.hhs.gov/sites/default/files/opre/nscaw2_intro.pdf

underway.[15] A supplemental NSCAW study focusing on children who had been in foster care for one year was published in 2001 in parallel with the first NSCAW study.[16] Because of its focus on foster care, its results are particularly relevant for the current study. There was no parallel study on foster care for NSCAW II nor is it planned for NSCAW III.

The NSCAW studies have substantially increased our knowledge of the well-being of children involved with the child welfare systems. The Administration for Children and Families, through its contractor RTI international has provided reports profiling the well-being of children involved in child protection investigations, and hundreds of NSCAW studies have significantly enhanced knowledge on a wide range of questions regarding child well-being (see https://www.zotero.org/groups/421939/candl/items/tag/NSCAW).

NSCAW set an important example. The NSCAW project has developed an impressive set of methods and measures for evaluating the well-being of children involved with the child welfare system. However, with the important exception of the Illinois Survey of Child and Adolescent Well-Being that we discuss below, NSCAW is not useful to assessing child well-being *within a state*, both because of sample size and other methodological considerations, and because of confidentiality requirements. Moreover, only a small percentage of children in the primary NSCAW samples were placed in out-of-home care, because the study sampled children involved in investigations, most of whom remained in their home. Because eligibility for NSCAW was based on being involved in a recent maltreatment investigation, children in out-of-home care in the primary sample had been placed within four months of the investigation, whereas many children in out-of-home care have been there substantially longer. Therefore, children in NSCAW who are placed in out-of-home care may not be representative of children in out-of-home care generally. The NSCAW One Year in Foster Care study mentioned above provides better information about children in out-of-home care, but it is now more than 18 years old and has not been replicated.

Nevertheless, NSCAW has had an important influence on the assessment of the well-being of children involved with DCFS. NSCAW pioneered a methodology and set of measures that have been employed in several studies of children in DCFS for gathering standardized data from caseworkers, caregivers and children. NSCAW has also provided important comparison data for several well-being studies (see below). The current study borrowed methodology from NSCAW, as we discuss in Chapter 2.

---

[15] Office of Planning, Research & Evaluation, Administration for Children & Families. (2017). *National Survey of Child and Adolescent Well-Being (NSCAW), 1997–2014 and 2015–2022*. Retrieved from https://www.acf.hhs.gov/opre/research/project/national-survey-of-child-and-adolescent-well-being-nscaw

[16] U.S. Department of Health and Human Services, Administration for Children, Youth and Families (2001). *National Survey of Child and Adolescent Well-Being: One Year in Foster Care Report*. Washington, D.C. Retrieved from https://www.acf.hhs.gov/sites/default/files/opre/oyfc_report.pdf

Well-Being and Monitoring the *B.H.* Consent Decree

The ACLU Illinois sued DCFS in 1988, citing failure to provide adequate services for children in care.[17] After several years of arguments, the two parties came to an agreement, which resulted in the *B.H.* consent decree that set standards to achieve safety, permanency, and well-being for children in placement, one of many consent decrees across the country[18]. The Children and Family Research Center was founded in 1996 to help monitor DCFS' performance relative to *B.H.* Early reports from CFRC focused on safety and permanency outcomes, using data from DCFS's integrated database.[19] In 2001, CFRC undertook the first Illinois Child Well-Being (IL-CWB) study to add well-being to its monitoring function.[20] CFRC collaborated with the Northern Illinois University Public Opinion Laboratory to conduct caseworker and caregiver interviews and to abstract data from medical and educational records. A random sample of 350 cases was drawn from the population of children in out-of-home care at a given point in time in 2001. In 2002, CFRC conducted a separate study of the well-being of older youth in out-of-home care who were headed to independence.[21]

CFRC conducted a second IL-CWB study in 2004[22] and a third in 2005,[23] both times in partnership with the Survey Research Laboratory at the University of Illinois at Chicago. For both studies, random samples of children in out-of-home care at a given point in time were drawn, and caseworkers and caregivers were interviewed. In addition, interviews with older children themselves were added. By the time of the second IL-CWB study, the first NSCAW study had been implemented and was beginning to produce results. The second and third IL-CWB studies adopted similar methods and many of the same standardized measures.

The Illinois Survey of Child and Adolescent Well-Being (ISCAW), which began in 2008, used a different methodology than the IL-CWB studies, and studied a different population of children served by DCFS. ISCAW capitalized on the implementation of the NSCAW II study by the research firm RTI International, under contract with the federal Administration for Children and Families. Illinois was one of 36 states in

---

[17] B.H. v. Johnson. 128 F.R.D. 659 (N.D. Ill. Dec. 19, 1989); 715 F. Supp. 1387 (N.D. Ill. May 30, l989), 49 F.3d 294 (7th Cir. 1995), (Apr. 7, 1995), Mezey, S. (1998). Systemic reform litigation and child welfare policy: The case of Illinois. *Law & Policy*, *20*, 203-230. Mezey, S. (2000). *Pitiful plaintiffs: Child welfare litigation and the federal courts*. Pittsburgh: The University of Pittsburgh Press.

[18] Kosanovich, A, & Joseph, R.M. (2005). *Child welfare consent decrees: Analysis of thirty-five court actions from 1995 to 2005*. Washington, DC: Child Welfare League of America.

[19] See, e.g., Poertner, J. & Garnier, P. (1999). *Outcomes Report 1999*. Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

[20] Hartnett, M.A. & Bruhn, C. (2006). *The Illinois Child Well-Being Study. Year One Report*. Urbana, IL: Children and Family Research Center. Retrieved from http://cfrc.illinois.edu/pubs/rp_20050201_IllinoisChildWellBeingStudyYearOneFinalReport.pdf

[21] Shin, H. & Poertner, J. (2002). *The well-being of older youth in out-of-home care who are headed to independence*. Children and Family Research Center, University of Illinois Champaign-Urbana, School of Social Work.

[22] Hartnett, M.A., Bruhn, C., Helton, J., Fuller, T. & Steiner, L. (2009). *Illinois Child Well-Being Study: Year Two Final Report*. Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

[23] Bruhn, C., Helton, J., Cross, T.P., Shumow, L. & Testa, M. (2008) Well-being. In Rolock, N. & Testa, M. (Eds.) *Conditions of children in or at risk of foster care in Illinois 2007: An assessment of their safety, stability, continuity, permanence, and well-being*. Children and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign. Urbana, IL

which NSCAW II data were being collected. DCFS was able to provide financial support to RTI International to expand the Illinois component of NSCAW II to over 800 children and youth—a sample size large enough to enable Illinois data to be extracted from the NSCAW data set and used as a self-contained data set. The Annie E. Casey Foundation provided additional support for analysis and reporting of ISCAW data. To use the term Illinois Survey of Child and Adolescent Well-Being or ISCAW is convenient but a bit misleading, since it is not a separate study from NSCAW II. Implementing ISCAW consisted of a) supporting RTI International to include a larger number of Illinois cases in the NSCAW II dataset, and b) pulling out the ISCAW data from the larger NSCAW II data set for separate analysis.

NSCAW II and ISCAW resembled the IL-CWB studies in that they used caseworker, caregiver and child interviews, and many of the same measures. However, the population studied in ISCAW was fundamentally different, consisting of children recently involved in maltreatment investigations. Only a small number of children in the ISCAW data set were in out-of-home care, and, at baseline, almost all of those children had been in out-of-home care four months or fewer (since they had been selected for the sample by being involved in a recent child maltreatment investigation and baseline data collection took place within four months of the investigation). NSCAW/ISCAW had a one year follow-up data collection, but by then many of the children who were in out-of-home care at baseline had reunified with their families or had another permanent placement, and relatively few had newly entered out-of-home care following baseline data collection. Therefore the small sample sizes in ISCAW for children in out-of-home care made it difficult to assess their well-being and the short amount of time children had been in placements meant that one could not be sure that the results were representative of the broader population of children in out-of-home care in Illinois.

The Steering Committee of the current study recognized the limitations of ISCAW for assessing the well-being of children in out-of-home care. It recommended that the study return to the methodology of the previous IL-CWB studies, and draw a sample of children who were in out-of-home care at a given point of time in 2017. Indeed, in most ways, the 2017 IL-CWB is a replication of the Round Two and Round Three IL-CWB studies. The name 2017 IL-CWB study was deliberately chosen in order to communicate this resemblance to those two studies. Because it is different in critical ways from the ISCAW study (and from the NSCAW studies), we ask people *not* to use the name "ISCAW" or "ISCAW II" to refer to the current study.

Other DCFS Well-Being Studies

DCFS is supporting other efforts to study the well-being of the children it serves. Several analyses have made use of the Child and Adolescent Needs and Strengths (CANS), a widely used assessment developed at the Mental Health Services and Policy Program at Northwestern University.[24] Caseworkers complete the CANS based on all available case information to rate the child and family in different areas of well-being, such as Life Domain Functioning, Traumatic Stress Symptoms, Behavioral/Emotional Needs, Risk

[24] See Rosanbalm, K. D., Snyder, E. H., Lawrence, C. N., Coleman, K., Frey, J. J., van den Ende, J. B., & Dodge, K. A. (2016). Child wellbeing assessment in child welfare: A review of four measures. *Children and Youth Services Review*, *68*, 1–16.

Behaviors, and Child Strengths.[25] The CANS is first completed at children's entry into DCFS care as part of the Integrated Assessment, a comprehensive evaluation in which caseworkers collaborate with licensed clinicians to interview the child and family, review all existing assessments, conduct an interview using an extensive semi-structured protocol, and write a comprehensive report detailing the child and family's needs.[26] Caseworkers repeat the CANS at six-month intervals throughout the life of the case, though DCFS data files are much more complete for CANS collected at entry into care than later.

DCFS uses CANS data in policy analyses. For example, a recent study used the CANS to identify the number of youth and biological parents involved with substance abuse that required intervention.[27] DCFS also collaborates with both the Mental Health Services and Policy Program and Chapin Hall at the University of Chicago on many policy-relevant analyses of CANS data. One recent analysis used CANS data from the Integrated Assessment to assess the frequency of service needs among the parents of the children assessed, including the comorbidity of substance and mental health problems.[28] Another study contrasted outcomes for youth with and without special health care needs within DCFS.[29]

Using CANS and other data, DCFS is also conducting the CWAC Child Well-Being Indicators Project**,** a study profiling the well-being of children entering care.[30] In 2015, DCFS formed the CWAC Well-Being Committee to assess the well-being of Illinois children and youth as they enter care and over time. The committee has recommended a set of developmentally appropriate measures of well-being in four domains: 1) cognitive/educational, 2) physical, 3) emotional/behavioral and 4) social. The emphasis of the project has been on data already being collected by DCFS, particularly the CANS, as well as administrative data on health and education, which have been supplied from data files from Medicaid and the Illinois State Board of Education. Three additional instruments are also used: the Devereaux

---

[25]Jaudes, P. Weil, L. l., Prior, J.., Sharp, D., Holzberg, M., & McClelland, G. (2016). Wellbeing of children and adolescents with special health care needs in the child welfare system. Children & Youth Services Review, 70276-283.; Lyons, J. S., Uziel-Miller, N. D., Reyes, F., & Sokol, P. T. (2000). Strengths of children and adolescents in residential settings: Prevalence and associations with psychopathology and discharge placement. *Journal of the American Academy of Child & Adolescent Psychiatry*, *39*, 176–181.

[26] Smithgall, C., Jarpe-Ratner, E., Gnedko-Berry, N., & Mason, S. (2015). Developing and testing a framework for evaluating the quality of comprehensive family assessment in child welfare. *Child Abuse & Neglect*, *44*,194-206. doi:10.1016/j.chiabu.2014.12.001

[27] Illinois Department of Children and Family Services (n.d.) *Annual Progress & Services Report (APSR) FY17*. Springfield, IL: DCFS.

[28] Jarpe-Ratner, E., Yang, D., Smithgall, C., & Bellamy, J. L. (2015). Using child welfare assessments and latent class analysis to identify prevalence and comorbidity of parent service needs. *Children and Youth Services Review*, *57*, 75-82.

[29] Jaudes et al., (2016), ibid

[30] Budde, S. & Risser, H. (September 2017). *CWAC Child Well-Being Indicators Project. Plan for Analyzing Indicators of Child Well-Being for Youth in Care in FY18 (Year One)*. Chicago: Juvenile Protection Association. …

Early Childhood Assessment,[31] the Strengths and Difficulties Questionnaire,[32] and a modified version of the Social Support Network Questionnaire.[33]

Researchers from the Juvenile Protection Agency and Northwestern University completed a preliminary CWAC report in July 2018. They presented baseline CANS findings for 321 children and youth enrolled in four immersion sites across the state that are seeking to improve outcomes by providing a locally-controlled, comprehensive service response to intact families.[34] CANS data revealed that the percentage of children with moderate to severe needs was relatively small. The most common needs requiring action were in the areas of adjustment to trauma (35.5%), family social functioning (31.1%), and substance exposure (16.2%). When the index child was age zero to five, substance exposure was more likely as an area of need requiring action (27.6%).

The Program Evaluation of the Illinois Birth Through Three Waiver Program (IB3) is also studying the well-being of young children in care. The IB3 program is supported by federal money made available through a waiver of certain requirements of the Title IV-E program, the federal mechanism for providing states with funds to support out-of-home care. The IB3 program provides evidence-based parenting interventions to deal with the effects of maltreatment on families with children aged 0–3 who enter out-of-home care in Cook County. For the program evaluation, researchers from the University of North Carolina-Chapel Hill (UNC-SSW) and the University of Wisconsin at Milwaukee are partnering with Chapin Hall at the University of Chicago and with the Survey Research Laboratory at the University of Illinois at Chicago. Evaluators are studying a cohort of 8,910 age-eligible children who were taken into DCFS care from July 1, 2013 to June 30, 2017.[35] Within this cohort, 1,889 (21%) children taken into care were assigned to the waiver demonstration; 47% of them to intervention agencies and 53% to comparison agencies. Within 45 days of case opening, about 90% of children were screened for developmental risk; 56% were categorized as high risk and 32% as moderate risk. Within the intervention group, about 47% of caregivers had received the target evidence-based training (either Child Parent Psychotherapy [CPP] or the Nurturing Parenting Program [NPP]), while only 28% in the services-as-usual (SAU) group received typical parent training, which did not utilize CPP or NPP. Children in the intervention group had a 53% higher likelihood of being reunified with family compared to children in the SAU group. However, the intervention had no significant effect on child emotional and behavioral problems or child development. Total costs savings for the project amounted to $432,568.

---

[31] Mackrain, M., LeBuffe, P., & Powell, G. (2007). *Devereux Early Childhood Assessment for Infants and Toddlers*. Lewisville, NC: Kaplan Early Learning Company

[32] Goodman R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology and Psychiatry*, *38,* 581-586.

[33] Gee, C. B., & Rhodes, J. E. (2007). A social support and social strain measure for minority adolescent mothers: A confirmatory factor analytic study. *Child: Care, Health and Development*, *34*, 87–97

[34] CWAC Child Well-Being Subcommittee (July 2018). *Preliminary Findings Report. Project Name: CWAC Child Well-Being.* Chicago: Juvenile Protection Association.

[35] School of Social Work, University of North Carolina, et al. (October 2018). *Draft Executive Summary Reporting Period: 7/1/2013 – 9/30/2018.* Chapel Hill: UNC School of Social Work.

Review of Previous Illinois Well-Being Findings in this Report

Comparison with previous studies will help us understand whether results on well-being have been consistent over time or are changing. In each substantive chapter that follows (child development, health etc.) we present results from previous Illinois studies, especially previous ILCWB studies, and reflect on how they compare and contrast with our current results.

Chapter 2

Methodology

The 2017 Illinois Child Well-Being Study is in most ways a replication of the Second Illinois Child Well-Being Study conducted in 2004[36] and the Third Illinois Child Well-Being Study conducted in 2005.[37] This enabled the research team, which had limited time and funding, to field the study more quickly by adapting interview protocols and other methods from the previous studies. It also makes it easier to compare results from the current study to results from the previous studies.

The current study sampled 700 children who were listed as in care in Illinois' statewide automated child welfare information system (SACWIS) on October 23, 2017[38]. Because some of the children in this sample were actually ineligible, a replacement subsample of an additional 97 children was sampled (using the same sampling method) on March 28, 2018 to replace ineligible children. The Survey Research Laboratory of the University of Illinois at Chicago conducted the study and produced the data files for the study. SRL interviewed caseworkers, caregivers and children (age seven and older) themselves to produce the data analyzed here. Additional data on these cases were downloaded from SACWIS data files.

Sampling Methods

Stratified random sampling was used to insure that enough cases of children in different age groups and with different lengths of care were adequately represented. As Table 2-1 shows, half the children in the sample had been in care less than three years and half more than three years, and additional stratification by child age was done within the length of care categories. Older children were oversampled to enable analysis of aspects of well-being specific to older children and adolescents. The sample was weighted with simple post-stratification weights that adjusted the sample distribution of age by year based on the population distribution of age by years in care[39].

All children were in placements (the permanent placements of adoptive, guardianship, or intact family placements were excluded). Children must also have been in placement a minimum of three months to be eligible. This ensured that both caregivers and caseworkers would have adequate time and knowledge about that child and that there would also be sufficient information within the case files for each child. Other selection criteria were as follows:[40]

- Children were currently in DCFS care.

---

[36] Hartnett, et al. (2009), ibid.
[37] Bruhn, C., et al. (2008), ibid.
[38] The original random sample included 700 cases. CFRC undertook additional random sampling beyond the original 700 cases in order to replace 97 cases in the sample that were unexpectedly ineligible. Thus, in total, 797 cases were sampled. For more information, see Parsons, J., Retzer, K. & Owens, L. (2018). *2017 Illinois Child Well-Being Study: Final Methodological Report*. SRL Study #1208. Survey Research Laboratory, University of Illinois at Chicago. Chicago: SRL.
[39] For more information on constructing sample weights, see Parsons, et al., 2018.
[40] See Parsons, et al. (2018), p. 5

- Incarcerated youth were ineligible.
- Children needed to be no older than 17.5 as of November 6, 2017, the scheduled data collection start date, so that cases would not age-out of the eligible age group too quickly.
- Children who were included in the sample frame for the recently conducted IB3 evaluation were ineligible.
- Only one child per caregiver was selected

The last two selection criteria were applied in order to reduce survey burden on caregivers. Incarcerated youths were excluded out of human subject protection concerns. Additional details on the construction of the sample are available in the Final Methodological Report by the Survey Research Laboratory at the University of Illinois at Chicago.[41]

Table 2-1 Sampling Strategy for the 2017 Illinois Study of Child Well-Being

Year in Care, Current Spell	Current Age	Target Percent of Sample
3 months to < 3 years	3 mos. to < 3 yrs. 3 yrs. to < 5 yrs. 5 yrs. to < 9 yrs. 9 yrs. to < 17 yrs.	10% 10% 10% 20%
3 years plus	3 yrs. to < 5 yrs. 5 yrs. to < 9 yrs. 9 yrs. to < 17 yrs.	10% 10% 30%

Recruitment

A professional in Information Technology and Services at DCFS found caseworker and caregiver contact information for all 797 cases in the sample. SRL sent caseworkers an advance notification e-mail and then called them to conduct the caseworker interview (see below). Prior to the caseworker interview, the interviewer administered the DCFS Caseworker Evaluation Form (CWEF) if the child was age 7 or older and therefore eligible to be interviewed. The CWEF collects information from the caseworker on the fitness of children age 7 and older for an in-person interview. CWEFs were then sent to the DCFS Guardian's Office to seek informed consent from the Guardian for the child to be interviewed (see Human Subject Protection below). At the completion of the caseworker interview, the interviewer obtained current caregiver contact information from the caseworker

[41] See Parsons, et al. (2018), ibid.

Following the caseworker interview, the caregiver was sent an advance letter notifying them about the study and the request for a telephone interview. If the DCFS Guardian granted permission for their child to participate, caregivers of children aged 7 and older were told that they were expected to arrange for the child's interview in their role as a foster caregiver, even if they elected not to be interviewed themselves. Interviewers then called caregivers to request their participation and interview them at that time or at a mutually convenient scheduled time. It should be noted that some caregivers refused to provide access to the child despite the expectation communicated to them by letter that they would do so. Appointments to interview the children in person were made through the caregiver. Child assent was obtained in person.

Human Subject Protection

The methodology was reviewed and approved by the Institutional Review Boards (IRBs) of the University of Illinois at Urbana-Champaign, The University of Illinois at Chicago, and the Department of Children and Family Services. The advance letters to adult participants advised them that their participation was voluntary, that the information they provided would be confidential, and that they could refuse to participate in the survey or refuse to answer any questions without penalty. Before all interviews, caseworkers, caregivers and children were informed verbally about voluntary participation, confidentiality, and the right to refuse participation. Interviews did not proceed unless the respondent formally agreed to participate. As mentioned above, the DCFS Guardian Administrator gave consent for the participation of sampled minors after the child's caseworker had been contacted to verify the capacity of the child to be interviewed.

All children were asked to give assent before the interview. The assent form explained to the minor that he/she had the right to refuse to participate in the study, as well as the right to refuse to answer any questions or stop the interview without any penalty. The assent form also informed the minor that there were conditions that would require a report of one or more of the child's answers to DCFS. Information would be reported to DCFS if it indicated that there was an immediate safety issue and/or if the child was an immediate danger to him/herself or others. If a minor did not provide assent, he/she was not interviewed. The assent form was written in clear and age-appropriate language.

SRL included "red flag" programming to alert the interviewer that an answer to a particular question required follow-up.[42] The programming prompted them to follow the emergency protocol specified in their manual. Interviewers were provided with two scripts that were available to read to the child depending on the problem that emerged. (abuse/neglect and suicidal ideation). Interviewers then completed an Incident Report Form, which was uploaded to DCFS psychologists, who followed-up with caseworkers. Flags were programmed for the following problems:

- Suicidal ideation
- Child aged 11 years or younger was left home alone
- An adult has thrown something at the child in the past month in present home
- An adult has pushed/shoved child really hard in past month in present home

[42] For more information, see Parsons et al. (2018), ibid.

- Child “somewhat or sometimes” deliberately huts himself/herself
- An adult has beaten him/her up within the last 3 months in present home
- An adult has pointed knife or gun at him/her within last 3 months in present home
- Someone physically hurt child on purpose within the past 12 months, and child knows people who did it and those person were responsible for taking care of child
- Child has been paid for sexual intercourse

Data Sources

The vast majority of the data for the study were collected from the interviews with the caseworker, caregiver and child (only those children age seven or older who were capable of participating in an interview). The interviews were adapted from the Second Round and Third Round IL-CWB study interviews. The interviews included questions developed for this project, questions previously developed for the National Survey of Child and Adolescent Well-Being (NSCAW) but also useful for this project, and standardized measures of child well-being (some of which were also in NSCAW). Some demographic data were also downloaded from DCFS SACWIS files. The tables in the Appendix give an overview of the items and measures used in the study.

Caseworker Interviews

Caseworkers were interviewed about what they learned from their assessment of the family and the actions they took to support safety, permanency and well-being in that case. Caseworkers were asked to report information on the following domains:

- Risk factors
- Child services
- Child education
- Adoption possibilities (if applicable)
- Living environments
- Caseworker involvement in the case

Caregiver Interviews

The caregiver interview solicited information from the caregiver about the child’s well-being. The interviews covered the following domains:

- Child health
- Child health services
- Child education
- Child delinquency
- Behavior and social competence
- Developmental status
- Mental health service needs and use

Child Interviews

If the child provided assent to be interviewed, they completed an in-person interview at their residence or at their child welfare agency. In-person interviews were necessary because the interview includes Audio-CASI segments, or computer self-administered interviews, to facilitate asking sensitive questions. The interviewer administered the first section by reading the questions out loud to the child, and entered the answers given into the computer. In the second, computer-administered part of the interview, the child listened to pre-recorded questions on the computer, which the interviewer was not able to hear. Children aged 10 and 11 pointed to their answers on a show card that matched the response categories of the question number, and the interviewer entered the answer into the computer. Children aged 12 and older entered their own answers into the computer. Children aged 14+ were also asked to complete the Ansell Casey Life Skills assessment on paper. Children received their choice of a $20 gift card for Walmart or McDonald's for their participation.

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

- Relationship with peers
- School engagement
- Out-of-home care
- Depression
- Exposure to violence
- Trauma
- Youth activities
- Parental monitoring
- Future expectations
- Protective factors
- Injuries
- Relationship with caregivers
- Child maltreatment and child discipline
- Closeness to caregiver(s)
- Satisfaction with caseworker services
- Services received
- Youth behavior problems
- Substance abuse
- Sexual activity
- Delinquency
- Life skills for independent living
- Life satisfaction

Response Rates

The Survey Research Laboratory selected a method identified by the American Association of Public Opinion Research for calculating response rates[43]. SRL used completed interviews as the numerator in the calculation, while the denominator included interviews, refusals, noncontact of eligible respondents, and a proportion of subjects whose eligibility status was unknown. Caseworker interviews were completed in 527 cases, for a response rate of 80.9%. Caregiver interviews were completed in 381 cases, for a response rate of 62.4%. Child interviews were completed in 145 cases. The response rate was 48.7%. The SRL report[44] provides additional information on refusal rates and cooperation rates.

Data Analysis

We computed frequency distributions for all variables measuring well-being. For many continuous variables, we also calculated the mean. Standard errors were calculated for each percentage and mean. We conducted additional analyses to examine whether well-being results differed for key subgroups of the population of children in out-of-home care. Cross tabulations (with Pearson $\chi 2$ and exact significance tests) and analyses of variance examining differences in well-being by the following covariates: placement setting, child sex, child age group, race-ethnicity, region, and sexual orientation (heterosexual vs. LGBTQ+). Results that are statistically significant (at α=.05) and useful are presented in the text. We omitted the full results of statistical significance tests for ease of presentation, but output from all analyses are available from the authors.

Sample Characteristics

Table 2-2 presents characteristics of the children and youth in the sample. The sample was about evenly split between boys and girls. The sampled was fairly evenly distributed across age groups—note that adolescents were oversampled so they formed a larger proportion of our sample than their representation in the population of children in care. Most children were either White or African-American, with these two groups being roughly equal. The four regions were about equally represented, though the Southern region subsample was somewhat smaller. About equal numbers had been in care under 2 years and 2 to 4 years and a smaller percentage had been in care 5 years or more—we oversampled for children with longer stays in care. Statistical weights were used to compensate for oversampling or certain groups.

[43] See Parsons, et al., (2018), ibid.
[44] Parsons, et al., (2018), ibid.

Table 2-2 Child Characteristics

	f	%/se
Gender		
Female	254	48.1 (2.2)
Male	273	51.9 (2.2)
Age		
Under age 3	122	23.1 (1.8)
3 to 5 years	139	26.4 (1.9)
6 to 8 years	74	14.0 (1.5)
9 to 11 years	65	12.4 (1.4)
12 to 17 years	127	24.1 (1.9)
Race- Ethnicity		
African American	224	42.5 (2.2)
Latino	38	7.3 (1.1)
White	253	48.1 (2.2)
Other	11	2.2 (0.6)
Placement Type		
Relative foster placement or fictive kin	247	47.0 (2.2)
Non relative traditional foster care	203	38.6 (2.1)
Group home or residential treatment	26	5.0 (0.9)
Specialized foster care	46	8.8 (1.2)
Other	4	0.7 (0.4)
Region		
Cook	146	27.6 (1.9)
Northern	123	23.4 (1.8)
Central	160	30.4 (2.0)
Southern	98	18.5 (1.7)
Number of years child has been in care		
Under 2 years	222	42.2 (2.2)
2 to 4 years	242	45.9 (2.2)
5 years or more	63	11.9 (1.4)

Table 2-3 presents characteristics of caregivers in the sample. A majority were White but over a third were African American. Just under half were related to child by blood or marriage. The median level of education was an associate's degree. Just over half were working full time; otherwise work status varied

across caregivers. Again, the four regions were about equally represented; the Southern region subsample was somewhat smaller.

Table 2-3 Caregiver Characteristics

	f	%/ se
Race- Ethnicity		
White	210	55.0 (2.5)
Black	132	34.7 (2.4)
Latino	20	5.2 (1.1)
Other	20	5.1 (1.1)
Age		
21 to 24 years	8	2.1 (0.7)
25 to 34 years	60	16.1 (1.9)
35 to 44 years	97	25.8 (2.3)
45 to 54 years	106	28.2 (2.3)
55 to 64 years	72	19.2 (2.0)
65+ years	32	8.6 (1.4)
		Mean= 46.73 (6.3)
Related to child by blood or marriage	158	43.6 (2.6)
Region		
Cook	90	28.7 (2.6)
Northern	80	25.6 (2.5)
Central	89	28.4 (2.5)
Southern	54	17.4 (2.1)
Highest level of education received		
Elementary School	19	5.3 (1.2)
High school equivalent (GED)	31	8.5 (1.5)
High school diploma	117	32.1 (2.5)
Associate's degree (AA degree)	62	17.1 (2.0)
RN degree	2	0.7 (0.4)
Bachelor's degree	70	19.3 (2.1)
Master's degree	54	15.0 (1.9)
M.D, J.D., Ph.D., or Dental	8	2.1 (0.7)
Work Status		
Full-time	185	51.3 (2.6)
Part-time	45	12.4 (1.7)
Unemployed	7	2.1 (0.8)
Retired	31	8.7 (1.5)
Cannot work due to illness or injury	35	9.7 (1.6)
Homemaker	44	12.2 (1.7)
Student or other reason	13	3.6 (1.0)

In the child interview, we asked youth age 12 and older about their sexual orientation and sexual attraction. We received responses from 85.2% of youth who were asked about sexual orientation and 90.5% of youth who were asked about sexual attraction. Table 2-4 presents results for these questions. Most girls and boys reported being heterosexual and attracted to the opposite sex. Girls and boys reported an LGBTQ+ orientation in 21.8% of cases, including not knowing their sexual orientation. Girls being attracted to girls or to both sexes were 14.6% of the sample. In 6.4% of cases, the youth interviewed reported not being attracted to either sex. No boy reported being gay, being attracted to boys, or being attracted to both sexes.

Table 2-4 Youth Sexual Orientation and Attraction (Age 12 to 17, N=60)

	f	%/ se
Sexual Orientation		
Straight or heterosexual girl	26	43.8 (6.4)
Gay or lesbian girl	3	4.8 (2.7)
Bisexual girl	6	9.8 (3.8)
Girl - other sexual orientation	1	2.0 (1.8)
Girl - does not know sexual orientation	1	1.3 (1.4)
Straight or heterosexual boy	21	34.4 (6.1)
Bisexual boy	1	2.1 (1.9)
Boy – does not know sexual orientation[a]	1	1.8 (1.7)
Sexual Attraction		
Girl attracted to boys	23	40.9 (6.5)
Girls attracted to girls	3	5.5 (3.0)
Girl attracted to both boys and girls	6	10.0 (4.0)
Girl not attracted to boys and not attracted to girls	2	3.5 (2.4)
Boy attracted to girls	21	36.6 (6.4)
Boy not attracted to boys and not attracted to girls[b]	2	2.9 (2.2)

Note. All analyses used weighted data. The sample sizes presented are unweighted [a] No boy in the sample self-identified as gay. [b] No boy reported being attracted to boys or both to boys and girls.

Chapter 3

Child Development

Assessing child development is critical in a study of child well-being. Progress in children's development underlies physical, mental and emotional health, and is necessary for learning, educational progress and the development of family and peer relationships. Child development is a particularly important well-being topic for DCFS, given that 39.7% of children in DCFS care in 2017 were five years old or younger.[45] Early childhood is a sensitive period for developing a range of capabilities in life – one critical ability focused on age zero to two is the ability to form attachments.[46] Maltreatment is a significant risk factor for children's development. Maltreatment can negatively affect the development of brain pathways and other physiological systems, leading to such problems as impaired attachments, persistent fear, hyperarousal, diminished executive functioning, insufficient response to positive feedback, impaired social relationships, and difficulty reaching developmental milestones.[47]

NSCAW has assessed child development through interviews with caregivers and through screening measures such as the Bayley Neurodevelopmental Screener (BINS) and the Battelle Developmental Inventory (BDI).[48] To administer the screening measures, NSCAW interviewers ask the child to perform a series of cognitive and motor tasks that are scored to indicate the child's level of development.

NSCAW research has found that children involved in child protection investigations score poorly relative to other children on a range of developmental measures.[49] In NSCAW I, from one- to two-thirds of preschool-aged children had developmental delays in one or more areas (e.g., brain functioning, language skills, or behavior).[50] Difficulties were evident at every age measured. About half of children under age 2 had scores indicating possible developmental delays or neurological impairment. Children under age 3 in NSCAW had poorer cognitive skills on average than most children. Both infants and toddlers had lower social competence and daily living skills. Children under age 6 were behind in

---

[45] Wang, S. (January 2017) *Demographic analysis of children in the care of the Illinois Department of Children and Family Services*. Unpublished data analysis. Children and Family Research Center, University of Illinois at Urbana-Champaign, Urbana, IL: CFRC.

[46] Smyke, A. T., Zeanah, C. H., Fox, N. A., Nelson, C. A., & Guthrie, D. (2010). Placement in foster care enhances attachment among young children in institutions. *Child Development*, 81, 212–223.

[47] Child Welfare Information Gateway. (2015). *Understanding the effects of maltreatment on brain development*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

[48] Dolan, M., Smith, K., Casanueva, C. & Ringeisen, H. (2011). *NSCAW II Baseline Report: Introduction to NSCAW II*. OPRE Report #2011-27a, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

[49] Casanueva, C., Ringeisen, H., Wilson, E., Smith, K., & Dolan, M. (2011). *NSCAW II Baseline Report: Child Well-Being*. OPRE Report #2011-27b, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

[50] Casanueva, et al., (2008), ibid.

language development, and large proportions of 5 and 6 year olds had difficulties with executive functioning, a concept that encompasses control of attention and behavior.[51]

The picture was much the same in the NSCAW One Year in Foster Care study. On the BINS, 78% of children aged 13 to 24 months scored in a range indicating medium to high developmental risk. On the BDI, 28% of children aged three and younger scored in a range indicating a need for developmental intervention. The authors reported, "…the vast majority of children who have spent one year in out-of-home care have substantial social and cognitive impairment."[52] Other studies have produced similar findings: a 2016 meta-analysis of 31 studies found that children in foster care had significantly greater difficulties on cognitive adaptive and behavioral functioning than children in general, though not different from children at risk who remained in the home.[53]

It is essential that child who have developmental problems be identified and provided with the appropriate services to promote development and learning.[54] Early intervention (EI) services can facilitate the development of young children who lag behind[55] and can position children with enduring problems to receive special education services. An important step is the development of an Individualized Family Services Plan (IFSP), a formal document committing service providers to provide early intervention services or monitoring that are tailored to a child's needs.[56] The federal Child Abuse and Prevention Treatment Act (CAPTA) requires states to provide for referral of child maltreatment victims to EI services.[57] But multiple NSCAW studies have found that many young children involved with child welfare do not receive the EI services they need. For example, an early NSCAW analysis found that 35.2% of children aged 0 to 3 needed early intervention (EI) services, but only 12.7% had received an IFSP including those services.[58] Later NSCAW analyses found that the percentage of children aged 0 to 5 with developmental need who received an IFSP or an Individualized Education Plan IEP) was only 17.7%.[59] Moreover, only 53% of children in NSCAW referred for EI services actually received them.[60]

---

[51] Roos, L., Schnabler, S., Fisher, P., & Kim, H. (2016). Children's executive function in a CPS-involved sample: Effects of cumulative adversity and specific types of adversity. *Children and Youth Services Review*, 711, 84-190.
[52] U.S. Department of Health and Human Services, 2001, ibid., p. 20
[53] Goemans, A., van Geel, M., van Beem, M., & Vedder, P. (2016). Developmental outcomes of foster children: A meta-analytic comparison with children from the general population and children at risk who remained at home. *Child Maltreatment*, 21,198-217.
[54] Institute of Medicine 2000. *From neurons to neighborhoods: The science of early childhood develop*ment. Washington, DC: The National Academies Press. Retrieved from https://doi.org/10.17226/9824.
[55] Shonkoff, J. P., & Meisels, S. J. (2000). *Handbook of early childhood intervention* (2nd ed.). New York: Cambridge University Press.
[56] Casanueva, et al. (2008) ibid.
[57] Casanueva, et al. (2008) ibid
[58] Casanueva et al. (2008) ibid
[59] Casanueva, C., Stambaugh, L., Tueller, S., Dolan, M., & Smith, K. (2012). NSCAW II Wave 2 Report: Children's Services. OPRE Report #2012-59, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved from https://www.acf.hhs.gov/sites/default/files/opre/nscaw_childrens_services_report_wave_2_june_2014_final_report.pdf
[60] Johnson-Motoyama, M., Moses, M., Mariscal, E., & Conrad-Hiebner, A. (2016). Development, CAPTA Part C Referral and Services among young children in the U.S. Child Welfare System: Implications for Latino Children. *Child Maltreatment*, 21, 186-197.

Child Development in Previous Illinois Well-Being Studies

In the Round One IL-CWB, caseworkers reported that 21.2% of children had developmental delays. Broken out by age group, this was 34.1% of preschoolers, toddlers and infants; 9.2% of children age 6 to 13; and 26.5% of youth age 14 and older. Nurse audits of case records found that 54% of children under age 6 were screened, and 22% of this group had developmental delays, though the sample size was small. The Early Childhood Unit (ECU) of DCFS assessed every child under the age 3 in Cook County, and found developmental delays in 58% of children, though this was only 13 children in this small subsample. In the Round Two ILCWB, a nurse audit of case records found that 21.4% of children had developmental delays.

In the ISCAW study, 59% of infants in traditional foster care and 48% of infants in kinship care in the sample were at risk for developmental delay on the Bayley Infant Neurodevelopmental Screener. Of children aged 0 to 4, 27% in traditional foster care were at risk for cognitive delay according to the Battelle Developmental Inventory, as were 3% of those in kinship care. Children in out-of-home care who were age 0 to 6 scored slightly below the normal range on average on the Preschool Language Test, which means that a substantial proportion had problems with language development. School-aged children in out-of-home care scored at about the 25th percentile on the Kaufman Brief Intelligence Test. On the Vineland Daily Living Skills measure, 22% of children in traditional foster care scored in the low range as did 17% in kinship care. In the traditional foster care group, 28% of caregivers were told by a professional that their child had a disability and this was also reported by 24% of kin caregivers.

Many children in traditional foster care in ISCAW had interventions to address special needs: 17% had an IFSP, 62% had special education through an individualized educational plan (IEP), and 29% had physical, occupational, or speech therapy on a regular basis. Children in kinship care were significantly less likely to have these services: 7% IFSP, 37% IEP, and 7% physical, occupational or speech therapy. The percentage of young children in out-of-home care who were enrolled in early childhood education or care programs was 80%.

Current Analysis and Results

The caregiver interview included the Ages and Stages Questionnaire (ASQ), a common standardized instrument to assess the development of children aged 0 to 5. Caregivers answer a series of questions on the ASQ about their child's capabilities in multiple domains of development. Because of a recently discovered error in the interview protocol written for the Round Two IL-CWB and inadvertently carried over into the current study, ASQ results were only available for a subset of caregivers (see Table 3-1), although the sample size is still large enough to provide reasonable estimates.

Developmental Difficulties. Most children did not show indications of developmental difficulties on the ASQ. Nevertheless, in each of the domains of Communications, Gross Motor Skills, and Fine Motor Skills, more than 20% of children either showed signs of a possible developmental delay or had scores that suggested the child could benefit from monitoring.

On the Communication scale, the groups that were at greater risk were boys (31.4% in the delay/monitoring range vs. 13.1% for girls), White and Hispanic children (30% vs. 19.7% for African

American children), and children in Cook County (48.8% vs. less in other regions). On the Gross Motor Skills scale, Hispanic and African-American children were at greater risk than White children (30.0% and 22.4% vs. 14.5%), and children in Cook County were again at higher risk (34.9%) than children in other regions.

Table 3-1 Ages and Stages Questionnaire: % in Monitoring Zone and Identified with Possible Delay (Children Aged 0 to 5)

Scale		Monitoring		Possible Delay		Monitoring/Possible Delay	
	N	*f*	%/ se	*f*	%/ se	*f*	%/ se
Communication	186	33	17.6 (2.8)	11	6.0 (1.7)	44	23.6 (4.5)
Gross Motor Skills	173	16	9.0 (2.2)	21	12.1 (2.5)	37	21.1 (4.7)
Fine Motor Skills	163	23	14.1 (2.7)	16	10.0 (2.4)	39	24.1 (5.1)
Problem-Solving	173	17	10.0 (2.3)	7	4.0 (1.5)	24	14.0 (3.8)
Personal Social Skills	174	12	6.9 (1.9)	7	3.7 (1.4)	19	10.6 (3.3)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Developmental Assessments and Interventions. Caregivers were asked about the developmental assessments and interventions children aged 0 to 5 received (see Table 3-2). Over 58% of caregivers reported that their young children had been tested for learning problems, and over one-quarter had been told the child had a learning problem. Also, 18.5% of children aged 0 to 5 had an Individualized Family Services Plan, a comprehensive plan to provide services to address children's special needs, and 25.8% of those with a child aged 3 to 5 reported that their child had been classified as needing special education.

Table 3-2 Developmental Assessment and Interventions for Children Age 0 to 5 - from Caregiver Interview

	N	f	%/ se
Age 0 to 5			
Child tested for learning problems	182	106	58.1 (3.7)
Told child had a learning problem	180	47	26.5 (8.3)
Individualized Family Services Plan	86	16	18.5 (4.2)
Educational services or therapies in your home	170	42	24.9 (3.3)
Therapeutic or educational daycare	170	30	17.8 (2.9)
Educational services or therapies at a center	164	17	10.2 (2.4)
Any developmental intervention, age 0 to 5[a]	170	82	48.4 (3.8)
Age 0 to 3			
Early Head Start	97	9	9.4 (3.0)
Other educational program	97	15	16.0 (3.7)
Any developmental intervention, age 0 to 3[a]	104	59	56.7 (4.9)
Age 3 to 5			
Child classified as needing special education	97	22	25.8 (4.8)
Daycare	43	23	53.5 (7.7)
Regular preschool or nursery school	73	41	56.2 (5.9)
Head Start	69	21	30.3 (5.6)
Special education preschool	73	11	15.7 (4.3)
Any preschool or Head Start[b]	73	59	80.8 (4.7)
Any developmental intervention, age 4 to 5	66	23	34.8 (5.9)

Note. All analyses used weighted data. The sample sizes presented are unweighted. [a] The child aged 0 to 5 received one or more of the following: educational services or therapies in your home, therapeutic or educational daycare, educational services or therapies at a center, Early Head Start, special education preschool, or other educational program. [b] The child aged 3 to 5 received one or more of the following: regular preschool or nursery school Head Start, and special education preschool

Table 3-2 also shows developmental interventions children aged 0 to 5 received. A majority of those aged 3 to 5 received a developmental intervention. The most common was educational services or

therapies in their home (24.9%) and therapeutic and education daycare (17.8%). Altogether 48.4% of caregivers of children aged 0 to 5 reported that their child received a developmental intervention. Surprisingly, there was only a modest relationship between ASQ scores and receiving a developmental intervention. Children who were in the possible delay/monitoring range on the ASQ Fine Motor Skllls scale were more likely to receive a developmental intervention (68.6% vs. 41.4%), but otherwise there was no significant relationship. Many children who scored in the delay/monitoring range on the ASQ were not receiving a developmental intervention (e.g., 39.5% of children who scored in that range on the ASQ Communication scale were not receiving a developmental intervention).

Children aged 0 to 5 were more likely to receive a developmental intervention if they were in specialized foster care (71.4% of 7 children) or in traditional foster care (55.6%) than if they were in kinship care (37.5%). Children in kinship care were also less likely to be tested for learning problems (44.3%) and kin caregivers were less likely to be told that a child had a learning problem (11.3%). In addition, children in kinship care were less likely to receive an IFSP (9.4%) or to receive educational services or therapies in their home (23.1%). Among children aged 0 to 3, the only ones receiving educational or therapeutic services at a center were in traditional foster care (20.5% of this group).

Service delivery also differed by region and race-ethnicity. Children aged 0 to 5 were more likely to receive a developmental intervention in Cook County (73.8%) and the Northern region (58.3%) than in the Southern region (38.5%) and Central region (25.0%). Sizeable percentages of children aged 0 to 5 had an Individualized Family Services Plan in Cook County (30.0%) and the Northern region (23.1%), but no child did in the Central and Southern regions. No child in the Southern region received therapeutic or educational daycare, and none in the Central and Southern regions received educational or therapeutic services at a center. Only children in Cook County were enrolled in Early Head Start (18.2% of Cook children age zero to three). African-American children were less likely than other racial ethnic groups to receive educational or therapeutic services at home (16.2%) and no African-American child received educational or therapeutic services at a center.

Early Childhood Education and Daycare. Looking at early childhood education, 80.8% of children aged 3 to 5 received some form of preschool or Head Start. Over half of caregivers of children aged 3 to 5 reported that their child had daycare, as did 93.2% of caseworkers for children under age 5 (an analysis not reported in a table, se=2.9).

Special Needs. Caseworkers were asked if the child had any learning problems, developmental disabilities, or other special needs (see Table 3-3). This was asked for every child in the sample regardless of their age. Though we present these results in this chapter on child development, this question also pertains to children's emotional and behavioral health and education and so is relevant for later chapters as well.

Table 3-3 Caseworker Identification of Special Needs at Entry into Out-of-Home Care (N=517)

	f	%/ se
Specific learning disability	46	9.0 (1.3)
Developmental delay	31	5.9 (1.0)
Speech or language impairment	23	4.5 (0.9)
Prenatal substance exposure	14	2.7 (0.7)
Emotional/behavioral disturbance	11	2.1 (0.6)
Premature birth	6	1.1 (0.5)
Hearing impairment	5	0.9 (0.4)
Medically complex	5	1.0 (0.4)
Mental retardation	4	0.8 (0.4)
Cerebral palsy	3	0.6 (0.4)
Visual impairment	1	0.2 (0.2)
Sexual abuse issues	1	0.2 (0.2)
Other	13	2.6 (0.2)
Any special need	151	29.2 (2.0)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Caseworkers identified one or more special needs for 29.2% of children. The most common special needs were specific learning disability, developmental delay, and speech or language impairment, but there was a wide array of specific conditions. Caseworkers identified special needs frequently in every age group: 26.0% children age 0 to 3, 19.5% of children aged 3 to 5, 22.2% of children aged 5 to 9, and 32.3% of youths aged 9 to 17. Special needs were more likely in specialized foster care (57.8%) and group homes and residential treatment (52.0%) than in kinship care (26.9%) or traditional foster care (21.0%). Boys were more likely to have special needs than girls (34.3% vs. 23.9%). The particular special needs that differed by placement setting included specific learning disability (group home and residential treatment, 28.0%; specialized foster care 22.2%), developmental delay (specialized foster care, 13.3%), and mental retardation (group home and residential treatment, 8.0%). Three to five year olds were more likely to be identified with speech and language impairments (35.5%) compared to other age groups.

Discussion

Like previous Illinois well-being studies, the 2017 Illinois Study of Child Well-Being found that a substantial proportion of young children in out-of-home care appear to have developmental issues. This was evident in the ASQ scores, in caregivers being told their child had a learning problem, and in involvement in the IFSP process or special education or other developmental interventions. The proportions of young children with developmental difficulties tended to range from about one-fifth to one quarter across these different indicators. These results are similar to results from previous studies of young Illinois children in out-of-home care. These may be underestimates, as they do not represent the results of formal assessments, and caregivers and caseworkers may not be alert to all signs of developmental difficulty. Studies with formal evaluations tend to find much higher percentages of children with developmental difficulties. These studies include the Round One IL-CWB study, which included the Early Childhood Unit assessments in, and NSCAW/ISCAW, which used standardized screening measures implemented by interviewers (e.g., the Bayley measure)

The positive news is that slightly more than half of caregivers of children aged 1 to 3 reported that their child received some form of developmental intervention. The most common developmental interventions for children aged 1 to 3 were those provided in the home. However, we lack information on the nature and quality of developmental interventions in the home and their frequency and duration over time. This makes it difficult to assess whether these services could be effective. It is surprising that children whose scores on the ASQ suggested developmental delay or a need for monitoring were not more likely to receive a developmental intervention than other children. It means that some children who were rated by the ASQ as needing intervention were not receiving it. Research is needed to study how out-of-home caregivers connect to developmental services, what specific developmental interventions children receive, and what the effects of these interventions are on development.

Additional information is needed to understand why young children were much more likely to receive a developmental intervention in Cook County and the Northern region than in the Central and Southern Regions, and why young African-American children were reportedly less likely to receive educational or therapeutic services. The lower rate of developmental interventions for children in kinship care, a finding similar to one from the second IL-CWB, also needs to be understood. All these findings raise questions about the equity of service delivery.

Consistent with 2008-2009 findings from ISCAW, the majority of children aged 3 to 5 are in some form of preschool, most often in a regular preschool or Head Start[61]. Even so, there is room for improvement,[62]given that DCFS policy is for all children in that age group to receive early childhood education. Enrollment in a special education preschool is less common. The substantial number of children with special needs combined with the small number in special education preschool suggests

---

[61] See Cross, T.P. & Helton, J. (2010). *Enrollment in early childhood education programs for young children involved with child welfare*. Research brief. Urbana, IL: Children and Family Research Center. University of Illinois at Urbana-Champaign.
[62] Illinois Department of Children and Family Services. (March 2015). *Educational Services*. Springfield, IL: DCFS. Retrieved from https://www2.illinois.gov/dcfs/aboutus/notices/Documents/procedures_314.pdf#page=33

that a number of children who are enrolled in regular preschools and Head Start have special needs. Future research should examine the presence of special needs for DCFS-involved children in preschool and Head Start and how these special needs are being addressed.

Much of our data on child development focuses on children aged 0 to 5, but it is important to remember that developmental issues are relevant throughout the age range of children in out-of-home. Caseworkers identified over a quarter of the sample as having special needs, and the percentage was substantial in each child age group. We will see the prominence of children's special needs in most of the chapters below, particularly physical health, emotional and behavioral health, and education chapters. One of the most important lessons of the 2017 Illinois Child Well-Being is the need to be aware of and respond to the developmental challenges and special needs that children bring when they enter out-of-home care.

Chapter 4

Physical Health

More than thirty years of research have shown that children entering out-of-home care are significantly more likely to have health problems than other children. A 2015 review of studies by the American Academy of Pediatrics found that 30% to 80% of children begin foster care with at least one physical health problem, a third have a chronic health condition, and about one-fifth have dental problems.[63] Children in foster care also frequently have nutritional deficits that threaten their health and development.[64]

Abuse and neglect can lead to physical health problems, and neglect of children's health needs can exacerbate health problems that arise.[65] Moreover, children in foster care often have had other adverse experiences that pose health risks as well, such as homelessness, exposure to drugs prenatally, insufficient pre-natal care, prematurity, and exposure to lead and other environmental toxins in the home or neighborhood.[66]

Health care professionals have described many barriers impeding the delivery of health services to children in foster care.[67] A limited range of providers takes Medicaid, the health insurance that most children in foster care have, and reimbursement is insufficient for the time that children with chronic health conditions require. Often their health problems are neither diagnosed nor treated prior to their entry into out-of-home care, so responding to health problems is an important responsibility when children enter care. Biological parents may retain decision-making authority on children's health care even when children are placed in out-of-home care, complicating delivery of health services. Placement moves make it difficult for caregivers to know about children's health care needs, to maintain a consistent heath care provider over time, and to manage medications and home treatments. Information about allergies, immunizations, previous conditions, medications and other treatments gets lost or is not compiled. Foster parents may have limited ability to identify children's health problems or access health resources without support,[68] so treatment can be haphazard and focused on emergencies. Health care providers often have little understanding of the child welfare system and of trauma-informed care, and health care is often poorly coordinated with other services.

---

[63] Szilagyi, M.A., Rosen, D.S., Rubin, D., Zlotnik, S. (2015). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics*, *136*, E1131-E1140.

[64] Tooley, U., Fisher, P., & Makhoul, Z. (2016). Nutritional status of foster children in the U.S.: Implications for cognitive and behavioral development. *Children and Youth Services Review*, *70*, 369-374.

[65] Deutsch, S. A., & Fortin, K. (2015). Physical health problems and barriers to optimal health care among children in foster care. *Current Problems in Pediatric and Adolescent Health Care*, *45*, 286–291.

[66] Deutsch & Fortin (2015), ibid.

[67] Council on Foster Care, Adoption, and Kinship Care (2015), ibid. Deutsch & Fortin (2015) ibid; Szilagy, et al. (2015), ibid.

[68] Pasztor E.M., Hollinger, D.S., Inkelas, M., & Halfon, N. (2006). Health and mental health services for children in foster care: The central role of foster parents. *Child Welfare*, *85*, 33–57.

NSCAW II research compared health care services for children in out-of-home care and other children involved with child welfare services, and made comparisons when possible to national child data.[69] These analyses suggest that, despite the barriers, children in out-of-home care were actually *more* likely to receive certain health services than children involved in child protection investigations who were not placed out-of-home. For example, almost all children in out-of-home placement in NSCAW had a usual medical home, according to caregivers. This was significantly higher than among NSCAW children still in parents' homes and comparable to national health statistics. Almost all children in formal kin homes or residential treatment or group homes were up-to-date with immunizations; this was slightly higher than the rates for children who remained at home and children in foster care. Over 90% of children in out-of-home care had a well-child visit in the previous year, which was significantly higher than the percentage for NSCAW children living at home or in informal kin placements. Caregivers for children in out-of-home placements were also significantly less likely to report delaying children's medical care because of cost (5% or less) compared to children at home or informally with kin (12% to 13.5%). At the same time, children in out-of-home care were much less likely to have had an injury, accident, or poisoning that needed medical care compared to children at home. Majorities of children in all groups had received dental care in the past year.

Physical Health in Previous Illinois Well-Being Studies

In the first IL-CWB study in 2001, almost all caregivers reported that children had received immunizations, though immunization was documented in only 80% of case records. Case record review revealed that 77% of children were enrolled in Healthworks, providing them health insurance, and 67% received well child care. Case records documented that 46% of children had a current dental examination, 40% a current hearing examination, and 14% a current vision examination. According to caregivers, 96% of children over the age of three received an annual dental checkup, although 21% of youth reported that it had been more than 12 months since they had seen a dentist.

Caseworkers reported that 39% of children had been diagnosed by a doctor with physical health problems, 42% of caregivers identified health problems for their child in the sample, and a nurse audit of children's case records found that 24% of children had a physical health diagnosis. The most common illnesses were asthma and other respiratory illnesses, diseases of the musculoskeletal system, and diseases of the nervous system such as cerebral palsy and epilepsy. According to caregivers, 100% of children with gynecological problems received treatment, as did 92% of children with eye problems, 71% of children with medical problems generally, and 70% of children with developmental problems. Children at the target ages for braces needed them in 23% of cases, but only 30% of those in need received braces.

In the Round Two IL-CWB, 90% of caregivers rated their child as having good to excellent health overall. Nevertheless, 64.3% of caregivers reported that their child had serious and/or chronic physical health conditions. Caseworkers reported that 22% of children had a physical health condition, and that 20.9%

---

[69] Ringeisen, H., Casanueva, C., Smith, K., & Dolan, M. (2011*). NSCAW II Baseline Report: Children's Services*. OPRE Report #2011-27f, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

of children needed services for health problems within the last twelve months. A nurse audit found that 29.3% of the sample had non-acute physical health conditions diagnosed by a physician in their case records. Majorities of children who needed specific health services received them, according to both caregivers and caseworkers.

In the child interview in the Round Two IL-CWB, 23.1% of children and youth reported that they had a serious or chronic health problem. Almost two-thirds (65.1%) of youths age 11 to 15 reported suffering an injury in the previous year, including a cut or a sprain (47%), a burn or a bite wound (28.5%), a broken bone (9.7%), and being stabbed or having a gunshot wound (2.3%). Just under half of children in traditional foster care and kinship care got medical help for their injury (49% and 48% respectively), but a majority of children in specialized foster care and group care did (75% and 100% respectively).

A 2016 study explored the well-being of youth in DCFS who had special health care needs.[70] Researchers studied a sample of children, who had the Child and Adolescent Needs and Strengths (CANS) scale completed at their integrated assessment upon entering out-of-home care. They found that 8.9% of the subsample was rated on the CANS as having a chronic illness or serious medical condition, or a physical limitation that impaired their activity, or more serious physical limitation. This special health care needs (SCHN) group had significantly higher needs as indicated on a CANS Life Functioning scale than children without SHCN, and significantly lower scores on the CANS Child Strengths scale. Adolescents with SHCN also had higher traumatic stress scores on the CANS than adolescents without SHCN. Both groups of children and adolescent improved on their CANS scores over 12 months. The researchers noted greater improvement among children with SHCN, though one needs to be careful in such analyses to consider the statistical artifact of regression to the mean, which can artificially suggest that more extreme groups change more from baseline[71]. The authors noted the contrast between the low rate of SHCN identified by the CANS and much higher rates in other research, and suggested that a number of children in DCFS not identified as SHCN by the CANS also have healthcare needs that need to be addressed.

Current Analysis and Results

Questions about the child's health were asked in each type of interview. Results about children's health from the caregiver interview are presented in Table 4-1. Over 94% of caregivers reported that their child was in good to excellent health, comparable to findings from Round Two IL-CWB. However, this percentage was lower for children in group homes and residential treatment (85.7%) and specialized foster care (82.8%). Almost all children (98.0%) were up-to-date with immunizations.

[70] Jaudes, P. K., Weil, L. E. G., Prior, J. M., Sharp, D. P., Holzberg, M., & McClelland, G. M. (16). Wellbeing of children and adolescents with special health care needs in the child welfare system. *Children and Youth Services Review*, *70*, 276–283.
[71] See, for example, Campbell, D.T. & Kenny, D.A. (2002). *A primer on regression artifacts*. New York: Guilford.

Table 4-1 Child Health – Responses by Caregivers and Children

Measure	N	f	%/ se
Caregiver Responses			
Child has good to excellent health	380	357	94.1 (1.2)
Child is up-to-date with immunizations	380	373	98.0 (0.7)
Child has enduring health problem	378	128	34.0 (2.4)
Child needs care from specialist	380	89	23.5 (2.2)
Child has dental problems that require service	314	46	14.7 (2.0)
Child has serious or chronic health problem[a]	381	178	46.8 (2.6)
Child Responses			
Child has an illness, disability or handicap	82	18	22.3 (4.6)
Child has a recurring health problem	81	16	20.2 (4.5)
Child has a serious and/or chronic health problem[b]	82	26	32.3 (5.2)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

[a] For the caregiver version of this variable, children were coded as having a serious or chronic health problem if one or more of the following conditions applied: a) caregivers rated children as in fair to poor health; b) children had enduring health problems, c) child currently needed health care from a specialist, d) child currently needed special medical equipment.

[b] For the child version of this variable, children were coded as having a serious or chronic health problem if they reported an illness, disability, or handicap and/or a recurring health problem.

Caregivers were asked several questions measuring whether their child had serious or lasting health problems. Each of the following questions applied to one-fifth or more of children, according to caregivers: 1) having an illness, disability or handicap, 2) having a recurring health problem, 3) having an enduring health problem, 4) needing care from a specialist. We calculated that nearly half of children (46.9%) had serious or chronic health problems, based on caregivers' responses to several questions.[72] This percentage was higher for children in specialized foster care (69.0%). Serious or chronic health problems were also more common among boys (52.5%) than girls (40.4%). Out of 12 caregivers of LGBTQ+ youths, 7 reported that their child had a serious and/or chronic health problem (58.3%); this percentage was more than twice that of other adolescent youths (28.1%).

[72] Children were coded as having a serious or chronic health problem if one or more of the following conditions applied: a) caregivers rated children as in fair to poor health; b) children had enduring health problems, c) child currently needed health care from a specialist, d) child currently needed special medical equipment. The same method was used in the second ILCWB study; see Hartnett, M.A., Bruhn, C., Helton, J., Fuller, T. & Steiner, L. (2009*). Illinois Child Well-Being Study: Year Two Final Report*. Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign

Table 4-1 also presents results on health from the child interview. Youths were asked two questions about health problems: about a fifth of youths reported that they had an illness, disability or handicap, and about a fifth that they had a recurring health problem. Altogether 32.4% of youths answered yes to one or both questions. Following the method used in the Round Two IL-CWB, we considered this the youths' report of whether they had a serious and/or chronic health problem. Again, out of 12 LGBTQ+ youth answering these questions, 7 reported they had a serious and/or chronic health problem (58.3%); this percentage was more than twice that of other youth (28.1%).

Almost half of youths (48.4%) reported suffering an injury in the previous year (see Table 4-2). The most common was a bad cut or scrape, but 9.3% reported a broken bone or dislocated joint and 8.3% a head injury or concussion. Fortunately, no child reported being shot or stabbed. When youths had an injury, a majority of the time youths reported seeing a doctor or nurse for it. For the entire sample, 27.7% of youths reported that they had seen a doctor or nurse for an injury in the previous year.

Table 4-2 Child Report of Injuries in the Past 12 Months (N=81)

Type of injury	Has had injury		Saw doctor for injury	
	f	%/ se	f	%/ se
Bad cut/ scrape	29	36.3 (5.4)	15	18.1 (4.3)
Bite (animal/ person)	13	16.4 (4.1)	2	2.7 (1.8)
Bad sprain/ torn ligament	11	13.8 (3.9)	7	8.5 (3.1)
Broken bone/ dislocated joint	7	9.0 (3.2)	6	7.4 (2.9)
Head injury/ concussion	7	8.3 (3.1)	6	7.0 (2.9)
Bad burn	5	6.3 (2.7)	0	0.4 (0.7)
Gunshot/ stab wound	0	0.0 (0.0)	0	0.0 (0.0)
Any injury	39	48.4 (5.6)	22	27.7 (5.0)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Caseworkers reported making referrals in a majority of cases for routine check-ups or immunization and for routine or preventative dental care (see Table 4-3). They also reported occasionally making referrals for services for a dental problem and hearing and vision screening and services. When they did not make referrals when children needed a service, it was primarily because children were already receiving the service. The vast majority of children received the health service they were identified by caseworkers as needing.

Table 4-3 Caseworker Reports of Health Service Needs and Receipt

		Needed service	Caseworker made a referral (as a percentage of all children)	No referral because child was already receiving services (as a percentage of children needed service but not referred)	Child received the service after the referral (as a percentage of children needing service and referred for service)
	N	%/ se	%	%	%
Routine check-up or immunization	525	95.6 (0.9)	80.7 (1.7)	95.7 (2.1)	98.7 (0.6)
Routine or preventative dental care[a]	431	91.6 (1.3)	69.3 (2.2)	87.6 (3.3)	95.5 (1.2)
Services for a dental problem	429	12.9 (1.6)	8.6 (1.3)	67.0 (10.0)	87.4 (5.5)
Hearing screening or services[a]	526	35.1 (2.1)	18.3 (1.7)	80.0 (3.8)	98.2 (1.4)
Vision screening or services[a]	521	47.1 (2.2)	24.2 (1.9)	91.4 (2.4)	93.3 (2.2)

Note. All analyses used weighted data. The sample sizes presented are unweighted. [a] Children 2 and older

Caseworkers were significantly more likely to report that youth age 12 to 17 needed services for a dental problem (22.9%). They were also significantly more likely to report a need for vision screening among youth in group homes and residential treatment (65.4%) and specialized foster care (60.9%) than among children in kinship care (47.5%) or traditional foster care (40.8%). On the other hand, caseworkers were significantly more likely to report that children in kinship care needed hearing screening (41.3%) than in other placement settings (27.9% to 36.2%). Hearing screening was a greater need for boys (39.2%) than girls (30.7%), and for preschoolers (36.4%) than other age groups (13.0% to 20.1%). White children were more likely to be referred for hearing screening or services (22.9%) than were African-American children (14.0%).

There were regional differences in the health care data reported by caseworkers. Caseworkers in the Central region were more likely to say that children needed routine dental care (97.7%). Caseworkers in Cook County were less likely to say that children needed services for a dental problem (4.6%). Caseworkers in Cook County were less likely to identify a need for hearing screening or services (21.5%)

or to refer children for these services (12.5%). However, the regions did not differ in the percentage of children who received different health services that they needed.

Discussion

As in the Round Two IL-CWB, the vast majority of caregivers reported that their child was in good to excellent health. But this needs to be put in context, because caregivers' responses' suggested that nearly half of children had a serious or chronic health condition. This is similar to the percentage of caregivers who reported a child health problem in the Round One IL-CWB, and somewhat lower than in the Round Two IL-CWB—but all these percentages are high. Almost a third of youths interviewed reported a serious or chronic health problem—this was slightly higher than in the Round Two IL-CWB. Clearly, health issues are a concern for a large proportion of children in out-of-home care. Boys were more at risk than girls.

The health of youths in specialized foster care and group homes and residential treatment deserves more attention, although we need to be cautious about interpreting percentages because of the smaller sample sizes for these groups. Lower percentages of youth from these settings were judged to be in good health and higher percentages needed vision screening and medical care for injuries. A larger percentage of children in specialized foster care had a serious or chronic health condition.

Children were receiving health services at high rates, similar to rates found in previous IL-CWB studies. The vast majority of caregivers and caseworkers reported that their child was receiving preventive health and dental services, and, when needed, was receiving services for dental problems, and hearing and vision screening. Regional and racial-ethnic differences in identifying different health care needs should be studied further.

The results for injuries are worrisome, though somewhat difficult to interpret because we do not know how severe a child's injuries were. Nevertheless, the finding that over a quarter of children saw a doctor or a nurse for an injury in the previous year suggests that children in out-of-home care are at risk for injuries that require medical attention. This seems high relative to the annualized rate of 11.3% for nonfatal unintentional injury found by a study of American youth conducted for the Centers for Disease Control.[73] This raises questions about whether children were in safe environments and are provided appropriate monitoring and taught safety practices. It is also concerning that caseworkers reported dental problems in over one-fifth of adolescents. These areas deserve more research.

[73] Borse NN, Gilchrist J, Dellinger AM, Rudd RA, Ballesteros MF, Sleet DA. (2008) *CDC Childhood Injury Report: Patterns of Unintentional Injuries among 0 -19 Year Olds in the United States, 2000-2006*. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Chapter 5

Emotional and Behavioral Health

More than three decades of research have shown that large percentages of children and adolescents in foster care have emotional and behavioral health problems, with estimates ranging from 30% to more than 50%[74]. Abuse and neglect are traumatic and introduces enormous stress into children's lives. Maltreatment can lead to developmental problems that make behavior and emotional self-control difficult.[75] Maltreated children are also at higher risk for other forms of victimization and adverse childhood experiences, including parental substance abuse and psychiatric illness, domestic violence, neighborhood violence and poverty.[76] Maltreatment of adolescents can lead to mood problems as well as substance abuse and other risk behaviors. Children's removal from home and instability in foster care can exacerbate children's mental health problems[77].

NSCAW research has made it clear how common emotional and behavioral problems are across the age range of children and adolescents involved in the child welfare system. A disproportionate share of preschoolers in the most recent NSCAW study had difficulties with emotion regulation.[78] On the Child Behavior Checklist, a caregiver checklist of child behavior problems, the percentage of school-age children and youth who score in the clinical range was 22.9%, almost three times the rate of 8% for children in general.[79] When youths age 11 and older completed their own behavior problem checklist, 20.7% scored in the clinical range. Altogether 41.4% of the children and youths in NSCAW had an emotional or behavioral problem.

The percentages of adolescents with risky behaviors in NSCAW II were high: 19.3% showed evidence of problematic substance abuse over a twelve-month period, 28.3% had a status offense like running away or truancy, and 12.2% appeared in court because of a behavioral problem. Over one in four girls (28.4%) and 30.5% of boys reported having had sex. Looking at 15 to 17 year olds, 49.0% of girls and 59.8% of

---

[74] Cross, T.P. & Bruhn, C. (2010). Delivery of mental health services for a state's population of children in foster care: A comparison of Illinois and national data. *Illinois Child Welfare*, 5, 87-107.

[75] See, e.g., Harker, J. (2017). The effects of early trauma and adversity on socialization and brain development. In R. Gibb & B. Kolb (Eds.) *The Neurobiology of Brain and Behavioral Development.* First Edition. (pp. 439-467). Cambridge, MA: Academic Press.

[76] See, e.g., De Bellis, M. D., Broussard, E. R., Herring, D. J., Wexler, S., Moritz, G., & Benitez, J. G. (2001). Psychiatric co-morbidity in caregivers and children involved in maltreatment: A pilot research study with policy implications. *Child Abuse & Neglect,* 25, 923–944. Edleson, J. L. (1999). The overlap between child maltreatment and woman battering. *Violence Against Women*, *5*, 134–154. Merritt, D. (2009). Child abuse potential: Correlates with child maltreatment rates and structural measures of neighborhoods. *Children and Youth Services Review*, *31*, 927–934. Walsh, C., MacMillan, H. L., & Jamieson, E. (2003). The relationship between parental substance abuse and child maltreatment: Findings from the Ontario Health Supplement. *Child Abuse & Neglect*, *27*, 1409–1425.

[77] Rubin, D. M., O'Reilly, A. L. R., Luan, X., & Localio, R. (2007). The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics*, 119, 336–344.

[78] Casanueva et al., (2011), ibid.

[79] Casanueva, et al., (2011), ibid.

boys in NSCAW II had had sex, much higher than the 27.0% of girls and 28.0% of boys found in the 2006-2010 National Survey of Family Growth.

Children in out of home care are more likely than many other children at risk to receive mental health services.[80] Despite this, a number of studies have found that many children in foster care do not receive the mental health services they need[81]. An early NSCAW study found that only about a quarter of children and youths with mental health problems received services from a mental health specialist[82]. A more recent NSCAW analysis reported that more than half of children in need age 1.5 to 10 years old had not received any behavioral health service in the past year.[83] Even when children in NSCAW did receive mental health services, these services often did not meet standards for best practice[84]

Emotional and Behavioral Health in Previous Illinois Well-Being Studies

All of the previous Illinois well-being studies focused extensively on children's mental and behavioral health. The high percentages of children and youth with mental health problems was a consistent theme across four studies. In the Round One ILCWB from 2001, scores from the Child Behavior Checklist (CBCL) completed by caregivers indicated that 45% of children were in the clinical or borderline clinical range on mental health problems, and 46% of caregivers answered yes to a question about whether their child had an emotional or mental problem. Caseworkers reported that 42.5% of children had mental health conditions and that 28% had behavior problems. Similarly, a nurse audit of case records found that 42% of children had mental health diagnoses.

In the Round Two IL-CWB, caregiver scores on the CBCL indicated that 41.4% of children age 6 to 17 had mental health problems in the clinical and borderline clinical range and 32.7% in the clinical range. Over a quarter (27.4%) of caseworkers reported that the child needed a mental health service and 45.6% that their child needed services for an emotional, behavioral, or attention problem. On the Youth Self Report (YSR) measure of mental health problems, 33.0% of children scored within the clinical or borderline range. On the other hand, only 3.7% of the sample children scored in the clinical range on the Children's Depression Inventory and only 5.8% on a measure of post-traumatic stress symptoms, and their scores

---

[80] 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.

[81] see e.g., Cross & Bruhn, 2010, ibid., Leslie, L. K., Hurlburt, M. S., Landsverk, J., Barth, R., & Slymen, D. J. (2004). Outpatient mental health services for children in foster care: A national perspective. *Child Abuse & Neglect*, 28, 697–712.

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

[83] Ringeisen, H., Casanueva, C., Smith, K., & Dolan, M. (2011). *NSCAW II Baseline Report: Children's Services*. OPRE Report #2011-27f, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

[84] 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*, 742-749.

were low on a measure of loneliness and social dissatisfaction—the authors discussed the tendency for children in foster care to minimize their experiences of distress.

In the Round Three ILCWB results, caregiver scores on the CBCL showed that 44% of children aged 6 to 17 had mental health problems in the clinical or borderline clinical range[85]. On the YSR self-report measure, 31% of children scored in the clinical or borderline clinical range. Again only small percentages of children scored in the clinical range on the Children's Depression Inventory (5%) and on the measure of post-traumatic stress symptom (5%).

In the Illinois Survey of Child and Adolescent Well-Being, caregiver CBCL scores were in the clinical or borderline clinical range for 61% of children in traditional foster care and 26% in kinship care. Teachers' scores on a parallel measure of children's mental health were similar. Again, children's average score was fairly low on a measure of loneliness and social dissatisfaction.

Results on risky behaviors are also available from several ILCWB studies. In the Round Two study, a large majority of adolescents aged 16 to 17 reported having had sexual intercourse and over a third of those aged 12 to 15. More than a quarter of youth with sexual experiences reported that their first one was non-consensual. Among girls who reported sexual experiences, 18% of those aged 16 to 17 said they had been pregnant and 9% of those aged 12 to 15. In the Round Three study, about a third (34%) of youth had had sexual intercourse. In the Round One study, 22% of youths reported that they had tried alcohol but only 4% that they had used drugs to get high. In the Round Three study, on the other hand, 56% of youths in foster care over the age of 11 reported having used at least one illegal substance in their lives. In the Round One study, 26 % of youths indicated that they had been arrested, and in the Round Three IL-CWB, 52% of foster youth over the age of 11 reported committing at least one delinquent act in the past 6 months.

Behavioral Health Service Delivery. In the Round One ILCWB, 48.7% of children were receiving psychotherapy, but the percentage of those in need who received it was not reported. The Round Two and Round Three ILCWB analyzed mental health service delivery in greater depth.[86] Caregivers were asked both whether their child was currently receiving a range of different mental health services and whether their child had ever received any of a set of mental health services –these latter questions were patterned after NSCAW, enabling the researchers to compare Illinois and national mental health service delivery. It should be noted that the *currently receiving* list and the *ever received* list of mental health services presented to caregivers were somewhat different, making it difficult to compare results from the two sets of services.

---

[85] As reported in Bruhn, C., et al., (2008) ibid. A later analysis using a slightly different threshold reported a higher percentage, see Cross, T.P. & Bruhn, C. (2009) Well-being. In Rolock, N. & Testa, M. *Conditions of children in or at risk of foster care in Illinois 2008: An assessment of their safety, stability, continuity, permanence, and well-being*. Children and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign. Urbana, IL: Children and Family Research Center., and Cross & Bruhn (2010), ibid.

[86] The initial analyses of mental health services delivery were reported in Hartnett, et al., 2009, ibid, for the Second ILCWB study and in Bruhn, et al., 2008, ibid, for the Third ILCWB study. Cross & Bruhn (2009), (2010), ibid, present the results of further analysis of mental health service delivery for these two studies.

In the Round Two IL-CWB, caregivers reported that 50.0% of children across the sample were *currently* receiving a mental health service. The most common mental health services were counseling (42.9% of children), in-school therapy (20.7% of children), and outpatient psychiatry (18.8% of children). When the analysis was limited to children in need of mental health services (based on their scores on mental health measures in the study), 77.0% were currently receiving mental health services.

The Round Two IL-CWB analysis of whether children had *ever* received different mental health services paradoxically showed that 38.9% of children had received a mental health service in their lifetime.[87] This was a lower percentage than the percentage *currently* receiving a mental health service (see above), a result that is likely a function of the differences in the questions in the two lists. The percentage of children who had ever received a specialty mental health service delivered by treatment professionals was 18.6%[88]. Among children with mental health need, 35.9% received specialty mental health services.[89] The most common mental health services ever received were in-school counseling services (35.4%) and in-home counseling and crisis services (17.4%), and 10.8% had been psychiatrically hospitalized.

Analyses of the Round Three IL-CWB data only looked at the *ever received* mental health services list. The percentage who had received any mental health service was 45.6% and the percentage who had received a specialty mental health service was 23.7%.[90] The most common mental health services ever received were again in-school counseling services (39.7%) and in-home counseling and crisis services (22.2%), and 16.0% had been psychiatrically hospitalized. Among children with mental health need in the Round Three sample, 50.4% received a specialty mental health services.

Using the *ever-received* list of mental health services from both the Round Two IL-CWB and Round Three IL-CWB*,* several analyses compared the percentage of Illinois children in care receiving mental health services to national comparisons drawn from NSCAW. Children in care nationally were significantly more likely than children in care in Illinois to receive a range of mental health services.[91]. The Illinois Survey of Child and Adolescent Well-Being found that 14.6% of Illinois children newly placed in out-of-home care in 2008-2009 received a specialty outpatient mental health services and 9.5% received private professional mental health services; these percentages were significantly less than in an out-of-home comparison group from NSCAW.

---

[87] See Cross & Bruhn (2010), ibid.

[88] See Cross & Bruhn, 2010, ibid. The following were counted as specialty mental health services: psychiatric hospital, inpatient detoxification unit, residential treatment center or group home, emergency shelter, day treatment, outpatient drug or alcohol clinic, or mental health or community mental health center.

[89] Cross & Bruhn (2010), ibid.

[90] See Bruhn, et al., (2008), ibid.; Cross & Bruhn, ibid.

[91] Bruhn, et al., (2009), ibid. Cross & Bruhn (2009),ibid. Cross & Bruhn, (2010); ibid; Hartnett, et al. (2009), ibid,

Current Analysis and Results

Prevalence of Emotional and Behavioral Problems. The current study included a range of different measures of emotional and behavioral problems. One of the most reliable and valid measures is the Child Behavior Checklist (CBCL) used in thousands of studies over nearly half a century. To complete the CBCL, caregivers review a list of over 100 possible individual child behaviors indicating potential problems and check off those that are true about their child. Items are totaled to yield scores measuring total behavior problems and a range of specific syndromes. Scale cut off scores have been identified that indicate children who need mental health interventions (clinical range) or may need them (borderline clinical range).

Table 5-1 shows CBCL results for children age 3 to 5. More than one in ten children (11.0%) had problems in the clinical range and another 6.8% in the borderline clinical range on the Total Problems Score, for a total of 17.8%. The most common syndrome identified on the CBCL for this age group was attention problems (16.6%).

Table 5-1 Scores from Caregiver's Report of Child's Emotional and Behavioral Well-Being, Child Behavior Checklist (CBCL) (Under 6 years old) (N=141)

Measure	Borderline Range		Clinical Range		Total Borderline/Clinical	
	f	%/ se	*f*	%/ se	*f*	%/ se
Total Problem Score	10	6.8 (2.1)	16	11.0 (2.6)	25	17.8 (4.7)
Internalizing Score	12	8.2 (2.3)	13	9.4 (2.5)	25	17.6 (4.8)
Externalizing Score	10	7.3 (2.2)	14	9.8 (2.5)	24	17.1 (4.7)
Emotionally Reactive	12	8.5 (2.4)	8	6.0 (2.0)	20	14.5 (4.4)
Anxious/Depressed	9	6.7 (2.1)	4	2.7 (1.4)	13	9.4 (3.5)
Somatic Complaints	6	4.4 (1.7)	4	2.7 (1.4)	10	5.4 (3.1)
Withdrawn/Depressed	6	4.1 (1.7)	8	5.9 (2.0)	14	7.5 (3.7)
Sleep Problems	5	3.9 (1.6)	6	4.3 (1.7)	11	8.1 (3.3)
Attention Problems	16	11.1 (2.6)	7	5.5 (1.9)	23	16.6 (4.5)
Aggressive Behavior	7	5.1 (1.9)	6	4.4 (1.7)	13	7.2 (3.6)

Note. All analyses used weighted data. The sample sizes presented are unweighted.
f=frequency of a given response. N varies because of missing data.

Table 5-2 shows CBCL results for children and youth age 6 to 18. Just under one third of children and youth (31.6%) had scores on the Total Problem Score in the clinical range and another 9.9% were in the borderline clinical range, for a total of 41.5%. Internalizing problems such as anxiety and depression and somatic problems (bodily complaints); and externalizing problems such as conduct problems and attention deficit were about equally common – for each about a third of children and youth fell in the clinical or borderline clinical range. A number of children had both. As Table 5-2 shows, no one specific syndrome (e.g., anxious/depressed, withdrawn/depressed, etc.) predominated, but many different ones were represented.

Table 5-2 Scores from Caregiver's Report of Child's Emotional and Behavioral Well-Being, Child Behavior Checklist (CBCL) (6 to 18 years old)

Measure		Borderline Range		Clinical Range		Total Borderline/Clinical	
	N	*f*	%	*f*	%	*f*	%
Total Problem Score	195	19	9.9 (2.1)	62	31.6 (3.3)	81	41.5 (5.4)
Internalizing Score	195	19	9.5 (2.1)	44	22.6 (3.0)	63	32.1 (5.1)
Externalizing Score	193	18	9.2 (2.1)	53	27.6 (3.2)	71	36.8 (5.3)
Anxious/Depressed	195	22	11.3 (2.3)	16	8.0 (1.9)	38	19.3 (4.2)
Withdrawn/Depressed	195	17	8.5 (2.0)	17	8.6 (2.0)	34	17.1 (4.0)
Somatic Complaints	195	6	3.2 (1.3)	13	6.9 (1.8)	19	10.1 (3.1)
Social Problems	183	26	14.1 (2.6)	25	13.6 (2.5)	51	27.7 (5.1)
Thought Problems	185	14	7.6 (1.9)	30	16.1 (2.7)	44	23.7 (4.6)
Attention Problems	186	23	12.6 (2.4)	32	17.3 (2.8)	55	29.9 (5.2)
Rule-Breaking Behavior	181	16	9.1 (2.1)	31	17.3 (2.8)	47	26.4 (4.9)
Aggressive Behavior	185	20	11.1 (2.3)	32	17.3 (2.8)	52	28.4 (5.1)

Note. All analyses used weighted data. The sample sizes presented are unweighted.
f=frequency of a given response. N varies because of missing data.

Caregivers were also asked to identify specific emotional and behavioral problems children had—see Table 5-3. Because caregivers are not mental health professionals and their determination of a problem is not necessarily reliable, we also asked caregivers to identify whether a doctor had diagnosed the

problem. The most common child emotional and behavioral problems identified by caregivers were extreme stress from abuse and neglect, attention deficit disorder, oppositional or defiant behavior, conduct or behavior problems, and attachment problems. According to caregivers, the most common problem diagnosed by doctors were attention deficit disorder, oppositional or defiant behavior, and extreme stress from abuse/neglect.

Table 5-3 Caregiver Report of Child Emotional and Behavioral Problems

Diagnosis		Parent perception		Doctor diagnosis	
	N	f	%/ se	f	%/ se
Attention deficit disorder	304	89	29.4 (2.6)	60	19.8 (2.3)
Depression	318	60	18.8 (2.2)	33	10.3 (1.7)
Bipolar or extreme mood swings	317	49	15.3 (2.0)	17	5.3 (1.3)
Conduct or behavior problems	315	91	29.0 (2.6)	-[a]	-
Oppositional or defiant behavior	311	91	29.1 (2.6)	41	13.3 (1.9)
Extreme stress from abuse/neglect	307	97	31.4 (2.7)	38	12.4 (1.9)
Attachment problems	314	67	21.2 (2.3)	13	4.0 (1.1)
Eating disorders	316	25	7.8 (1.5)	2	0.7 (0.05)
Sexually aggressive behavior	313	14	4.4 (1.2)	2	0.6 (0.04)
Alcohol/ substance abuse	320	6	1.8 (0.8)	4	1.3 (0.06)
Other emotional/ mental health problems	316	25	8.0 (1.5)	-[a]	-

Note. All analyses used weighted data. The sample sizes presented are unweighted. [a] Doctor diagnosis question not asked.

Table 5-4 shows results from the Youth Self Report, a measure that parallels the CBCL but is completed by youths themselves if they are age 11 or older. Scores for over one-third of youth fell in the clinical to borderline clinical range. Youths were somewhat more likely to report internalizing problem than externalizing problems. Six of 11 LGBTQ+ youths scored highly on the Thought Problems YSR scale (54.5%), compared to 18.5% of other youths, and 6 of 12 scored highly on the Somatic Complaints YSR scale (50%), compared to 6.5% of other youths.

Table 5-4 Youth Emotional and Behavioral Well-Being Scores from the Youth Self-Report Scale (N=70)

Measure	Borderline Range		Clinical Range		Total Borderline/Clinical	
	f	%/ se	*f*	%/ se	*f*	%/ se
Total Problem Score	6	9.0 (3.6)	18	27.9 (5.6)	24	36.9 (9.2)
Internalizing Score	6	8.4 (3.3)	14	19.4 (4.7)	20	27.8 (8.0)
Externalizing Score	7	9.9 (3.5)	7	10.1 (3.5)	14	19.9 (7.0)
Anxious/Depressed	6	8.4 (3.3)	5	7.4 (3.1)	11	15.8 (6.4)
Withdrawn/Depressed	8	9.6 (3.3)	5	6.4 (2.7)	13	16.0 (6.0)
Somatic Complaints	5	6.7 (2.8)	5	6.5 (2.8)	10	13.2 (5.6)
Social Problems	9	11.0 (3.5)	8	9.8 (3.3)	17	20.8 (6.8)
Thought Problems	8	11.4 (3.8)	10	14.0 (4.1)	18	25.4 (7.9)
Attention Problems	6	8.3 (3.1)	12	14.8 (4.0)	20	25.0 (7.1)
Delinquent Behavior	3	3.7 (2.2)	5	7.0 (2.9)	8	10.5 (5.1)
Aggressive Behavior	9	12.2 (3.8)	8	10.0 (3.4)	17	22.3 (7.2)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Table 5-5 shows results from two other child self-report scales, the Children's Depression Inventory (CDI) and the Trauma Symptom Checklist for Children. Only small percentages of children reported that they had depressive symptoms or trauma symptoms in the clinical range. Negative mood was the score that most commonly indicated a problem. Out of 12 LGBTQ+ youth completing the CDI, 7 scored in the clinical range on the Negative Mood Scale (58.3%), a significantly percentage than heterosexual youth (17.5%).

Table 5-5 Child Self-Report of Depression and Trauma Symptoms

Measure		Clinical range	
	N	f	%/ se
Overall	125	11	8.7 (2.5)
Negative Mood	126	21	17.0 (3.4)
Interpersonal Problems	124	8	6.3 (2.2)
Ineffectiveness	129	8	6.5 (2.2)
Anhedonia	131	11	8.3 (2.4)
Negative Self-esteem	128	1	0.7 (0.7)
Trauma	114	11	9.5 [a] (2.8)

Note. All analyses used weighted data. The sample sizes presented are unweighted. [a] 26 children were in the clinical and subclinical range (23.1%)

Youths aged 11 to 17 were asked about their use of alcohol and drugs and about their sexual behavior. These questions yielded useful results, though the sample sizes are small so the percentages are not precise estimates. Table 5-6 shows results for these questions, broken out for younger adolescents (age 11 to 14) and older adolescents (age 15 to 17). Substantial proportions of older adolescents had used alcohol, smoked tobacco, and smoked marijuana. Nearly a third of older adolescents reported illicit use of prescription drugs and 20.4% reported using hard drugs (the question asked if youths had used “hard drugs such as cocaine, crack, or heroin”).

Two-third of the older adolescents had had sexual intercourse (across age groups, 79.4% of boys had had sexual intercourse and 60.4% of girls). Six children age 11 to 14 had had sexual intercourse, for 3 of them the first time they had sex was not consensual. The first time was also not consensual for four of the 20 youths aged 15 to 17 who had had sex. Altogether 26.9% of youths who had had sex reported that their first time was not consensual. Only a third of older adolescents always used protection when having sex, though the sample size for this question is very small. Five out of 15 girls aged 15 to 17 (33.3%) reported having been pregnant, but no boy reported having gotten someone pregnant.

Table 5-6 Youth Report of Alcohol and Substance Use and Sexual Risky Behavior

Behavior	Age 11 to 14			Age 15 to 17		
	N	*f*	%/ se	N	*f*	%/ se
Alcohol and substance use in life						
Alcohol	52	8	16.4 (5.2)	29	16	55.8 (9.3)
Smoked Tobacco	52	4	7.8 (3.8)	29	13	45.1 (9.3)
Smoked Marijuana	52	3	6.4 (3.4)	29	14	47.2 (9.3)
Sniffed Glue	51	2	3.2 (2.5)	29	2	7.5 (5.0)
Hard Drugs	52	2	3.2 (2.5)	29	6	20.4 (7.6)
Illicit Use of Prescription Drugs	52	2	3.2 (2.5)	29	9	32.2 (8.8)
Sexual behavior						
Has had sexual intercourse	52	6	11.9 (4.6)	29	20	66.6 (8.9)
First time was consensual	6	3	53.6 (22.0)	20	16	83.8 (8.5)
Always uses protection when having sex	6	4	68.0 (20.6)	20	7	33.8 (10.8)
Has been/ gotten someone pregnant [a]	6	0	0.0 (0.0)	20	5	27.3 (10.3)

Note. All analyses used weighted data. The sample sizes presented are unweighted. [a] Five out of 15 girls aged 15 to 17 (33.3%) reported having been pregnant, but no boy reported having gotten someone pregnant.

Table 5-7 shows the frequency of delinquent behaviors youths 11 to 18 had engaged in during the last six months. No one delinquent behavior predominated, but, in the previous six months, over one-fifth of youths had committed one to three delinquent acts and almost one-fifth had committed four or more delinquent acts. The average number of delinquent acts was .92; girls' average was 1.15 and boys' was .48.

Table 5-7 Child Self-Report of Delinquent Behavior in the Past 6 Months (N=81)

	f	%/ se
Unruly in public	11	13.6 (3.8)
Carried a hidden weapon	10	12.6 (3.7)
Destroyed others property on purpose	10	12.5 (3.7)
Avoided paying for things	9	11.7 (3.6)
Took things from store without paying	7	8.2 (3.1)
Sold marijuana	6	7.7 (3.0)
Been paid for sex	6	7.2 (2.9)
Been arrested for non-minor offense	5	6.7 (2.8)
Sold hard drugs	4	4.5 (2.3)
Taken something not yours from a car	4	4.4 (2.3)
Number of delinquent acts		
Zero	48	59.7
One to three	18	22.2
Four or more	15	18.1

Note. All analyses used weighted data. The sample sizes presented are unweighted. The following were reported by <4% of the sample: Panhandled, Stole from building, Drunk in public, Snatched someone's purse/ wallet, Stole car/ motorcycle, Been in a gang fight, Threatened people for money/ things, Illegally hitchhiked, Set fire to property on purpose.

Differences in Emotional and Behavioral Problems by Placement Setting. Children and youth in specialized foster care (SFC) had high rates of problems on a number of measures. On the Total Problem Score of the Child Behavior Checklist, 69.6% of children in specialized foster care scored in the clinical or borderline clinical range, as did 42.9% on the CBCL for 3 to 5 year olds. When caregivers reported what specific emotional and behavioral problems their child saw a doctor for, rates were high for children in SFC: oppositional and defiant behavior, 50.0%; attention deficit disorders, 50.0%; depression, 43.3%; oppositional and defiant behavior, 39.3%; extreme stress from abuse and neglect, 37.0%. The number of Youth Self Report scores from children in SFC was too small to analyze.

Children and youth in group homes or residential treatment also had high rates on a number of emotional and behavioral problem measures. More than half (56.3%) scored in the clinical to borderline clinical range on the CBCL for youths aged 6 to 17. Rates in this group for seeing a doctor for an emotional or behavioral problem were high: for extreme stress due to abuse and neglect, 62.5%; attention deficit disorder, 56.3%; oppositional defiant behavior, 50.0%; depression, 35.3%, bipolar

disorder or mood swings, 31.3%. Youths in group homes or residential treatment were the only group to have children seen by a doctor for alcohol or drug problems: 18.8% of this group. A majority of youths in group homes scored in the clinical and borderline clinical range on the Youth Self Report, and majorities reported having smoked cigarettes and marijuana and having engaged in sexual intercourse. Youths in group homes committed an average of 2.88 delinquent acts over the previous six months compared to .715 or fewer for every other group.

Children in traditional foster care also had emotional and behavioral problems at fairly high rates, though less than in SFC and in group homes and residential treatment. The percentage of this group scoring in the clinical to borderline clinical range was 50.0% on the CBCL for youths aged 6 to 17, 18% on the CBCL for age 3 to 5, and 46.7% on the Youth Self Report. Rate of substance abuse and delinquent behavior were fairly low, however.

Children and youth in kinship care had the lowest percentages. Children in kinship care were less likely to score in the clinical or borderline clinical range: 28.1% for the CBCL, age 6 to 17; 9.4% for the CBCL, age 3 to 5; and 15.4% on the Youth Self Report. For a range of different emotional and behavioral problems, they were significantly less likely to see a doctor. Few children in kinship care reported having used tobacco and marijuana and few had engaged in sexual intercourse. They had low rates of reporting delinquent behavior.

Behavioral Health Service Delivery. Using information provided by caregivers, Table 5-8 shows the proportions of children and youths who were receiving a range of different mental health services at the time of the interview. Percentages are reported both for the sample as a whole and for that subset of children and need who had a mental health need, as measured by several clinical measures in the study (see the footnote to Table 5-8).

Most caregivers reported that their child was currently receiving a mental health service. When children had a mental health need, that proportion was 85.3%. Counseling was the most common mental health service currently used and in-school counseling and outpatient psychiatry were also common.

Caregivers were also presented a second list of emotional and behavioral health services and asked which ones their child had *ever* received. The second list of emotional and behavioral health services was used in the NSCAW study. In previous IL-CWB studies, this enabled researchers to compare service delivery in Illinois to service delivery nationally as measured in the NSCAW study.[92] We are not able to do that in this study, however, because currently there are no contemporaneous NSCAW data. It should be noted that the second list of emotional and behavioral health services (for the questions about having *ever* received a service) differs from the first list of services (for the questions about *currently* receiving an emotional or behavioral health service). Most notably, the second list does not include an option for a service provided by a private practitioner. In addition, while a question in the second list asks whether a child has received mental health services at a community health center, it does not ask

[92] See Bruhn, et al. (2008), ibid.; Cross & Bruhn (2009), ibid; Cross & Bruhn (2010) ibid; Harnett et al. (2009), ibid.

about other possible agencies at which a child might have received behavioral health services, such as a family services center or a Children's Advocacy Center.

Table 5-8 Caregiver Report on Child Behavioral Health and Support Services Child Currently Receives (2 to 17 years old)

				Subsample with Mental Health Need[2]		
	N	f	%/ se	N	f	%/ se
Counseling	317	142	44.7 (2.8)	145	101	69.5 (3.8)
Group therapy	319	34	10.7 (1.7)	145	30	20.3 (3.3)
In-school therapeutic services	315	72	22.8 (2.4)	143	57	39.7 (4.1)
Self-esteem/anger management classes	319	17	5.4 (1.3)	145	17	11.7 (2.7)
Outpatient psychiatry	317	60	19.0 (2.2)	144	55	38.4 (4.1)
Outpatient psychiatric care	316	32	10.2 (1.7)	142	31	21.4 (3.5)
Inpatient psychiatric care	319	10	3.3 (1.0)	145	10	7.2 (2.2)
Tutoring	318	34	10.8 (1.7)	144	26	18.0 (3.2)
Mentoring	319	39	12.2 (1.8)	145	29	19.9 (3.3)
Crisis intervention	318	20	6.3 (1.4)	144	20	13.8 (2.9)
Any mental health service[1]	320	192	60.0 (2.7)	147	126	85.9 (2.9)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

[1] "Service delivery was identified as current receipt of any of the following services based on responses of caregivers: inpatient psychiatric services, day treatment, outpatient psychiatric services, counseling or services from a mental health center, group therapy, in-school therapy, self-esteem or anger management classes, mentoring, crisis intervention, SACY programs or services, therapeutic day program, outpatient alcohol or substance abuse clinic services, or services from a family or medical doctor (for emotional, behavioral, attention, learning, or substance abuse problems)."

[2] "In order to evaluate the presence of any mental health condition, a variable was constructed based on the following criteria: Clinical/borderline or clinical/subclinical score on the Child Behavior Checklist, Youth Self Report, Children's Depression Inventory, or Post-traumatic Stress subscale OR Caregiver's indication that the child has been diagnosed by a doctor as having ADHD, Depression, Bipolar Disorder, Conduct Disorder, or Oppositional Defiant Disorder"

Table 5-9 Caregiver Report on Whether Child has Ever Received Different Behavioral Health Services

				Subsample with Mental Health Need[1]		
	N	f	%/ se	N	f	%
In-school counseling	190	74	39.0 (3.6)	113	59	52.2 (4.7)
In-home counseling	308	51	16.7 (2.1)	136	42	30.5 (4.0)
Psychiatric hospital	315	40	12.8 (1.9)	143	37	25.5 (3.7)
Behavioral health service from a family doctor	315	36	11.4 (1.8)	142	30	21.2 (3.4)
Residential treatment center	316	25	7.7 (1.5)	144	23	16.1 (3.1)
Hospital medical inpatient unit	312	21	6.8 (1.4)	141	20	13.9 (2.9)
Mental health center/community center	314	18	5.6 (1.3)	142	17	11.8 (2.7)
Behavioral health service from hospital emergency room	314	16	5.2 (1.3)	141	14	10.0 (2.5)
Emergency shelter	188	7	3.6 (1.4)	111	7	6.0 (2.3)
Day treatment	186	5	2.8 (1.2)	110	5	4.8 (2.1)
Inpatient detoxification	113	3	2.4 (1.4)	70	3	3.9 (2.3)
Outpatient drug or alcohol clinic	110	2	2.1 (1.4)	67	2	3.4 (2.2)
Any mental health service	320	122	37.9(3.9)	147	96	65.7(3.9)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

[1] "In order to evaluate the presence of any mental health condition, a variable was constructed based on the following criteria: Clinical/borderline or clinical/subclinical score on the Child Behavior Checklist, Youth Self Report, Children's Depression Inventory, or Post-traumatic Stress subscale OR Caregiver's indication that the child has been diagnosed by a doctor as having ADHD, Depression, Bipolar Disorder, Conduct Disorder, or Oppositional Defiant Disorder"

The most common mental health services *ever* received were in-school counseling services and in-home counseling and crisis services. It is noteworthy that 12.8% of children and 25.5% of children with a mental health need had been psychiatrically hospitalized. The percentage of children who had ever received a mental health service in the second list was 37.9%. Among children with mental health need, 65.7% had ever received a mental health service in the second list.

Differences in Service Delivery by Age and Placement Setting

We tested for group differences in service receipt among those children and youths with mental health need. Children aged 3 to 5 with mental health need were significantly less likely to be receiving a mental

health service than older groups of children and youth (86.2% or higher). Although all the school age groups were about equally likely to receive counseling (73.9% to 80.2%), children age 9 or older were more likely to receive in-school counseling (51.9% to 54.4%) than children age 6 to 8 (23.3%).

Youth in group homes and residential treatment center had a much more extensive history of mental health treatment than other youth. Of course, placement in a residential treatment center is a mental health intervention in itself. In addition, a large majority of this group (84.6%) had seen a guidance counselor in school, 71.4%, had been psychiatrically hospitalized, 41.7% had been treated in a community mental health center or other community center, 38.5% had been in a hospital medical inpatient psychiatric unit, and 23.1% in an emergency shelter. Many children in specialized foster care also had a history of intensive mental health services: 35.0% had been psychiatrically hospitalized, 24.0% treated in a hospital inpatient unit, and 16.0% had been in a residential treatment center at some point. Children in kinship care and traditional foster care were less likely to have had intensive mental health services, but it was still much more common than for children in general: for example, 21.2% of children in kinship care had been psychiatrically hospitalized, as had 18.2% of children in traditional foster care.

Discussion

Emotional and behavioral problems are among the most common challenges faced by children in out-of-home care. The 41.6% of youths aged 6 to 17 scoring in the clinical range on the CBCL was strikingly similar to the result on this variable for the CBCL from the Round One IL-CWB (45%), the Round Two IL-CWB (41.4%) and the Round Three IL-CWB (44.0%). This suggests that there has been a consistently high rate of emotional and behavioral problems among children in out-of-home care for at least the past 17 years.

CBCL data also indicated that almost one-fifth of preschool children had emotional and behavioral problems requiring attention. Caregivers identified emotional stress due to maltreatment in almost a third of children. The most common categories of problems identified by caregivers involved behavioral difficulties (attention deficit difficulties, oppositional defiant behaviors, conduct problems).

Small percentages of youths reported experiencing clinically significant depression or trauma symptoms. The rate at which caregivers identified clinically significant child depression symptoms (on the CBCL) was about twice the rate that youth self-reported clinically significant depression symptoms. Ratings on child emotional and behavioral disturbance from different informants often disagree,[93] and youths may be motivated not to disclose their difficulties, particularly with depression. The higher scores of LGBQT+ youth on the several mental health scales suggests that they may be at greater risk for mental health problems than heterosexual youth.

[93] Achenbach T.M., McConaughy S.H., & Howell CT (1987). Child/adolescent behavioral and emotional problems: Implications of cross-informant correlations for situational specificity. *Psychological Bulletin*, 101:213–232. Kazdin AE (1994): *Informant Variability in the Assessment of Childhood Depression*. New York, Plenum.

Substantial proportions of adolescents in out-of-home care reported they engaged in risky behaviors. These included using alcohol, tobacco, marijuana, hard drugs, and committing delinquent acts. The substantial proportion of youths who have been sexually active, including some young adolescents, raises concerns about the risks of pregnancy, sexually transmitted infections and the possibilities of exploitation and compromises to adolescents' emotional and social development. Concern is further heightened by the proportion of sexually active adolescents who do not use protection, who have been involved in a pregnancy, and who have been forced to have non-consensual sex. Again, these findings parallel similar results from the Second Year and Third Year IL-CWB.

It is beyond the capacity of this study to assess the impact of placement setting on emotional and behavior problems. Children and youth in specialized foster care and group homes and residential treatment had higher rates on a range of emotional and behavioral problems, but these problems may have predated their placement and may help explain why they were placed in settings that provide more intensive support and services. More needs to be understood about why children in traditional foster care had mental health problems at higher rates than children in kinship care. While it is possible that traditional and kinship foster care differ in their impact on mental health, children with mental health problems may also be more difficult to place in kinship care, and children without supportive kin to take them in may be more likely to have emotional or behavioral problems. Children in kinship care had the lowest rate of mental health problems, but these rates are still elevated compared to children in general. For example, 28.1% of children and youth age 6 to 18 in kinship care scored in the borderline clinical or clinical range on the CBCL, which is higher than the 16.1% of children and youth in general with scores in that range. Not surprisingly, differences by placement setting in receiving mental health services paralleled differences by placement setting in having emotional or behavioral problems.

Analysis of caregiver data indicates that the vast majority of children with a mental health need were currently receiving some form of mental health service. The most common of these current services were counseling, in-school services, and outpatient psychiatry. The 85% in need currently receiving mental health services is somewhat larger than the 77% reported in the Round Two IL-CWB. This suggests a slight improvement in the percentage of children with mental health need receiving mental health services.

A second set of variables measured whether children had *ever* received an emotional or behavioral health service. The most common services children had *ever* received were in-school services and in-home services, but more than a quarter of those with mental health need had been psychiatrically hospitalized. The percentage ever receiving any of these services, 37.9%, was about the same percentage as in Second Round IL-CWB (38.9%) and somewhat lower than in the Third Round Il-CWB (45.6%). However, even though these variables have been used in key analyses in the past because they enabled a comparison with national data, we question their utility now because they omit important types of services, particularly in this age when emotional and behavioral health services are provided in a wider array of settings and circumstances than in the past.

It is important to acknowledge other limitations in analyzing mental health services in this study. The most common mental health services such as counseling and in-school services can involve widely varying types and amounts of therapeutic work with children, and we have little or no understanding of how the service was delivered, what issues were addressed, and what the quality of the service was.

Future work on the 2017 Illinois Child Well-Being Study should analyze additional data we have on the specific child disorders that are being treated, whether children are receiving the intended treatment fully, and whether caregivers think the treatment is helping. Future research could more thoroughly assess whether children are receiving the services they need. One question to explore is whether evidence-based practices specific to different types of emotional or behavioral problems are being used, and whether there is clinically significant change in children's problems over time.

Chapter 6

Education

Given the range of cognitive, emotional, behavioral and health problems that children in placements face, it is not surprising that many struggle at school[94]. A research review by the National Working Group on Foster Care and Education found that 35.6% to 47.3% of youth in out-of-home care receive special education services[95]. The review cited studies showing youth in foster care were twice as likely to be absent from school. Studies cited in the review have found that 17 to 18 year olds in foster care were reading at the 7th grade level on average, were about twice as likely to have an out-of-school suspension than other students and were about three times as likely to be expelled. Studies also showed that just 65% of youth in foster care complete high school by age 21, a minority of those who graduate from high school enroll in college, and somewhere between 3% and 10.8% of former foster youth attain a bachelor's degree.

Placement in out-of-home care often creates school problems in itself. Research has found that anywhere from 31% to 75% of children entering foster care had to change schools.[96] Frequent changes of placement can lead to frequent school changes, making it even harder to fit in and make progress. One estimate is that more than a third of 17 to 18 years in foster care have experienced five or more school changes.[97] Lack of access to student's educational and other service records can hamper schools response' to children's needs. The diffusion of adult responsibility for children that is common in foster care can mean that children do not have an adult to advocate for them at school, monitor their educational progress, and help with homework and school activities.

Federal legislation in the past 10 years has attempted to ease the educational difficulties of children in out-of-home care. The Adoption and Safe Families Act ([P.L.] 105-89) identifies child educational progress as one of several outcomes on which to evaluate state child welfare agencies.[98] The federal Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) requires child welfare agencies to develop an educational plan for children in out-of-home care that keeps students in their school following placement or make any necessary transfer prompt. [99] The 2015 Every Student

---

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

[95] National Working Group on Foster Care and Education (2018), ibid

[96] National Working Group on Foster Care and Education, (2018) ibid

[97] National Working Group on Foster Care and Education (2018). ibid.

[98] Stone, S., D'Andrade, A., & Austin, M. (2007). Educational services for children in foster care: common and contrasting perspectives of child welfare and education stakeholders. *Journal of Public Child Welfare*, *1*, 53-70.

[99] National Working Group on Foster Care and Education, (2018) ibid

Succeeds Act (ESSA) takes several steps to help children.[100] It requires state education agencies to join with child welfare agencies and develop a state plan for protecting the educational stability of children in foster care. The state plan must also address the need to enable children in out-of-home care to enroll immediately in a new school without having to wait for documents and records to be transferred. Education and child welfare agencies must also collaborate to develop procedures to provide transportation to support school stability. ESSA also includes additional supports for collaboration between education and child welfare, such as establishing points of contact in both agencies. The Child and Family Services Improvement and Innovation Act (P.L. 112-34) requires agencies to support educational stability at every change in placement and not just the initial one.[101] The Federal Uninterrupted Scholars Act (USA) of 2013 facilitates child welfare professionals' access to children's educational records[102]. We are aware of no studies, however, of how well these Federal policies have been implemented and what their effect has been.

Education in Previous Illinois Studies

The three previous Illinois Studies of Child Well-Being Studies and a report from the Chapin Hall Center for Children at the University of Chicago examined educational functioning for children and youth in out-of-home care between 2001 and 2009[103]. Data came from review of educational records as well as child and caregiver interviews. Most children were functioning adequately at school, but large percentages had substantial educational challenges. The percentage of children who had non-promotional transfers between schools during a two year period ranged from 27% to 35%, and 28% to 32% of children were absent from school more than 10 days a year. Across four studies, the percentage in special education ranged from 39% to 47%. Two studies found that about 40% of youth in out-of-home care were behind one grade or more in school, and two studies found that 30% to 34% were overage for their grade. Two studies found that one-third of these students had letter grades below C, both in math and in English. Across three studies, half to two-thirds of children in out-of-home care performed below grade level or in the bottom quartile in achievement tests in reading and math. Two studies found that a quarter or more of these students had been suspended from school at some point, and a quarter also had a behavior plan on file at the school. The Chapin Hall study found that more than half of 13 to 15 year olds dropped out of school over a five-year period, and less than 30% of 14 year olds later graduated from high school. The Chapin Hall study also found that part of the difficulty was the low achievement level of the schools that children in out-of-home care attended. The researchers attributed low achievement scores partly to the lower achieving schools, partly to differences in academic achievement by race and socioeconomic status, and partly to the effects of out-of-home care.

---

[100] Legal Center for Education and Foster Care. (2016). How will the Every Student Succeeds Act (ESSA) support students in foster care? Retrieved from http://www.fostercareandeducation.org/Portals/0/documents/QA%20ESSA%202015%20FINAL%202%2019%2016.pdf

[101] Child Welfare Information Gateway. (2015). *Major Federal legislation concerned with child protection, child welfare, and adoption.* Retrieved from https://www.childwelfare.gov/pubpdfs/majorfedlegis.pdf

[102] National Working Group on Foster Care and Education (2018). ibid.

[103] Smithgall, C., Gladden, R.M., Howard, E., Gorge, R. & Courtney, M. (2004). *Educational experiences of children in out-of-home care*. Chapin Hall Center for Children at the University of Chicago. Chicago: Chapin Hall. Retrieved from https://www.chapinhall.org/wp-content/uploads/Smithgall_Educational-Experiences-Children-Out-of-Home_Report_2004.pdf

Current Analysis and Results

Questions about education were included in the caseworker, caregiver and child interviews. However, time and resource limitations have prevented us from collecting data directly from school records, as was done in previous IL-CWB studies. It is important to be cautious about interpreting education data in the current report, since caseworkers', caregivers' and students' reports on education are likely to be less reliable than school records and may be subject to biases in their recall and judgment.

Table 6-1 shows results from caseworker questions about the child's educational progress. Almost all children were currently in school and the vast majority were expected to advance to the next grade. Just over 1 in 10 had previously been retained a grade at least once.

Table 6-1 Caseworker Report on Child's Education

	N	f	%/ se
Currently in school	256	254	99.4 (0.5)
Will advance to next grade	245	238	97.1 (1.1)
Has been retained a grade at least once	242	26	10.7 (2.0)
Number of schools child has attended in past two years	243		
One		92	37.8 (3.1)
Two		107	44.1 (3.2)
Three		27	11.0 (2.0)
Four or more		17	7.1 (1.6)
Reasons for changing school	151		
Change due to location of foster placement		104	69.0 (3.8)
Normal school transition (e.g., middle to high school)		29	19.4 (3.2)
Foster parent moved		17	11.1 (2.6)
Former school did not meet needs		13	8.5 (2.3)
Other		9	6.0 (1.9)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

However, a majority of children (62.1%) had attended two or more schools in the past two years, and 18.1% had attended three or more schools. These percentages were still high (53.8% and 16.8% respectively) when we eliminated promotions between schools (e.g., from middle school to high school) and counted only non-promotional transfers. By far the most common reason for changing schools was the geographic location of a new foster care placement. Youths aged 12 to 17 were particularly likely to change schools: 72.4% of them had changed schools one or more times in the past two years. LGBTQ+ youth were also more likely to change schools: 10 out of 12 (83.3%) had attended two or more schools in two years.

Table 6-2 presents results from caseworkers' reports on the child's school difficulties. A large majority of children had no school disciplinary actions against them in the previous year, but 15.9% had detentions, 25.1% in-school suspensions, 8.5% out of school suspensions, and 11.4% other disciplinary actions. Many children had missed 1 to 9 days of school in the last 30 and 3.9% had missed 10 days or more. According to caseworkers, this does not appear to be a result of truancy: analyses not shown in the table indicate that almost all absences were excused absences. Only two students were expelled. Students age 9 to 11 were significantly more likely than other age groups to have disciplinary actions in the previous year (21.4%). On the other hand, students age 12 to 17 were more likely than other age groups to have both in-school and out-of-school suspensions (each 13.2%), and detentions (29.8%). Moreover, 7.4% of that age group had missed 10 or more days of school in the last 30; no student in the other age groups had missed that much school.

Table 6-2 Caseworker Report on Child's School Difficulties

		Number of Occurrences During Time Period					
		0		1 to 9		10 or more	
	N	f	%/ se	f	%/ se	f	%/ se
Detentions in one year	206	173	84.1 (2.6)	26	12.5 (2.3)	7	3.4 (1.3)
In-school suspensions in one year	254	190	88.5 (2.2)	24	11.1 (2.1)	1	0.4 (0.4)
Out-of-school suspensions in one year	221	203	91.5 (1.9)	19	8.5 (1.9)	0	0.0 (0.0)
Expulsions in one year	236	234	99.2 (0.6)	2	0.8 (0.6)	0	0.0 (0.0)
Other disciplinary actions in one year	220	195	88.6 (2.1)	17	7.9 (1.8)	8	3.4 (1.2)
Days missed school in past 30 days	244	134	54.7 (3.2)	101	41.4 (3.2)	9	3.9 (1.2)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Caregiver reports suggest that most children were performing adequately in school: the majority of children reportedly had no grades lower than C and were at grade level or higher in reading and math. But a significant minority had struggles (see Table 6-3). Almost one quarter had report cards with grades lower than C. Each of the following difficulties applied to about a third of the sample: reading below grade level, doing math below grade level, caregiver being told the child has a learning problem, and child being classified as needing special education. Over half of caregivers reported that their child had been tested for learning problems.

Table 6-3 Caregiver Report on Children and Youths' Education (N=a)

Measure	N	*f*	%/ se
Grades on recent report card all "C" or higher	187	148	78.9 (3.0)
Child is reading at or above his or her grade level	199	139	69.8 (3.3)
Child is doing math at or above grade level	202	135	66.6 (3.3)
Child has been tested for learning problems	366	207	56.5 (2.6)
Caregiver was told child had a special learning problem	376	124	33.0 (2.4)
Child was classified as needing special education	281	111	39.7 (2.9)

Note. All analyses used weighted data. The sample sizes presented are unweighted. f=frequency of a given response.
[a] N varies from 69 to 70 because of missing data.

Table 6-4 and 6-5 show that the youth interviewed reported a mostly positive experience of school, though substantial proportions reported problems. All of the children reported that they went to school regularly, and large majorities reported being average to above average in language arts, history, math, and science. Overall 16.5% of youths reported that they had changed schools 3 or more times in the past two years.

About one quarter of youths reported getting at least one grade below C and almost one-fifth reported being held back or repeating at least one grade – results very similar to those reported by caseworkers and caregivers. The percentage of youths who reported that they had been expelled was 6.8%; this was substantially larger than the 1% expulsion rate we obtained from the caseworker interview. White students were significantly more likely to get a grade below C (39.5%) than African-American students (17.0%) or Other Race students (13.2%). African- American students were significantly more likely to have been held back a grade (30.0%) than White students (9.5%) or Other Race students (10.8%).

Table 6-4 Child and Youth Self-Report on Education

Measure	N	f	%/ se
Goes to school regularly	145	141	100 (0.0)
Has grades all "C" or higher	134	103	76.9 (3.7)
Has changed schools 3 or more times	140	22	16.5 (3.1)
Has been held back a grade/repeated a grade	139	26	18.4 (3.3)
Has missed school last month because he or she would not go	67	5	6.8 (3.1)
Has missed school because of suspension	67	5	8.0 (3.3)
Has been expelled from school in the past 2 years	140	10	6.8 (2.1)

Academic Subject		Failing or Below Average		Average		Above Average	
	N	*f*	%/ se	*f*	%/ se	*f*	%/ se
Language Arts	82	10	12.8 (3.7)	40	49.3 (5.5)	31	37.9 (5.4)
History	75	4	4.9 (2.5)	39	52.1 (5.8)	32	43.0 (5.7)
Math	81	13	15.7 (4.0)	36	44.9 (5.5)	32	39.4 (5.4)
Science	82	3	3.4 (2.0)	47	57.6 (5.5)	32	39.0 (5.4)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

On school engagement questions (see Table 6-5), majorities of children reported that they often or almost always enjoyed being in school, got along with their teacher, listened carefully in school, got homework done, did their best work at school, found class interesting, and got along with other students. On the other hand, majorities reported at least sometimes hating going to school, finding school work too hard, and not completing assignments. A little more than a quarter of youth reported that they had been punished for their behavior at school. Out of 13 LGBTQ+ youth, 6 reported often or always hating to go to school (46.2%), a significantly higher percentage than heterosexual youth (13.2%).

Table 6-5 Child's Report about their School Experience

		Never		Sometimes		Often or Almost Always	
	N	*f*	%/ se	*f*	%/ se	*f*	%/ se
Enjoys being in school	144	8	5.2 (1.9)	32	22.4 (3.5)	104	72.4 (3.7)
Gets along with teachers	144	2	1.7 (1.1)	22	15.1 (3.0)	120	83.2 (3.1)
Listens carefully	144	5	3.2 (1.5)	30	20.6 (3.4)	110	76.1 (3.6)
Gets homework done	142	5	3.4 (1.5)	18	12.6 (2.8)	119	84.0 (3.1)
Does best work in school	144	0	0 (0.0)	25	17.4 (3.2)	119	82.6 (3.2)
Finds class interesting	144	13	8.7 (2.4)	49	33.8 (3.9)	83	57.5 (4.1)
Gets along with other students	144	10	7.3 (2.2)	44	30.4 (3.8)	90	62.3 (4.0)
Hates going to school	141	57	40.3 (4.1)	60	42.7 (4.2)	24	17.0 (3.2)
School work too hard	144	26	18.2 (3.2)	80	55.4 (4.1)	38	26.4 (3.7)
Does not complete assignments	140	38	27.5 (3.8)	54	38.9 (4.1)	47	33.6 (4.0)
Punished for behavior	144	103	71.2 (3.8)	33	22.8 (3.5)	9	6.1 (2.0)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

We calculated an average school engagement score following methods used with NSCAW.[104] On average, students scored 3.23 (se=.05), which is between "often" engaged and "almost always" engaged on a 4-point scale. White students were significantly more engaged (mean=3.38) than African-American students (mean=3.02). Students aged 7 and 8 were significantly more engaged (mean=3.35) than students aged 15 to 17 (mean=2.98).

[104] U.S. Department of Health and Human Services, Administration for Children and Families. (2005). *National Survey of Child and Adolescent Well-Being (NSCAW) CPS Sample Component Wave 1 Data Analysis Report.* Retrieved from https://www.acf.hhs.gov/sites/default/files/opre/cps_report_revised_090105.pdf. The items were: how often the child enjoys being in school, tried to do his or her best, finds classes interesting, gets along with teachers, gets along with other students, listens carefully, and completes homework. Higher scores on this 4-point scale denote greater school engagement.

Discussion

Several results suggested that children were engaged in school and most reported positive experiences on a number of different aspects of their school life. Virtually all children of age were enrolled in school and were expected to advance a grade. A majority of the sample was performing adequately or better in school, according to caregivers and youth themselves, though we cannot necessarily vouch for the accuracy their reports.

On the other hand, the results also showed that many children faced obstacles to school success. Having to change schools because of foster care placements remains a problem—most children were in two or more schools in two years. Attendance was an issue for a significant minority of children. It would be good to know more about what is interfering with students getting to school: most absences were reportedly excused, but we do not know to what extent health problems, court dates, or other factors led to absences. School disciplinary issues were a problem for a significant minority of students. Though the numbers were small, it is concerning that half of LGBTQ+ youths often or always hated going to school. It raises questions about whether they were treated badly there because of their sexual orientation.

Poor academic performance and grade retention were problems for some children and youth. Disproportionate percentages were getting bad grades or performing below grade level, and many were being referred to special education and for learning problems.

Several of these results are consistent with previous IL-CWB reports. School changes and school absence were problems in those reports too. The level of suspensions was as high as in previous IL-CWB studies. On the other hand, several results differ from previous IL-CWB results. But it is hard to interpret these, because the current results were based on our interviews, while previous IL-CWB results were based mainly on school records. Students in the current report were slightly less likely to have a letter grade in their courses below C compared to previous IL-CWB studies, though the percentage is still relatively high. Compared to previous IL-CWB studies, a lower percentage of students were behind a grade or more, and smaller percentages were judged by caregivers to be performing below grade level. A somewhat higher percentage of children had two or more non-promotional transfers between schools within two years.

It is noteworthy that results from our interviews with caregivers, children and caseworkers tend to be more positive for several variables than the results gathered from school records in the previous IL-CWB studies. It is possible that this represents genuine improvement since the last IL-CWB study, but it would also be a very human response for caregivers and children to recall information more positively than school records indicate. Educational progress need to be explored more with school records.

The present findings suggest that more needs to be done to help children in out-of-home care with their education. Increased efforts are needed to reduce frequent school changes due to foster care placements, to increase school attendance, to deal with behavior problems at school, and to improve academic performance. One positive step is DCFS' new opportunity to access data from the Illinois State

Board of Education, thanks to a 2015 data sharing agreement.[105] One strategy would be to evaluate implementation of the Fostering Connections to Success and Increasing Adoptions Act, which intended to decrease school changes, as well as other legislation. The National Working Group on Foster Care and Education has described 25 promising programs from around the country to help improve educational outcomes for children in out-of-home care[106]. The following are among the methods used by these programs:

- Targeted early intervention and screening to help children in foster care enter school ready to learn;
- Required data collection and information sharing between child welfare and education agencies;
- Better collaboration between child welfare and education agencies;
- Increased supports and services for students in foster care, including related to maintaining school stability;
- Educational advocacy for students in foster care to get the extra supports they need and ensure systems are working together;
- Targeted services for students in foster care to help them prepare for, and complete, postsecondary education.
- Support groups for youth transitioning from out-of-home care to college campuses.

[105] Personal communication, Kimberly Mann, Deputy Director, DCFS- Office of Child Well-Being June 2017
[106] National Working Group on Foster Care and Education (2018), ibid, pp. 9-14..

Chapter 7

Child Safety

Children are placed in out-of-home care to protect their safety, and maintaining their safety is a paramount concern. Nevertheless, children in out-of-home care may still face threats to their safety in their placement, their school, or their neighborhood. This chapter presents results of analyses related to the safety of children in out-of-home care. Analyses were conducted on variables that measured whether children were deliberately hurt by others and whether they were exposed to violence.

The original NSCAW baseline study of children in maltreatment investigations examined recent exposure to violence among children who had been placed in out-of-home care in 1999-2000.[107] Interviews were conducted near the close of a maltreatment investigation, so children in out-of-home care in the NSCAW baseline study had only been in their placement for a short time period. NSCAW interviewers administered the Violence Exposure Scale for Children—Revised (VEX-R) to children aged 5 and older. The interviewer shows children cards with pictures of 23 different violent and criminal acts and asks children whether they witnessed those acts committed by adult. For most of these acts, they are also asked if they experienced these acts themselves from an adult. Data support the reliability and validity of the VEX-R,[108] though the measure has not been widely tested,[109] and some researchers have expressed caution about the accuracy of measures of children's exposure to violence with very young children.[110]

From VEX-R results presented in a data table in the NSCAW I baseline study report, we calculated the percentages of children in out-of-home care who reported recently witnessing or experiencing a series of violent acts committed by adults in the home.[111] Spanking was the only violent act that occurred with any frequency: 17.7% of children reported witnessing a child being spanked in their current placement and 17.4% reported having been spanked themselves. Other violent acts occurred much less frequently, but often enough to suggest some risk for children. For example, 9.4% of children reported seeing an

---

[107] U.S. Department of Health and Human Services, Administration for Children, Youth, and Families (2005), ibid.

[108] Raviv, A., Erel, O., Fox, N., Leavitt, L., Raviv, A., Dar, I., et al. (2001). Individual measurement of exposure to everyday violence among elementary school children across various settings. *Journal of Community Psychology*, *29*, 117-140. Raviv, A., Shimoni, H., Fox, N. A., and Leavitt, L. A. (1999). Children's self-report of exposure to violence and its relation to emotional distress. *Journal of Applied Developmental Psychology*, *20*, 337-353. Shahinfar, A., Fox, N. A., Leavitt, L. (2000). Preschool children's exposure to violence: Relation of behavior problems to parent and child reports. *American Journal of Orthopsychiatry*, *70*, 115-125. Stein, B., Zima, B., Elliott, M., Burnam, M. A., Shahinfar, A., Fox, N., et al. (2001). Violence exposure among school-age children in foster care: relationship to distress symptoms. *Journal of the American Academy of Child and Adolescence Psychiatry*, 40, 588-594.

[109] See Oh, D.L., Jerman, P., Boparai, S. K. P., Koita, K., Briner, S., Bucci, M., & Harris, N. B. (2018). Review of tools for measuring exposure to adversity in children and adolescents. *Journal of Pediatric Health Care*, *32*, 564–583.

[110]Thompson, R., Proctor, L. J, Weisbart, C., Lewis, T. L., English, D. J., Hussey, J. M., & Runyan, D. K. (2007). Children's self-reports about violence exposure: An examination of the Things I Have Seen and Heard Scale. *American Journal of Orthopsychiatry, 77*, 454-466.

[111] These calculations were done on results presented in Table 3-17 on pages 3-32 and 3-33 of U.S. Department of Health and Human Services, Administration for Children, Youth, and Families (2005), ibid

adult pushing or shoving someone really hard in their placement, 7.8% reported seeing an adult shoving a child, 6.6% said they saw someone stealing from another person, 5.5% reported seeing an adult slapping a child, 4.2% reported that they had been beaten up, and 1% to 2% reported seeing a weapon being pointed or having one pointed at them.

Helton and Gotchez-Kerr analyzed VEX-R results from NSCAW II data collected in 2008-2009.[112] Rates of physical violence in out-of-home care were 9% or less across categories and types of out-of-home care. The risk was somewhat higher in residential treatment and group homes: 13% of youth in these settings experienced violence.

Examining maltreatment reports in out-of-home care is outside the scope of the current study. However, analysis by the Children and Family Research Center for the annual report, *Conditions of Children or at Risk of Foster Care in Illinois* has examined the rate of reports of maltreatment for Illinois children in out-of-home care[113]. The Federal government's method for calculating this rate was used: the number of substantiated reports of maltreatment per 100,000 days for the state population of children in out-of-home care. To put this in perspective, it may help to state that 100,000 days in care is the equivalent of about 274 children in out-of-home care for one year. This rate has increased in recent years from 5.3 substantiated reports in 100,000 days to 13.1 in 2017.

Child Safety in Previous Illinois Well-Being Studies

The Round Two IL-CWB presented results from the VEX-R scale on children's experiences of violence over the course of their life. Majorities of children had witnessed an adult yelling at a person and an adult slapping a person. Other exposure to violence was frequent enough to be disturbing: almost one in five had witnessed adults beating up someone and dealing drugs and more than one in three had witnessed an adult stealing from a person and getting arrested. Smaller percentages reported witnessing extreme violence: 8.5% reported seeing an adult pointing a weapon at a person, 3.8% witnessed a stabbing, and 1.2% witnessed a shooting. As we mentioned above, the Round Two study also found that nearly a quarter of youth with sexual experiences reported that their first one was non-consensual.

However, very few children in the Round Two IL-CWB had witnessed or experienced violence in their current placement. Seven children reported that they had had something thrown at them, although further inquiry revealed that this had actually occurred in other placements for five out of these seven. The ISCAW study's data on exposure to violence only included 25 children in out-of-home care, but it is still meaningful that 84% of them had witnessed severe violence in their life and 34% had experienced severe violence in their life.

---

[112] Helton, J. & Gotchez-Kerr, T. (2017). Safe from harm? Youth self-report of physical assault in child welfare Placements. *Journal of Interpersonal Violence*, Online First. https://doi.org/10.1177/0886260517734224

[113] Fuller, T., Nieto, M., Wakita, S.,Wang, S., Adams, K., Tran, S., Chiu, Y., & Braun, M. (2018). *Conditions of Children in or at Risk of Foster Care in Illinois* FY2018 Monitoring Report of the B.H. Consent Decree. Urbana, IL, Children and Family Research Center.

Current Analysis and Results

Physically Hurt by Someone. Youths were asked whether they had been physically hurt in the previous 12 months by a deliberate act by someone (see Table 7-1). A third of youths had experienced this at least once, and for 10% it had occurred four times or more. Most of those who were hurt (74.9%) knew their assailant. Three children reported being physically hurt in the last year by someone who had responsibility for taking care of them, 4.7% of the sample of youths asked this question. Over 10% of the sample reported experiencing a physical attack in the last year that caused physical injury, but only 5.5% experienced a physical attack for which they got medical treatment. Small percentages of the sample experienced physical attacks that changed their feelings (e.g., led to depression and anxiety) or changed what they did (e.g., where they went or how they acted).

Table 7-1 Child Report on Being Physically Hurt by Another Person in the Past 12 Months (N=81)

	f	%/ se
Physically hurt by someone at least once	26	32.6 (5.2)
Physically hurt by someone they know	20	24.4 (4.8)
Physically hurt by someone who was responsible for taking care of him/her[a]	3	4.3 (2.3)
Physical attack by person caused physical injury	8	10.2 (3.4)
Got medical treatment as a result of being physically hurt by someone	4	5.5 (2.6)
Physical attack by someone changed their feelings[b]	6	6.9 (2.8)
Physical attack by someone changed what they did[c]	5	6.2 (2.7)

Note. All analyses used weighted data. The sample sizes presented are unweighted. [a] N=74.[b] Such as depression and anxiety. [c] Such as where they went and how they acted.

The rate of being physically hurt differed by child age: 53.3% of youths age 15 to 17 reported this, compared to 37.5% of children age 9 to 11 and 13.9% of youths aged 12 to 14. The rate also differed by placement setting, though some group sample sizes were small: 10 out 15 youths in group homes or residential treatment (66.7%) reported being physical hurt by someone in the previous year compared to 26.9% of those in kinship care and 33.3% in traditional foster care.

Exposure to Violence. As in the Round Two IL-CWB and NSCAW studies, we analyzed results from the Violence Exposure Scale – Revised (VEX-R). Table 7-2 presents VEX-R results on children's lifetime history of witnessing and experiencing violence. Majorities of children had witnessed adults yelling at someone and had experienced being yelled at. Almost half of children had witnessed spanking. The percentages of children witnessing each of the following forms of violence were greater than 20%: someone being slapped hard, stealing, someone being beaten, and drug dealing. Close to half had witnessed someone

being arrested. A few children had witnessed shooting or stabbing. One fifth had personally experienced being slapped hard by an adult at home and 14.5% being beaten up by an adult at home.

Youths in group homes and residential treatment had especially high rates of experiencing violence, though the sample size was small. Majorities of these youths had witnessed people throwing things at someone and stealing; 42.1% reported witnessing a weapon being pointed at someone, 26.3% witnessed someone being shot; 21.1% witnessed someone being stabbed, and 14.5% reported having been beat up by an adult. Among 13 LGBQT+ youth, 5 (38.5%) report having been beaten up by an adult at home in their life, significantly more than heterosexual youth (13.0%).

Table 7-2 Percentage of Youth 7 to 17 Who Witnessed or Experienced Violence by an Adult in the Home in their Life (N=141)

	Witnessed		Experienced	
	f	%/ se	f	%/ se
Adult yelling	97 [a]	68.5 (3.9)	99[b]	70.4 (3.9)
Something thrown at a person	39	28.0 (3.8)	17	12.4 (2.8)
Being pushed	33	23.1 (3.6)	18	12.9 (2.8)
Being spanked	77	54.9 (4.2)	66	47.0 (4.2)
Being slapped hard	31	22.3 (3.5)	31	21.8 (3.5)
Being beaten up	35	24.8 (3.7)	20	14.5 (3.0)
Stealing	43	30.5 (3.9)	NA	NA
Being arrested	63	44.9 (4.2)	NA	NA
Drug dealing	27	19.1 (3.3)	NA	NA
Being pointed at with a weapon	24	17.4 (3.2)	10	7.4 (2.2)
Being shot	10	7.4 (2.2)	NA	NA
Being stabbed	7	5.2 (1.9)	NA	NA

Note. All analyses used weighted data. The sample sizes presented are unweighted. NA= not applicable or not asked in this instrument [a] Witnessed adult doing act to another person. [b] Experienced adult doing act to them.

Table 7-3 presents VEX-R results related to children's current life. Though a number of children witnessed and/or experienced yelling, the percentages of children witnessing or experiencing different forms of violence in their current home were generally low (though some percentages are arguably high compared to what average children experience). Children also reported someone stealing in their placement in 8.0% of cases and someone being arrested in 8.9% of cases.

Overall 14.7% of children reported witnessing spanking in their current home and 8.6% of children reported being spanked themselves in their current home. However, when we look at children aged 9 to

11, an age range at which caregivers would be more likely to use spanking, 20.0% had been spanked in their current home. Boys were more likely to be spanked than girls (13.6% vs. 4.1%).Children in kinship care were at higher risk (15.6%) than children in traditional foster care (2.2%), and 2 out of 12 children in specialized foster care reported being spanked (16.7%).

Table 7-3 Percentage of Youth 7 to 17 Who Witnessed or Experienced Violence Recently (N=141)

	Witnessed in Last Month		Experienced in the Last Month		Witnessed in the Current Home		Experienced in Current Home	
	f	%/ se	f	%/ se	f	%/ se	f	%/ se
Adult yelling	45[a]	31.7 (5.1)	39[b]	27.9 (4.9)	39	27.5 (5.0)	44	31.6 (5.0)
Something thrown at a person	10	7.3 (7.1)	2	1.2 (7.2)	6	3.9 (5.6)	1	0.6 (5.4)
Being pushed	5	3.7 (6.6)	0	0.0 (0.0)	3	2.4 (5.5)	1	0.9 (6.1)
Being spanked	16	11.6 (4.7)	9	6.1 (4.2)	21	14.7 (5.1)	12	8.6 (4.8)
Being slapped	5	3.2 (6.4)	3	2.3 (5.6)	4	2.7 (5.9)	8	5.6 (8.1)
Being beat up	3	2.2 (4.9)	0	0.0 (0.0)	5	3.9 (6.2)	2	1.3 (6.4)
Stealing	11	7.9 (6.8)	NA	NA	11	8.0 (6.8)	NA	NA
Being arrested	10	7.4 (4.7)	NA	NA	12	8.9 (5.1)	NA	NA
Drug dealing	4	2.9 (7.1)	NA	NA	3	2.0 (6.1)	NA	NA
Being pointed at with a weapon	5	3.3 (8.1)	0	0.0 (0.0)	3	2.3 (6.9)	0	0.0 (0.0)
Being shot	1	0.6 (9.1)	NA	NA	1	0.6 (9.1)	NA	NA
Being stabbed	0	0.0 (0.0)	NA	NA	0	0.0 (0.0)	NA	NA

Note. All analyses used weighted data. The sample sizes presented are unweighted. NA= not applicable or not asked in this instrument. [a] Witnessed adult doing act to another person. [b] Experienced adult doing act to them.

Discussion

By its nature, placement in out-of-home care means that children have experienced major threats to their safety. This chapter provides some detail about the safety threats children have experienced in their lives. It also discusses threats to their safety they have experienced recently, including those in their current home. Substantial proportions of children have witnessed or been subject to a wide range of violent actions that speak to the difficult environments they came from. It was common in their life for children to witness slapping, weapons being brandished, arrests being made, stealing, spanking, and people being beaten up. Almost half of children had been spanked, and about one-seventh had experienced being beaten up. These findings are very consistent with VEX-R results from the Round Two IL-CWB study conducted in 2004.

LGBTQ+ youth were at special risk for being beaten up. Children in group homes and residential treatment have experienced violence at especially high rates. Note too a finding from Chapter 5 that relates to children's safety: 26.9% of youths who had experienced in sexual intercourse reported that their first time was not consensual

Placement typically represented an improvement in safety, as the percentages of children who had witnessed or experienced violence recently or in their current home was much smaller, as was found in previous IL-CWB and NSCAW studies. Nevertheless, children's reports suggest that many still experience threats to their safety. The percentages of children who witnessed people being arrested or stealing in their current homes are small in one sense, but it is hard to imagine most children experiencing this at anything close to that frequency. Over half of older adolescents had been physically hurt by someone in the past year, and two-thirds of those in group homes and residential treatment. This threat of injury by attack needs to be studied more and actions taken to reduce this threat.

The finding that 14.9% of children age 9 to 11 report being spanked in their current placement deserves special attention. A large majority of these children were in kinship care. DCFS licensing standards for foster family homes prohibit corporal punishment,[114] though we do not know how often spanking occurred in licensed versus unlicensed homes. The use of spanking by caregivers needs to be explored more, as considerable research indicates that corporal punishment is harmful to children's well-being and development.[115] It is arguably more grievous when used with children who have already been traumatized because of maltreatment.

Overall, these findings suggest that placement in out-of-home care leads to greater safety. But continued vigilance about children's safety is still needed, particularly for older adolescents and youths in group homes and residential treatment. Focused studies of violence are needed with groups of children who are at greater risk.

---

[114] Illinois Department of Children and Families Services (2012) *Part 402 Licensing standards for foster family homes*. Retrieved from https://www2.illinois.gov/dcfs/aboutus/notices/Documents/rules_402.pdf

[115] Gershoff, E.T. (2010). More harm than good: A summary of scientific research on the intended and unintended effects of corporal punishment on children. *Law and Contemporary Problems*, *73,* 31-56.

Chapter 8

Children's Experience of Out-of-Home Care

"Parents and professionals are so focused on protecting children from harm…that they sometimes forget to treat them as individuals with distinct wishes, strengths, and viewpoints."
-Tali Gal[116]

Learning how children experience their life in placements offers an important perspective on well-being in out-of-home care. How well children function is the focus of most well-being research in child welfare. But we also have a moral responsibility to consider how they *feel* about their life and whether they experience love, joy and satisfaction. In this chapter, we set aside for the time being measures of child functioning, and consider data on children's experience of their life in their placement, mostly culled from the child interviews.

Research shows that most children and youth have positive feelings about their foster care placement. The 2001 NSCAW One Year in Foster Care (OYFC) Study found that the proportions of children who like the people they were living with and felt like a part of the family were each greater than 90%[117]. Over half of children stated that their new neighborhood and school were better than before. Youths' reported fairly high scores on average on measures of relatedness and closeness with their foster caregiver, although closeness was not rated as highly as in a sample of children in general reporting on their relationship with their birth parents.[118] The majority of foster parents had considered adopting the child if reunification was not possible. The biggest obstacle to adoption that was identified was the fact that biological parents' rights had not been relinquished or terminated. Half of children wanted their current placement to be their permanent home and 36% wanted their current caregiver to adopt them. Baker et al.'s review of 27 studies found that children were typically relieved to have left their chaotic and unsafe family situation and appreciated the care and safety provided by their foster caregiver[119]. Children often positively compare their foster care environment to the home they were removed from.[120] One aspect they appreciate in foster care was the improvement in the disciplinary methods that foster parents used compared to their homes.

The first NSCAW report on children involved in maltreatment investigations examined the experience of children who had recently been placed in out-of-home care.[121] Most children liked their caregiver (80.5%) and felt like part of the family (86.9%). Over a third of children wanted their placement to be their permanent home, and over a quarter wanted their caregiver to adopt them. Most had moved

---

[116] p vii, Gal, T. (2011). *Child victims and restorative justice: A need-rights model*. New York: Oxford University Press.
[117] U.S. Department of Health and Human Services, 2001, ibid.
[118] U.S. Department of Health and Human Services, 2001, ibid.
[119] Baker, A.J., Creegan, A., Quinones, A., & Rozelle, L. (2016). Foster children's views of their birth parents: A review of the literature. *Children and Youth Services Review*, *67,* 177-183.
[120] See, e.g., Ahmed, K., Windsor, L, & Scott, S. (2015). In their own words: abused children's perceptions of care provided by their birth parents and foster carers. *Adoption and Fostering*, *39*, 21–37.
[121] U.S. Department of Health and Human Services, Administration for Children, Youth and Families (2005), ibid.

neighborhoods and schools, but a majority thought their new neighborhood and/or school were as good or better than their old ones. Most thought they would live with their parents and their siblings again, and most felt it would be "different this time".

Children in out-of-home care in the NSCAW study did not differ significantly on their future expectations from children who had remained in the home following a maltreatment investigation. Across the sample, 75% of children believed that they would graduate from high school and have a good job in the future, whereas 20% believed there was a 50% or less chance that they would graduate from high school or have a good job by the age of 30. Sixty-two percent of children believed they would have children when they were older, and 15% believed there was a 50% or higher chance that they would have a child before they were 18 years-old. More than half (60%) of children believed they would live to be 35 years-old. Overall, the majority of children ages 10 and up believed they would graduate high school, have a good life, and start a family in the future.

This NSCAW report also examined the relationship between children in out-of-home care and their caregivers. On average, children scored 3.3 on the Rochester Assessment Package for Schools–Student (RAPS) Relatedness scale, a score that indicates a strong degree of relatedness with caregivers. Compared to a general sample of American youth, children in out-of-home care engaged in similar activities with their caregivers like playing sports and working on school projects. However, children reported talking more with both their primary and secondary caregivers about school and personal problems than other American youth, on average. Based on these findings, the reports suggested that children in out-of-home care are more likely to receive guidance from caregivers than the general American youth population, who seek support from other groups like friends and mentors rather than their caregivers.

Most children in out-of-home care remain attached to their birth parents. More than half in the NSCAW OYFC study thought they would live with their parents again, three-quarters believing that "things will be different this time". Yet most saw their birth mother less than once a month, and 41% never saw their birth father. Majorities wanted to see their mother and father more often. Baker and colleagues' review explores some of the emotional complexities of the attachment to their birth parents that children in foster care continue to have.[122] Across studies, children continued to feel attached to their birth parents, longed for them and wanted to see them. Most studies found that children were afraid to be separated from their birth parents. Most studies also found that children tended to minimize blame of their birth parents, and even take on blame themselves.

Children's relationships with siblings contribute greatly to their well-being, and are especially important if parents abuse or neglect the child. [123] Siblings can be reliable sources of comfort and support. Yet

---

[122] Baker, et al., ibid.

[123] Child Welfare Information Gateway (2013). *Sibling Issues in Foster Care and Adoption*. Washington, DC: Children's Bureau/Administration for Children, Youth and Family. Retrieved from https://www.childwelfare.gov/pubPDFs/siblingissues.pdf

placement in out-of-home care can separate children from their siblings. About two-thirds of children in out-of-home care in the United States also have a sibling in care, but, for a variety of reasons, siblings often go to different placements and are separated. Shlonsky and colleagues' studied over 11,000 children in foster care who also had siblings in care[124], and only 45.9% of these children were placed with all their siblings.

Both Federal and state policy address sibling issues in foster care. The Federal Fostering Connections to Success and Increasing Adoptions Act of 2008 makes Federal funding contingent on states' efforts to maintain sibling connections. As in most states[125], it is DCFS policy to place siblings together whenever possible (if both children need to be placed) and to facilitate contact between siblings when they cannot be in the same home.[126] .

Journalistic exposés have detailed the difficulties children face in out-of-home-care.[127] These books present numerous case examples that illustrate instability in substitute care, scarce resources, and limitations in child welfare decision-making. The books describe the sometimes wrenching challenges associated with children leaving their home, changing their neighborhoods and schools, being separated from siblings and other relatives, and adapting to placements that do not necessarily match well with their needs. Lacking empirical data and focusing on highly salient but not necessarily representative cases, these accounts cannot be considered as presenting the entire truth of the substitute care system. But they do remind us of the kind of negative experiences that can happen and suggest some of the risks that children in out-of-home care face.

Children's Experience of Life in Out-of-Home Care in Previous Illinois Studies

Several studies have assessed Illinois youths' experience of out-of-home care. Wilson and Conroy interviewed 1100 Illinois children from 1993 to 1996 to assess their satisfaction with their foster placement[128]. A large proportion of children felt loved and safe. Children rated their quality of life as significantly higher in their foster home compared to their previous home. More than three-quarters of children were "happy" or "very happy" with their caseworkers. A large majority of children felt that their agency had helped them, whether it was DCFS or a private agency. However, less than a third of children felt that they had been consulted in the determination of their permanency goals.

---

[124] Shlonsky, A., Webster, D., & Needell, B. (2003). The Ties That Bind: A Cross-Sectional Analysis of Siblings in Foster Case. *Journal of Social Service Research*, *29*, 27–52.
[125] Child Welfare Information Gateway (2013), ibid.
[126] Illinois Department of Children and Family Services (2014). *How to Connect with your Brothers and Sisters.* Springfield, IL: DCFS. Retrieved from https://www2.illinois.gov/dcfs/aboutus/notices/Documents/cfs_1050-95_sibling_visitation_rights_booklet.pdf
[127] See, e.g., Beam, C. (2013). *To the End of June: The Intimate Life of American Foster Care.* Boston: Houghton-Mifflin. Toth, J. (1997). *Orphans of the living*. New York: Touchstone.
[128] Wilson L &Conroy J (1996) *Satisfaction of 1100 Children in Out-of-Home Care, Primarily Family Foster Care, in Illinois' Child Welfare System: The Final Report of the 1996 Annual Client Evaluation*. Retrieved from www.eoutcome.org/Uploads/COAUploads/PdfUpload/SatisfactionInIllinoisChildWelfare.pdf

Johnson and colleagues conducted in-depth interviews with 59 Illinois youths in foster care.[129] Most youths had to change schools because of their placement, and their friends had changed. Most thought the new school was better but some found it worse. The interviewees often found these changes difficult and missed their family and friends from home. The majority got along well with their foster parents and felt they were treated better and had a better quality of life in foster care. About a third worried about returning home, mostly out of fear their family would have the same problems as before. Most youths wanted visits from their birth parents

All of the IL-CWB studies reported results on children's experience of life in out-of-home care. In the first IL-CWB study, 82% of children reported experiencing significant emotional support from their foster caregiver. Large majorities of children reported that caregivers monitored them, that they felt safe in their placement and belonged there, and that they experienced little or no conflict in their home. All children reported that their caregivers had high expectations for them. Almost half of children wanted their current home to be their permanent home. Two thirds of children felt that they had a significant connection with their birth mother but only 27% felt this way about their birth father.

In both the First Round and Second Round IL-CWB studies, most youth reported that caregivers were often monitoring them and that they had an excellent relationship with their caregivers. Only a small proportion said they disliked living with their current caregiver and had attempted to leave. Most caregivers were monitoring the child often (based on the average score on a parental monitoring scale). Most children reported that caregivers used positive methods of discipline such as explanation and time out, but also that most caregivers did yell at them.

The Round Three IL-CWB reported other results on children's feelings about their placement. In response to the question; "If you could live with anyone, would you live with?", 26% of youth responded by saying it was their current foster parent. A much larger percentage (65%) wanted their current foster placement to be permanent. The report authors suggested that this apparent contradiction reflected youths wish to live with their birth parent counterpoised by the recognition of the risks and barriers to doing so.

The CFRC's *Conditions of Children* report presents relevant results on siblings in care[130]. In 2017, children with one or two siblings in care were initially placed with their siblings in 79.7% of kinship care cases and 65.6% of traditional foster care cases. For children with three or more siblings in care, 44.3% were placed with all their siblings in kinship care cases and 13.4% in traditional foster care cases.

[129] Johnson, P. R., Yoken, C., & Voss, R. (1995). Family Foster Care Placement: The Child's Perspective. *Child Welfare*, *74*, 959–974.
[130] Fuller et al., 2018, ibid.

Current Analysis and Results

Numerous questions in the child interview asked about youths' experience of life in out-of-home care. Different sections assessed their relationship with their caregiver, their birth parents, their siblings, and their caseworker. Caseworkers reported on the reasons for the most recent change in placement, if a change had occurred. Questions in two different interviews asked about the caregivers' thoughts about adopting the child.

Relationship with Caregiver. Table 8-1 presents results on the child's experience of their caregiver. A large majority of children felt good when they were with their caregiver and felt close to them. Large majorities felt their caregiver cared about them, trusted them, helped them, thought they were capable, and enjoyed spending time with them. However, 42.7% said it was "sort of true" or "very true" that their caregiver did not know how the child felt about things. Children rarely gave their caregiver the most extreme negative rating on any item--anything negative was almost always "sort of true".

Table 8-2 suggests that children shared a range of normal daily activities with their caregiver. Majorities of children reported shopping and going to the movies with their caregivers. Most children talked over things with their caregiver: grades, other school things, personal problems, dating, although plenty of youths did not have personal conversations with their caregiver. Other activities such as going to a religious observance with their caregiver or doing a school project occurred with minorities of children, though we do not know how often such activities were naturally a part of foster families' lives. Just over a fifth of youths had had a serious argument with their caregiver.

Table 8-3 tells us more about youths' out-of-home experience (some questions were not asked of youth in group homes or residential treatment). Almost all youth with a kin or foster caregiver liked living with the foster family and felt like part of the family. Not surprisingly, fewer youth in group homes or residential treatment liked who they were living with (50.0%). A large majority of children with kin or foster caregivers felt that they could stay there until they grew up, and most wanted their caregiver to adopt them. A large majority of youths had to change neighborhood when they moved in the current placement, and now have different friends. Most did not see old friends from before they moved and missed someone from where they lived before.

Youth with kin caregivers were somewhat less likely to have different friends because of their move (71.7% vs. 93.5% for traditional foster care), and more likely to still see old friends from before (65.5% vs. 35.6% for traditional foster care). A majority of boys (58.5%) of boys still saw their old friends but only 38.7% of girls.

As Table 8-4 shows, half thought the new neighborhood was better but about a quarter thought it was worse, and the results were about the same regarding their new school. About half of youths found changing schools hard and half easy.

Table 8-1 Child Report of Relationship with Caregiver

		Not at all true to not very true		Sort of true		Very true	
	N	f	%/ se	f	%/se	f	%/ se
Feels good when with caregiver	67	0	0 (0.0)	12	18.3 (4.7)	54	81.7 (4.7)
Caregiver trusts me	67	8	11.7 (3.9)	22	33.2 (5.8)	37	55.1 (6.1)
Caregiver is fair with me	66	4	6.8 (3.1)	14	21.4 (5.0)	47	71.8 (5.5)
Caregiver enjoys spending time with me	66	2	3.3 (2.2)	16	24.4 (5.3)	48	72.4 (5.5)
Caregiver does a lot to help me	66	3	4.0 (2.4)	11	17.2 (4.6)	52	78.9 (5.0)
Feels unhappy when with caregiver	67	55	83.2 (4.6)	7	10.7 (3.8)	4	6.1 (2.9)
Feels mad when with caregiver	67	53	80.1 (4.9)	12	18.0 (4.7)	1	1.8 (1.6)
Caregiver doesn't have enough time for me	66	55	83.4 (4.6)	10	14.8 (4.4)	1	1.8 (1.6)
Caregiver doesn't know how I feel about things	66	38	57.3 (6.1)	19	29.6 (5.6)	9	13.1 (4.2)
Caregiver doesn't let me make own decisions	66	47	72.0 (5.5)	14	21.6 (5.1)	4	6.4 (3.0)
Caregiver doesn't think I can do much	66	56	84.7 (4.4)	7	10.6 (3.8)	3	4.7 (2.6)
Don't know what caregiver wants from me	66	49	75.0 (5.3)	11	17.0 (4.6)	5	8.1 (3.4)
		Not at all		A little bit to somewhat		Quite a bit to very	
Feels close to caregiver	66	2	2.9 (2.1)	9	13.4 (4.2)	55	83.7 (4.5)
Thinks caregiver cares about him or her	66	0	0.0 (0.0)	8	11.9 (4.0)	58	88.1 (4.0)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Children were asked where they would like to live now, where they expected to live next year, and whom they will live with when they turn age 16 (see Table 8-5). About one-third would choose to live with their birth mother right now, about a third with their current foster parent, and smaller percentages with a variety of other relatives or friends. Most children expected to be living with their current foster caregiver next year; only 16.5% expected to be reunited with their birth mother. Almost a third of children wanted to live with their current foster parent when they turned 16, about a fifth with their birth mother, 13.9% with their birth father, and smaller percentages with other people in their lives or alone. Boys were more likely to want to live with their mother at age 16 (32.8%) than girls were (16.1%).

Table 8-2 Child Activities with Caregiver in the Past 4 Weeks (n=67)

	f	%/ se
Gone shopping with caregiver	56	83.5 (4.6)
Discussed grades with caregiver	53	80.3 (4.9)
Discussed other school things with caregiver	48	71.8 (5.6)
Gone to movie with caregiver	38	56.8 (6.1)
Discussed personal problems with caregiver	37	55.1 (6.1)
Discussed dating to caregiver	34	51.2 (6.2)
Gone to religious event with caregiver	26	39.8 (6.0)
Played sports with caregiver	16	24.3 (5.3)
Had serious argument with caregiver	15	22.8 (5.2)
Did school project with caregiver	15	22.4 (5.1)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Table 8-3 Child Report on Out-of-Home Care Experience

	N	f	%/ se
Wants caregiver to adopt him or her[a]	67	69	63.0 (4.6)
Likes living with the people he or she lives with	143	130	91.0 (2.4)
Feels like part of this family	122	118	96.6 (1.6)
Feels like he or she can stay there until they grow up	115	99	86.1 (3.2)
Moved to different neighborhood when changed placement	144	125	86.6 (2.8)
Has different friends now because of move	140	116	82.6 (3.2)
Sees old friends from before moved	144	69	48.2 (4.2)
Misses someone from where you lived before	144	100	69.2 (3.9)

Note. All analyses used weighted data. The sample sizes presented are unweighted. [a] Children and youth in group homes or residential treatment were not asked these questions.

Table 8-4 Child Report on Changing Neighborhood and Schools

		Worse		Same		Better	
	N	f	%/ se	f	%/ se	f	%/ se
New neighborhood compared to old one	119	17	14.2 (3.2)	43	35.6 (4.4)	60	50.2 (4.6)
New school compared to previous one	102	24	24.0 (4.2)	20	19.5 (3.9)	58	56.5 (4.9)
		Very hard to hard		Very easy to easy			
		f	%	f	%		
Difficulty of changing schools	83	39	47.4 (5.5)	44	52.6 (5.5)		

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Table 8-5 Child's Wishes and Expectations about Who They Will Live with at 16-years Old (N=145)

	Child wants to live with		Who child thinks they will live within a year		Who child would like to live with at age 16	
	f	%/ se	f	%/ se	f	%/ se
Birth mother	48	32.9 (3.9)	24	16.5 (3.1)	29	20.1 (3.3)
Current foster parent	47	32.3 (3.9)	94	64.9 (4.9)	44	30.1 (3.8)
Birth father	31	21.1 (3.4)	8	5.5 (1.9)	16	11.1 (2.6)
Birth siblings	20	13.5 (2.8)	0	0.0 (0.0)	7	4.7 (1.8)
Aunt/uncle	19	13.3 (2.8)	5	3.2 (1.5)	9	5.9 (2.0)
Grandmother	17	12.0 (2.7)	1	0.6 (0.7)	10	6.8 (2.1)
Friend	12	8.2 (2.3)	0	0.0 (0.0)	1	0.6 (0.6)
Grandfather	7	4.9 (1.8)	1	0.6 (0.7)	2	1.6 (1.0)
Foster sibling	6	4.0 (1.6)	0	0.0 (0.0)	0	0.0 (0.0)
Alone	5	3.7 (1.6)	1	0.7 (0.7)	7	4.5 (1.7)

Note. All analyses used weighted data. The sample sizes presented are unweighted. Other categories of people who the child would live with are less than 4%, for example, former foster parent, teacher, or girlfriend/boyfriend.

Relationship with Birth Mother. We learn about children's relationship with their birth mother and father[131] in Table 8-6. About a third of youths saw their birth mother at least once a week, about a quarter less often, and more than a third never saw her. These were about the same proportions for frequency of visits that the caseworkers reported (see Table 8-7). For some children who had contact

[131] We use "birth mother" and "birth father" to identify the caregiver from whose home the child was removed. The terms used in the child interview were "real mother" and "real father". We assume that a large majority of these were biological parents, but it is also possible for this to be an adoptive parent or other type of caregiver who had custody.

with their mother, visits were not in person—perhaps some were by Skype or phone. Youths were more likely to see their birth mother at least once a month if they were in kinship care (63.5%) or in a group home or residential treatment (64.6%) than if they were in traditional foster care (37.3%) or specialized foster care (22.2%).

Most children usually did fun things on visits with their birth mother, and a number of children talked to her about important things, at least occasionally (Table 8-6). Visits were at different locations, most often at the caregiver's home and/or at the birth parents' home; other locations were common as well (Table 8-8). A large proportion of visits were supervised. More than two-thirds of children wanted to see their birth mother more (Table 8-9), though a few wanted to see her less and one quarter reported being afraid of their mother at least occasionally (Table 8-6).

In about half of cases, the kin or foster caregiver had contact with the birth mother (Table 8-8), more commonly with kinship care (68.8%) than traditional foster care (39.0%) or specialized foster care (12.5%). In most of those cases, the foster caregiver was at least occasionally present during the mother's visit (Table 8-6), though this percentage was lower for youths in group homes and residential treatment (58.8%). When there was contact, the foster caregiver and birth mother almost always got along (Table 8-8). Considering all cases in the sample (not just those with caregiver and child interviews), caseworkers reported that 82.7% of mothers had supervised visitation with the child (see Table 8-7)

Relationship with Birth Father. More than half of children never saw their birth father, although more than a fifth saw their birth father at least once a week, and a fifth less often than that (see Table 8-6). Again, these proportions were consistent with what caseworkers reported. Most children in kinship care saw their father at least occasionally (64.3%) and so did most youth in group homes and residential treatment (57.1%), but only 25% of children in traditional foster care saw their father and 12.5% of those in specialized foster care. For about a quarter of children who saw their birth father, the visits were not in person. Caregivers saw the child's birth father in 38.2% of cases (Table 8-10); when caregivers did see the father, they almost invariably got along. Visits with the birth father occurred in a variety of locations.

Children's Experiences of Birth Parent Visits. Children enjoyed visits with their birth parents, though the visits could also present challenges. Almost all children reported feeling happy and two-thirds relaxed after visits with their parents, but small percentages reported different negative feelings such as sad, guilty, and afraid (see Table 8-11). Almost two-thirds of children reported a mixture of positive and negative feelings after parent visits, but more than a third of children reported only positive feelings and no child reported only negative feelings. Parent visits seemed to be harder for youths in group homes and residential treatment: they were more likely than other youths to feel sad after a parent visit (70.6%), upset (58.8%), worried (58.8%), and angry (43.8%), and less likely to feel relaxed (23.5%).

A quarter of children reported that parent visits were sometimes or usually cancelled (Table 8-12). This was more common for boys (32.3%) than girls (18.3%). Most children either never saw family members they liked or rarely. Most children missed their family sometimes or usually.

Table 8-6 Child Report on Relationship with Birth Mother and Birth Father

		Never		Less than once a month		Once or twice a month		About once a week		Several times a week		Everyday	
	N	f	%/ se	f	%/ se	f	%/ se	f	%/ se	f	%/ se	f	%/ se
Child sees birth mother	131	49	37.5 (4.2)	14	10.4 (2.7)	24	18.0 (3.4)	16	12.1 (2.8)	18	13.4 (3.0)	11	8.7 (2.5)
Child sees birth father	106	57	53.6 (4.8)	11	10.6 (3.0)	14	13.1 (3.3)	14	13.4 (3.3)	7	6.7 (2.4)	3	2.6 (1.5)

		None of the time		Hardly to some of the time		Most of the time to all of the time	
	N	f	%/ se	f	%/ se	f	%/ se
Foster Caregiver is at visits with mother	65	25	38.5 (6.0)	19	28.7 (5.6)	21	32.9 (5.8)
Child does fun things with mother	65	2	3.5 (2.3)	10	16.1 (4.6)	52	80.4 (4.9)
Child talks to mother about important things	86	12	14.4 (3.8)	35	40.7 (5.3)	39	44.9 (5.4)
Child is afraid of birth mother	87	66	76.1 (4.6)	16	18.3 (4.1)	5	5.7 (2.5)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Table 8-7 Visits from Birth parents –from Caseworker Interview

	Birth mother visits		Birth father visits	
	f	%	f	%
Number of Visits per Week	N=497		N=501	
0	153	30.7	294	58.8
1	190	38.2	96	19.1
2	73	14.6	43	8.6
3	81	16.4	67	13.5
	Mean= 1.17, SE= 4.7		Mean= .77, SE= 4.8	
Supervision of Parent's Visits	N=344		N=207	
Parents supervised	285	82.7 (2.0)	172	83.5 (2.6)
Parents unsupervised	9	2.8 (0.9)	6	2.7 (1.1)
Parents both supervised and unsupervised	50	14.6 (1.9)	29	13.8 (2.4)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Table 8-8 Child Report on Current Relationship with Mother

	N	f	%/ se
Caregiver sees child's birth mother	108	57	52.6 (4.8)
Caregiver and birth mother get along	50	46	92.6 (3.7)
Child sees mother in person	82	65	79.5 (4.5)
Visits with mother are at…			
Present home	65	29	43.8 (6.2)
Her home	65	20	30.7 (5.8)
Child welfare agency	65	4	6.8 (3.1)
Other home	65	4	6.6 (3.1)
Treatment center	65	2	3.0 (2.1)
Other location	65	32	49.6 (5.8)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Table 8-9 Child's Desire for Visits with Birth parents

		Wants to see parent more		Wants to see parent same		Wants to see parent less	
	N	f	%/ se	f	%/ se	f	%/ se
Birth mother	87	59	68.4 (5.0)	17	19.9 (4.3)	10	11.7 (3.4)
Birth father	55	32	58.4 (6.6)	20	36.8 (6.5)	3	4.9 (2.9)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Table 8-10 Child Report on Current Relationship with Birth father

	N	f	%/ se
Caregiver sees child's birth father	91	35	38.2 (5.1)
Caregiver and birth father get along	31	28	92.5 (4.8)
Child sees father in person	53	39	74.8 (6.0)
Visits with father are at …			
Present home	39	12	31.5 (7.5)
His home	39	9	23.4 (6.8)
Child welfare agency	39	6	15.7 (5.9)
Other home	39	4	9.5 (4.7)
Treatment center	39	0	0.0 (0.0)
Some other location	39	12	31.3 (7.5)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Table 8-11 Child's Feelings after Visit with Parent

	N	f	%/ se
Happy	124	115	92.2 (2.4)
Relaxed	124	81	64.4 (4.3)
Upset	125	38	30.1 (4.1)
Sad	125	34	27.6 (4.0)
Worried	125	34	27.2 (4.0)
Lonely	125	24	19.2 (3.5)
Guilty	125	21	16.7 (3.3)
Afraid	124	19	15.3 (3.2)
Angry	124	16	12.9 (3.0)
Has tried to avoid visiting family	121	13	10.5 (2.8)
Only positive feelings	125	45	35.6 (4.3)
Only negative feelings	125	0	0.0 (0.0)
Both positive and negative feelings	125	81	64.4 (4.3)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Table 8-12 Children's Experience Regarding Visits with Birth family

		Never		Only once in awhile		Sometimes		Usually	
	N	f	%/ se	f	%/ se	f	%/ se	f	%/ se
Family visits are cancelled	122	37	30.7 (4.2)	54	44.0 (4.5)	22	18.1 (3.5)	9	7.2 (2.3)
Child gets to see other family they like	99	35	35.4 (4.8)	24	24.4 (4.3)	29	29.4 (4.6)	11	10.8 (3.1)
Child misses family	143	23	16.3 (3.1)	18	12.7 (2.8)	31	21.7 (3.4)	70	49.3 (4.2)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Caregiver Monitoring and Disciplinary Behavior with the Child. Children were asked questions about how their out-of-home caregiver monitored and disciplined them (Tables 8-13 and 8-14). Large majorities of children said that caregivers consistently knew where they were and whom they were with. The majority of caregivers set curfews. Overall, they usually asked when the child would return home, but this was much more frequent for girls (68.3%) than boys (31.7%). The majority of caregivers rarely left their child at home without them, and few children said they left home without telling their caregiver. Children were asked what disciplinary methods caregivers had used in the previous 12 months (see Table 8-14). A substantial proportion of caregivers (44.9%) explained why something was wrong at least three times in the last year and 40.1% grounded the child at least three times in the previous year. Most children reported that they had not been yelled at by a caregiver in the last 12 months; if it had happened, it was usually only one or two times.

Table 8-13 Child Report of Caregiver Monitoring

		Never to almost never		Once in a while to pretty often		Very often	
	N	f	%/ se	f	%/ se	f	%/ se
Caregiver knows whereabouts of child	80	2	2.8 (1.9)	10	12.2 (3.7)	68	85.0 (4.0)
Caregiver knows who child is with	80	4	4.5 (2.3)	13	15.8 (4.1)	64	79.7 (4.5)
Caregiver gives child curfew	78	10	13.1 (3.8)	12	14.9 (4.0)	56	72.0 (5.1)
Caregiver asks when child will return	78	16	20.6 (4.6)	21	26.5 (5.0)	41	52.9 (5.7)
Child has been left at home without caregiver (7-11)	31	31	100 (0.0)	0	0.0 (0.0)	0	0.0 (0.0)
Child leaves house without telling caregiver	80	71	89.2 (3.5)	7	8.8 (3.2)	2	2.0 (1.6)

Note. All analyses used weighted data. The sample sizes presented are unweighted

Table 8-14 Child Report of Caregiver Disciplinary Behavior in the Past 12 Months (N=80)

	0 times		1-2 times		3-5 times		6-20 times		20 or more times	
	f	%/ se	f	%/ se	f	%/ se	f	%/ se	f	%/ se
Times adult explained why something is wrong	23	28.9 (5.1)	19	24.1 (4.8)	13	15.9 (4.1)	10	12.9 (3.8)	15	18.1 (4.3)
Times put in "timeout" by adult[a]	43	53.6 (5.5)	22	27.2 (4.9)	6	7.5 (2.9)	4	4.9 (2.4)	5	6.8 (2.8)
Times adult yelled at you	42	52.4 (5.6)	17	21.2 (4.6)	3	3.5 (2.1)	12	15.6 (4.1)	6	7.3 (2.9)
Times been grounded by adult	27	34.3 (5.3)	21	25.6 (4.9)	10	12.3 (3.7)	13	16.6 (4.2)	9	11.2 (3.5)

Note. All analyses used weighted data. The sample sizes presented are unweighted. [a]N=81

Children's Experiences with Caseworkers and Placements. Most children felt that their caseworker listened to them all the time (Table 8-15). Overall, a majority of youths felt that caseworkers understood their situation very well, but this was true for only 42.9% of youths age 12 to 17. About half of children felt caseworkers explained the child's problems to them very well and the services available to help them; but only 27.8% of youths in group homes and residential treatment felt this way. Another 38.9% of the child interview sample rated caseworkers as doing this somewhat well. Many children had experience with caseworkers, especially since more than two-thirds (68.8%) had had at least one other placement prior to the current one.

Table 8-16 shows the caseworker's report of the primary cause of the child leaving their last placement. There were myriad reasons. One reason was the foster family requesting the removal, although we do not know the reasons why those requests were made. But even more children were moved because of issues with the foster home or because of the foster parent moving or becoming disabled.

Table 8-15 Child Report of Relationship with Caseworker in the Past 6 Months

	N	f	%/ se
Child has met with caseworker	142	134	94.7 (1.9)
Child feels that caseworker listened to him/her all of the time	133	85	63.6 (4.2)
Caseworker understood child's situation very well	132	73	55.4 (4.3)
Caseworker explained well the problems the child has and what services are available	125	63	50.4 (4.5)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Table 8-16 Main Reason for Child's Most Recent Placement Change- Caseworker interview (n=314)

	f	%/ se
Foster family requested removal of the child	44	20.4 (2.8)
Child moved to a placement with siblings or relative	29	13.8 (2.4)
Child removed due to issue with previous foster home	27	12.8 (2.3)
Former foster parent disabled/ incarcerated/ moved/ unable to care for child	27	12.5 (2.3)
Current placement is pre-adoptive placement	15	7.2 (1.8)
Higher level care required	13	6.0 (1.6)
Time limit on that placement (emergency placement)	13	5.9 (1.6)
Child moved due to abuse or criminal activity in former foster home	10	4.7 (1.5)
Investigation into previous foster family	10	4.5 (1.4)
Foster parent and child or FP and agency mutual agreement	6	2.7 (1.1)
Child behavioral issues	5	2.2 (1.0)
Foster parent did not support adoption or reunification	4	2.0 (0.9)
Child ran away	4	1.9 (0.9)

Note. All analyses used weighted data. The sample sizes presented are unweighted.
The following were reported by 1% of the sample or less: lower level of care required, child asked to move, logistical problems (e.g., distance to school), former foster parent died, foster home closed.

The Child's Siblings. Under Illinois law, DCFS must support the sibling relationships of children in its care.[132] DCFS strives to place siblings together whenever possible, but siblings may nevertheless be placed apart. Several questions in the current study concern the child's siblings (see Tables 8-17 through 8-19). Caseworkers reported that 69.4% of the children in the study had siblings in care. Almost two-thirds of these children (64.1%) lived with their siblings, but 35.9% of them had siblings in another placement. It was more difficult to place them together when children had a large number of siblings (see Table 8--*18*): 24.1% of children had 3 to 4 siblings in out-of-home care, but only 8.8% of the placements with brothers and/or sisters included 3 to 4 siblings. The child's caseworker was in touch with the child's siblings 90.2% of the time, but only 9.2% of these cases included plans to bring the child and sibling together in the same home. Most children saw one or more of their siblings at least once a month, but many did not, and the majority of children wanted to see their siblings more often (Table 8-19).

[132] Illinois Department of Children and Family Services. (2019). *Keeping siblings connected*. Springfield, IL: DCFS. Retrieved from https://www2.illinois.gov/dcfs/lovinghomes/fostercare/Pages/Keeping-Siblings-Connected.aspx

Table 8-17 Caseworker Information on Child's Siblings

	N	f	%/ se
Child has siblings also in out-of-home care	525	365	69.4 (2.0)
Siblings in out-of-home care live with child	365	234	64.1 (2.5)
Child is in contact with siblings in other placements	131	116	88.9 (2.8)
There are plans to get child and siblings in same home	129	12	9.2 (2.6)
Caseworker has contact with child's siblings	122	110	90.2 (2.7)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Table 8-18 Status of Child's Siblings

	Number of siblings in out-of-home care (N=365)		Number of siblings living with child (N=234)	
	f	%/ se	f	%/ se
1-2 siblings	254	69.7 (2.4)	211	90.3 (1.9)
3-4 siblings	88	24.2 (2.2)	21	8.8 (1.9)
5-6 siblings	16	4.3 (1.1)	2	0.9 (0.6)
7-8 siblings	2	0.6 (0.4)	0	0.0 (0.0)
9-10 siblings	5	1.3 (0.6)	0	0.0 (0.0)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Table 8-19 Child's Contact with Siblings Who Live Elsewhere

	See at least once a month			Want to see more		
	N	f	%/ se	N	f	%/ se
Sibling 1	119	68	57.3 (4.5)	118	83	70.1 (4.2)
Sibling 2	94	46	49.4 (5.2)	90	58	64.4 (5.1)
Sibling 3	66	32	48.3 (6.2)	66	44	65.8 (5.9)
Sibling 4	51	27	52 (7.0)	50	31	63.2 (6.9)
Sibling 5	34	19	54.7 (8.6)	34	21	62.8 (8.4)
Sibling 6	18	7	40.0 (11.9)	18	15	86.0 (8.5)
Sibling 7	9	4	38.2 (16.7)	9	7	71.9 (15.5)
Sibling 8	4	1	34.5 (27.2)	4	3	65.5 (27.2)
Sibling 9	1	1	45.6 (49.8)	1	1	100.0 (NA)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

The Child's Adoption. Several questions in the caseworker interview explored the child's prospects for adoption (see Tables 8-20 through 8-22). Almost 90% of caseworkers had discussed the possibility of adoption with caregivers. Caseworkers reported that 86.3% of caregivers had expressed interest and that 91.4% of those who had made a decision were planning to adopt. Caseworkers report multiple factors supporting caregivers' decision to adopt (see Table 8-21). Most prominent was the caregiver's love and affection for the child. Other prominent supportive factors included having a familial relationship with the child and the caregiver's long-term intention to adopt. Being concerned that the child would have to move if not adopted was a concern in a majority of kin care cases (61.0%); less so in traditional foster care (31.8%). Among the small number of caregivers who were not planning to adopt, the biggest reasons were the expectation that the child would return to their original home, and interest in adopting the child by the child's family members (Table 8-22). With 12 to 17 year olds, the reason not to adopt was sometimes the youth's goal to be independent (38.9%).

Table 8-20 Caregiver and Child's Adoption- Caseworker Interview

	N	f	%/ se
Discussed possible adoption with caregivers	443	398	89.9 (1.4)
Caregivers expressed interest	442	381	86.3 (1.6)
Caregiver plans to adopt child if child does not return home	432	395	91.4 (1.4)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Table 8-21 Factors Supporting Caregiver's Decision to Adopt Child- Caseworker Interview (N=395)

	f	%/ se
Foster parents' love/affection	366	92.7 (1.3)
Child related to foster parent's family	278	70.4 (2.3)
Foster parents always planned to adopt	235	59.4 (2.5)
Concerned child will move if not adopted	191	48.4 (2.5)
Foster parents already adopted siblings	114	28.9 (2.3)
Same race/ethnicity	74	18.8 (2.0)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Table 8-22 Factors Influencing Caregiver's Decision not to Adopt Child- Caseworker Interview (N=39)

	f	%/ se
Child expected to return home	15	38.8 (8.0)
Another family related to child might adopt	13	33.1 (7.7)
Another family not related to child might adopt	9	22.7 (6.8)
Current foster parent not the best suited	7	19.4 6.5)
Child's race/ethnicity is different	0	0.0 (0.0)
Any other reason adoption not planned	17	43.4 (11.8)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Discussion

These results speak both to the positive caretaking mission of out-of-home care and to the sadness that children nevertheless experience. Most children reported positive experiences with their caregivers and caseworkers. Almost all youths liked living with the foster family and felt like part of the family, and most thought they could stay there until they grew up. A large majority of caregivers were reportedly interesting in adopting the child. Children usually reported that caregivers monitored them and disciplined them in appropriate ways. Most children had a positive experience with their caseworker too, though this was not true of many children in group homes and residential treatment.

At the same time, these results reflect the losses these children have experienced and continuing challenges in their daily experience. Most of these children had to change neighborhoods and schools, and changing schools was not always easy. Many thought their new neighborhood and school were better but some thought they were worse. Many missed people they had left behind. A number wanted to live with their birth mother or father and a number planned to do so when they turned 16, but few expected to live with their birth parent within the next year. Many did not have contact with their birth mother and father, and for others contact was sparse. Children in traditional and specialized foster care were especially unlikely to have much contact. Most children had brothers and sisters in out-of-home care, but in more than a third of these cases their siblings were in a different home, and in many cases contact with siblings was infrequent.

Our findings are consistent in many ways with those from prior IL-CWB research and other Illinois studies. Like the current study, previous studies found that most children felt supported by caregivers. They reported monitoring and parental discipline that was for the most part appropriate. Many children in previous studies also wanted to remain in their current placement and many wanted it to be permanent. Children in previous studies also missed their birth parents and wanted to see them. In the *Conditions of Children* report, children with one or two siblings were likely to be living with all of them whereas children with three or more siblings were not likely to be living with them. The present study results also resemble those from NSCAW and other studies.

A limitation of the current study is that it only assesses foster care at a single point in time, so it provides little information about the stability of foster care. This is a serious concern, given that studies have found that 22% to 70% of foster care placements disrupt in any given year.[133] One telling finding in the current study is that the majority of children had had at least one other out-of-home placement prior to the current one. It is encouraging that a majority of youths felt they could stay in their current placement until they grew up and that a majority of caregivers was serious about adoption. The data from other studies on the instability of substitute care should temper our conclusions about the positive experience of children in out-of-home care. Journalistic accounts that are critical of the foster care system need to be taken seriously as indicators of the need for constant vigilance to make the system

[133] Blakey, J.M.; Leathers, S.J.; Lawler, M.; Washington, T. Natschke, C.; Strand, T.; & Walton, Q. (2012). A review of how states are addressing placement stability. *Children & Youth Services Review*, 34, 369-378,

work for children. Nevertheless, the biggest lesson of this chapter is that most children reported feeling safe, supported and cared for in out-of-home care.

Chapter 9

Resilience

Child maltreatment can lead to a range of negative outcomes that are difficult to overcome.[134] Placement in out-of-home care can be a necessary step to keep children safe and provide an environment that is more likely to promote their well-being, but, as the results from previous chapters attest, many children in foster care still lag on a wide range of outcomes[135]. Children aging out of foster care have especially poor outcomes.[136] Yet some children are resilient and do well despite the maltreatment they have suffered.[137] Supporting children's resilience is an important part of the child protection response and has the potential to promote children's continued well-being into adulthood. This chapter examines results from the 2017 Illinois Study of Child Well-Being that are relevant for understanding the resilience of Illinois children in out-of-home care.

Several variables in the current study assess resources that children need for resilience. Others measure ways in which they demonstrate resilience in their current life. Having a supportive parent or other supportive adult in their lives is an important predictor of resilience.[138] The relationship with the caregiver is a predictor of adjustment of children in out-of-home care.[139] Results from the first NSCAW study speak to the presence of supportive adults in the lives children in out of home care. When children were asked a series of questions about having support from parents, relative or other adults, the percentages who said yes ranged from 82.3% to 94.5% across questions. Social competence and daily life skills are forms of resilience that are likely to increase the odds of successful adaptation to adulthood[140]. Current life satisfaction and positive future expectations measure confidence and hope that children will need going forward. Below we report results from measures of all these variables.

---

[134] See, e.g., Cicchetti, D., & Lynch, M. (1993). Toward an ecological/transactional model of community violence and child maltreatment: Consequences for children's development. *Psychiatry*, *56*, 96–118;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* (vol. 2, pp. 32–71). New York: Wiley.

[135] See also, e.g., U.S. Department of Health and Human Services, Administration for Children, Youth and Families (2001), ibid.

[136] See, e.g., Courtney, M. E., & Dworsky, A. (2006). Early outcomes for young adults transitioning from out-of-home care in the USA. *Child & Family Social Work*, *11*, 209–219. Courtney, M. E., Dworsky, A., Brown, A., Cary, C., Love, K., & Vorhies, V. (2011). *Midwest evaluation of the adult functioning of former foster youth: Outcomes at age 26.* Chapin Hall/ University of Chicago. Courtney, M. E., Dworsky, A., Cusick, G., Havlicek, J., Perez, A., & Keller, T. E. (2007). *Midwest evaluation of the adult functioning of former foster youth: Outcomes at age 21*. Chapin Hall/University of Chicago.

[137] See, e.g., Klika, J.B. & Herrenkohl, T.I. (2013). A review of developmental research on resilience in maltreated children. *Trauma, Violence and Abuse, 14*, 222–234.

[138] Haskett, M. E., Nears, K., Ward, C. S., & McPherson, A. V. (2006). Diversity in adjustment of maltreated children: Factors associated with resilient functioning. *Clinical Psychology Review*, *26*, 796–812.

[139] Legault, L., Anawati, M., & Flynn, R. J. (2006). Factors favoring psychological resilience among fostered young people. *Children and Youth Services Review*, 28, 1024–1038.

[140] See Banyard V.L. & Williams LM. (2007). Women's voices on recovery: A multimethod study of the complexity of recovery from child sexual abuse. *Child Abuse & Neglect*, *31,* 275–290.

A number of previous studies of child maltreatment victims have attempted to estimate the percentage of children who can be classified as resilient.[141] This typically involves developing a decision rule specifying that children scoring above a threshold on one or more measures of functioning are categorized as resilient. Usually multiple measures are used to identify children as resilient when they function well across an entire domain (e.g. social functioning) or across all domains. Studies have used widely varying methods and produced variable estimates. One review found that approximately 10% to 25% of maltreated children achieve resilience,[142] but some studies have found rates as low as 1.5%.[143] The complicated task of estimating the percentage of children who are resilient in our sample is beyond the scope of the current study, though future analyses of study data could try this. Instead, we measure a number of different variables that indicate or promote resilience and draw inferences about children's resilience from the profile of results we obtain.

Resilience in Previous Illinois Well-Being Studies

In the Round Two and Round Three IL-CWBs, 94% and 98% of youth respectively reported that they had an adult they could turn to for support. Majorities reported that parents, parent figures, or relatives could serve in this role. Almost all in the Round Three study reported that an adult outside of the family had encouraged them and believed in them and 88% said there was an adult who made a difference in their lives.

In the Round One IL-CWB study, almost half of children were involved in community activities. Most of the sample was split between students who had high self-esteem (42%) and adequate self-esteem (49%). In both the Round Two and Three studies, large majorities of youths were optimistic about living to be 35, graduating from high school, and finding a good job by age 30. In the Round Three study, 43% of youths believed they did not have a good chance to have a family when they were older. On the other hand, 21% believed they had a chance of having a baby before the age of 18, which could make adaptation to adulthood more stressful and difficult.

Current Analysis and Results

Youths reported on the support they received from adults. Across a range of questions, 88.7% or more of youths reported that they had a parent, another relative, and/or a non-relative adult who were supportive (see Table 9-1). The proportion of youths who reported they could go to a non-relative adult with a problem was a little smaller (77.6%).

---

[141] Walsh, W. A., Dawson, J., & Mattingly, M. J. (2011.). How are we measuring resilience following childhood maltreatment? Is the research adequate and consistent? What is the impact on research, practice, and policy? *Trauma Violence & Abuse*, *11*, 27–41.

[142] Walsh, et al., ibid.

[143] Cicchetti, D., & Rogosch, F. A. (1997). The role of self-organization in the promotion of resilience in maltreated children. *Development and Psychopathology*, *9*, 797-815. Haskett, et al., ibid

Table 9-1 Child Report of Adult Support

	N	f	%/ se
There are adults he or she can go to for help	82	79	95.8 (2.2)
Can go to parent or someone for problem	79	77	97.0 (1.9)
Can go to other relative for problem	79	70	88.7 (3.6)
Can go to a non-relative adult with problem	76	59	77.6 (4.8)
Has an encouraging non-relative adult	82	79	95.3 (2.3)
This person has made a difference in their life	79	71	89.9 (3.4)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Tables 9-2 and 9-3 present results on social competence from the Youth Self-Report. Nearly half of youths reported average involvement in sports and another 30.9% above average. Most reported being average in their sports ability, but 17.0% said they were above average.

Majorities said they spend more time on hobbies than their peers and were better at them. More than three-quarters said that they had a job or chores, and almost half report that they spend more time on jobs or chores than their peers. About a third of youths (37.9%) said they are in clubs, teams or other organized groups; almost half of them report they are more active than their peers in these groups.

Almost half of youths reported they had 1 to 3 close friends and almost half said they had 4 or more close friends. About half reported they do things less than once a week with friends outside of school, and about half reported doing things one a week or more with friends outside of school. Over 90% of youths said they did average or better than average on getting along with siblings and with other kids, on behaving with their caregiver, and on doing things by themselves.

Table 9-4 shows the results from the Ansell Casey Life Skills-Daily Living measure, an instrument that assesses whether youths have 17 different skills needed for independent living in today's society. On every item but one, large majorities of youths reported that they had the skills listed on the measure. They were very positive on a number of items relating to use of the Internet and other technology. Large majorities reported that they had adults that were checking in on them and that they could call in an emergency. Most reported that they could evaluate food labels to see how healthy food was, think about the impact of different foods on their health, and cook for themselves. Most knew how to use cleaning products and a fire extinguisher.

Table 9-2 Child's Report of their Social Competence in Sports, Hobbies, Job or Chores, and Social Groups

		Below Average		Average		Above Average	
	N	f	%/ se	f	%/ se	f	%/ se
Times spent playing sports compared to peers	65	16	24.1(5.3)	29	45.1 (6.2)	20	30.9 (5.7)
Good at sports compared to peers	65	4	6.3 (3.0)	37	56.0 (6.2)	25	37.7 (6.0)
Time spent on hobbies compared to peers	66	6	9.0 (5.3)	26	39.6 (6.0)	34	51.4 (6.2)
Good at hobbies compared to peers	66	2	3.2 (2.2)	28	43.2 (6.1)	35	53.6 (6.1)
Child's performance on job or chores compared to peers	65	3	4.4 (2.5)	33	51.3 (6.2)	29	44.2 (6.2)

		Yes		No	
		f	%/ se	f	%
Child has a job or assigned chores	82	65	78.7 (4.5)	17	21.3 (4.5)
Child belongs to clubs, teams or organizations	82	31	37.9 (5.4)	51	62.1 (5.4)

		Less active		Average		More active	
		f	%/ se	f	%/ se	f	%/ se
Child is active in these clubs etc. compared to peers	31	3	8.9 (5.1)	14	44.6 (8.9)	14	46.5 (9.0)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Table 9-3 Child's Report of their Social Competence with Peers, Caregiver, and in School

		No Friends		1-3 friends		4 or more	
	N	f	%/ se	f	%/ se	f	%/ se
Number of close friends	81	2	2.7 (1.8)	38	47.5 (5.5)	40	49.8 (5.6)
		Less than 1 time a week		1 or 2 times a week		3 or more times a week	
		f	%/ se	f	%/ se	f	%/ se
Does things with friends out of school	76	34	44.2 (5.7)	21	27.0 (5.1)	22	28.8 (5.2)
		Worse		Average		Better	
		f	%/ se	f	%/ se	f	%/ se
Compared to peers, how well does child get along with siblings?	78	2	2.0 (1.6)	43	55.4 (5.6)	33	42.6 (5.6)
Compared to peers, how well does child get along with other kids?	79	4	4.4 (2.3)	43	54.4 (5.6)	32	41.2 (5.5)
Compared to peers, how well does child get along with caregiver?	80	1	1.5 (1.4)	36	44.2 (5.6)	44	54.3 (5.6)
Compared to peers, how well does child do things by themselves?	82	2	2.6 (1.8)	40	48.3 (5.5)	40	49.1 (5.5)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Table 9-4 Child's Report of Life Skills (N=37)

	No to mostly no		Somewhat		Mostly yes to yes		Mean
	f	%/ se	f	%/ se	f	%/ se	
Knows where to go to get on the internet	2	4.7 (3.5)	4	10.1 (5.0)	31	85.2 (5.8)	4.50
Can find what they need on the internet	1	2.6 (2.6)	5	12.3 (5.4)	31	85.1 (5.9)	4.53
Knows how to use email account	1	3.5 (3.0)	2	5.1 (3.6)	34	91.4 (4.6)	4.67
Can create, save, print and send computer documents	3	7.7 (4.4)	2	6.6 (4.1)	32	85.6 (5.8)	4.55
Knows the risks of meeting someone in person that they met online	1	3.5 (3.0)	0	0.0 (0.0)	36	96.5 (3.0)	4.82
Would not post pictures or messages if they thought it would hurt someone's feelings	5	12.8 (5.5)	3	6.8 (4.1)	30	80.4 (6.5)	4.23
If someone sent them a message that made them feel bad or scared, they would know what to do or who to tell	1	2.6 (2.6)	3	7.5 (4.3)	33	89.9 (5.0)	4.69
They know at least one adult, other than their caseworker, who would take their call in the middle of the night if they had an emergency	8	21.2 (6.7)	0	0.9 (1.5)	29	78.0 (6.8)	4.07
An adult they trust, other than their caseworker, checks in with them regularly	5	14.4 (5.8)	3	7.7 (4.4)	29	77.9 (6.8)	4.18
When they shop for food, they take a list and compare prices	21	57.6 (8.1)	3	9.2 (4.8)	12	33.2 (7.7)	2.52
Can make meals with or without using a recipe	7	20.2 (6.6)	6	16.0 (6.0)	24	63.8 (7.9)	3.80
Thinks about what they eat and how it impacts their health	13	34.2 (7.8)	5	14.4 (5.8)	19	51.4 (8.2)	3.18
Understands how to read food product labels to see how much fat, sugar, salt, and calories food had	8	21.2 (6.7)	3	9.4 (4.8)	26	69.5 (7.6)	3.89
Knows how to do their own laundry	2	6.7 (4.1)	0	0.0 (0.0)	35	93.3 (4.1)	4.63
Keeps living space clean	3	8.6 (4.6)	7	17.9 (6.3)	27	73.5 (7.3)	4.12
Knows the products to use when cleaning the bathroom and kitchen	2	5.8 (3.9)	3	8.4 (4.6)	32	85.8 (5.7)	4.51
Knows how to use a fire extinguisher	11	29.7 (7.5)	3	7.0 (4.2)	23	63.3 (7.9)	3.67
							Overall: 4.15

Note. All analyses used weighted data. The sample sizes presented are unweighted.

Table 9-5 Children's Life Satisfaction (Age 8 to 12) (N=97)

	Level of Life Satisfaction										
	Very Low Rating		Low		Neutral		High		Very High Rating		
	f	%	f	%	f	%	f	%	f	%	Mean/ se
Overall rating of life[a]	0	0.0	0	0.0	19	19.8	39	40.0	39	40.3	4.2 (0.08)
How well is your life going?[b]	1	1.1	4	4.4	17	17.6	45	46.4	30	30.5	4.0 (0.09)
How often do you feel that your life is just right?[c]	0	0.0	6	6.6	24	25.1	29	29.5	38	38.9	4.0 (0.10)
How often do you wish you had a different kind of life?[d]	16	16.7	6	6.3	12	12.8	14	14.5	48	49.7	3.7 (0.16)
How much of what you want in life do you have?[e]	5	4.7	5	5.2	22	22.9	35	35.9	30	31.2	3.8 (0.11)

Note. All analyses used weighted data. The sample sizes presented are unweighted. [a] 1= very poor to 5=excellent, [b] 1= not very well to 5=extremely well, [d]1=always to 5=never, [e] 1=None of what you want to 5=Everything you want.

We used adaptations of child measures from the National Institutes of Health Emotion Measures Toolbox[144] to assess youths' life satisfaction. Children aged 8 to 12 were asked five questions related to their satisfaction with life (see Table 9-5) and youths aged 13 to 17 were asked ten questions (see Table 9-6). All questions utilized five point scales that were scored to range from lower to higher satisfaction (the exact wording of the choices depended on the question; see the footnotes in Tables 9-5 and 9-6).

On most items, a majority of children aged 8 to 12 gave high or very high ratings on life satisfaction. On the other hand, 35.8% reported always to sometimes wishing they had a different kind of life, and 32.8% that they had none of what they wanted in life to only some of what they wanted. Most adolescents also gave high to very high ratings on most life satisfaction questions. However, 39.4% of adolescents rated their life as very poor to fair, and 47.0% rated their life situation as very poor to fair.

Youths aged 10 and older answered a series of questions about their future expectations for their life (see Table 9-7). Over 90% of youths anticipated graduating from high school. About half of youths thought there was some chance to a 50-50 chance that they would marry by age 25, while 21.3% thought it pretty likely to definite. A large majority of youths thought they would have a good job by age

[144] Health Measures (2018). *Emotion measures: NIH Toolbox Emotion Batteries*. Webpage. Evanston, IL: Northwestern University. Retrieved from http://www.healthmeasures.net/explore-measurement-systems/nih-toolbox/intro-to-nih-toolbox/emotion.

30 and would live to age 35. Over one-fifth of youths (13.7% of girls and 32.6% of boys) thought there was some chance or even likely that they would have a child before age 18.

Table 9-6 Adolescents' Life Satisfaction (Age 13 to 17) (N=48)

	Level of Life Satisfaction										
	Very Low Rating		Low		Neutral		High		Very High Rating		
	f	%	f	%	f	%	f	%	f	%	Mean/ se
Overall rating of life	1	2.7	2	4.1	15	32.6	17	35.9	11	24.7	3.8 (0.14)
How would you rate your life situation?[a]	1	2.6	6	12.9	15	31.5	17	36.8	8	16.2	3.5 (0.15)
How well is your life going?[b]	0	0.7	5	11.3	13	28.3	22	47.7	6	12.1	3.6 (0.13)
How often do you wish you had a different kind of life?[c]	14	28.7	9	18.4	11	23.6	6	13.3	8	16.0	2.7 (0.21)
How often do you feel that your life is just right?[c]	6	12.0	8	17.3	12	26.3	11	23.7	10	20.8	3.2 (0.19)
If you could live your life over, how much of it would you change?[d]	10	20.4	10	22.2	13	27.0	8	16.5	7	13.9	2.8 (0.19)
How many of the important things you want in life have you gotten?[e]	1	2.0	13	28.1	16	33.8	15	31.2	2	4.8	3.1 (0.14)
How much of what you want in life, do you have?	0	0.7	10	21.5	16	33.9	17	36.6	3	7.3	3.3 (13.5)
How satisfied are you with your life?[f]	2	3.3	6	12.1	12	25.8	20	42.0	8	16.8	3.6 (0.15)
How close to perfect is your life?[f]	10	22.2	10	20.3	17	36.1	8	18.0	2	3.4	2.6 (0.16)

Note. All analyses used weighted data. The sample sizes presented are unweighted. [a] 1= very poor to 5=excellent, [b] 1= not very well to 5=extremely well,
[c]1=never to 5=always, [d] 1=none of it to 5=all of it, . [e] 1= none of them, to 5 all of them., [f] 1=not at al to 5=extremely.

Table 9-7 Child's Future Expectations

		No chance		Some chance to about 50-50		Pretty likely to it will happen	
	N	f	%/ se	f	%/ se	f	%/ se
Chances of graduating high school (10+)	99	0	0 (0.0)	9	8.7 (2.8)	90	91.3 (2.8)
Chance of being married by age 25 (10+)	94	28	29.6 (4.7)	46	49.1 (5.2)	20	21.3 (4.2)
Chances of living to age 35 (10+)	99	2	2.3 (1.5)	13	13.1 (3.4)	84	84.6 (3.6)
Chances of having a good job by age 30 (10+)	96	1	0.9 (1.0)	14	15.0 (3.6)	81	84.1 (3.7)
Chances of having a family when older (10+)	97	4	3.7 (1.9)	37	38.5 (4.9)	56	57.8 (5.0)
Chances of having a child before age 18 (10+)	99	75	76.9 (4.3)	18	18.1 (3.9)	5	5.1 (2.2)

Note. All analyses used weighted data. The sample sizes presented are unweighted.

There are concerns however. First, not all children and adolescents reported life satisfaction; a substantial minority said their life was no better than fair. These youths deserve greater attention. Second, some had future expectations that were cause for worry—some thought they would die before age 35 and a disproportionate percentage thought they would have a child before age 18.

Third, one may be skeptical about children's positive reports of resilience in this chapter, given the difficulties they have been through, and the challenges to their physical health, emotional and behavioral health, education and safety that are detailed in other chapters. Previous research also suggests that only a minority of child maltreatment victims achieve resilience. It is sobering to consider the contrast between the skills and positive expectations youths report in this study, and the major challenges with daily functioning and difficulties with independence that many youths aging out of foster care experience.

Youths in this study may not have been entirely candid. One limitation of our study is the paucity of information from caregivers and caseworkers on children's resilience, which might corroborate children's reports. It also possible that youths are providing honest self-appraisal that is more positive than others' appraisals of them. Their history of living in a maltreating environment and being placed in foster care may lead them to have reduced expectations from others and from their environment. What they do have in potentially hostile environments is themselves and their belief in themselves. Having lower expectations from their environment and greater reliance on themselves may influence their report of their satisfaction and their ratings of the competence and skills. Their ability to think well of their life and themselves in the face of objectively limited functioning and challenged environments may be a strength.

Much more needs to be learned about the resilience of children and adolescents in out-of-home care. This may be a fruitful direction for additional research using the well-being study data set.

Discussion

The results presented in this chapter provide positive news about children's resilience. Large percentages of these children reported that they had adults they could turn to. Most children reported involvement in sports, hobbies, and jobs or chores, and some in clubs and other organizations. Almost all children and youths said they had close friends, and almost half had four or more. Large majorities reported having a range of daily living skills. Most children and adolescents reported satisfaction with their life, although meaningful proportions were dissatisfied or only marginally satisfied. Most children had positive expectations for their life. Most expected to live to at least 35, to avoid having a child before age 18, and to graduate from high school, get a job, and get married.

If these data are valid, this suggests that children and youths have strengths to count on to deal with the stresses and difficulties of experiencing child maltreatment, being removed from their home, and not yet having a permanent home to return to. Any policies and programs designed to enhance the well-being of children in care should build on these strengths. These results also suggest that their life in out-of-home care may support their resilience by facilitating their access to caring adults and to normal positive life experiences that could be out of reach if they lived in homes in which they were maltreated.

Chapter 10

Conclusion

The 2017 Illinois Child Well-Being Study identifies strengths shared by many children and youths in out-of-home care. According to data collected from caregivers, most young children appeared to be developing normally. A majority of infants and toddlers were receiving interventions to help them with their development and a large proportion of young children were in Head Start and preschool. Most children were described by caregivers as healthy. A majority of children and youth did not appear to be burdened with emotional and behavioral problems. Most reported being at grade level in school and reported positive behaviors and experiences there. Most appeared to be safe in their placements. Most had good relationships with caregivers and other adults from whom they gained support. Majorities of youth reported being involved in sports, a job or chores, and some were involved in clubs and other organizations. Most reported satisfaction with life, felt they had skills they would need for independence, and anticipated a positive future.

Yet many of our findings should provoke concern. Many children and youth are struggling. Large minorities from 20% to 40% or more had difficulties in every well-being domain we assessed. Caregiver data indicated that many young children had developmental delays and a notable minority of children and youth had special needs. Caregiver data suggested that almost half of children had a serious or chronic health problem. Almost half of children reported an injury in the last 12 months and a quarter had seen a doctor about an injury. A large percentage of children had emotional and behavioral problems at clinical or near-clinical levels. Substantial proportions of adolescents were involved in substance use and engaged in risky or delinquent behaviors. A number of children reported having sex against their consent. Many children had had to change schools frequently because of placements, a number had been absent a lot, and worrisome proportions had detentions and suspensions at school or poor school performance. The proportions were about one third for each of the following indicators: performing below grade level, being identified with a learning problem, and being classified as needing special education. Though a large majority of children wanted visits with their birth parents, visits from parents were sparse in many cases. A substantial minority of children and youth rated their lives and their life situation as very poor to fair

It is good news that children often received the services and supports they needed. While caregivers reported developmental delay in many young children, many were reportedly receiving developmental interventions and most were in preschool. Caseworkers reported that large majorities of children received the health services they were referred to. A large proportion of children and youth with emotional and behavioral problems were receiving a mental health service. Most children reported receiving support from their caregiver and having a positive relationship with their caseworker.

Gaps in service delivery remain however. Many young children with developmental need were not receiving developmental interventions. Despite a policy of enrolling every young child in care in preschool, 19.2% of 3 to 5 year olds were not enrolled. Likewise 14.7% of children and youth with a mental health need were not receiving mental health services. The injury data also raise questions about

whether injury prevention interventions are needed for children in care. More needs to be done to address the educational difficulties many children in care have, such as changing schools, poor attention, poor attendance, behavioral difficulties at school, and poor academic performance.

Differences by Placement Setting, Region, Race-Ethnicity and Sexual Orientation

We need to be aware of how children and youth's well-being differs depending on what placement setting they are in. One persistent theme is the substantially greater difficulties of children in group homes and residential treatment. They were more likely to have experienced various forms of violence than other children in the sample. They were more likely to have special needs. They were substantially more likely to experience a number of different mental health problems, and to engage in substance abuse, delinquent behavior as well as sexual behavior that may place them at risk. Children in specialized foster care also had higher rates of mental health problems, though not higher rates of substance abuse or delinquent behavior. Though most children in group homes and residential treatment saw their birth parents, they were more likely to experience distress after these visits than other children.

We are unable in the current study to determine to what extent the problems of youth in group homes and residential treatment and specialized foster care predated their placement, although it is likely that these are long-standing difficulties that help explain why they were placed in these more intensive settings. We also cannot determine whether their placement help ameliorate their problems or exacerbated them.

A number of findings suggest that the well-being of children in kinship care was in some ways better and in some ways worse than the well-being of children in traditional foster care. Children in kinship care were more likely to see old friends, and less likely to need to change friends as a results of their move. They were more likely to see their birth mother at least once a month, and more likely to have contact with their birth father. Kin caregivers were also more likely to have contact with their birth mother. However, some children in kin care reported being spanked, but no child in traditional foster care did. In addition, children in kinship care were less likely to receive developmental interventions, even though the ASQ scores suggest that their need for developmental intervention was similar. We need to be cautious about interpreting difference by placement setting, because there were often small sample sizes of children in group homes and residential treatment and specialized foster care. One consequence is that the percentages and averages found are very inexact estimates. Nevertheless, many differences we report are large enough to be statistically significant despite small sample sizes, suggesting that we can be confident that they are probably not a result of chance. These differences between kinship care and traditional foster care should be explored more.

For the most part, the results did not differ by region or race-ethnicity. However, some differences are worth exploring. According to caregiver report, children in Cook County and the Northern region were much more likely to receive a developmental intervention than children in the Central and Southern regions. A number of children had Individualized Family Service Plans in Cook County and the Northern region, but none was reported to us for the Central and Southern region. According to our data, no child in the Southern region received therapeutic or educational daycare, none in the Central and Southern

regions received educational or therapeutic services at a center, and only children in Cook County were enrolled in Early Head Start. Our data are too limited truly to assess the delivery of developmental interventions to young children in different regions of Illinois, but these results suggest that further inquiry is warranted.

There were a few service delivery differences by race-ethnicity. African-American children received developmental interventions at similar rates as other groups, but they were less likely to receive educational or therapeutic services at home or at a center. White children were more likely to be referred for hearing screening or services than were African-American children. African-American students also differed from White students in certain ways. African-American students were less likely than White students to get a grade below C. White students, on the other hand, scored higher on a measure of school engagement than African-American students. It is difficult to interpret these results without more information. Additional research on early intervention and education should explore these differences.

This was the first IL-CWB study to assess sexual orientation and attraction; 21.8% of the youth age 12 to 17 who were interviewed reported an LGBTQ+ sexual orientation. This group consisted of only 13 youths, so we lacked statistical power to do a thorough analysis of their well-being compared to other youths. Nevertheless, some differences between the LGBTQ+ group and other youths were large enough to be statistically significant despite the limited sample size. Though the small sample size means that the results we obtained for this group cannot be considered exact estimates, the results suggest some of the challenges youth with an LGBTQ+ orientation may face. LGBTQ+ youths were significantly more likely to score high on self-report measures of negative mood, somatic (bodily) concerns, and thought problems. They were more likely to report often or always hating going to school. They were more likely to report having been beat up by an adult at home at some point in their life. It is possible that, by chance, this group happened to have more challenges. But it is also possible that these youths face negative reactions to their sexual orientation that make their life even more difficult than other youths in out-of-home care. We recommend more research specifically focused on exploring the well-being of LGBTQ+ youth in out-of-home care.

Limitations

This study has limitations that need to be taken into account in interpreting the results. As noted in the Round Two IL-CWB, we have a limited set of standardized instruments.[145] The study relied solely on data from caseworkers, caregivers and children themselves, and because of limitations in time and resources, was not able to access data from systems that measure well-being. Thus we lack data from early intervention and other programs for young children, from doctors' records, and from schools. Caseworkers, caregivers, and children themselves may possibly have biases that affect the results and have limitations on what they were willing to disclose.

[145] See Hartnett, et al. (2009), ibid.

We echo the Round Two IL-CWB in noting that the lack of repeated measurements means that we cannot measure change over time. We do not know if children are remaining stable in their placements and the system is progressing toward permanent placements. We do not know if children's physical, emotional and behavioral health problems improve over time, and whether they overcome the educational and life challenges they face.

Our knowledge is limited about the services and supports we studied. Many caregivers of young children reported that they were receiving developmental interventions, including many in the home, but we do not know what those interventions were and whether they were likely to be effective. We know that caseworkers reported that children were receiving health services, but we do not know whether children were receiving consistent monitoring and coordination of care when they had chronic conditions. We know that children are receiving mental health services, but we do not know the quality and "dose" of those services, how well matched they are to children's problems, and whether evidence-based practices are being used. Overall children report being safe from violence in their current homes, but we need to know more about the relatively high rates of physical attacks from others that children report, and the higher risk for older adolescents and those in congregate care. We know that most children report positive experiences in their substitute homes and positive expectations for their life, but we lack corroboration from other data sources that would give us full confidence that their reports are valid.

Ultimately, an omnibus study of well-being relying solely on data from caseworkers, caregivers, and children is limited. There are aspects of child well-being and especially of interventions to promote well-being that these informants will have limited information on and lack the expertise to report on reliably. We recommend in the future pursuing a well-being research program with a suite of small studies that examine specific aspects of well-being in detail, and include data from systems as well as from caseworkers, caregivers and children. We discuss this further below.

Similarity to Previous Well-Being Studies

The 2017 Illinois Child Well-Being Study uses essentially the same protocol as the Round Two IL-CWB from 2003 and the Round Three IL-CWB from 2004, enhancing the opportunity to compare the studies. There are also comparable results from the Round One IL-CWB. Throughout the report, we compared the current results with results from the previous IL-CWB studies.

The results are remarkably similar, both positive and negative. We cannot yet point to one result in the current study that differs substantially from a parallel result in the previous studies. In one comparison, the similarity was uncanny. The percentage of children in the clinical or borderline clinical range on the Child Behavior Checklist measure of problem behavior was 45% in 2001, 41.4% in 2003, 44.0% in 2004, and 41.6% in 2017-2018 (i.e., in the current study). Children in the current study were somewhat more likely to receive emotional and behavioral health services than in previous studies, but the difference was not large.

This raises questions about the value of future well-being studies of children in the care of DCFS. Does it make sense to do the same study repeatedly if we keep getting the same results? As we mention elsewhere in this chapter, the future of well-being research may be better served by a suite of smaller studies exploring individual well-being topics in greater depth and assessing more fully the nature and effects of interventions to promote well-being.

Now that I Know That, What Do I Do?

As we near the end of this report, we are reminded of a 1966 comic strip Charles Schulz wrote for the Peanuts cartoon series. The strip is accessible online, see https://www.gocomics.com/peanuts/1966/12/17.[146] Linus has been reading, and goes to share some new information he has learned with his sister Lucy. Linus says, "When Juliet asks 'O Romeo, Romeo, whereforth art thou Romeo', she is not wondering where he is. Rather she is commenting on the fact of his being named Romeo!" A befuddled Lucy looks out at readers and says, "Now that I know that, what do I do?". Readers who have made their way through this report may ask the same question: Now that I know that, what do I do?

In this section, we suggest a number of things to do. Our suggestions concern both the current report and future analyses of data from this study. Indeed, we think these suggestions are useful for all the Illinois initiatives we mentioned in Chapter 1 that measure the well-being of children in out-of-home care.

Advocacy for Children and Youths. Our findings indicate that many children in out-of-home care have a substantial need for services and they do not always receive them. These services and supports exist in several different systems: early intervention, education, health, and mental health. Children need advocacy in these systems. Advocates for children could use many findings in this report to support arguments to improve the response to children in out-of-home care in different systems. Numbers help underline appeals based on case narratives, and lend greater credibility to advocates when seeking to improve services and secure more funding.

Reality Check on DCFS Policy. DCFS has developed numerous policies and practices to support the well-being of children in out-of-home. Data from this study can be used to assess the implementation of these policies. This may help identify gaps in implementation, but it may also provide evidence that DCFS is carrying out policies effectively. Our finding that most children who have siblings in care are living with them provides evidence that DCFS is typically able to implement its policy on siblings. The finding that this is less likely with larger sibling groups illustrates an obstacle to full implementation of this policy. DCFS has a policy of providing early childhood education to all children in care aged 3 to 5, and the finding here that 80.8% of children in that age group are in Head Start or preschool suggests success implementing that policy—though there is still progress to be made. We recommend systematically cross-checking DCFS policies against results from well-being data.

---

[146] Gocomics.com (n.d.). Peanuts by Charles Schulz for December 17, 1966. Retrieved from https://www.gocomics.com/peanuts/1966/12/17

Well-Being Impact Statements. We are coining a colloquial term – the "well-being impact statement". Well-being data could be useful to help shape new programs and policies developed for the population of children in out-of-home care. Practitioners and policy could collaborate with researchers to develop "well-being impact statements" in the process of developing new initiatives.

Consider a hypothetical new initiative, for example, for DCFS to collaborate more closely with mental health providers serving children in care. A perusal of the current study suggests that a key step will be to reach out to guidance counselors and school social workers, a group that is providing a sizable proportion of the counseling children in care receive. Imagine a new effort to increase early intervention for young children in care with developmental delays. One would want to explore more our finding that caregivers are reporting a substantial percentage of young children receiving interventions in the home. Is that something that could be enhanced, supported, or supplemented?

We like to think of well-being research not as a product but as a process. A well-being study is not a report to be printed out and put on a shelf or a pdf to be tucked away in the far reaches of one's hard drive. A well-being study is a living, breathing process of seeking, producing, sharing and discussing empirical results among policy stakeholders, practitioners and researchers. Communication about results can arise in many ways, at many times, and in many settings. A legion of researchers have experience with well-being data on children in DCFS. A partial list of the institutions with experienced researchers includes Chapin Hall at the University of Chicago, Northwestern University, the Juvenile Protection Association, the University of Illinois at Chicago, the University of Illinois at Urbana-Champaign, Northern Illinois University, Southern Illinois University, and Aurora College. Many researchers work closely with DCFS and serve on advisory committees. We recommend that more opportunities for collaboration among researchers, policy-makers and practitioners be developed to enhance the process of considering well-being data in the development of policy and practice.

Guidepost to Future Research

The 2017 Illinois Child Well-Being study is well suited to help guide future research. It is very broad, covering many areas, but also very thin, exploring none of them in depth. The study raises more questions than it answers. It highlights children's strengths and needs without explaining how they developed, how these strengths and needs are affecting their lives, what helps them make use of their strengths and address their needs, what happens to their strengths and needs over time, and how interventions can help them. Many smaller studies could be developed to pursue these questions. We recommend that DCFS professionals, policy stakeholders, researchers, and students study well-being findings from this study and other well-being studies to craft plans for future research.

Appendix : Interview Measures

Table A-1 Caseworker Interview

Measurement Area	Measurement Name	Author/Publisher	Information Gathered
Characteristics**	N/A		
Risk Assessment*	Developed for NSCAW	Project-developed questions based on questions from Michigan, New York, Washington, Illinois, Colorado risk assessment forms and checklists	Factors determining case decisions, including prior history of abuse or neglect, caregiver substance abuse, domestic violence in the home, caregiver mental health problems, poor parenting skills, excessive discipline, and so forth.
Services to Child*	Developed for NSCAW, adapted for IL		Services child may have received, asked of all cases
Education	Developed for IL Wellbeing Study		
Adoption*	Developed for NSCAW		Adoption possibilities for children in out-of-home care; also factors that encouraged or discouraged the caregiver's decision about adoption
Living Environments*	Developed for NSCAW		History of child's living situations since investigation, including type of living arrangement and child's contact with birth parents
Caseworker Involvement*	Developed for NSCAW		Caseworker's individual involvement with case, including referrals made for family members, caseworker contact with siblings, number of contacts with service providers and family, and attitudes about service to family

Table A-2 Caregiver Interview

Measurement Area	Measurement Name	Author/Publisher	Information Gathered
Characteristics**		N/A	Gender, ethnicity, relationship to child, employment status, highest level of education, household composition
Child health problems, immunization, service needs and use**	Short form health survey (SF-12)	JE Ware Jr, M Kosinski, SD Keller - Medical care, 1996	General health and how well the respondent is able to do usual activities
Child dental, vision, and hearing services**	Child and Adolescent Services Assessment (CASA)	Burns, Angold, Magruder, Habib, Costello, & Patrick (1996)	History of health, injury, and disability status of child; services received by the child
Education	Developed for IL Wellbeing study		Special needs, testing and special education services, school attendance, grades, and discipline in schools
Delinquency	Developed for IL Wellbeing study?		
Behavior and social competence *	Child Behavior Checklist (CBCL), Vineland Adaptive Behavior Scale (VABS)	Achenbach, (1991b); Sparrow, Carter, & Cicchetti (1993)	Degree to which child exhibits different types of behavior problems
Developmental status	Ages and Stages Questionnaire (ASQ)	Brooks Publishing, 1999	Developmental and social-emotional screener
Mental Health service needs and use	Developed for IL Wellbeing study?		

Table A-3 Child Interview

Measurement Area	Measurement Name	Author/ Publisher	Information Gathered	Ages Included
Child Demographics**	N/A		Age, gender, ethnicity, placement type	All
Relationship with Peers*	Dissatisfaction Questionnaire for Young Children	Asher & and Wheeler (rev.), 1985	Success in making and keeping friendships; school adjustment; administered only to children in school (excludes home-schooled situations)	5 to 7
School Engagement*	Drug Free Schools (DFSCA) Outcome Study Questions	U.S. Department of Education	School achievement, student disposition toward learning and school; administered only to children in school (excludes home-schooled situations)	6+
Out-of-Home Care*	University of California at Berkeley Foster Care Study	Fox, Fransch, & Berrick, 2000	Adjustment of children in out-of-home placement, including concerns about how well they fit in with their foster family and how permanent they view the placement	6+
Depression*	Children's Depression Inventory (CDI)	Kovacs, 2003	All aspects of well-being, including behavior problems	7+
Exposure to Violence*	Violence Exposure Scale, Revised	Fox & Leavitt, 1995	Violence observed and experienced in the home	8+
Trauma*	Trauma Symptom Checklist for Children (TSCC)	Briere, 1996	Indicators of post-traumatic stress disorder	8+
Relationship with Peers*	Dissatisfaction Questionnaire for Young Children	Asher & and Wheeler (rev.), 1985	Success in making and keeping friendships; school adjustment; administered only to children in school (excludes home-schooled situations)	8+
Youth Activities*	Youth Self Report (YSR), Social Competence Scale	Achenbach, 1991a	Involvement in activities which may promote social skills or cognitive development	8+
Parental Monitoring*	Supervision-Child Scale from Fast Track Project	Dishion, Patterson, Stoolmiller, & Skinner, 1991	Extent to which the caregiver monitors the child activities	10+
General Life Satisfaction	NIH TB General Life Satisfaction Short Form	National Institutes of Health and Northwestern University 2006-2017	One's cognitive evaluation of life experiences and whether one likes his/her life or not	8-12, 13-17

Future Expectations*	Adapted from Expectations about Education, Employment, and Life Span section from the Adolescent Health Survey	Bearman, Jones, and Udry, 1997	Expectations related to children's life experiences	10+
Protective Factors*	Resiliency Scale – Long SCAN	Longscan, Runyan et al., 1998	Resources that a child has to facilitate resiliency	11+
Injuries*	Child Health and Illness Profile – Adolescent Edition	Starfield et al., 1995	Nature and extent of injuries in the past 12 months	11+
Relationship with Caregivers*	Rochester Assessment Package for Schools	Lynch & Cicchetti, 1991	Degree of supportive relationships between child and adult	11+
Child Maltreatment and Child Discipline*	Parent-Child Conflict Tactics Scale	Straus, Hamby, Finkelhor, Moore, & Runyan, 1998	Additional maltreatment information in order to better understand the effects of the severity and specific type of abuse	11+
Closeness to Caregiver(s)*	National Longitudinal Study of Adolescent Health, In-Home questionnaire	Carolina Population Center, University of North Carolina at Chapel Hill (2002)	Degree of supportive relationships between child and adult	11+
Satisfaction with Caseworker Services*	Developed for NSCAW		Degree of satisfaction with caseworker services	11+
Services Received* *	Developed for NSCAW		Factors that affect the service provision process; includes items administered only at Wave 4 for emancipated youth	11+
Youth Behavior*	Youth Self Report (YSR), Total Problems Scale	Achenbach, 1991a	Magnitude of aggressive behavior and impulse control	11+
Substance Abuse*	Youth Risk Behavior Survey (YRBS); The CRAFFT; The National Longitudinal Study of Adolescent Health	CDC (2005); Knight, Sherritt, Shrier, Harris, Chang (2002); Harris, Florey, Tabor, Bearman, Jones, and Udry (2003)	Misuse of controlled substances as associated with depression and maltreatment	11+

Sexual Activity*	LongSCAN	Runyan et al., 1998;	Early Sexual Activity	11+
Delinquency*	Modified Self-Report of Delinquency	Elliott & Ageton, 1980	Participation in delinquent or criminal activities	11+
Independent Living	Ansell-Casey Life Skill Assessment (ACLSA)	Casey et al 2010	Skills for independent living	14+

*In NSCAW II
**In NSCAW II, modified for Illinois