OFFICE OF THE INSPECTOR GENERAL

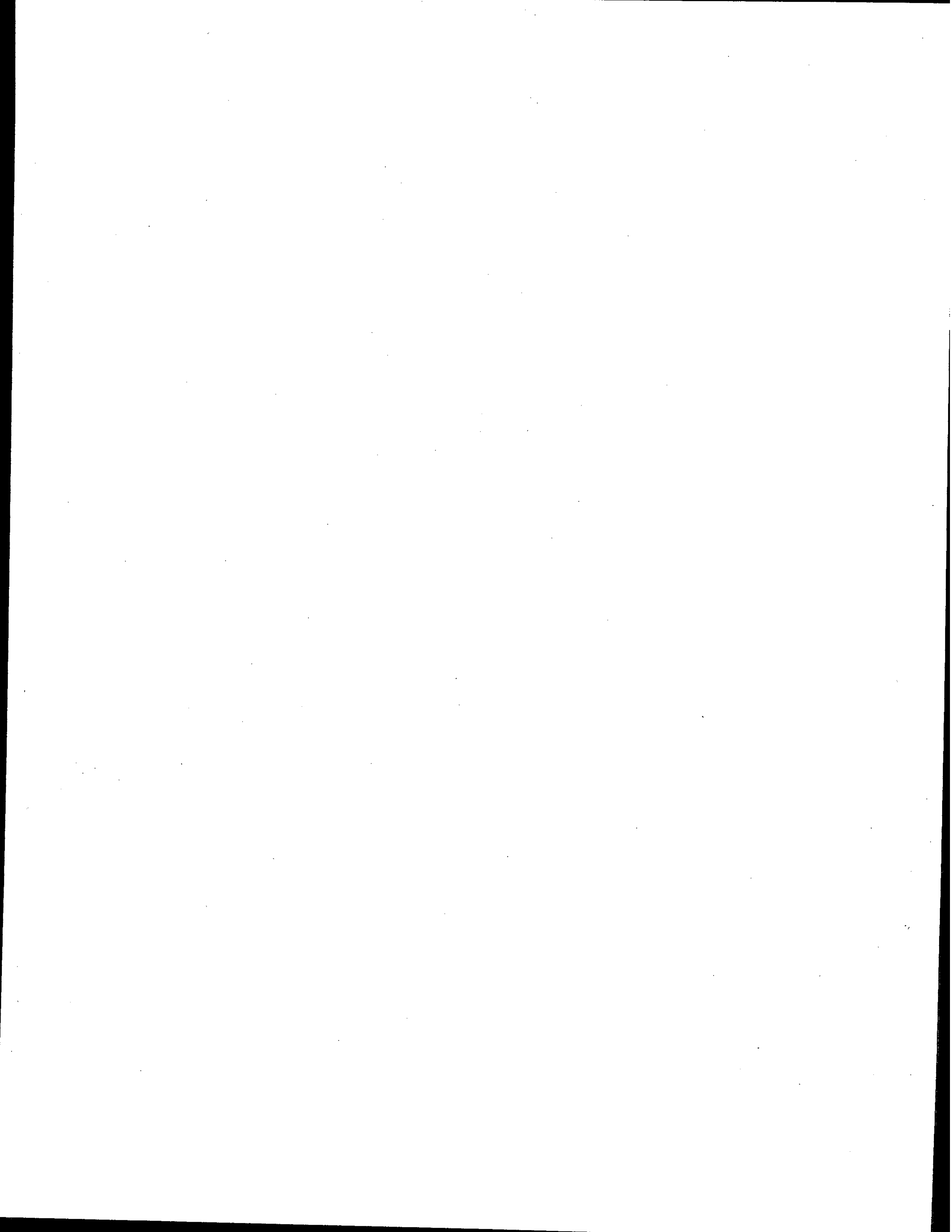
Illinois Department of Children and Family Services

REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY

Pursuant to 20 ILCS 505/35.5

January 1998

Denise Kane
Inspector General



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Dedication

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LETTER FROM THE INSPECTOR GENERAL

To the Governor and Members of the General Assembly:

Sunday is the day that I have the time to really "read" the newspaper. On Sunday mornings I turn to the book section and read all the book reviews. It is my moment of self reassurance. I imagine that my high school teachers would be proud of my small but gallant effort to expand my horizons. The October 26 Tribune's book review of Nicolaus Mills' *The Triumph of Meanness: America's War Against its Better Self* by Robert Schmuhl caught my attention. The title of the book review was "So long, Civility." In his book, Mills regrets the rise of "attitude" and the loss of objectivity and probing analysis in American journalism. This review struck a chord in me because the loss of civility and the substitution of marketing's popular "focus groups" for critical analysis has permeated the policy and management of child welfare. "Jerry Springerism" has become the acceptable practice over what used to be the disciplines of journalism, public policy, management, and ethics. Complex child welfare issues that present dilemmas and challenges are now reduced to no more than loud sound bites.

This growing disregard of a civil and disciplined analysis erodes the integrity of child welfare. It allows self interest or popular biases to reign over fiduciary duty. Rude, confronting or aggressive behavior becomes acceptable as expressive and more genuine than civility. This context of disrespect squelches the opportunity for even-handed arguments and alternative hypothesis building. Facing a problem squarely requires objectivity and a degree of commitment. And because the child welfare profession functions in a societally sanctioned decision-making capacity for abused and/or neglected children and their families, its objectivity is a required burden. On the clinical side, the child welfare professional is expected to rule out competing hypotheses and examine the behavioral requirements that accompany any decision. On the administrative side, the manager is required to strive above a narrow bureaucratic role if he/she desires a professional problem solving environment.

I have been told that a civilization is measured by its care of the very young and old. What I wasn't told was how civilly we do it is a good measurement of our ability to succeed.

I wish to thank Governor Edgar and the legislators for the opportunity to serve the public for another four-year term. I also wish to thank Ellen Mulaney, who for four years has worked pro bono on the development of our ethics project. Our office had to bid farewell to one of our investigators, Johnny Heath, who passed away this past Spring. We wish to dedicate this annual report to his memory. We all miss him.

With Warmest Regards,

Denise Kane
Inspector General

The OIG had requests to open 564 full investigations during FY 97 and 619 requests for technical assistance with criminal background checks.

I. OIG INVESTIGATIVE PROCESS

The OIG investigative process begins when the State Central Register notifies the OIG of a child's death or when a member of the general public files a Request for Investigation with the Office. Complaints and death investigations are screened to determine whether the facts suggest possible serious misconduct by a DCFS employee or private agency employee. If a complaint is accepted for full investigation, the OIG will initiate an investigation including a full records review and interviews of relevant witnesses. When the investigation is completed, the OIG prepares a report to the Director of DCFS with recommendations for discipline, systemic changes, or sanctions against private agencies. The OIG then monitors the implementation of the recommendations.

If a complaint is not appropriate for full investigation by the OIG, the OIG may refer the complaint to law enforcement (if possible criminal acts were committed), the DCFS Ombuds Office, or other state agencies such as the Department of Professional Regulation.

Confidentiality

While conducting investigations, care is taken to conceal the identity of the complainant. All information acquired during an OIG investigation is considered confidential and cannot be released outside of the Department except in compliance with applicable confidentiality statutes. The OIG's reports are not generally distributed outside of the agency and are shared within the agency only with the Director and those involved in implementation of the recommendations. The employee or private agency subject of the report may review the Report (with confidential information deleted) and have an opportunity to respond to it, prior to the imposition of any discipline or sanction, except where circumstances demand immediate action. In addition, the OIG has prepared several reports with confidential information deleted, for use as teaching tools for private agency or Department employees.

Impounding

The OIG is charged with investigating misconduct "in a manner designed to ensure the preservation of evidence for possible use in a criminal prosecution." To conduct thorough investigations, investigators often must impound files to ensure the integrity of records. Impounding involves the immediate securing and retrieval of records by the OIG. Once an investigator determines it is necessary to impound relevant DCFS or private agency case files, the investigator will consult with the OIG supervisor. When files are impounded, the investigator leaves a receipt for impounded files with the office or agency. Additionally, individuals with a need for information contained in the files may make copies of the necessary portions of the files in the presence of the investigator. Impounded files are returned as soon as practicable.

File Return Policy

When the Department transferred significant caseloads to private agencies in 1996, the Department did not retain copies of its files before transferring the files to private agencies. As a result, the OIG began instituting a policy whereby it makes an additional copy of all files impounded and returns originals to DCFS Legal to ensure that the Department maintains records.

Criminal Investigations

If evidence indicates that a criminal act may have been committed, the OIG will notify the Illinois State Police, Attorney General or other appropriate law enforcement agency. The OIG will assist the law enforcement agency with gathering necessary documents. If the law enforcement agency elects to investigate, the OIG will close that portion of the OIG case referred but retain the case on monitor status. If the law enforcement agency declines to prosecute, the OIG will determine if administrative action is appropriate.

OIG Reports

The OIG's reports are submitted to the Director of DCFS, pursuant to statute. The OIG also reports to the Governor's Office. An OIG report contains a summary of the complaint, an historical perspective on the case, including a case history and detailed information about prior DCFS contact with the family. An analysis of the findings is provided along with recommendations.

Monitoring

The OIG monitors implementation of OIG recommendations in preparation for the annual report. Future monitoring will be more interactive to ensure that OIG recommendations are implemented in their entirety and in a timely fashion. Monitoring may take several forms. The OIG may monitor to ensure that Department or private agency staff implement the recommendation or, the OIG may work directly with the Department in implementing recommendations calling for systemic reform. In addition, the OIG may incubate accepted reform initiatives within the OIG for future integration into the Department. Recommendations made to private agencies are generally monitored directly by the OIG or by the OIG and a representative of the Department's Agency Performance Teams. Results of monitoring of significant OIG recommendations are contained in this Annual Report.

Death Review

The OIG investigates all cases in Illinois in which a child has died where the child was a ward of DCFS, the subject of an open investigation or family case, or the subject of a closed abuse and neglect report or case within the last twelve months. Death investigations which resulted in major report recommendations are included in the Investigations Section of this Report.

Foster Parents contact the OIG Foster Parent Hotline by calling: 1 (800) 722-9124

II. OIG FOSTER PARENT HOTLINE

Pursuant to statute, the OIG operates a statewide, toll-free telephone number for foster parent access. Foster parents have called the hotline to request assistance in addressing the following concerns:

- Child Abuse Hotline information; Child support information;
- Foster parent board payments;
- Youth College Fund payments;
- Problems accessing medical cards;
- Complaints regarding DCFS caseworkers and supervisors ranging from breaches of confidentiality to general incompetence;
- Licensing questions; and
- General questions about DCFS and OIG.

The Foster Parent Hotline received 611 telephone calls in FY 97.

In FY 97, the OIG Foster Parent hotline received 611 calls. Of those, 508 calls were either directed to other agencies or referred to various offices within DCFS. The remaining 103 calls resulted in OIG investigations.

The Foster Parent hotline is an effective tool that enables the OIG to: communicate with concerned persons; respond to the needs of foster children; and address the day-to-day problems that foster care providers often encounter.

The Ombuds Office receives its inquiries through a toll-free number: 1(800) 232-3798.

III. OMBUDS OFFICE

This year marks the second year that the OIG has supervised the Ombuds Office. The primary purpose of the Ombuds Office is to maximize client and public accessibility to DCFS services and offices. The Ombuds Office also investigates and responds to inquiries, complaints, and concerns that relate to child welfare issues. The Ombuds Office ensures that recurring complaints or problems are addressed by the appropriate DCFS offices, bureaus, divisions, or staff. The OIG monitors the Ombuds Office through monthly meetings and case reports. The offices share case information and refer appropriate cases to each other. The OIG has been working with Ombuds to formalize responses to recurrent complaints, thus freeing

Ombuds staff to respond to more complex problems. For example, the Ombuds Office received numerous complaints regarding delinquent foster care payments. In response to these complaints, the Ombuds Office developed a referral system to streamline the process of receiving back payments and notifying the Department of the delinquent agencies. In FY 98, the supervision of the Ombuds Office will be transferred to the DCFS Office of the Guardian.

IV. RECOMMENDATIONS

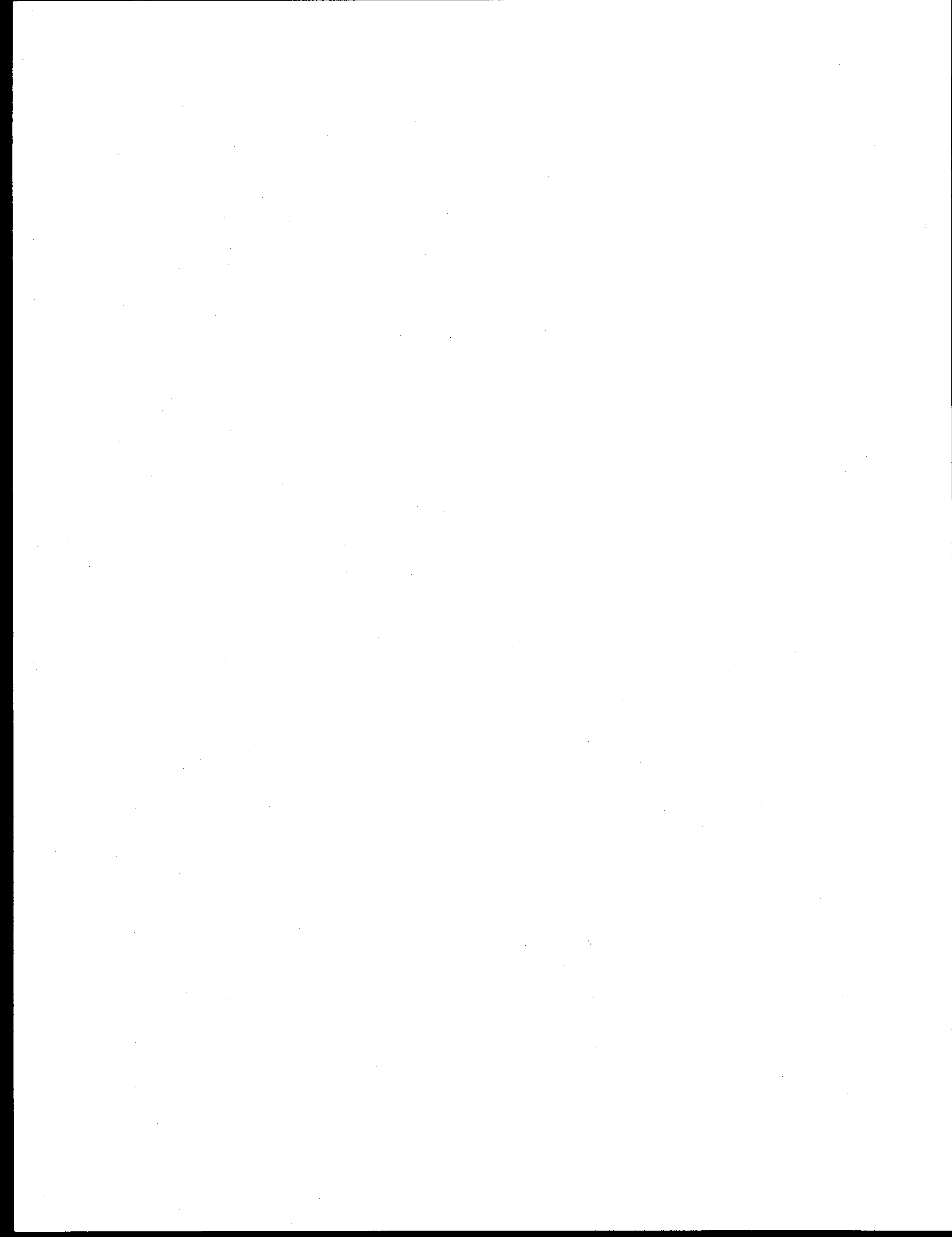
In formulating report recommendations, the OIG first determines whether an employee of the Department or private agency engaged in misconduct or poor casework practice. The OIG then assesses the misconduct or bad practice to determine whether to recommend discipline. Ideally, discipline should be constructive in the sense that it serves to educate an employee on matters related to his/her misconduct. However, it must be more than an educational opportunity. It must also function to hold employees responsible for their conduct. Hence, discipline should have an accountability component as well as a constructive or didactic one. Without the accountability component, there is little to deter misconduct. Without the didactic component, an employee may conclude that s/he has simply violated an arbitrary rule with no rationale behind it.

Once the decision regarding discipline has been made, the OIG will determine whether the facts suggest a systemic problem or an isolated instance of misconduct or bad practice. If the facts suggest a systemic problem, the OIG may investigate further to determine appropriate recommendations for systemic reform.

The investigations for FY 97 are divided into three major categories: Death Investigations, Private Agency Investigations, and General Investigations.

At the end of the report, reform recommendations are then organized into a format that allows analysis of recommendations according to the function of the child welfare system that the recommendation is designed to strengthen. The OIG is a small office in relation to the

Department of Children and Family Services. Rather than address problems in isolation, the OIG views its mandate as strengthening the ability of the Department and private agencies to perform their duties. The categories are: to promote child safety and protection; to address children's health and educational needs; to promote permanency for children; to develop and promote community resources "of sufficient quality" to meet the needs of children and their families; and to provide general support for child welfare casework.



INVESTIGATIONS

Death Investigations

Death Investigation 1

ALLEGATIONS

A three-year-old was drowned in the bathtub by her mother's paramour nine months after she was returned home.

INVESTIGATION

The mother had a history of substance abuse, but the children were returned home after the mother completed a substance abuse program and fully complied with services. Shortly after the return of her children, workers suspected that the mother had relapsed. Because of her long history of drug abuse, the OIG felt this was a case where concurrent planning should have been utilized (concurrent planning allows time for a parent to make efforts to have their children returned, but allows for other permanency options if the parent does not make progress within a reasonable time period).

RECOMMENDATIONS

(1) DCFS and private agency staff must be trained in the concept of "concurrent" or contingency planning for substance abuse cases.

(2) In order to provide as much continuity as possible in the provision of services, when a parent leaves one treatment facility and enters another, either for a continuation of treatment or in accordance with an aftercare plan, a collaborative service planning conference should be held with both providers.

(3) Caseworkers must determine if the parent has a significant relationship with an adult who will be in a caretaker position. These individuals must be considered in the return home plan.

(4) Thorough head to toe physical examinations should be given to children when they leave foster care and return home. During the examination, the physician should discuss with the parents developmental issues that are appropriate to the child's age.

(5) Representatives from the Legal Department of DCFS, the State's Attorney's Office, the Office of the Public Guardian and the Court should develop a policy to determine when and how to bring a parent who is in violation of an Order of Protection to the attention of the court.

(6) All children, prior to returning home, must be enrolled either in school or in an early childhood program such as Zero to Three or Head Start.

STATUS

(1) A new permanency goal specific to families showing signs of "high risk" or "poor prognosis" has been implemented through the Permanency Initiative. The new goal, Return Home through Concurrent Planning, emphasizes working toward family reunification while at the same time being prepared to plan for the adoption of the child. This information is included in the training materials accompanying the *Child Welfare Intervention Guide* used to implement the Permanency Initiative during training held November 3-5, 1997.
(2) The Department has developed the *Substance Exposed Infants Protocol for Clinical Practice and Collaborative Intervention*. Training implementation of the SEI Protocol is planned for Spring, 1998.
(3) The Department currently requires the consideration of all individuals associated with a household prior to the return home of a child. A current Child Endangerment Risk Assessment Protocol (CERAP) and in-home visit and assessment of all members, related or unrelated, of the household is required to ensure the safety of the child. This information is included in the training materials accompanying the *Child Welfare Intervention Guide*. This process will be further clarified in upcoming policy issues.
(4) The Department's medical requirements for aftercare include the following: not more than 30 days prior to reunification, the child should have a thorough physical examination by his/her health care provider to be used as a baseline; a subsequent medical exam should be scheduled for 30 days after the child goes home and then, medical checkups quarterly unless the doctor recommends that they are no longer necessary. (Subsequent physical exams should be measured against the baseline to evaluate ongoing physical well-being.) If at all possible, the child's medical provider should remain the same after the child returns home. The caseworker must request the results of all medical exams. The parent is to be present at the time of the exam. At the time of the exam, the parent and provider will discuss issues of ongoing care of the child. If the child was a victim of severe physical abuse or has a medically complex condition and the parent does not have the benefit of Medicaid, the requirement for periodic medical checkups must be included in the Aftercare ("wrap") plan. This information is included in the training materials accompanying the *Child Welfare Intervention Guide*. This process will be further clarified in upcoming policy transmittals.
(5) The Department agrees with this recommendation and is currently developing a policy addressing when and how to bring a parent who is in violation of an Order of Protection to the attention of the juvenile court.
(6) The Department is currently drafting a reunification policy to guide staff in evaluating and enrolling children in educational and developmental programs upon their return home.

Death Investigation 2

ALLEGATIONS

A two year old died from severe burns to over 70% of his body after falling into an "industrial-sized" pot of boiling water which his aunt had left sitting on the floor. The aunt was heating water on the stove because the home did not have a hot water heater. During the child's sixteen day stay in the hospital, the medical center social worker observed that the boy's mother and aunt visited only three or four times and did not display any grief or remorse. Medical center staff determined that the pot in question was actually only 12 inches in diameter. DCP failed to indicate the child's aunt for neglect until learning that the child would die and made no move to remove the other children in the home. Two weeks after the death of the two year old from the burn incident, his infant brother died from bronchial pneumonia. Temporary custody was then taken of the boys' sister and their cousin.

INVESTIGATION

The Chicago Police Department investigated and found that the family's story regarding the first child's incident was consistent and did not charge anyone with criminal abuse or neglect. The DCP worker had reported the size of the pot based on erroneous information she received from the Chicago Police Department which she had no reason to disbelieve. The Medical Examiner's report states that the second child died of natural causes and there was no indication to support a finding of neglect or abuse pertaining to him. However, psychological testing indicated that the aunt had significant intellectual limitations. Although the OIG investigation did not reveal a basis to criticize the investigator's failure to remove the other children, services were not offered on a timely basis to ensure the safety of the remaining children. These issues included environmental deficiencies in the home and the mental deficiencies of the mother and aunt and their minimal knowledge of parenting skills. Also, counseling should have been provided for the boys' sister who witnessed the accident and their mother.

After temporary custody was taken the children were placed with a foster mother who assumed the role of a model parent for the children's mothers. This foster mother invited the mothers into her home and worked with them personally on their parenting skills.

The investigation also revealed serious deficiencies of management in responding to complaints about this case. The Child Protection Manager missed two scheduled appointments to meet with the OIG regarding this case. The Public Guardian's Office reported that this Child Protection Manager commented that "these cases come and go." Since the Child Protection Manager made himself unavailable for comment, the OIG must accept the Public Guardian's version of the conversation. This behavior was unprofessional and could lead to an erosion of confidence in child protection services.

RECOMMENDATIONS

(1) The Department should develop a plan to help Child Protection Investigators assess potential environmental hazards.

(2) The OIG is participating in a Psychological Initiative project with the Department. The Initiative should ensure that psychological evaluations of developmentally disabled parents include testing of adaptive behaviors.

(3) The Department needs to address the gap in services that exists for those parents whose test results indicate intellectual deficits but at the same time present with levels of functioning that preclude their eligibility in specially funded programs for the developmentally disabled. Services need to be available to facilitate the return home of children and provide at least initial support after the return.

(4) The Associate Deputy Director in the Child Protection Division should meet with the Child Protection Manager and discuss with him the importance of acting professionally when dealing with the public and those in the child welfare field.

(5) The foster parent should receive a commendation letter from the Director for her commitment and excellent modeling of hands on parenting.

(6) In the event that a new home situation is found for the aunt, some of the aunt's "visiting" sessions with the foster parent should be moved to that home to see if she will generalize her behavior to this setting.

STATUS

(1) The Department will complete a plan to help workers assess potential household hazards by Feb 1, 1998.

(2) The Department will complete a review and revision of its current use of psychological evaluations by Feb 1, 1998.

(3) The Department is using an Independent Service Coordinator (ISC) agency, for assessment and determination of the appropriate services necessary for this population that is precluded from eligibility in programs for the developmentally disabled. In addition, assessment and referral for services were requested for the aunt and the mother. The mother refused services, but the aunt is engaged in and currently receiving services.

(4) The Department held the counseling meeting and included the OIG.

(5) The Department will send a commendation letter from the Director.

(6) The Agency Performance Team worked with the private agency to facilitate "visiting" arrangements.

Death Investigation 3

ALLEGATIONS

The OIG initiated this investigation in response to the death of a 15-month-old in the care of a home day care provider. According to the Medical Examiner's report, the child died of suffocation and blunt head trauma. The day care provider was charged with involuntary manslaughter. The OIG investigation focused on the Department's licensing role and relationship with the provider.

INVESTIGATION

The performance of DCFS licensing personnel in this case was inadequate. In 1989, the day care provider's 30 year old son was indicated for sexual penetration of a four year old child at the home, but was never criminally charged. A review to assess the day care license following the indicated finding did not occur until one year after the incident. The license remained active during this time. DCFS licensing personnel failed to perform a risk assessment or develop a safety plan or correction plan to address the fact that an indicated sexual offender was in the home. License revocation was never pursued. The provider's license expired in 1990, however ,she continued to care for children in her home. Between 1990 and 1996 DCFS staff visited the home several times to either investigate complaints or review license renewal applications. The son's presence or absence in the home was never confirmed. Department licensing documents were dated and signed three to six years after the actual licensing activity. While the Child Care Act requires annual visits by licensing staff, this requirement is not spelled out in the Department's Rules and Procedures. Thus, annual visits are not consistently made. In this case, annual monitoring visits were not conducted while the license was active.

The licensing division licenses day care providers and investigates complaints against licensed and unlicensed providers. An estimated 25% of staff time is devoted to investigating unlicensed providers. Such investigations result only in recommendations to the provider that they become licensed or referrals for prosecution. If referred for prosecution, the cases are rarely prosecuted. As a result, 25% of licensing time is spent investigating compliance with a law that is rarely enforced.

RECOMMENDATIONS

(1) The OIG recommended discipline and counseling for the licensing representative and her supervisor for failing to conduct monitoring visits, failing to perform a risk assessment or develop a safety plan or correction plan, lacking timeliness in their review, failing to initiate license revocation proceedings, failing to issue an administrative order of closure, failing to confirm the presence or absence of the indicated sexual offender in the home, failing to inform the provider of her licencing status, and dating and signing licensing documents three to six years after licensing activity.
(2) The license revocation process needs to be operationalized in both day care and agency and institution licensing. Clear and effective procedures should be developed and followed for those cases where there is a basis for license revocation.
(3) Unannounced annual monitoring visits of licensed day care homes should be required in the Rules and more frequent monitoring should occur when the licensed provider is under a corrective action or safety plan.
(4) Current structure and resources in licensing are inadequate to keep pace with the Department's responsibilities for both licensed and unlicensed day care facilities. If the Department cannot be relieved of its responsibility for investigations of unlicensed facilities, then consideration should be given to establishing a licensing team solely responsible for complaint investigations, intervention, and follow-up of licensed and/or unlicensed day care providers.
(5) While any individual may have the right to apply for a day care home license, there are applicants who are not eligible to have their license applications processed by the Department. Rules and Procedures should be amended to address, up-front, the eligibility of applications for day care home licensure.
(6) The Department should conduct a media campaign informing the public of day care licensing and encouraging families to verify licensure of day care home providers.

STATUS

(1) The licensing representative and supervisor were counseled regarding poor practice in this case. The disciplinary meeting for the licensing representative was conducted in November 1997.
(2) The Department is in the process of operationalizing the license revocation process. The targeted completion date is January 1998.
(3) Annual monitoring is required by the Child Care Act. While the Department's licensing rules require compliance with the Child Care Act, they do not specify what the Child Care Act requires. Thus, some workers may not understand that they are required to make annual visits. The Department agreed to clarify this and amend Rule 406 to specify the annual visit requirement.
(4) The Department will continue to explore options to ensure enforcement of findings from investigations of unlicensed day care providers or to determine whether a separate agency should be responsible for such investigations.
(5) Rules and Procedures will be drafted to provide guidelines for bars to applications.
(6) The Department will conduct a media campaign informing the public of day care licensing.

Death Investigation 4

ALLEGATIONS

A DCFS caseworker contacted the OIG because she was having difficulty finding a psychiatric facility to conduct an evaluation and make recommendations regarding visitation and reunification between a mother and son. The mother, who was mentally ill, had been found not guilty by reason of insanity for the murder of her daughter. The boy had been in a stable placement with his grandmother, but had been moved by the caseworker because the grandmother did not support the goal of reunification. The Adoption Act did not recognize the killing of the sister as a basis for unfitness because the mother had not been convicted.

INVESTIGATION

This case demonstrates a common misperception that services aimed at restoring children to their families must be offered in every case in which a child is removed. In some cases, a parent's conduct toward their children has been so egregious that there are no services towards reunification that are reasonable; the behavior alone may justify termination of parental rights. In addition, if the parents are untreatable or there exist chronic factors in the parent's functioning that are so complex that they defy reasonable treatment efforts, then alternative planning, including termination of parental rights, should be pursued. The OIG found that the Return Home goal set by the DCFS caseworker for this case did not appear to be based on a critical analysis of case facts. Rather, it appeared that Return Home was applied to this case as a matter of routine. After OIG intervention, this case was screened for adoption in July 1996, and proceedings began to terminate parental rights. The OIG assisted in arranging therapy for the son beginning in January, 1996. This case demonstrates the necessity to expand the grounds for parental unfitness under the Adoption Act to include a determination, in a criminal case, of not guilty by reason of insanity where the criminal charges resulted from the death of a sibling.

RECOMMENDATIONS

(1) The OIG supported SB 522 (now law) which amended the Adoption Act to include a finding of not guilty by reason of insanity for killing a sibling as a basis for a finding of unfitness.

(2) The Department should alter its Rules and Procedures to ensure that a return home goal is not automatically assigned to new cases without regard for the high-risk of harm to the child or the parent's capacity to change the problem that put the child at risk.

(3) The Department should develop specialized interventions with families who come to the attention of the Department and/or court because of mental illness of the parent.

(4) The Department should provide an adoption subsidy to ensure that the son's therapeutic needs are met in the future.

STATUS

(1) SB 522, which included these suggested changes, became law last year.

(2) DCFS has adopted a new set of permanency goals that provide a range of responses to family needs based on presenting conditions. Worker training on implementation of the new permanency goals printed in the *Child Welfare Intervention Guide* was held November 3-5, 1997.

(3) Parenting Assessment Teams (PATs) will be established in each region of the State to assist DCFS and the Juvenile Court in evaluating parenting capabilities of mentally ill parents who are alleged perpetrators of child abuse or neglect. Currently, two PATs are operating. (See discussion of Parenting Assessment Team, page 55.)

(4) The State's Attorney's office may withdraw their supplemental petition for termination of parental rights because the child has stated that he does not want to be adopted but would like to stay in his current placement long term. Without legal termination of parental rights, an adoption subsidy cannot be issued.

Death Investigation 5

ALLEGATIONS

A thirteen month-old died while in the care of his babysitter. The Medical Examiner's Office classified the death as a homicide and determined that the child died from shaken baby syndrome. The Department indicated the babysitter for the death, but not until a full year after the Medical Examiner's determination. The State's Attorney did not prosecute the babysitter criminally, but proceeded in Juvenile Court to attempt to have the babysitter's biological children removed from her care.

INVESTIGATION

The child that died while in the care of the babysitter suffered from a rare collagen disorder that frequently results in broken bones. The proceeding in Juvenile Court focused on whether and to what extent the child's disease contributed to his death. In December 1996, the court ruled that the State had failed to prove that the babysitter's children were at risk of harm or that the babysitter had abused the child who died. The child protection investigation presented exceedingly complex medical questions concerning the child's medical condition and his death. The DCP investigator failed to consult with the Department Medical Director, Dr. Paula Jaudes, who was hired in 1995 and is available to assist Department personnel with issues requiring medical expertise. The OIG learned that Dr. Jaudes receives few requests for assistance.

RECOMMENDATION

The Department should distribute reinforcing information to all investigators and workers concerning the availability of the DCFS Medical Director as a resource, the types of issues with which she can assist, and the procedures for contacting her or other medical professionals for consultation review of records.

STATUS

The Department issued a memorandum to all staff on 12/01/97 detailing the availability of Dr. Jaudes.

Private Agency & Contractor Investigations

Private Agency & Contractor Investigation 1

ALLEGATIONS

The OIG received complaints about employee practices at a private agency alleging 1) that employees improperly used the Law Enforcement Agencies Data System (LEADS) to perform criminal history checks for employment purposes; 2) that employees asked the Department to perform checks on employees for past records of child abuse or neglect, informing the Department that the checks were for prospective placements for children; 3) that employees falsified their academic credentials; 4) that child abuse and neglect history checks were not conducted on all employees; 5) that employees submitted personal references for each other to complete their personnel records; and 6) that there was inadequate staff supervision.

INVESTIGATION

At the time the allegations were received by the OIG, the agency and the Department were working together to implement a corrective action plan as a result of a prior OIG investigation. The new allegations also noted that the agency was given advance notice of the records to be reviewed by DCFS during the corrective action process. The new allegations implicated the validity of corrective action planning and implementation processes. This OIG investigation substantiated most of the recent allegations. The OIG concluded that the agency's problems were sufficiently serious to warrant a review of every child's case by DCFS. In addition, the investigation focused on the corrective action planning process which had failed to detect these serious problems. The investigation revealed that rather than identify specific tasks for the agency to perform, the Department had instead required the agency to contract with consultants to improve the agency. Thus, there was a failure to hold the agency responsible for the specific lack of management that had led to the first set of allegations against the agency.

RECOMMENDATIONS

(1) The Department needs to implement controls to prevent abuse of criminal history checks and child abuse and neglect history checks.

(2) DCFS should amend Rule 401 Licensing Standards for Child Welfare Agencies to include screening and hiring procedures; amend all FY 98 contracts to include hiring procedures; and, contact all service providers advising them of hiring procedures.

(3) When monitoring an agency's implementation of a corrective action plan, DCFS must verify agency reported compliance in all areas.

(4) DCFS should review all agency records to determine the reason for the agency's lack of timely checks for child abuse and neglect histories of employee candidates.

STATUS

(1) The OIG and the Department collaborated to develop new controls for the use of LEADS in performing criminal history record checks.

(2) The Department has sent licensing representatives to every licensed agency and verified the credentials of employees at those agencies. Rule 401 Licensing Standards for Child Welfare Agencies is being amended to include screening and hiring procedures.

(3) This agency is no longer under a Corrective Action Plan, however the agency has opted to continue with a hold on intake until a new executive director is hired. The Department has created a new unit, the Purchase of Service Monitoring Division, that, among other duties, will be responsible for the monitoring and enforcement of corrective action plans for private agencies.

(4) The agency implemented an administrative Employee Hiring, Screening, and Exiting Protocol to assure timely adherence to DCFS policy. The agency completed a review of all existing employee records to correct deficiencies.

Private Agency & Contractor Investigation 2

ALLEGATIONS

The OIG investigated a private therapist with whom the Department contracted for services. Allegations included the therapist calling a client's work place requesting personal information about the client from his supervisor, the therapist volunteering confidential information to the client's supervisor, the therapist instructing the client to bring him cakes and pies, and the therapist sending his two sons to the client's home to pick up something.

INVESTIGATION

The therapist was found to have called the client's supervisor as alleged, requesting and volunteering information inappropriately. The therapist had also instructed the client to bring him a pie and had sent his son and nephew to the client's home to pick it up. His written reports were rambling and unintelligible and his files contained projective "ink blot" tests not countersigned by a Ph.D. as required. The OIG also found that the therapist misrepresented himself as both a Ph.D. and as an L.C.S.W. In addition, the therapist was mistakenly assigned two service provider identification numbers which allowed him to be paid through a series of small contracts, thereby evading the higher scrutiny which is required for larger contracts.

RECOMMENDATIONS

(1) DCFS should review its resource databases to ensure that providers do not have more than one identification number.
(2) DCFS should not contract with this therapist for any services.

DEPT. OF PROFESSIONAL REGULATION REFERRAL

The OIG submitted a complaint against the therapist to the Department of Professional Regulation. On May 27, 1997, the Illinois Department of Professional Regulation ordered the therapist to "cease and desist" representing himself as an L.C.S.W.

STATUS

(1) There are four ways to create a provider ID: a) by Licensing when a license is issued; b) by the Home of Relative Payment Unit (HPU) when a home of relative foster care placement is made; c) by the Case Assignment Unit (CAU) and 906 Hotline staff when placements are made; and d) by any staff that processes a voucher for payment. At the present time, it is not practical to eliminate duplicate provider IDs in all cases due to limited capabilities of the outdated database system. There are about 110,000 provider IDs in the present data base. Duplicate provider IDs are now necessary in certain instances such as more than one agency placing children in a foster home and one provider having different types of licenses (e.g., day care and foster care). The current system contains an edit that will notify the data entry staff that the provider already has another ID. However, it will not prevent the creation of a duplicate ID. Currently, about 450 staff have the security clearance to establish provider IDs. By December 1, 1997, the security access to provider IDs will be significantly limited. Data entry staff will no longer be able to establish an ID and will be required to go to the Regional Business Manager or Administrative Services Manager to establish a new ID. This is expected to reduce the number of staff with the ability to create an ID to about 50. To address current multiple IDs, when there is movement on an ID such as an expiration or an application for new licensure, the Department initiates a search of all ID numbers associated with that social security number and clusters them together for reference. With the implementation of SACWIS, the information system that the Department is developing, one registration per provider will be a system requirement.
(2) DCFS no longer contracts with the therapist. No other sanctions were levied.

Private Agency & Contractor Investigation 3

ALLEGATIONS

The OIG investigated a residential treatment center for adolescent sex offenders after receiving a complaint about staff instability, training, and competency, including concern that there was sexual activity among the residents because of a lack of supervision. It was also alleged that the agency was involved with inappropriate Medicaid billing.

INVESTIGATION

The investigation concluded that staff training was inadequate. There was a high rate of turnover of staff at all levels. Treatment methodologies were inconsistent and unsupported by research in the field of sexual aggression. The youths' treatment plans were not individualized. The mixing of youth of different ages, sizes, intellectual functioning, and histories of aggression combined with inadequate staffing levels and training resulted in an unsafe environment. The facility placed a small, developmentally delayed 12-year-old ward in the same bedroom as an 18-year-old ward who had been adjudicated a delinquent minor for the offense of aggravated criminal sexual abuse for having anal intercourse with young males whom his mother babysat in their home. The facility also knew that the 18-year-old had a history of sexual activity dating back to age 11. Prior to being admitted by this facility, he was terminated from another residential treatment center due to numerous incidents of oral and anal sex with other residents even under the strictest conditions. Upon termination, that facility recommended that he be immediately placed in a secure, locked facility stating the outlook for treatment was poor. DCFS funds were inappropriately used to subsidize a consultant at a private school. Additionally, the OIG learned that one of the principals of the facility was a former Department employee in charge of the Request for Proposal process for residential sexual offender treatment programs. With the Department's knowledge, he was actively involved in developing his own residential treatment program while advising the Department on which entity should receive this grant. The investigation also revealed related parties transactions which, by contract requirement, should have been disclosed to the Department for review.

RECOMMENDATIONS

(1) The facility should develop a corrective action plan that includes the following: (a) develop training to ensure that all current and new staff are adequately trained in treatment procedures; (b) establish a behavior management system that complies with current DCFS regulations; (c) ensure that DCFS no longer pays for services provided through educational entitlements for youth qualifying for special education and ensure that all special education laws and regulations as well as DCFS educational policies are followed; (d) arrange for a program evaluation by outside evaluators competent in behavior management and sex offender treatment; and (e) develop a plan for recruiting and retaining competent staff at all levels.

Additionally, the Department should:

(2) continue contracting with this agency only under the conditions that the agency develop a Corrective Action Plan and the agency select and operationalize a new Board of Directors;

(3) issue a new Request for Proposal for residential and intensive outpatient services for sexually aggressive children and youth and conduct a neutral review of all applications;

(4) remove youth who are under fifteen years of age or have other vulnerabilities from this facility.

(5) Reconsider the use of unlocked residential facilities for sex offenders who have been adjudicated delinquent or found guilty of sexual acts; and

(6) continue reform efforts to involve law enforcement in investigations of sexual acts by minors that are of a criminal nature.

INVESTIGATIVE REFERRALS

The allegation of Medicaid fraud was referred to the Illinois State Police and the Attorney General's Medicaid Provider Fraud Unit. The OIG's additional financial concerns about related party transactions were referred to the DCFS Office of Internal Audits. The internal audit revealed that the facility had obtained a loan at a 25% interest rate from a recent member of the Board of Directors who was the owner of the for-profit management service the agency contracted with as well as the founder of the not-for-profit. That member's co-worker remains on the board.

STATUS

(1) A revised corrective action plan was completed by the facility following feedback from the OIG and Deputy Director of Operations and Community Services. The facility's plan documented a substantial improvement in its training and policy implementation. A member of the Department staff specializing in services to sexually aggressive youth and an independent evaluator have scheduled an on-site visit to evaluate the agency's compliance with OIG recommendations.
(2) To date, the board has seven members, three of whom were former members. One appears to have a related party conflict. Three additional members may come on in December. The Department and OIG will further monitor board development to ensure that all board members can provide genuine oversight.
(3) The Department has established a workgroup to look at the conversion of existing residential slots into Sexually Aggressive Child and Youth (SACY) slots incorporating SACY guidelines. The Department will contact former applicants with expertise with these youth to assure them that future contracting for this population will be conducted in an unbiased manner.
(4) DCFS conducted a clinical review of all cases. All but four wards under 15 years of age were transitioned out. Intake at the facility reopened May 1, 1997 under the stipulation that it no longer accept referrals for placement of children under age 15, and that it limit program capacity to 20 youth age 15-17 for a one year period.
(5) DCFS supports SB 789, currently before the legislature, which would give the Department the authority to license secure care facilities for children who are not adjudicated delinquent. The Department also will reexamine its practices regarding the placement of those youth who have been adjudicated delinquent or found guilty of sexual crimes.
(6) The Department continues to work with the OIG in revising Rules and Procedures relating to investigation, Unusual Incident Reports, and SACY.

Private Agency & Contractor Investigation 4

ALLEGATIONS

The Court referred this investigation to the OIG after it was forced to enter a finding of "no reasonable efforts" due to the failure of a private agency to provide necessary services to a ward with a developmental disability and his family. The Court had previously ordered the agency to refer the child's mother for counseling, test her for drug use, and enroll the child in appropriate special education, but it appeared that significant staff turnover prevented the agency from complying with the Court order.

INVESTIGATION

The investigation revealed that at the time the agency first received the case, caseworkers documented serious concerns about the 4-year-old ward's level of functioning. Rather than assist the foster mother in accessing the child's entitlement to remedial intervention to address his slower development, the agency took several months to arrange a psychological evaluation, which noted that the child had an IQ of 49 and was in need of immediate intervention. Again, the agency failed to act, but instead arranged for a new psychological to address the child's bed wetting. The agency boasts several educational and developmental specialists. In all, the agency failed to enroll the child in an appropriate educational intervention for 1½ years. Staff turnover on the case was high. The quality of Administrative Case Reviews (ACR) of the ward's case was questionable given the exchange of misinformation, and the number and gravity of issues that went unaddressed for nearly two years. In addition, the agency failed to take action on behalf of the minor when it learned of a possibly "botched" medical procedure on the child.

RECOMMENDATIONS

(1) The agency should thoroughly review and evaluate its casework services to the child, his mother and his foster parent to determine what went wrong, and submit a written report to DCFS of its findings and proposed measures to be taken to prevent the problems from occurring in other cases.

(2) The agency and DCFS should work together to complete an in depth analysis of the care being provided to children with disabilities.

(3) The agency needs to improve the services being provided to the client and his family in their attempts to reunify.

(4) The agency's case managers and supervisors must be provided with training to gain an understanding of developmental disabilities, early education programs, services addressing disabilities, and appropriate resources in the Chicago area.

(5) The "botched" medical procedure should be referred to the Medical Director of DCFS, the DCFS Guardian and DCFS Legal for evaluation.

(6) The Department should determine the credentials required for professionals who perform psychological evaluations on Department wards.

(7) The Department should require that every foster child under the age of five be screened for early childhood development, including but not limited to, vision and auditory evaluations.

(8) The Department should review and address the issue of payment to the agency for services not rendered to the ward.

(9) The Department should examine the limitations imposed by federal law on the use of federal foster care matching funds to pay for for-profit child care agencies and how these limitations are related to all private for-profit child placement agencies in Illinois.

STATUS

(1) The agency submitted a response to the investigation that reflected a lack of responsibility for the inaction and a lack of appreciation for the need of early intervention services to children with developmental disabilities.

(2) The OIG identified 168 children in this agency that were eligible for developmental screenings. The agency only scheduled 68 of these 168 for screening and only 41 of these children attended the screening. Of the 41 screened, 11 were found to be in need of further case studies for special education needs and 15 were found to be at risk of developmental delays and in need of monitoring.

(3) The child has been reunited with his family.

(4) The agency is currently working with the Department and the OIG to address this recommendation.

(5) This matter was referred to the DCFS Medical Director, and the DCFS Guardian. The DCFS Medical Director recommended that the case not be referred to DCFS Legal.

(6) The agency, the Department and the OIG are working on a corrective action plan to address the concerns presented by this investigation. The OIG and DCFS Clinical are coordinating a project to determine the credentials required for providers who perform psychological evaluations on Department wards.

(7) In response to the findings of this investigation, the OIG developed and is implementing a special project to ensure identification of wards in need of early childhood development screening and intervention. (See discussion of ChildFind Initiative, page 42.) In August 1997, DCFS increased staff to complete the remaining assessments and will explore the obstacles to the identification of children in need of special education services. The OIG requested a status report on the enrollment of the identified children in either special education or educational enrichment programs. The City of Chicago agreed to ensure that any child in need of an enrollment in an educational enrichment program will be accommodated.

(8) The Department paid for services to this child through a traditional foster care contract. An audit submitted by the agency indicates a deficit of $107,370 in the contract. DCFS will further analyze the audit and request additional expenditures detail from the agency to determine areas of overspending.

(9) DCFS Legal confirmed that the Department cannot get federal reimbursement for foster care payments to for-profit agencies. DCFS is strongly encouraging for-profit entities providing foster care to seek not-for-profit status.

General Investigations

General Investigation 1

ALLEGATIONS

The OIG investigated an allegation that a caseworker failed to comply with a court order requiring the removal of a 7-year-old ward from her placement after it was discovered that the caretaker was not, in fact, her father. The caseworker stated in Court that he did remove the child and place her with her grandmother in July. Four months later, however, allegations arose that the girl's sister was brutally beaten in the home of the purported father. During the DCP investigation of these allegations, it became apparent that the ward who was to have been removed in July had remained with the caretaker. When the 7-year-old ward was questioned about her sister's physical abuse, she disclosed allegations of physical and sexual abuse by three teenage males who were living in the home, the home from which the Court had ordered her removed. Following these disclosures, the grandmother stated that the caseworker never placed the ward with her in July and stated further that the caseworker contacted her and requested that she not disclose that he never placed the minor with her.

INVESTIGATION

The OIG investigation revealed that the caseworker failed to have any contact with the minor for the entire time that he was the assigned caseworker. He also failed to provide any services to the minor or any member of her family. While he maintained that he placed the minor with her grandmother in July, he did not document any visits to the grandmother's home or any casework services, including confirming that the child was enrolled in a school in her grandmother's district. The OIG found the grandmother credible in her account of the caseworker asking her to tell others that her granddaughter had been placed with her in July.

RECOMMENDATION

The OIG recommended the discharge of the caseworker.

STATUS

The caseworker's employment with the Department was terminated in February 1997. The caseworker filed a civil service complaint contesting his discharge, which is pending.

General Investigation 2

ALLEGATIONS

A DCFS client alleged that her caseworker sexually propositioned her in exchange for casework services, committed perjury by misrepresenting information regarding her in court, limited her visitation with her children after progress with service objectives and threatened that her children would not be returned.

INVESTIGATION

The OIG could not substantiate the client's allegations of sexual propositions by the caseworker. The investigation did reveal that the caseworker's supervisor failed to follow up on a complaint made by the client related to these allegations. The OIG also found that throughout the case, the caseworker presented the client in a negative light and misrepresented the Department services provided to the family and the client's performance of service objectives. During the time that the caseworker was managing the case, he failed to provide the majority of required services to the family as detailed in DCFS Rules and Procedures. The caseworker also refused to allow the client to have a copy of her own psychological evaluation, which she was entitled to. The OIG also concluded that the caseworker's supervisor failed to provide the caseworker with adequate supervision in several respects.

RECOMMENDATIONS

(1) The caseworker should be disciplined for his mischaracterizations of case facts to both the Court and at the Administrative Case Review (ACR).

(2) The caseworker should read and discuss with his supervisor and administrators a series of articles provided by the OIG.

(3) The supervisor should review and discuss the case work with the caseworker.

(4) The supervisor should meet with the Regional Administrator to discuss issues of employee performance evaluations, client complaints regarding caseworkers and the client's right to view his or her own psychological evaluation.

(5) The issue of employee performance evaluations and the disclosure of psychological evaluations should be raised at the next Supervisory Council meeting.

STATUS

(1) The disciplinary process in this case is pending. The region first initiated discipline against the supervisor relative to this case. The region is currently working with Labor Relations in drafting the charges against the worker for his poor performance on this case.

(2) The case worker was provided with the articles to be reviewed.

(3) The supervisor did discuss the critical issues and problems specific to his performance on the case.

(4) An administrative meeting was held at which time the Supervisor was given an oral reprimand for "failure of supervision" in regards to this case. All of the above issues were discussed with the Supervisor as well as her lack of guidance to the worker, lackadaisical response to the serious allegations against the worker, failure to understand the rules for the disclosure of psychological evaluations and for appropriate contents of employee performance evaluations.

(5) To effectively ensure that supervisors are familiar with the Department's policies regarding employee performance evaluations and disclosure of psychological evaluations, this information will be published in the December issue of *Supervision*, a Clinical Services Division newsletter for supervisors and managers. Supervisory Council meetings, when fully attended, include approximately 40 supervisors which is only about 1/9 of all supervisors.

General Investigation 3

ALLEGATIONS

The OIG investigated allegations that a caseworker had a sexual relationship with one of his clients and that he might be the biological father of the client's youngest child.

INVESTIGATION

The OIG did not find evidence to substantiate the client's allegations of a sexual relationship with the caseworker. The client's boyfriend was found by the court, as a result of a paternity test, to be the child's biological father. The allegations were first raised several months after the child's birth with the caseworker's supervisor after the caseworker began discussing adoption as a permanency plan for the client's children. The supervisor allowed the caseworker to remain on the case, despite the allegations.

RECOMMENDATION

In cases where a supervisor or administrator learns that allegations of sexual impropriety have been made by a client against a caseworker, the supervisor or administrator should document the allegations and any other information learned and forward the matter immediately to the OIG for investigation. The supervisor or administrator should immediately reassign the case from the caseworker against whom the allegations were made to a caseworker against whom such allegations are unlikely to be made again (e.g., if allegations are made by a female client against a male caseworker, the case should be transferred to a female caseworker).

STATUS

The Department agrees with this recommendation. A protocol to address sexual impropriety allegations against caseworkers by clients, transferring those cases to other workers and forwarding the information to the OIG for investigation will be established and published in the Employee Handbook.

General Investigation 4

ALLEGATIONS

In the past three years, the OIG has investigated many allegations of misconduct toward clients by DCFS Division of Child Protection (DCP) investigators. These allegations included, but were not limited to: propositioning clients for sex, propositioning clients for sex in exchange for favorable findings on DCP investigations, purchasing and consuming drugs with clients, using their position to supply Norman Funds (money) to clients in exchange for sexual favors, living with clients temporarily, having sex with underage clients, physically and/or sexually assaulting clients, and engaging in telephone harassment toward clients.

INVESTIGATION

Investigations of the above allegations were difficult. In many instances, the central, and sometimes only, witnesses in these investigations were the alleged perpetrator and the complainant. It has been difficult to determine whether or not the complaining witness was attempting to manipulate the system for a favorable finding by the DCP investigator, or if the knowledge of the complainant's history prompted a DCP investigator to identify the complainant as a "safe" victim, especially true when the client is a teen parent. Often, the setting of these interviews is at the complainant's apartment. Criminal arrests and convictions for prostitution, drug use, and/or deceptive practices, as well as prior DCFS involvement for allegations of child neglect, abuse, or substance exposed infants can further complicate an investigation. The issue has always been determining whether or not the complainant's past experience/exposure to the criminal justice network or sexual activity caused them to file a false complaint.

RECOMMENDATIONS

(1) In an effort to protect clients and investigators and avoid these allegations, DCP should require that male investigators be accompanied by a female investigator for the limited purpose of interviewing minor mothers under the age of twenty-one and female wards between the ages of twelve and twenty-one.
(2) Supervisors must assess the risk of assigning cases to investigators where there exists an element of vulnerability.
(3) The Department should conduct extensive in-service training for caseworkers on avoiding situations where the possibility of misuse of power or accusations of misuse of power exist.

STATUS

The Department agrees with all of the recommendations and will draft a policy initiative that details the advisability of such "double-teaming" when necessary.

General Investigation 5

ALLEGATIONS

The OIG investigated a complaint that workers routinely fail to retrieve court ordered psychological evaluations of parents or children involved with DCFS.

INVESTIGATION

The OIG found that a significant number of court ordered and court funded psychological evaluations conducted by were never collected from the Clinical Services Department, Cook County Juvenile Court. Thus, information critical to informed decision-making could not be integrated into family service planning. Failure to integrate critical information in a timely manner may have resulted in: increased risk to children who were left in abusive family situations or allowed unsupervised visits; prolonged foster care placement; or inadequate or inappropriate services. Sometimes, due to caseworker turnover, or lack of communication between the Department and private agencies, duplicative psychological evaluations would be ordered and performed without knowledge of the prior evaluations.

RECOMMENDATIONS

(1) Require case conferences to bridge multiple systems (juvenile court, hospitals, private child welfare agencies, treatment providers, etc.) when critical information is forthcoming that may affect permanency planning and delivery of services.

(2) Expand the Department's Management Accounting & Reporting System/Child & Youth Centered Information System (MARS/CYCIS) database capability to allow for increased access by private agencies.

(3) Train DCFS and private agency caseworkers on understanding the appropriate use of psychological evaluations.

(4) Develop policy, procedures and training in the understanding, purpose and use of an assessment of parenting ability compared to a psychiatric/psychological evaluation.

(5) Refer all the cases involved in this investigation to the Department's Division of Clinical Services of DCFS for review.

STATUS

(1) Family staffings must now be held quarterly, at each critical decision point, and a month prior to each administrative case review and permanency hearing. This information is included in the *Child Welfare Intervention Guide* used to implement the Permanency Initiative during training held November 3-5, 1997.

(2) Eleven agencies currently have access to the data base. Ten more will be added in December 1997, and by 2000 all agencies will have access to this information. With the implementation of SACWIS in late 2000, all agencies will have access to this information.

(3) Trainings on use of psychological evaluations have been held and are continuing for all DCFS and Purchase of Service (POS) staff. In addition to the training, consulting psychologists are now placed in DCFS field offices to provide consultation to staff around the use of psychological evaluations. A Central Region psychologist is in the process of being identified. Additional psychologists have recently been hired to provide assistance to POS agencies.

(4) The OIG and the Department have been working with the Clinical Evaluation Services Initiative (see page 44) to develop standards for use of psychological evaluations and to establish protocol for workers to assist them in determining when various types of psychological evaluations are necessary. In addition, through research and assistance from the DCFS Clinical Division, the Department seeks to establish standards for parenting assessments and use of visitation to enhance parent/child relationships.

(5) The OIG referred the cases to the DCFS Clinical Services Division. Eight cases were closed and twelve are currently under clinical review.

General Investigation 6

ALLEGATIONS

A ward had been listed as a runaway on the Child & Youth Centered Information System (CYCIS) even though he had been living in an unlicensed home for six months. The DCFS caseworker and the DCFS supervisor, as well as the child's guardian ad litem knew that the child was not on the run. It was also reported that the ward did not receive services that he was entitled to, and the caretakers were not paid for the care of the ward during the six month period.

INVESTIGATION

The caseworker and supervisor knowingly allowed the ward to live in an unlicensed foster home, albeit for good reason, and wrongfully identified the minor's status as runaway in the Department's tracking system. The caretaker family has since been licensed and have received board payments retroactive to the initial date of placement. The caseworker failed to expedite the foster home licensing of the family, did not document services and referrals he claimed to have provided during the time that the ward was living with the family, and admitted that services which were to be provided by him were not delivered. The OIG concluded that the caseworker's caseload of twenty cases was manageable and should not have been an impediment to properly servicing this case.

RECOMMENDATIONS

(1) The caseworker should be disciplined for failing to provide appropriate services to the ward.
(2) The supervisor should be disciplined regarding the unethical and problematic decision to enter knowingly false data onto the tracking system and failing to assist the worker with arriving at an appropriate way to handle a difficult situation.
(3) The Department should ensure that supervisors and caseworkers are familiar with Department policies regarding placement in unlicensed foster homes.
(4) The Department should ensure that the ward is given full consideration for a DCFS college scholarship.

STATUS

(1) The caseworker has a history of past discipline related to failure to perform duties and court no-shows. On August 22, 1997, a three day suspension was approved for his performance in another case. Due to multiple cases and charges currently pending against the caseworker, DCFS has been working with Labor Relations in the drafting of charges specifically related to this case.
(2) The supervisor was given an oral reprimand for improper handling of this case.
(3) The Department has worked diligently to address the issue of children who are placed in unlicensed, unrelated settings. As a result of this effort, the number of children who are placed in such settings has been reduced to less than 15% of the original number. Policy Guide 96.11 was issued September 1, 1996, to remind DCFS and private agency staff that it is Department policy to place children under age 18 only in licensed foster family homes unless the caregiver is a relative of the child and such relationship has been verified, and a safety check has been completed.
(4) The scholarship application will be initiated in the spring of 1998 by the supervisor. The Field Service Manager will ensure that the application is initiated by the supervisor.

General Investigation 7

ALLEGATIONS

The OIG was asked to investigate the non-payment of a Foster Parent Reimbursement claim submitted by a foster family related to a parasite they contracted from a foster child. The claim was in excess of $13,000.

INVESTIGATION

After being placed in a foster home, a foster child was diagnosed with giardia. The foster family members then also contracted the parasite. The foster child's medical costs were covered under the Department of Public Aid's Medicaid, but the foster family had no health insurance and had to pay for their own medical treatment. Medical costs for an emergency room visit and medications in 1985 totaled $182.66. The family was treated again in 1990 and in 1991. The foster mother also claimed that medication she received from the treatment caused her to develop blood clots and vein inflammation. She hired an attorney to pursue these claims, and was requesting an amount from the Department in excess of $13,000.

RECOMMENDATION

The Department should pay for the costs incurred in treatment of the giardia, $310.66. However, there was a substantial lack of evidence to support the claim that the medication caused the blood clots and vein inflammation which led to later surgery for the foster mother. Therefore, the OIG concluded that DCFS was not responsible for any of the hospitalization, surgery, or after surgery costs ($13,000) incurred for that condition.

STATUS

DCFS, through the Foster Parent Reimbursement Program, paid the foster family the amount of $310.66 for their past medical costs. The claim for $13,000, however, was denied.

OIG INITIATIVES

ADOPTION INITIATIVES

Many of the initial complaints that came into the Office of the Inspector General (OIG) centered around the Department's adoption practices. In the Summer of 1994 the Inspector General released its first study recommending several ways the Department could improve its adoption practices. Since that time the OIG has continued to prioritize adoption concerns and has piloted several projects that have contributed to shaping the Department's focus on permanency for children. The Adoption highlights of FY 97 are described below.

(A) Adoption Redesign in Cook County

On January l, 1997, the Director issued the Cook County Adoption Redesign Interim Procedures which institutionalized the reform measures that the Director, OIG, Cook County adoption supervisors, and Department consultants had begun the year before. This work extends adoption expertise throughout the Department by assigning an adoption liaison to each placement team while keeping them assigned to their adoption teams. Cases ready for adoption remain with the placement team instead of being transferred to an adoption team, as was the prior practice. Retaining the case on the placement team can provide more continuity for the child and free the adoption worker to provide adoption services for more children.

During the second half of the fiscal year, Adoption Redesign was woven into the fabric of both Subsidized Guardianship and Performance Contracting and it became a centerpiece of the Department's permanency efforts. The OIG worked to incorporate safeguards to ensure that adoption would be strongly considered as the preferred permanency goal for each child.

Based on the OIG's experience with the Kinship Permanency Planning Project, a mediation project that enabled families to choose permanency options for children in their family (described below), Adoption Redesign Family Meetings became the vehicle for permanency meetings with the family. As a result, in Cook County the adoption liaison attends family meetings with the placement worker and explains the permanency options for the child(ren). The OIG provided two family meeting training sessions in each Cook region for a total of 154 workers.

While these efforts carry the Department within reach of providing good permanency options for children, the OIG has found that often the process is based on the self-interests of the agencies to move toward their own goals and not what will bring the child to the greatest permanency. Analysis of numbers alone can never yield an answer to the question "What is the best permanency goal for this particular child?"

The OIG urges the Department to continue to provide training regarding the permanency options and to closely monitor the reasons cited for ruling out adoption.

(B) Adoption Clinical Review Panel

Sometimes adoption raises difficult issues about the appropriateness of a placement or the best plan for a child. There may be competing parties who wish to adopt a child. Sibling involvement may complicate a plan. Children require a certain level of care, and it may be unclear whether the caretaker who wishes to adopt can provide it. Caseworkers sometimes have difficulty evaluating alternatives for the child.

In January of 1995, an external clinical review panel was created in response to an OIG recommendation regarding disputed adoption cases. The panel consists of psychologists and child welfare clinical experts who volunteer their time to review case material and construct clinical recommendations for the Department's Clinical Division. (The Department provides a monthly stipend to cover the panel members' expenses.) DCFS, private agencies and the OIG are invited to refer cases to the panel. Prior to the creation of the panel there was no external clinical option.

In FY 97 the adoption panel held twenty-two discussions reviewing eleven cases. At least six of the cases required multiple review by the panel due to incomplete materials. Panel decisions are based on sound clinical practice. This service is available on a statewide basis.

(C) Investigation of Recruitment of New Adoptive Homes

Positive changes in state and federal law and state practices will soon present a major crisis for the child welfare system in Illinois if proactive measures are not taken. As state and federal law require a more rapid effort to identify children for whom it is in their best interests to terminate parental rights, the need for new adoptive homes multiplies. For instance, conservatively, in Cook County, approximately 15% (or 1000-1500) of the foster children freed for adoption will not be adopted by foster parents or relatives, and, therefore, need a new adoptive home. As the need for new homes becomes more severe, the problems of recruitment and new home development become more acute.

Over the last two years the OIG received numerous complaints regarding the Department's efforts to recruit new adoptive homes for waiting children. The nature of these complaints range from the discouraging attitudes of the staff who field calls of prospective adoptive parents to the multiple systemic log jams created by a tired, worn out system.

The OIG investigation of current recruitment efforts uncovered a costly ($800,000) and outdated system which goes through the motions of recruiting families, making reports and following procedures. The average length of time a family who expresses

interest in adoption waits is approximately nine months. A lead agency is currently responsible for much of the Illinois child welfare recruitment efforts. However, only 102 children were placed in adoptive homes during FY 97 as a result of this agency's efforts. This number includes children adopted by relatives or foster parents.

At the same time as Illinois is employing dated recruitment efforts, the adoption community across the country has been responding to the crisis for new homes by using innovative recruitment techniques that are effective in linking children with permanent families. (DCFS Office of Permanency Services recently began its own recruitment efforts because the lead agency's efforts were insufficient.)

The Inspector General, realizing the need for a new approach, recommended that the Department create a Request for Proposal (RFP) to be circulated throughout the not-for-profit community that would fund programs to use family friendly rapid response techniques with targeted recruitment strategies. This rapid response requires home studies to be completed in 90 days. The funded agency would not only recruit and refer families to other agencies, but would also have the capacity to develop homes and place waiting children. The RFP process could identify the best programs available to help Illinois meet its challenge and assure that children do not grow up in foster care because we did not find permanent adoptive homes for them.

No decision has yet been made by the Department as to whether it will go forward with the RFP. The OIG is working with the Department, however, to at a minimum identify adoption agencies capable, for the short run, of assuming responsibility for recruiting, training and completing 90 day home studies for families interested in adopting children in our foster care system.

The other major OIG recommendation regarding recruitment dealt with distribution and publication of the Illinois Adoption Listing Book of waiting children. This book is compiled by the same lead agency. Since a Listing Book is one of the best ways to let prospective adoptive parents know which children are available for adoption, copies must be available for the general public, and should be available both as hard copy and electronically. The OIG recommended a nearly ten fold increase in the numbers of books that are produced and distributed (from 600 to 5,000). Each branch library should have a copy of the listing book in their reference department, as should selected health care professionals, churches and organizational representatives across the state. Subscriptions to prospective adoptive families could also be made available. Other states have found their listing books to serve a critical component in their recruitment effort.

The simple act of providing accurate information about the child in a uniform manner and with an appropriate photograph for the book could be the difference in whether or not that child is presented to an interested family. Although there is a requirement that every eligible child should be listed, the OIG discovered that many children who are eligible for listing are not listed in the book. As of publication of this annual

report, less than 50% of the children needing homes were listed. A process for listing every eligible child must be in place. The book itself needs to be revised to provide uniform, attractive photographs of the children with accurate descriptions.

Chances for Children

The Inspector General joined with Judge Nancy Salyers, Presiding Judge of the Child Protection Division, Cook County Juvenile Court, to demonstrate one example of positive, involved recruitment for new adoptive homes. The Walter Payton Foundation was the major sponsor of this event. Other supporters included One Church One Child, Voices for Illinois Children, the African American Family Commission, and the Harold Marx Fund. This effort, *Chances for Children*, was held April 26, 1997 at the Juvenile Court of Cook County. Over 400 prospective adoptive parents attended along with 132 foster parents and staff who brought 150 waiting children. Close to 100 volunteers from the Court offices, the OIG and the general public transformed the Court into a carnival setting for the children.

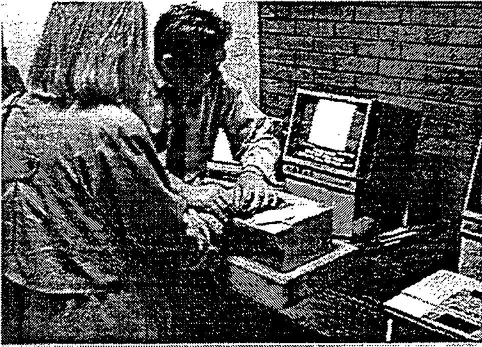
Ten workshops were held on general and specific topics related to adopting children who are DCFS wards and twelve agencies were represented in the information hall. Eighty-seven persons were fingerprinted during the event and 30 new families (49 individuals) entered into the licensing process afterward. While *Chances for Children* was not designed to be a "matching event," three children, to date, have been adopted as a result of meeting their adoptive parents at the event. Many in the adoption community were initially skeptical of the event, yet the evaluations from participants and the adoption community were overwhelmingly positive. The Walter Payton Foundation has been planning for next year's *Chances* event. The OIG will once again work with DCFS, private agencies, and the Courts to spearhead the second *Chances for Children* on Saturday, April 25, 1998. The new recruiting agency will then take over *Chances for Children* as well as organizing other events.

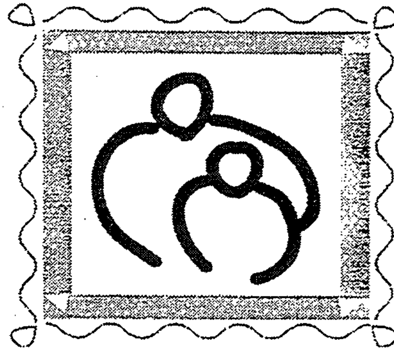
(D) Kinship Permanency Planning Mediation Project

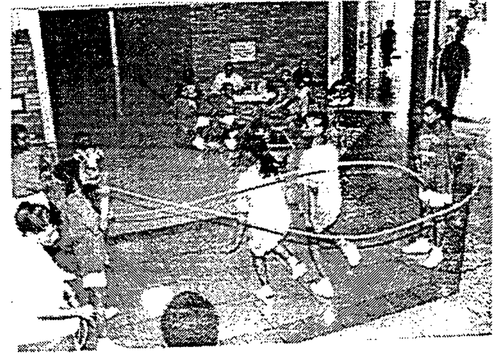
This project is a forerunner to the Department's current permanency efforts. The Project began after a 1993 study, by Mark Testa, Associate Professor, University of Chicago, determined that 67% of a focus group composed of relative foster parents might be interested in adopting their foster children but had not been given the option. At that time, the Department did not place an emphasis on permanency, nor did the Department allow birth parents to consent to adoption by a specific caregiver, thus bypassing the lengthy wait for termination hearings.

The Office of the Inspector General began the Kinship Permanency Planning Project in 1994 along with Northwestern Legal Clinic, Resource Alliance, Inc. (a mediation firm) and the Department. The project sought to bring permanency to families with relative care givers by helping them plan for their children's lives. In this process a family conference is convened by a mediator with the birth parents, relatives, caretakers, and significant others to discuss an appropriate permanent plan for the

Chances for Children


Potential adoptive parents initiating the licensing process by getting fingerprinted.




Broadview Double Dutch Team

The goals for Chances for Children are to recruit prospective adoptive families, to provide limited access to children who are available for adoption, to provide information about the adoption process, and to provide information and promote adopting children with unique and often severe needs.

"Voices" entertains young and old alike.

Save the date:
Chances for Children
April 25, 1998

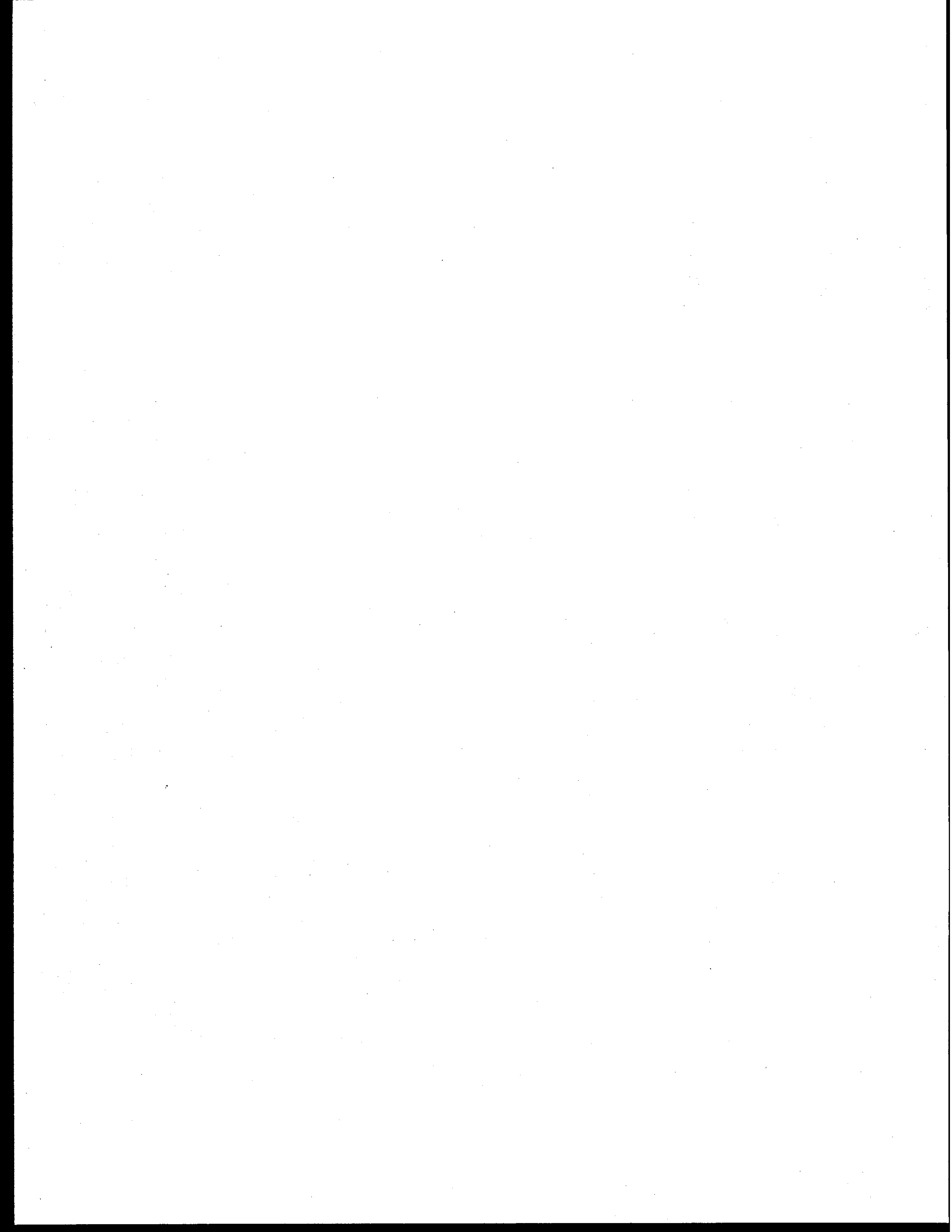
Children learn about exotic animals.

Informational Workshops

The information hall filled with potential adoptive parents.

Judge Salyers' personal touch.

JOHN HEATH/PHOTOS



child. Specially trained mediators (both RAI and DCFS staff) were available to provide this service and take the "specific consents". A "specific consent" allows a birth parent to agree to adoption by a specific individual. In the past, these consents were less frequent because some Department personnel believed that parents who had been indicated for abuse or neglect should not have any say regarding who adopted their children. This practice resulted in a lack of permanency for many children, since non-voluntary termination proceedings are time-consuming and backlogged. The Kinship Permanency Project was designed to identify those cases in which the Department and the indicated parent might agree on the best placement for the children. In three years of this pilot project there have been 1,336 referrals; of those, 915 have proceeded to mediation. Three hundred nineteen children are scheduled for finalized adoption, 51 children are now in Delegated Relative Authority, 53 children are still in the mediation process and 486 children's caregivers do not qualify for uncontested adoptions.

Today, taking specific consents from birth parents is an accepted practice and the need for families to come together to create a plan for their children is considered a preferred practice. This demonstration project has been internalized within the Department. The Legal Department of DCFS now receives referrals from caseworkers and together with the caseworker will determine which cases require mediation, which cases are appropriate for expedited adoption and which cases are appropriate for specific consent. The Project is available for children who are wards of the state and who have had a family meeting. The project conducts recent criminal background checks of the caregivers and all adults residing in the home to better assure the safety of children.

The OIG worked with the Department and many others to pass legislation that solidifies the practice of taking specific consents from birth parents during FY 97 (SB 522, see Legislation, page 52). Since specific consents are only valid for one year, the OIG initiated a multi-jurisdictional process to track all of the specific consents that will be taken across the state. This process will be centralized within the Legal Department of DCFS.

The OIG is pleased that this Project is now a part of the normal practice within DCFS, yet we realize that there must be safeguards in place so that the values that established the pilot are retained with the institutionalization. We encourage the use of family mediation whenever it can enable the family to create a permanent plan for its children.

(E) Diligent Search Center

The Office of the Inspector General, with the Northwestern University Legal Clinic, determined that diligent searches could be performed more efficiently if the function was centralized with technical equipment. Simultaneously, Illinois Action for Children approached the Director concerning the urgent need to find fathers earlier within the

process. As a result of these influences, in 1995, the Inspector General applied for and received a Housing and Human Services Adoptions Opportunities Grant to fund the first two years of a diligent search center. The Department sub-contracted with Illinois Action for Children to run the center in the Cook County Juvenile Center, where there are the highest number of cases requiring diligent searches.

Many lessons were learned during the center's first two years. Even though the center completed 600 searches the first year, referrals to the center began backlogging in the second year. One bottleneck was caused by the DCFS practice of sending certified letters to persons bearing the same name as the parent. The center incurred enormous expense and delay due to this practice. This problem became an opportunity, however, for the center's advisory council to question why the Department required certified letters. After researching the issue, DCFS Legal recommended that a certified letter only be sent to the last known address of the parent in question. It was at this address that the center most often found the parent. To further alleviate this backlog of cases, before a case may be referred to the diligent search center, the caseworker must now send a certified letter to the last known address of the parent, thus freeing center resources to focus on the more complex cases.

In response to new legislation, the Department will require searches when children are first brought into care as well as when termination of parental rights is recommended. DCFS Legal has decided to continue with one centralized center to conduct searches for both the front and back end of a case. The Department is currently developing a Request for Proposal for this work. The current center will transition the work and equipment to the selected contractor.

CASEWORK BEST PRACTICE: BEST PRACTICE FOR PERMANENCY PROJECT

The Inspector General continued developing innovative training based on principles of best practice for child welfare, focusing on four major initiatives: (A) courtroom testimony training, (B) coordinated services for substance affected families, (C) partnering with families for permanence, which includes concurrent planning, and (D) parenting skills training. These initiatives are described below.

(A) Courtroom Training

The OIG further refined its two-day training for DCFS and private agency supervisors and workers on skills for testifying in court. Over the course of the training, participants have many opportunities to get "on their feet" practicing techniques of talking with attorneys out of court, presenting the case in court, handling cross-examination, and supporting permanency goal decisions at permanency hearings. As a part of the Department's effort to use universities for continuing education for department workers, the DCFS subcontracted with the Loyola University Child Law

Program to conduct ten of these training sessions during fiscal year 1998. A total of 500-560 DCFS and private agency supervisors and workers will be trained through this program during fiscal year 1998. Response to the training has been tremendous.

(B) Coordinated Services for Substance Affected Families

We are learning from studies throughout the country that children placed in substitute care due to parental substance abuse, as compared with children placed for other reasons, stay in out-of-home placement longer, experience more changes in placement, are less likely to return home, and have lower rates of adoption. This is particularly true for minority children. Investigations by the Office of the Inspector General of child deaths involving parental substance abuse confirm these findings. Substance abuse affects as many as eighty percent (80%) of all cases of substantiated child abuse and neglect nationwide (Child Welfare League of America, 1990). For all of these reasons, addressing practice issues with substance abusing families has been a top priority for the Best Practice Project. In FY 97, we focused on (1) collaborative service planning for families with child welfare workers and substance abuse treatment providers planning together; (2) redesigning intact family services for substance affected families; and (3) drafting a report for the Governor that recommended a range of changes in casework practice when parental substance abuse is involved. These efforts are described below:

1) Collaborative Service Planning Conference Model

The Collaborative Service Planning Conference Model is designed to produce better decisions for foster children whose parents have begun to make progress in substance abuse treatment. The model was developed after a 1994 study by the OIG revealed that substance abusing parents often had unrealistic views of what they needed to do (in addition to maintaining sobriety) to secure return of their children. Also, though the parents were actively involved in their substance abuse program, they were often in poor contact with their children's caseworker. In addition, substance abuse treatment programs often operated on a timeline that was not cognizant of a child's need for permanency.

In FY 97, the Inspector General began field testing a model of collaborative service planning. Child welfare and substance abuse treatment providers are trained together to plan with the family and child. During the collaborative planning meetings, the following occurs:

- the clients, extended family and chemical dependence providers are provided with a realistic picture of the case and the permanency plan for each child;
- the need to involve family members in child welfare decision making and in the chemical dependence treatment and recovery process is discussed; and

- a process of early and ongoing collaboration between the child welfare and chemical dependence programs is established, including an agreement on frequency of communication and joint case planning to assure consistent expectations for the parent's progress.

Initial results of the field test are encouraging in meeting children's needs for permanence. The field test pointed, however, to the need for more training of child welfare workers and their supervisors regarding substance abuse treatment, how to confront parents about their children's need for timely permanence, and how to facilitate staffings. Another round of field trials is being conducted during this fiscal year. We are also working with the DCFS/DHS Office of Alcohol and Substance Abuse Initiative to incorporate training and guidelines on collaborative service planning into agency practice.

2) Intact Family/Recovery Project

Through a number of investigations which involved substance exposed infants, the OIG determined that current generic intact family services did not fully address the specific needs of substance affected families. The OIG recommended the Department develop a Request For Proposal (RFP) to fund several intact family service programs to test an integrated model of child welfare and substance abuse services. This recommendation was accepted by the Department and a proposal has been developed through a joint effort of the OIG and DCFS Clinical Services. This integrated model recognizes that providing intensive substance abuse services is critical to the overall effort to successfully and safely provide child welfare services to intact families where there is a substance abusing parent. By the same token, substance abuse services are enhanced by addressing the child welfare issues present in these families.

Significant features of the Intact Family/Recovery Model include:

- Integrated child welfare and substance abuse cross trainings and services including:
    - (1) Coordinated home visits between child welfare and substance abuse providers;
    - (2) Monthly/bimonthly contact with early intervention programs and monthly parent-child observation in the child's school setting;
    - (3) Six months of weekly to monthly follow up home visits by the substance abuse provider; and
    - (4) Weekly to bimonthly follow up home visits by the child welfare worker for the life of the case;

- A mechanism for immediate court intervention for noncompliant parents through the use of a Memorandum of Agreement with graduated sanctions such as protective orders, the use of moderated community services for parents, and the ultimate sanction of taking custody of children for non-compliance.

If relapse occurs, the substance abuse provider will reassess, and if appropriate readmit the parent. The child welfare worker will reassess child safety, and if appropriate, petition the court for sanctions and/or placement of the children.

3) Inspector General's Report to the Governor on Recommendations for Improving the Child Welfare Response to Families Affected by Parental Substance Abuse

In December 1996, after a wave of child deaths involving substance addicted-parents, the Inspector General issued a report to the Governor with a number of recommendations for improving the state's child welfare response to families affected by parental substance abuse. These recommendations, and implementation to date, include the following:

1. DCFS clients in substance abuse treatment need collaborative service planning. (See Collaborative Service Planning Model, page 36.)

2. DCFS should redirect a portion of its funding for intact family services to a specialized program targeted at substance abusing families which integrates child welfare and chemical dependence treatment services. (See description of the Intact Family/Recovery project, page 37.)

3. In a recent investigation, the Inspector General identified the potential for individuals to abuse prescription drugs by seeking treatment and prescriptions from multiple primary care providers and/or pharmacies. The Illinois Department of Public Assistance (IDPA) provides a process by which a Medicaid recipient's use of public aid cards can be restricted to a single designated primary care provider, doctor and/or pharmacist. The program, called the Recipient Restriction Program, is designed precisely to reduce overuse of services, including limiting abuse of prescription drugs. IDPA provides an administrative review process for determining the need for such a restriction. In the next fiscal year, the Inspector General will work with the IDPA Medical Quality Assurance Department to make information about recipient restriction available to child welfare providers.

4. Child welfare workers should use a Memorandum of Agreement with parents who are required to enter substance abuse treatment as a condition for maintaining their children at home. The Agreement will spell out the parents' commitment to undergo treatment and consent to allow the treatment program to apprise the child welfare agency of progress. Failure to comply with the Memorandum of Agreement will result in referral to Juvenile Court. The Inspector General is testing the use of a Memorandum of Agreement, with graduated sanctions for non-compliance with substance abuse treatment recommendations, in the Lawndale Family Conference Project. The Memorandum of Agreement will also be incorporated into the Intact Family/Recovery project. During FY 98, a video describing the consequences of failing to comply with the terms of the Memorandum of Agreement will be developed for use with parents.

5. Because of the potential for relapse, Department practice must maximize involvement of outside professionals in the lives of families that come to the attention of the Department because of substance abuse. All children who come from substance abusing home environments who are being served by DCFS in their own homes should be in school or early childhood programs, including Headstart or a Zero to Three program. To assure the child's continued safety and well-being while receiving intact family services, the educator should be asked to notify the child welfare worker if the child misses more than two consecutive days. The Inspector General has met with the Chicago Board of Education and will continue to work on this recommendation.

(C) Partnering With Families For Permanency

Partnering with Families for Permanency is a joint project between DCFS, the OIG, the Child Care Association, Volunteers of America (VOA), Lutheran Social Services of Illinois (LSSI) and Lifelink/Bensenville Home & Aid Society. Partnering with Families for Permanency is a field test designed to provide more timely permanent homes, in a less adversarial manner, both for children who should be able to return home quickly and for children who are unlikely ever to be returned home.

The field test involves a study group of children and families served by VOA, LSSI, or Lifelink/Bensenville, with children under the age of 12 who have been in foster care for one year or less. The children will be assessed regarding the likelihood of reunification with their parents. Workers and supervisors have been trained in the use of two tools which have been developed by the Child Care Association -- an interview protocol which supplements existing assessment tools, and a decision-making matrix called a Permanency Assessment Matrix. The tools assist in the identification of families at both ends of the substitute care continuum: families whose strengths are such that children are likely to be able to be reunified with the family within a period of five to eight months from the time of entry into care, as well as families where the children are unlikely to be reunified.

In addition to these assessment tools, workers and supervisors from the participating agencies were trained on the following practice strategies for implementation within the *Partnering with Families for Permanency* field test:

1) Concurrent Planning
For families where children are determined unlikely to be reunified within a reasonable period of time, parents are offered time limited services with a clearly stated preferred goal of return home. At the same time, other permanency options are pursued, and an alternate permanent plan is established, with full knowledge and, if possible, participation of the parents. While the term "concurrent planning" is the phrase coined in state and federal legislation, it is a model contingent upon accountability. If the parent has not made reasonable progress within a six to nine month time frame, the alternative permanent plan -- the contingency plan -- is implemented. During the

period of service delivery, every attempt is made to place the child in a home which could become a permanent placement if the child cannot be returned to his/her parent.

2) Early Reunification Services

Caseworkers and supervisors are trained on reunification strategies. The Permanency Conference, described below, will be used with families identified for early reunification as a way of increasing the extended family's support of the parent's efforts at reunification.

3) Permanency Conferencing

Permanency Conferences, based on the Family Conference Model (described below), are meetings with the parent, extended kin, unrelated foster parent if applicable, and key service providers who are currently involved in treatment of the parent. Permanency conferences are an integral element of case planning regardless of the case's current goal. Regular permanency conferences are the means through which the agency engages families in case planning for timely permanency for their child(ren). Permanency conferences provide a forum through which caseworkers and parents develop a plan for timely permanence (reunification or an alternative, permanent placement) which maximizes the family's strengths, enlists the support of the family's social network and clearly emphasizes the primary importance of safety, stability and security of the child(ren) in the development of a permanent plan. If the desired alternative permanent plan is adoption or subsidized guardianship by a relative, caseworkers work with extended family members during the period of service delivery to help them come to a decision about making this commitment to the child(ren). If appropriate, the parent and family are offered the opportunity to mediate a possible specific consent for adoption.

(D) Parenting Skills Training

Parenting classes are one of the most frequently required services for parents of children in foster care. The quality of available parenting classes, however, varies widely. Most classes are not targeted for specific needs of individual parents or for the special needs, if any, of the children they parent. Most programs are presented in a didactic, classroom-style with little or no opportunity to observe the parent with a child. While these programs often meet an important community need for general information about parenting, they are often inadequate for the needs of parents in the child protection system. During the last year, the OIG, in conjunction with Professor Elsie Pinkston at the University of Chicago School of Social Services Administration, has field tested a parent education program aimed at improving the core parenting classes offered to DCFS clients. This program, called the Parent Partnership Program, was conducted with parents served by a private agency in Cook County. The program begins with an in-home assessment of the parent with the child and the collection of baseline data about the parent's skills. This process allows the caseworker, parent and instructor to develop a plan for addressing the problems which

the parent wants to work on with his or her children during the class. Thirteen group sessions, interspersed with six home visits, comprise the initial program. Over the next six months, the parent and caseworker meet for five structured "booster sessions" to support skill retention and generalization of earlier learning to new situations. The results of the program are promising and point both to the advantages of working closely with caseworkers and to the importance of home visits while the parent is in training. During the next year, the project staff will continue to develop the program within the initial agency, with the agency staff assuming the primary responsibility for the new parenting classes and the project staff monitoring pre- and post-tests.

Following the success of the field test, Dr. Pinkston is now working with DCFS's Division of Clinical Services to develop guidelines for parenting training. It is anticipated that these guidelines will result in Requests for Proposals from community agencies willing to replicate the key elements of the program. In addition, the project staff will implement a Parent Partnership Program in at least three additional sites in Cook County. Project staff will train DCFS staff to carry out parenting training that includes group leadership and assessment and intervention during home visits.
The Parent Partnership Program represents the successful transition of an innovative best practice casework model from field test to adoption by DCFS.

CHILD WELFARE AGENCY LICENSURE AND CONTRACTS & GRANTS

Licensing & Contracts Reform Project

As a follow up to the March 1996 study by the Office of the Inspector General (OIG) concerning licensing and contract functions, the OIG and DCFS co-sponsored a two-day training for Department personnel, and the OIG participated in and monitored the Department's efforts to amend the Licensing Standards for Child Welfare Agencies.

The training was offered to the Department's licensing, contracts, agency performance teams, and resource development personnel. The training was designed to provide an overview of organizational infrastructure and sound management of a typical not-for-profit agency to serve as a framework from which staff could better assess capabilities and development needs of child welfare agencies.

The training, which was videotaped, was held on November 14-15, 1996 and repeated on December 5-6, 1996. The total number of participants was 49. The training was well received. Evaluations of the training were completed by 40 participants; 85 to 90% of the evaluations rated the training as highly informative and useful, and indicated a need for more training on the subject. Presenters at the training were from the Office of the Attorney General, the Internal Revenue Service, the Illinois Department of Labor, United Way/Crusade of Mercy, and the Nonprofit Financial Center.

Proposed Amendments to the Licensing Standards for Child Welfare Agencies
In FY 97 the Department of Children and Family Services proposed major amendments to 89 Ill. Adm. Code 401, Licensing Standards for Child Welfare Agencies. The proposed amendments address deficiencies identified by the Office of the Inspector General, the plaintiffs in the B.H. lawsuit, the Office of the Public Guardian, and DCFS. The amendments were developed over a period of one year with input from licensed child welfare agencies, child advocates, and the DCFS advisory councils and commissions.

Important areas addressed include the qualifications, good character and responsibilities of the board of directors, the executive and financial management of the child welfare agency, requirements for agency personnel, ethical matters, and a licensing progression structure for child welfare agencies.

Contract Monitoring
The Auditor General performed an audit of the Department of Children and Family Services for fiscal years ending June 30, 1996 and June 30, 1995. Findings, conclusions, and recommendations by the Auditor General supported the findings and recommendations made by the Office of the Inspector General in March 1996, and the resolution adopted by the Child Welfare Ethics Advisory Board on May 28, 1996. Most significantly, the Auditor General noted that the Department needs to increase its contract monitoring, especially of new agencies providing services to children to better detect inappropriate or unallowable costs. The Auditor General recommended that the Department develop procedures to assess whether new agencies will be fiscally accountable to the Department and to closely monitor the expenditure of State funds by all direct service providers on a regular basis.

CHILDFIND INITIATIVE

As a follow up to recommendations in a number of OIG investigations, the OIG headed a collaborative effort to identify children with developmental disabilities and ensure delivery of appropriate services. The OIG began discussing the possibility of collaborating with Sue Gamm of the Chicago Public School (CPS) Specialized Services to provide Early Education screening for wards. Both the DCFS Clinical Services Division and the DCFS Educational Liaison's Office were invited to participate. On April 14, 1997 the CPS Department of Special Education agreed to conduct a 6 week screening of wards from July 7, 1997 through August 15, 1997 at 6 CPS locations across the city and provide 1 to 3 screening teams to conduct the screenings. In addition, CPS agreed to find early education enrichment programs (Head start, Pre-K programs) for all wards identified at risk for further delay and in need of monitoring and to refer for further case study children identified with special needs. The CPS invited the Department of Human Services for the City of Chicago to participate in the collaboration. At a June 25, 1997 meeting, the City of Chicago Department of Human

Services agreed to ensure that any child in need of enrollment in an educational enrichment program would have a seat.

Because of limited resources in Clinical Services and the Educational Liaison's Office, the OIG took the lead in scheduling children for screening. The Division of Clinical Services provided a computer generated list of age eligible children in DCFS Chicago regions and Purchase of Service agencies. Twelve private agencies participated in the initial ChildFind Initiative. These agencies were selected because of the large number of children who were age eligible for screening in each agency. The OIG contacted the agency directors and DCFS regional administrators and provided them with the list of their identified children and dates and locations of screening. The OIG requested that they schedule the children through the OIG. The OIG worked with the Department's Office of the Guardianship Administrator to obtain required consents for screening.

There are over 13,000 DCFS wards in Cook County who are under the age of 5. A third of these children are eligible for developmental screenings through the Chicago Public Schools. The OIG identified 2,431 children who reside in Chicago to participate in the ChildFind Initiative. Of these, 1,523 were scheduled to be screened and 943 were actually screened.

Of the 943 children screened:

- 443 or 47% passed
- 330 or 35% of the children were identified at risk for further developmental delay and should be monitored. These children would benefit from an early educational enrichment program, HeadStart, Pre-K.
- 144 or 15% of the children failed the screening and were referred to their local school for a further case study for special education. The CPS will and has followed up on any child referred for further case study as well as those who failed the hearing and/or vision screen.
- 4 children failed the hearing screen
- 24 children failed the vision screen
- 474 or 50% of the children (the combined number of children who were referred for special education case study and those referred for HeadStart, Pre-K programs) are in need of further intervention

The Chicago Public Schools developmental screenings for the 943 children were performed at no cost to the Department. If the Department had these children evaluated through a psychologist, the cost to the Department would have been $235,750.00 (per the current price schedules released by the Department in the Spring of 1997).

The ChildFind Initiative identified a significant number of children with developmental delays needing early childhood intervention, as well as a greater number of children who are eligible for a developmental screening. Research indicates that if delays are

identified early, remediation may be able to bring the child up to an age appropriate developmental level. With commitment to follow-up, the children who were identified as needing early childhood intervention can now be afforded the opportunity of remediation.

The same research on child development suggests that if a child's development is at risk or delayed and is not addressed the child may be at greater risk for abuse or neglect and developmental delay in all areas of development. In fact, educating caregivers about a child's development may lower the child's risk for future maltreatment and increase the protective parenting behaviors associated with non-maltreating parents. The findings of the ChildFind project support the need for mandatory developmental screenings when a child enters the child welfare system; and if the plan for the child is adoption or subsidized guardianship.

Since the project began, the Educational Liaison's Office and the Clinical Services Division have hired staff specializing in early childhood development. The Educational Liaison agreed to provide follow-up with all children screened and to address the adverse effect and organizational issues of non-screening in child welfare. The OIG has requested a status report from the Educational Liaison on enrollment of the children referred for either special education or educational enrichment programs. Of special concern are the children who failed the hearing and vision screens.

CLINICAL EVALUATION AND SERVICES INITIATIVE

Several OIG investigations have identified a problem within the child welfare system of fraudulent or poor quality psychological evaluations. The Department relies on psychological evaluations in making decisions whether to return children home, to allow unsupervised visitation, to terminate parental rights and to determine appropriate services.

The use of psychological evaluations has expanded during recent years. The information provided in the evaluations frequently does little to assist the Department or the court in making decisions. In 1991, the Department requested psychological assessments in Cook County which cost $1,048,008. The cost for 1995 was $3,332,018.

The child welfare system has institutionalized the use of psychological evaluations in lieu of critical decision making for the delivery of services. Some of the problems identified were:

- Most psychological tests are not relevant to parenting abilities;
- Referrals are made for psychological evaluations without complete case information provided to the evaluator;

- Courts and workers over-rely on psychological evaluations and order them without analyzing the need in a particular case; and

For assistance in developing solutions to the problems, the OIG contacted the Clinical Evaluation and Services Initiative (CESI). The Honorable Donald P. O'Connell, Chief Judge of the Circuit Court of Cook County, had requested that CESI evaluate and make recommendations concerning the referral and use of clinical services by Juvenile Court. CESI and the OIG are examining a random sample of parenting-related psychological evaluations to establish standards for referral and choice of tests.

Decision Tree

In May 1997 the OIG, CESI and the Clinical Services Division of DCFS worked on reforms regarding the referral and use of psychological evaluations. One component of this initiative focused on the appropriateness of conducting psychological evaluations on infants, toddlers, and school aged children. The effort produced a decision tree which child welfare professionals will use to identify those wards in need of a psychological evaluation and what is the appropriate type of evaluation to obtain. Training has begun on the use of the decision tree. The OIG will continue to work with CESI and the Department to develop other appropriate tools.

EMPLOYEE CONFLICT OF INTEREST RULES

In June 1996, the OIG and the OIG Ethics Panel recommended significant revisions to Department Rule & Procedures Part 437, dealing with Employee Conflict of Interest, based on specific problems encountered by the OIG in prior investigations. The Department accepted substantially all of the OIG's proposed amendments and the new Employee Conflict of Interest rules are effective for all Department employees.

ETHICS

The Child Welfare Ethics Advisory Board met five times during the fiscal year. Due to her appointment as Bureau Chief, Juvenile Justice Bureau, Office of the Cook County States' Attorney, Catherine Ryan resigned as Chair of the Advisory Board, and has since been replaced by Dr. Ada Skyles as Chair. Commander Roberta Bartik of

the Youth Investigation Division of the Chicago Police Department joined the Advisory Board in April 1997.[1]

The Advisory Board took up several issues raised by the Inspector General and by child welfare professionals who submitted inquiries. These issues included: (1) possible disincentives to hospitalization inherent in DCFS's SASS (Screening, Assessment and Support Services) Program and the inherent conflict of interest created by a system where professionals assessed the need for their own private services; (2) the impropriety of the Department's hiring a contractor to assess the need for a certain protocol who then would contract with private agencies to interpret the protocol (the Board felt that development of a document similar to a Covenant Not to Compete which would allow for the issue of limited numbers of qualified professionals in some contexts was advisable); (3) the need for the Department to reinstitute the use of Requests for Proposal in contracting; (4) the drafting of a Memorandum of Agreement providing for the supervision of a Department employee by a superior outside of her region when her husband was in a superior position to her in her region of employment; (5) the need for a protocol under which the Department gathers all pertinent records relating to any child whose death is being investigated (in this case a DCFS employee was afraid of being scapegoated and wanted to review pertinent medical records); (6) two instances where the question was raised whether a Department employee could act in an individual capacity giving advice to or testimony on behalf of an individual regarding rights or competence of parents. The responses of the Board were conveyed to the individuals making inquiries or were incorporated in the Inspector General's reports, as appropriate.

The OIG Ethics Staff answered several informal phone inquiries from child welfare professionals, the vast majority of which concerned conflict of interest issues. The staff assisted the Inspector General in her filing of two sets of comments in the B.H. v McDonald litigation. In her comments, the Inspector General objected to the proposed Supplemental Order in which the parties to the Consent Decree proposed replacing the Court-appointed monitor of the Department's performance with a Research Center at the University of Illinois, which would both monitor and conduct

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[1]As of July 1, 1997 the members of the Child Welfare Ethics Advisory Board were:
Roberta Bartik, Commander, Youth Investigation Division, Chicago Police Department
Michael Bennett, Ph.D., Jane Addams College of Social Work, University of Illinois at Chicago
James Connelly, Foster Parent
Thomas Geoghegan, Esq., Despres, Schwartz & Geoghegan
Esther Jenkins, Ph.D., Dept. Of Psychology, Chicago State University
Phyllis Johnson, DCFS Office of Quality Assurance
David Ozar, Ph.D., Loyola University Center for Ethics
Hon. Joseph Schneider, American Bar Foundation
Ada Skyles, Ph.D., Chapin Hall Center, University of Chicago
Eugene Svebakken, Director, Lutheran Child & Family Services
Betty Williams, Senior Vice-President, Metropolitan Family Services

research concerning Department compliance. The Inspector General objected to this Order because the Director of the Research Center, Dr. Susan Wells, is the stepsister of DCFS Deputy Director Joseph Loftus. This created both a real and apparent conflict of interest because of the personal relationship and high visibility of the parties. The Court declined to approve the portion of the Proposed Order granting the monitoring function to the Research Center.

Another major initiative of the Ethics Program was the beginning of the development of a Child Welfare Ethics Network between DCFS and private child welfare agencies. A committee consisting of executive directors of several large private agencies and a DCFS regional administrator began meeting in the winter and spring of 1997 to plan for the development of ethics education programs within agencies and for the sharing of information and common ethics concerns between the private and public sectors. The first major accomplishment of this committee was the presentation of a Child Welfare Ethics Forum, co-sponsored by the OIG and Loyola University, on June 3, 1997 at Loyola. More than one hundred supervisory and administrative professionals attended this Forum at which major ethical issues in the field surfaced. Discussion was held about ways to raise ethics awareness in the daily practice situations of child welfare professionals. The goal of the Committee is to create a Network, ultimately independent of the OIG, to act as a permanent sounding board for ethics issues. Planning for several issue-oriented ethics breakfasts during 1997-98 is underway.

FAMILY CONFERENCE MODEL

The Illinois Family Conference Model is based on the New Zealand family group conference model and American family mediation practices. Its purpose is to enhance and develop an effective, informal system of supportive and protective behaviors by extended family members who can monitor more effectively than the state the safety and care of their extended kin's child(ren). Its focus is not limited to "parent-based" standards; instead the extended families' plans of care are viewed as legitimate, so the state can support the family's efforts through services and resources, and provide a safe and viable alternative to the intrusiveness of state custody. Presently, there is a void in providing families an arena and process for decision making about child protection issues outside of the judicial process. There exist few interventions that allow us to look at the potential mutual influences and interactions of family members in diverting parents and their children from the state's formal child welfare system and the juvenile court's child protection division. In Illinois, there is no family conference or formal mediation offered to families at the investigative stage prior to the state filing a petition for custody. This gap makes this project relevant to current Illinois child welfare practices. Historically, once children are placed in the state's child welfare system, a formal service planning process is initiated. Over the last twenty-five years the practice and success of the service planning process have been questioned.

Because of Illinois' dismal record in effecting timely permanency goals, the Illinois legislature passed a series of laws that drastically limit the time a child may be in foster care before adoption becomes the mandated course of action. This legislation was developed to combat the burgeoning number of children growing up in the state's foster care system. Presently, the majority of children under Illinois' state guardianship are placed with relatives. The kin of these children, while gaining financial resources by entering the state's foster care system, in fact lose control and rights over the care of their children. The need to involve extended families prior to formal custody proceedings appears self-evident. A formative exploratory study of an intervention model that addresses the early involvement of extended family members in safety and care issues of their children could provide a relevant base of knowledge to the field of child welfare.

Cases involving serious physical abuse are excluded from this Best Practice Project. Families with histories of multigenerational violence and multigenerational drug addictions are excluded from the Illinois family conference model as they require more intrusive interventions for the safety of the children. Also excluded are parent(s) with no attachment to any extended family.

JUVENILE OFFENDER ALLEGATIONS

The OIG received numerous complaints in which children were indicated as perpetrators of abuse for relatively minor offenses while other children were not indicated for serious offenses. The OIG consolidated these cases with others to review the Department's treatment of juvenile offenders. As part of the consolidated review, the OIG examined one hundred and thirty-seven cases in which juveniles were indicated as perpetrators of abuse.

Analysis

Someone who abuses children may be subject to the criminal justice system, the child protection system or both. What separates the criminal justice system from the child protection system is the concept of caretaker. For example, if a stranger harms a child, law enforcement will investigate and charges may be brought against the stranger in criminal court. DCFS, however, would not investigate the act because the stranger was not in a "caretaker" role for the child. Similarly with children: if a child hurts another child on the playground at school, law enforcement might be called to investigate (depending on the seriousness of the act) and a delinquency petition could be brought against the child in juvenile court. DCFS would not be called to investigate because the first child was not a caretaker of the second child (although DCFS could be called with regard to the teacher, the child's caretaker at school, being negligent in his/her supervision of the children). If, however, the first child lives in the same house as the second child, law enforcement *and/or* DCFS may be called upon to investigate the allegations under the current system. This is because the Illinois statute defining perpetrator of abuse includes all those who live in the same home as

the victim, regardless of age, and, regardless of whether the perpetrator had a caretaker relationship with the child.

Within the juvenile justice system (delinquency court), the Juvenile Court Act provides for a wide range of options for intervention with children. The options range from a short period of informal supervision (from 30 days to 180 days) to probation or commitment to the Illinois Department of Corrections juvenile division. In a delinquency petition, the respondent is the child who allegedly perpetrated the harm. An order of probation can require the cooperation of the delinquent minor to engage in treatment with the sanction of violation of probation (up to and including commitment) if the minor fails to cooperate. Unlike law enforcement records, which are sealed and can be expunged at adulthood, a juvenile's record with DCFS is treated no differently from adult abuse records, resulting in the child's inability to hold certain jobs once he or she becomes an adult. In the juvenile justice system, however, only the most serious sexual offenses, with a higher threshold of proof, require registration as a sexual offender.

In the child protection system (child abuse and neglect court), a juvenile offender cannot be held accountable for his/her actions or for his/her failure to accept services or cooperate with his/her rehabilitation. Once a report has been indicated by DCFS, the only enforcement mechanism available in juvenile court is removal of unprotected/victimized children; this enforcement mechanism likely has no meaning for a juvenile offender.

The dual jurisdiction in these cases has resulted in the following problems:

- In the child protection system, a juvenile offender cannot be held accountable for his actions or for his failure to accept services or cooperate with his rehabilitation. As an example, a 15-year-old was indicated by DCFS for sexually penetrating his 4-year-old sister. A delinquency petition was never filed on the brother. Instead, the brother was made a ward of the court through the child protection division of the juvenile court. He was sent to a residential facility for sexual offender treatment where he attended the neighborhood public school. While at the facility, he ran away twice in four months and refused to cooperate in therapy. Because he had never been adjudicated delinquent, there was no basis for coercing treatment. He is currently on run with an outstanding warrant; he is being sought for a battery against the residential staff.

- Children who exhibit predatory sexual behavior are sometimes referred only to the abuse and neglect system and not to the juvenile justice system; even when the Department notifies law enforcement, police will sometimes defer to the Department and forego investigating or seeking prosecution.

- Children who exhibit simply inappropriate sexual behavior are sometimes indicated. An indicated finding of sexual abuse means that the child can be listed as a perpetrator of abuse in the Department's Child Abuse and Neglect Tracking System for up to 50 years (records of findings of sexual penetration, defined as any oral to genital or genital to genital contact, are retained for 50 years; records of findings of sexual molestation, which can include inappropriate touching are retained for 20 years.) The OIG study found that children with handicapping conditions (developmentally delayed, hearing impaired) and children under the age of 12 were "indicated" for inappropriate sexual behaviors that reached a threshold of concern but were far below the threshold of being predatory. In one case the OIG reviewed, a 15-year-old student of a state residential school, while on a bus for a field trip, inappropriately touched a female student's breast. The 15-year-old was indicated for sexual molestation (which will be listed in the DCFS Child Abuse and Neglect Tracking System for 20 years) even though the school felt an educational intervention was warranted. Both students were in special education classes. The 15-year-old clearly was not the other student's caretaker but the Department determined that the statutory definition of abuser, which includes those who reside in the same household, encompassed anyone residing in the same residential placement. While inappropriate behavior may warrant educational or child development intervention, it does not warrant the stigma of an indicated report. In over 40% of the cases examined by the OIG, the perpetrator was under 14 years old. A few were as young as 8 years old.

- Cases were indicated even when parents responded appropriately and protected child victims without state intervention: in one case reviewed by the OIG, a 15-year-old fought with his 12-year-old brother. He punched his brother in the abdomen. The younger brother had just torn up the older brother's school book, and ran into his father's bedroom chased by his brother. The fight lasted a few seconds. The father interceded, separating both boys and sending them to their separate rooms. The next morning the younger brother complained of stomach pains. He was taken to the hospital and treated for trauma to his spleen. The parents sent both boys to counseling and arranged for the older son to attend a private boarding school. Law enforcement youth officers completed an investigation which was closed with a "station adjustment," finding that the parents had appropriately responded to the unfortunate incident. The Department indicated the 15-year-old for abuse, even though it was clear that he was not the younger boy's caretaker. The parents faced a dilemma: they were afraid to have their older son come home for the holidays fearing that the younger son would be removed by the State. After an administrative review the case was unfounded.

- There is no uniformity within the Department about the treatment of juvenile offenders; children who were wards of the Department might have

inappropriate behavior addressed by an "Unusual Incident" report. The same behavior by a non-ward may trigger a hotline call, leading to an indicated finding, which could remain on the child's record into adulthood.

Recommendations

As a result of these problems, the Inspector General recommended that the Department distinguish between serious predatory behavior and inappropriate behavior. Calls received by the DCFS Hotline which allege serious predatory behavior should be delegated for investigation to law enforcement to ensure that juveniles are held accountable for behavior. The Department should refer families in which a child exhibits inappropriate sexual behavior for voluntary mental health intervention or educational prevention services. The state should not presume that parents, who are otherwise fit, will not get needed services for their children. Once referred, if the parents demonstrate a lack of ability to protect their children or a lack of cooperation with services, the agency can then initiate a neglect investigation, involving the Department and warranting state intervention.

The following cases should continue to be investigated by the Department:

- the facts demonstrate that the juvenile offender or child victim was previously or is currently being sexually abused by a caretaker;
- a parent's behavior or lack of cooperation during the law enforcement investigation puts the child victim at risk of future harm;
- the facts demonstrate lack of supervision by a parent, caretaker, or institution that place children at risk of harm;
- the facts demonstrate that the juvenile offender was in a caretaker role (e.g., minor parent or babysitter); or
- other facts arise which raise a reasonable suspicion of abuse or neglect on the part of the caretaker.

LEADS PROTOCOL

In 1993, the Inspector General recommended that the Department gain access to automated criminal history record information (Law Enforcement Agencies Data System: LEADS) in cases involving issues of violence or substance abuse to better assess safety risk to children. In 1994, the Inspector General facilitated an agreement between the Illinois State Police and the Department of Children and Family Services that allowed such access. In 1996, the Inspector General learned that the Department was restricting the use of LEADS to "Priority 1" allegations. Priority 1 allegations include: Death, Brain Damage, Skull Fracture, Subdural Hematoma, Internal

injuries, Wounds, Torture, Sexually Transmitted Diseases, Sexual Penetration, Molestation and Exploitation, Failure to Thrive, Malnutrition and Medical Neglect of Handicapped Infants. General abuse allegations or other allegations suggesting violence or substance abuse are not included. The Inspector General's Office has been working closely with the Department to draft a LEADS protocol that will ensure that LEADS checks are conducted in investigations where violence or substance abuse may be an issue.

LEGISLATION

(S.B. 522/P.A. 89-704) Work the OIG began in FY 95 culminated this fiscal year in passage of amendments to the Juvenile Court Act that facilitate expedited termination of parental rights in egregious cases. In addition, the new law amended the Department of Children and Family Services (DCFS) Act to clarify when family preservation services need to be made to work toward reunification; and added two grounds to the Adoption Act for terminating parental rights.

In the majority of cases of children in DCFS custody, the child's need for a timely permanent placement is best served by aggressive casework and provision of services aimed at strengthening the child's biological family so that the child can return home. Even in cases where there is an open question about whether the family can make sufficient improvements to allow the child to be returned within a reasonable period of time, it is often wisest to provide a period of services to the family in order to answer the question about whether the family is treatable. In some cases, however, a parent's conduct toward the child or the child's sibling has been so egregious that the behavior justifies termination of parental rights without offering any services directed toward reunification. In other cases, the parent's incapacity to care for the child, combined with an extremely poor prognosis for treatment or rehabilitation, justify a determination that the provision of rehabilitative services is unreasonable. For both classes of cases, termination of parental rights should be an option early on in the case. It is these cases the legislation is intended to address.

The OIG initially worked on the legislation following investigations where termination of parental rights should have been considered early on in the cases. Instead, the Department continued working with the families toward the goal of reunification. Thereafter, either the children grew up in foster care without the opportunity for a permanent home, were returned home and then re-entered foster care having been severely abused or neglected, or were returned home and subsequently killed.

The OIG elicited and gained the support for this legislation from a variety of organizations and agencies including the Illinois Foster Parent Association (IFPA), the Office of the Presiding Judge of the Child Protection Division of the Circuit Court of Cook County, and the Cook County Office of the Public Guardian.

This legislation proved to be the precursor to "The 1997 Permanency Initiative" **(Public Acts 90-27 and 90-28)** passed during the spring legislative session. These Acts expanded upon the concepts introduced in the expedited termination legislation, including identifying the criteria for expedited termination. The Acts also set shorter time frames for decision making in all cases and amend provisions in the Juvenile Court Act concerning permanency hearings.

P.A. 89-704 also amended the Adoption Act to create a process for parents of children in foster care to consent to the adoption of their children while specifying the individual with whom the child shall be placed, so long as the individual is approved by DCFS. Previously, the Department did not uniformly utilize specific consents as an alternative to termination proceedings. The specific consent legislation was designed to identify those cases in which the biological parent and the Department agree about the best adoptive placement for the child, thus eliminating the need for termination hearings in those cases. This provision originally was drafted by Northwestern University's Legal Clinic. The OIG worked with Northwestern's Legal Clinic, the Illinois Foster Parent Association, the Cook County Juvenile Court and other groups to gather support for the specific consent concept.

MENTAL HEALTH CONFIDENTIALITY TASK FORCE

The Mental Health Confidentiality Task Force was formed in response to a directive from Director McDonald to identify necessary reforms to allow the Department to have better access to relevant confidential information and to address the concerns of the judiciary that an inordinate amount of judicial time was spent reviewing voluminous confidential information to determine whether to release it to the parties. The Task Force is composed of the following members:

Denise Kane, Inspector General of DCFS
Jean Ortega-Piron, Guardian, DCFS
Professor Mark Heyrman, Mandel Legal Aid Clinic, University of Chicago
Professor Thomas Geraghty, Northwestern University Legal Clinic
Dr. Dan Anzia, Dept. of Psychology, Lutheran General Hospital
Dr. Laura Miller, Dept. of Psychiatry, University of Illinois
Joseph Scally, Dept. of Psychiatry, University of Illinois
Dan Baechle, DCFS Legal
Julie Biehl, Clinical Evaluation Services Initiative, Cook County Juvenile Court
Barbara Kahn, Clinical Evaluation Services Initiative, Cook County Juvenile Court
Bruce Boyer, Northwestern University Legal Clinic
Susan Atwood Jardine, DHS Legal
Mary Ellen Barone, Office of the Inspector General of DCFS
Mary Bird, Office of the Inspector General of DCFS
Ann McIntyre, Office of the Inspector General of DCFS
Barbara Shulman, Office of the Inspector General of DCFS

Discussion
The Task Force identified the following situations in which the Department or a party to a court proceeding need to access confidential information:

- in investigating an allegation of abuse or neglect to determine whether to indicate
- in investigating an allegation of abuse or neglect to determine whether to indicate where there is a simultaneous criminal investigation pending
- in investigating an allegation of abuse or neglect to determine where to place children
- in determining an appropriate permanency goal for children
- in determining appropriate case and service plans for a family
- in developing a case for termination of parental rights

Confidential information includes mental health records, substance abuse records and medical records containing treatment, testing or diagnosis of HIV/AIDS.

The Task Force noted that while the legislative schemes for the different types of confidential information are complex, all confidential information can be accessed with a valid consent. The committee determined that in all but two of the identified situations in which confidential information would be needed (termination or pending criminal charges being the exceptions), the parent or other person would be likely to consent in cooperation with the Department. This is because the parent or other person will understand that the Department will not be able to recommend return of the children or increased visitation unless it reviews relevant records. The Task Force subsequently examined the current training and protocol for procuring consents. The Department also reviewed a prior OIG report and experience concerning workers' general lack of familiarity with the rules and procedures and applicable statutes concerning release and redisclosure of confidential information.

The Task Force determined that many problems in Court and in case planning could be avoided if workers were aggressive and diligent in securing consent and documents at the outset.

Recommendations
The Task Force recommended that the Department adopt and implement a revised user-friendly protocol and training for securing consents.

In addition, the Task Force recommended that the Department keep track of all occasions in which a motion is filed in Cook County Juvenile Court for access to confidential mental health records for the next two years to determine whether these suggested changes are alleviating the identified problem. For each such motion, the Department should note the specific type of mental health records needed and the reason that the worker did not procure a consent for release of the information.

A representative of the Department, the court system and the OIG should meet at 6 month intervals to determine 1) whether workers are procuring necessary consents; 2) whether workers are accessing available information; and 3) whether motions for release of confidential information in the Child Protection Division of Cook County and in downstate courts are more infrequent. DCFS, the court system and the OIG should determine, in December 1999, whether the consent protocol should be amended or whether a legislative change is necessary regardless of the use of consents.

PARENTING ASSESSMENT TEAM (PAT)

The Mental Health Task Force, convened in 1993 by the Governor and the OIG, identified systematic problems in state agencies and identified areas to improve assessment, case management and coordination of services to parents with mental illness. The Mental Health Task Force made a number of recommendations which are summarized below.

1) Develop a standardized data format for use by both DMH and DCFS to facilitate communication of relevant information about parenting capabilities and risks with mentally ill parents.

> The Parenting Assessment Team (PAT) has adapted a standardized data format that is currently used by the PAT and child welfare workers. The 15 page data format is completed by child welfare workers and the PAT to compile and share critical social and psychiatric information for the purposes of dissemination and analysis of parenting capability.

The OIG has provided Law Enforcement Agencies Data System (LEADS) information to the PAT. This information is critical to identify areas of risk where a history of violence, substance abuse or sexual abuse may be a factor in the safety of the child(ren). Since 1995 the OIG has conducted over 110 LEADS checks for the PAT.

2) Develop a Parenting Assessment Team to promptly perform comprehensive, methodologically sound, non-adversarial assessments of parenting capabilities and risks for use by the courts and DCFS.

> Since its inception in 1994, the PAT has accepted over 180 referrals and has completed over 70 assessments. The Juvenile Court and child welfare professionals have found the PAT to be reliable and methodologically sound and have increased the number of referrals for assessment. However, because of the overall demand for and the comprehensiveness of the assessment, a backlog of cases was created. In addition, because of the shortage of specialized services in the Chicago area, the PAT found it difficult to avoid self referrals of current clients. In May 1997, DCFS agreed to expand the number of PATs in the three Chicago-Cook County Regions. There are currently two

PATs and a third will soon be established. This should reduce the time a parent waits to be assessed and ensure that follow up services are accessible. DCFS intends to hire a full time PAT coordinator to assign referrals, monitor the assessment process and ensure that PAT recommendations are integrated into service plans. The Department also reported that they intend to replicate the PAT model throughout the State.

3) Use of specialized case management teams to provide programs for mentally ill parents who could achieve adequate parenting skills with psychosocial rehabilitation and treatment.

DCFS has reported it plans to develop specialized case management teams to provide case management and treatment.

THE SEXUAL ABUSE/CUSTODY TASK FORCE

Statement of Problem

From its inception, the Office of the Inspector General has received requests for investigation from parents who claim that the Division of Child Protection wrongly indicated or wrongly unfounded sexual abuse allegations against themselves or their former spouse. By their nature, sexual abuse investigations are often the most difficult investigations because there may be no physical evidence and the only witnesses may be the perpetrator and the victim. When the allegations are against a non-family member, a child's safety risk can be minimized merely through prohibiting contact between the child and the alleged abuser, an individual with no legal rights to contact with the child. When the allegations are against a parent, however, the issues are more complicated. The risk of a bad decision increases, since a wrongly indicated report may mean that a child's relationship with a natural parent is compromised or destroyed and a wrongly unfounded report may mean that the perpetrator has unsupervised access to the victim. When the allegations are against a parent during or after divorce proceedings, the issues are further complicated. Since a complex and antagonistic relationship often exists between the two parents, motivations of the outcry witness may be subject to question. Moreover, the naturally close relationship between the child and the complaining parent may influence the child in subtle ways. To complicate matters further, the cases involve joint jurisdiction of both divorce and child custody court systems, each with their own rules and procedures. Within the context of these complex interpersonal relationships, truth is often difficult to discern.

The current system, however, does not tolerate ambiguity. Investigators with some degree of training in sexual abuse are required to determine whether to indicate or unfound the allegations. An unfounded report means that services or restricted contact cannot be compelled between parent and child. Understandably, one parent or the other frequently complains about the outcome of the investigation. The

complaining parent is often not the person who called the hotline. Most often, a treating therapist will have reported the suspected abuse based on a disclosure made during therapy with either the parent or the child. After the allegations are investigated by the Department, a disgruntled parent may complain to any or, more often, all of the following offices for resolution:

DCFS Administrative Expungement Hearing Office
Ombuds Office
Office of the Inspector General, DCFS
Office of the Director of DCFS
Legislative Office
Office of the Governor

Once received, the complaints are extraordinarily difficult to resolve. To add to the complexities initially presented, a reviewing entity must now also deal with the passage of time and the consideration of the possibility of irretrievably distorted memories through prior interviews. As a result, even small numbers of these complaints can consume a large amount of time and resources.

To develop procedures for handling these cases, the Office of the Inspector General hired Joan Palmer, LCSW, to review current literature and prepare a report outlining the issues. In addition, the Office of the Inspector General convened a task force, composed of the supervisor of guardian ad litems in Cook County Domestic Relations Court, a vice president of a private hospital who specializes in the evaluation of sexual abuse, a licensed clinical social worker, the Director of Forensic Clinical Services of the Circuit Court of Cook County, representatives of the Office of the Inspector General and a representative of the Child Advocacy Center.

Recommendations

The Task Force made a series of recommendations designed to cause the affected systems to work together to assure 1) that these complex cases are handled initially by personnel with appropriate training and 2) that the various offices and affected Departments and court systems develop a panel of outside experts who could be called upon to evaluate complex cases.

RECOMMENDATIONS FOR REFORM

This section of the report organizes reform recommendations made by the OIG according to the function of the child welfare system that the recommendation is designed to strengthen. These recommendations are gleaned from both investigative reports and OIG projects.

I. RECOMMENDATIONS TO PROMOTE CHILD SAFETY AND PROTECTION

ASSESSING RISK - *Mental Health Issues*

- The OIG continued to collaborate with the Parenting Assessment Team, which performs comprehensive, methodically sound, non-adversarial assessments of parenting capabilities and risks for use by the courts and DCFS. In the last fiscal year, the OIG worked with the Department to expand the number of teams in Cook County and is currently working to replicate the Team throughout the State.

MENTALLY ILL / DEVELOPMENTALLY DISABLED CARETAKERS

- Expand the grounds for parental unfitness under the Adoption Act to include a determination, in a criminal case, of not guilty by reason of insanity where the criminal charges resulted from the death of a sibling.

- The Department should develop specialized interventions with families who come to the attention of the Department and/or court because of mental illness of the parent.

- Ensure that psychological evaluations of developmentally disabled parents include testing of adaptive behaviors.

- The Department needs to address the gap in services that exists for parents whose test results indicate intellectual deficits but whose levels of functioning preclude their eligibility in specially funded programs for the developmentally disabled. This service needs to be available to facilitate the return home of children and provide at least initial support after the return.

ASSESSING RISK - *Substance Abuse Issues*

- The OIG recommended the Department develop a Request For Proposal (RFP) to fund several intact family service programs to test an integrated model of child welfare and substance abuse services, including:

  (1) Coordinated home visits and shared communication between child welfare and substance abuse providers;
  (2) Monthly/bimonthly contact with early intervention programs and monthly parent-child observation in the child's school setting;

(3) Six months of weekly to monthly follow up home visits by the substance abuse provider; and
(4) Weekly to bimonthly follow up home visits by the child welfare worker for the life of the case.

- A mechanism for immediate court intervention for noncompliant parents through the use of a Memorandum of Agreement with graduated sanctions such as protective orders, the use of moderated community services for parents, and the ultimate sanction of taking custody of children for non-compliance.

- In substance abuse cases, DCFS and private agency staff must be trained: (1) to identify factors that make parents unlikely to succeed in treatment; (2) to communicate clearly and honestly with parents; and (3) to put contingency ("concurrent") plans in place in those cases where a parent is unlikely to succeed.

- In order to provide as much continuity as possible in the provision of services, when a parent leaves one treatment facility and enters another, either for a continuation of treatment or in accordance with an aftercare plan, a collaborative service planning conference should be held with both providers.

- DCFS should implement the Intact Family/Recovery Program. The Department should redirect funds currently allocated for generic intact family service programs, to those child welfare providers who also have substance abuse treatment programs or are associated with substance abuse programs to ensure that the private agencies servicing the cases deliver the special services needed.

CRIMINAL HISTORY RECORD CHECKS

- In 1993, the Inspector General recommended that the Department gain access to automated criminal history record information (Law Enforcement Agencies Data System: LEADS) in cases involving issues of violence or substance abuse to better assess safety risk to children. In 1994, the Inspector General facilitated an agreement between the Illinois State Police and the Department of Children and Family Services that allowed such access. In 1996, the Inspector General learned that the Department was restricting use of LEADS to only the most serious hotline allegations. The Inspector General has been working closely with the Department to ensure that an appropriate LEADS protocol is issued and implemented.

HANDLING COMPLEX INTRAFAMILIAL SEX ABUSE INVESTIGATIONS

- In response to complaints received regarding child protection investigations of intrafamilial sex abuse allegations in the context of divorce/custody proceedings, the OIG recommended that 1) appropriate and specific training be

directed to child protection personnel concerning these issues, and 2) that the various offices and affected Departments and court systems develop a panel of outside experts who could be called upon to evaluate complex cases.

ASSESSING SAFETY RISKS POSED BY ENVIRONMENTAL HAZARDS

- The Department should provide guidelines to help child protection investigators assess when environmental conditions might pose a serious risk to children.

JUVENILE COURT - VIOLATIONS OF ORDERS OF PROTECTION

- The Department should develop guidelines for bringing violations of Orders of Protection to the attention of the Juvenile Court.

PLACEMENT ISSUES

- The Department should ensure that supervisors are made aware of the protocol regarding exceptions to unlicensed placements, when necessary.

- Youth who are under fifteen years of age or have other vulnerabilities should be removed from a residential treatment center for sexual offenders.

- Develop guidelines for the use of locked residential facilities for sex offenders who have been adjudicated delinquent or found guilty of sexual crimes.

LICENSING

- Clear and effective guidelines must be developed to instruct licensing investigators when licensing violations are sufficiently serious to warrant license revocation.

- The requirement for unannounced annual monitoring visits of licensed day care homes should be spelled out in Department Rules and Procedures. More frequent monitoring should be required when the licensed provider is under a corrective action or safety plan.

- The Department and legislature should examine whether a separate agency should be responsible for investigating unlicensed facilities.

PREVENTION OF CASEWORKER MISCONDUCT

- The Division of Child Protection should require that male investigators be accompanied by a female investigator when interviewing minor mothers under the age of twenty-one and female wards between the ages of twelve and twenty-one.

- Where a supervisor learns that allegations of sexual misconduct have been made against a caseworker, the supervisor should document the allegations and any other information learned and either fully investigate the matter themselves or forward the matter to the OIG for investigation. The supervisor should

immediately reassign the case from the caseworker against whom the allegations were made to a caseworker against whom such allegations are unlikely to be made again (e.g., if allegations are made by a female client against a male caseworker, the case should be transferred to a female caseworker).

II. RECOMMENDATIONS ADDRESSING CHILDREN'S HEALTH AND EDUCATIONAL NEEDS

BETTER ACCESS TO MENTAL HEALTH RECORDS

- A task force convened by the OIG recommended that the Department adopt and implement a revised user-friendly protocol and training for securing consents for release of mental health records.

BETTER USE OF PSYCHOLOGICAL EVALUATIONS

- In May 1997 the OIG, CESI and the Clinical Division of DCFS worked collaboratively on reforms in child welfare regarding the referral and use of psychological evaluations. One component of this initiative focused on the appropriateness of conducting psychological evaluations on infants, toddlers, and school aged children, including teen wards. The collaborative effort produced a "decision tree" which child welfare professionals will use to correctly identify those wards in need of a psychological evaluation and what is the appropriate type of evaluation to obtain. Child Welfare training has begun on the use of the "decision tree".

- DCFS should complete the implementation of a previous OIG recommendation that DCFS and private agency caseworkers receive training on the appropriate use of clinical evaluations and psychological evaluations. DCFS should develop policy, procedures and training in the understanding, purpose and use of an assessment of parenting ability compared to a psychiatric/psychological evaluation.

- The Department should determine the credentials required for professionals who conduct psychological evaluations of Department wards.

MEDICAL CONSULTATION

- The Department should distribute reinforcing information to all investigators and caseworkers concerning the availability of the DCFS Medical Director as a resource, the types of issues with which she can assist, and the procedures for contacting her or other medical professionals for consultation, including reviewing medical records.

MEDICAL EXAMINATIONS

- Thorough head to toe physical examinations should be given to children when they leave foster care and return home. During the examination, the physician should discuss with the parents developmental issues that are appropriate to the child's age.

EDUCATIONAL PROGRAMS

- All at risk preschool children, prior to returning home, must be enrolled either in state preschool or, if available, in an early childhood program such as Zero to Three or Head Start. Attendance at such school programs affords extra protection to these children, enabling school personnel to monitor attendance and safety of the child returned home.

- The Department should require that every preschool foster child be screened for early childhood development, including but not limited to, vision and auditory evaluations.

- The Clinical Services Division provided a computer generated list of age eligible children in DCFS Chicago regions and Purchase of Service agencies. The OIG then selected 12 private agencies to participate in the initial ChildFind project. All children produced by the agencies received developmental screenings, including vision and hearing tests.

PROVIDING ADEQUATE SUPPORT SERVICES

- Private agencies' case managers and supervisors must be provided with training to gain an understanding of developmental disabilities, early education programs, services addressing disabilities, and appropriate resources in the Chicago area.

III. RECOMMENDATIONS TO PROMOTE PERMANENCY FOR CHILDREN

TO INCREASE ADOPTIONS

- The OIG recommended redesigning the caseworker assignment procedure by assigning an adoption liaison to each placement team while retaining the case with the placement team (previously, cases would be transferred to new workers when identified for adoption). Retaining the case on the placement team can provide more continuity for the child and free the adoption worker to provide adoption services for more children.

- The OIG worked to incorporate safeguards to ensure that adoption would remain the preferred permanency goal (over subsidized guardianship) for each child.

- The Kinship Permanency Planning Project (a mediation project that enabled families to choose permanency options for children in their family) and Adoption Redesign Family Meetings were initiated by the OIG to facilitate adoptions and guardianships by stable family members.

- In the past year, the OIG continued its work with the Adoption Panel, a highly experienced group of outside consultants who lend their expertise to the resolution of difficult placement and adoption questions raised by the Department.

- The Inspector General joined with the Honorable Nancy Salyers, Presiding Judge of the Child Protection Division, Cook County Juvenile Court, to present, *Chances for Children*, an adoption fair for prospective adoptive families and children who need to be adopted. *Chances for Children* was held April 26, 1997 at the Juvenile Court of Cook County. Over 400 prospective adoptive parents attended along with 132 foster parents and staff who brought 150 waiting children. Close to 100 volunteers from the Court offices, the OIG and the general public transformed the Court into a carnival setting for the children, and provided informative workshops for prospective adoptive parents.

- The OIG recommended that the Department identify those cases in which the Department and the parent could agree about a safe and appropriate placement for the child and then work with the parent to secure a voluntary consent for adoption by the specified caretaker. In this way, the Department and the Courts could avoid the time-consuming and expensive termination of parental rights hearings for some children. "Specific Consent" legislation became law in June 1997.

PARTNERING FOR PERMANENCY

- In collaboration with the Child Care Association and Lifelink/Bensenville, the OIG recommended field-testing a decision matrix to determine the most appropriate goal for a family (e.g., adoption or reunification), appropriate services aimed at reaching the goal and whether a given family was likely to accomplish the goal. A cornerstone of the matrix is the use of "concurrent planning," in which parents are offered time limited services with a clearly stated preferred goal of return home. At the same time, other permanency options are pursued, and an alternate permanent plan is established, with full knowledge and, if possible, participation of the parents.

EXPEDITED TERMINATION

- The OIG recommended and advanced the initial legislation that allowed for expedited termination of parental rights in egregious cases. In addition, the new law amended the Department of Children and Family Services Act to clarify that family preservation services do not need to be provided if reunification is not a viable goal.

- The Department should require case conferences when critical information may affect permanency planning and delivery of services.

- The Department should alter its rules, policies, and practices to ensure that a return home goal is not automatically assigned to new cases without regard for the severity of high-risk of harm to the child or the parent's capacity to change the problem that put the child at risk.

IV. RECOMMENDATIONS TO DEVELOP AND PROMOTE COMMUNITY RESOURCES "OF SUFFICIENT QUALITY" TO MEET THE NEEDS OF CHILDREN AND THEIR FAMILIES

DCFS MONITORING OF PRIVATE AGENCIES WITH CURRENT DCFS CONTRACTS

- DCFS should ensure that all service providers understand and apply DCFS recommended hiring practices.

CORRECTIVE ACTION PLANS

- When monitoring an agency's implementation of a corrective action plan, DCFS must establish clear expectations and monitor compliance.

JUVENILE OFFENDERS

- Deflect to law enforcement for investigation allegations against juvenile offenders who were not caretakers and defer less serious allegations for voluntary mental health or other relevant services.

DATA RESOURCES

- Expand data resource capability to allow private agencies and the Juvenile Court to access information in the Department's database.

- Implement controls to prevent abuse of criminal history checks and child abuse and neglect history checks.

DAY CARE

- Licensing regulations should specify minimum conditions necessary to apply for day care home licensure.

FEDERAL FOSTER CARE MATCHING FUNDS

- The Inspector General brought to the attention of the Department's General Counsel the federal law disallowing reimbursement for foster care funds paid to for-profit child care agencies.

V. RECOMMENDATIONS PROVIDING GENERAL SUPPORT OF CHILD WELFARE CASEWORK

INCREASING PROFESSIONALISM

- Last year, the OIG pioneered the adoption of an Ethics Code for Department employees. This year, the OIG has continued its work in developing the Child Welfare Ethics Forum (co-sponsored by the OIG and Loyola University), began work on an Ethics Training for management and developed a Child Welfare Ethics Network between DCFS and private child welfare agencies.

TRAINING

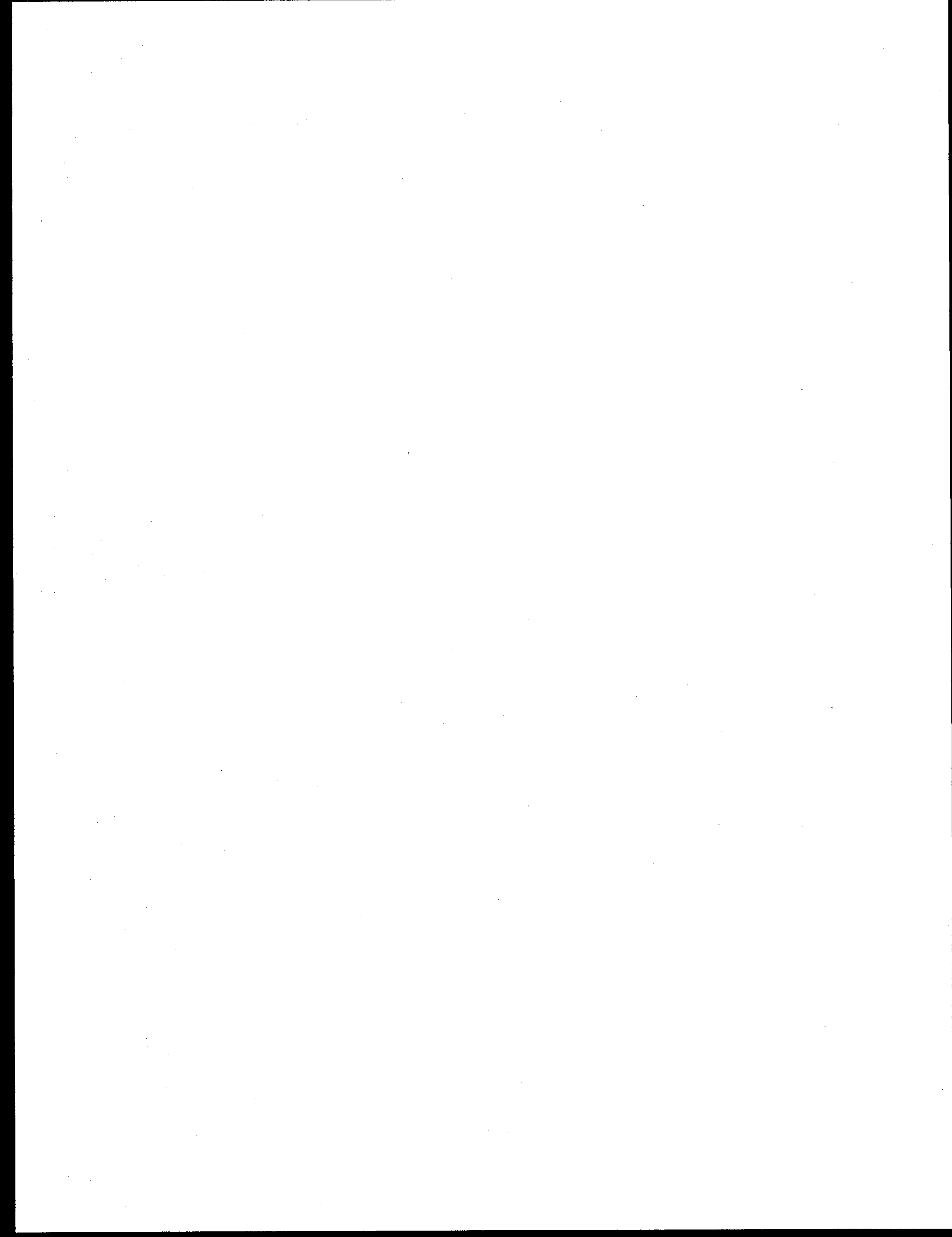
- The OIG developed and continues to present a two-day training for DCFS and private agency supervisors and workers on skills for testifying in court.

- The OIG designed and coordinated a two-day training for Department personnel regarding not for profit corporations.

DILIGENT SEARCH CENTER

- This past year, the OIG recommended that the Department assume responsibility for the management of the Diligent Search Center. The OIG had begun the Center in 1996, after receiving funding from the Department of Health and Human Services, to assist caseworkers in searching for missing family members.

APPENDIX: Recommendations for Improving the State's Child Welfare Response to Families Affected by Parental Substance Abuse



DCFS OFFICE OF THE INSPECTOR GENERAL

Recommendations for Improving the State's Child Welfare Response to Families Affected by Parental Substance Abuse

Extent of the problem

Substance abuse affects as many as eighty percent (80%) of all cases of substantiated child abuse and neglect (Child Welfare League of America, 1990). While Illinois data does not give an accurate picture of the extent of substance abuse among indicated reports of abuse or neglect (Illinois child protection data is kept by type of harm to the child, rather than the parent's presenting problems), anecdotally, workers speculate that there is some level of substance abuse by the biological or extended family in 60-80% of the indicated cases.

During fiscal year 1996, 3436 reports were made to Illinois DCFS regarding infants exposed to illegal drugs at birth. Fifty six percent (56%) of all substance exposed infant (SEI) reports occur in just six Local Area Networks (LANS) of the South and Central Regions of Cook County. Reports of substance exposed infants (SEI) have increased 3000% since FY85. While FY96 showed a 25% decrease in SEI reports, no one knows whether there are actually less SEI infants or whether it is a result of managed care and Medicaid policies regarding testing. It has been suggested that the cost associated with keeping reported infants in the hospital while DCFS makes a determination as to the child's custody has led to hospital staff performing fewer toxicology screens. (IDCFS SEI Protocol, March, 1996)

Forty percent of all SEI families reported have a history of prior DCFS substantiation of abuse and neglect. While most Illinois regions take protective custody in the range of 25-35% of indicated cases, Champaign takes 53% and Peoria takes 62%. In Cook, the percent of protective custodies taken increased from 22% in FY95 to 35% in FY96. Subsequent SEI reports (i.e., mothers who have already given birth to one or more substance exposed infants) have increased sharply in the last fiscal year, from 26% in FY95 to 38% in FY96.

Currently, DCFS has an inadequate response to indicated reports of substance exposed infants. While DCFS has proposed a pilot at Mt. Sinai Hospital in Chicago which, if successful, would improve assessment of SEI families and would improve linkage between DCFS, DASA and Public Health, the Department continues to underestimate the level of risk for SEI babies. This results in too few subsequent substance exposed infants being placed in substitute care, and too few and fragmented services being offered those who are not placed in foster care.

An example from among the child deaths investigated by the OIG in the past year illustrates the tragic consequences of providing too few services, with little expertise, to intact families where substance abuse is involved:

A three-month-old child died as a result of starvation due to parental neglect. At the time of the child's death, the child's mother had an open intact family case with DCFS based on substance abuse. The case was being serviced by a private agency that was unable to address the family's problems because it lacked expertise in substance abuse. The supervisor at the agency lacked the child welfare background necessary to effectively supervise and monitor workers in his unit. The two caseworkers at the private agency lacked sufficient clinical knowledge of substance abuse issues in order to provide adequate services to the mother. The DCFS unit assigned to the case did not adequately monitor the private agency's intact family unit.[1]

Mothers who cannot abstain from the use of drugs and alcohol during the third trimester of their pregnancy represent a small fraction of all substance abusing mothers and pose a high risk to their newborns. A recent California study looked at 401 pregnant women, fifteen years or older who utilize public health, social service and criminal justice agencies and who, based on assessment, had heavily used alcohol or other drugs during the year prior to pregnancy. The study showed that only about 12-13% of these women continued their substance abuse in the final trimester before delivery.[2] The birth of a substance exposed infant is more than *prima facie* evidence of child abuse; it is clear evidence of a substance abuse problem which is out of control. Subsequent births of substance exposed infants shows either a complete inability to control one's addiction or a blatant disregard for the newborn child's well-being; either way, unless there is another drug-free adult in the household to care for the newborn or the parent is offered and

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[1]In this case, the OIG has recommended that DCFS no longer refer substance abuse cases to the agency and that present funds currently allocated to generic intact family service programs should be reconfigured. Funds should be directed either to those child welfare providers who also have substance abuse treatment components, specifically the Project Safe program, or to those child welfare providers who collaborate with a Project Safe program and provide for integration of the two programs, characterized by an interdisciplinary team approach to families. (See a fuller description of the proposed intact family treatment model below.) The Department accepted both recommendations and has committed to auditing current providers to distinguish those with substance abuse expertise from those without such expertise. (This has not yet been put into affect.) Those without expertise will be required to collaborate with substance abuse experts to serve cases where substance abuse is the primary problem.

[2]Alcohol use was 77% in the quarter before pregnancy; 42% in the first trimester; 20% in the second trimester; and only 13% in the third trimester. Marijuana use was 43% before pregnancy; 28% in the first trimester; 11% in the second trimester. Powder cocaine use was 26% before pregnancy; 14% in the first trimester; lower thereafter. Crack cocaine use was 30% before pregnancy; 20% in the first trimester; and lessens thereafter.

accepts a combination of services and family support that can offer round-the-clock backup and monitoring, these children should be viewed as being at very high risk for abuse or neglect.

When there is no other drug-free adult in the child's household who accepts full responsibility for caring for the child when the parent cannot, parental substance abuse places that child at risk of child abuse and neglect in several ways. Heavy drug and/or alcohol use causes a parent to be less attentive to the child's safety needs; it may reduce the parent's ability to control abusive impulses. (Azzi-Lessing and Olsen) For poor families, procuring illegal drugs diverts household finances from purchasing basic necessities such as food and clothing. If the parent is procuring the drug or the means to buy the drug, or if the parent is on a binge, the parent may leave young children unattended. (CWLA, 1990) Parenting is inconsistent, depending on whether the parent is using the drug, coming off the drug, craving the drug, or in a period of abstinence. When the parent is either physically or mentally unavailable, infants and young children are at especially high risk since they are unable to fend for themselves. Young children without a sober caretaker in the home are deprived not only of basic physical care but also of the essential ingredients of nurturance which promote normal child development -- being cuddled, talked and responded to, and receiving other mental and social stimulation. The most vulnerable of these youngest children are those whose growth and development have been compromised by pre-natal drug exposure. (Zuckerman, 1994)

Inconsistent parenting, or the unavailability of a parent, particularly when a parent leaves the child alone or with others for significant periods of time while binging on drugs, can interfere with parent-child attachment, or bonding. It is believed that parent-child attachment acts as a protective factor, or buffer, which helps to prevent the parent from abusing or neglecting a child. Conversely, the research is clear that early disruptions in attachment put the child at higher risk for abuse or neglect.

Moreover, substance abuse is usually only one of several risk factors resulting in child abuse and neglect. The most commonly identified of these include social isolation, poor parenting skills, and high levels of family stress. In addition, certain risk factors have been shown to be common among women who abuse alcohol and other drugs -- the lack of a parental role model, mental health problems, the presence in the household of other drug users, domestic violence, and other violence. If a mother has been abusing drugs or alcohol since her teenage years, she may have few if any skills, either for the workplace or for parenting. She may require not "rehabilitation", but "habilitation", that is, learning skills for adult functioning and parenting for the first time. If it is reasonable to try to keep the family together or to attempt to reunify the family, then treating the substance abuse problem is an important first step, but it is often only a first step.

Nationally, studies are beginning to reveal that children placed in substitute care due to parental substance abuse, as compared with children placed for other reasons, stay in out-of-home placements longer, experience more changes in placement, are less likely to return home, and have lower rates of adoption. This is particularly true for minority children (Besharov, 1990; Fanshel, 1975; Walker et al. 1991)

Substance abuse treatment - what works and what doesn't - how success is measured

There is a paucity of literature specifically about the treatment of substance-abusing mothers. However, national studies of representative samples of clients in publicly funded substance abuse treatment programs show that of the people who successfully complete a course of substance abuse treatment, whether inpatient or outpatient, somewhere between 40%-60% show a substantial reduction in use of drugs and alcohol six months after treatment. Six key factors predict success in substance abuse treatment:

Length of time in treatment - The longer the client stays in treatment, the better.

Less severe addictions - People who are addicted to several drugs (poly-drug addictions) and cocaine addictions are more difficult to treat.

Fewer other stressors - People who suffer from other stresses, such as mental health problems, unemployment, or a lack of social support, do less well in treatment.

Multiple treatment experiences - It often takes several meaningful periods of treatment before a client can successfully kick the addiction. Short stays (e.g., one or two weeks) don't count.

Age -The older the client is, the more likely to succeed.

Involvement in comprehensive treatment program -- Treatment programs which offer not only treatment for the addiction, but also services to meet more of their clients' needs, such as social services, mental health, primary health care, and employment, have better results. This concept is often referred to as "one-stop shopping".

Several points should be made with respect to these factors:

1. **Substance abuse and child welfare services operate on different time lines.** The passage of time is on the side of successful adult drug treatment. The older the client, the more attempts at treatment, the longer the treatment spells, the more likely it is that the client can significantly reduce use of the drug. For children of chemically dependent parents, however, the passage of time can result in a host of lost opportunities -- if the child is in the home, for development and stimulation and for establishing a secure attachment with a primary care giver; if the child is in foster care, for getting on with the business of growing up in a permanent family. Children need to grow up with a vision of their future in a family. Both Illinois law and policy acknowledge this need by requiring six month reviews and a permanency hearing within 16 months from the time a child enters foster care. While the prevailing substance abuse treatment philosophy is "one day at a time", best practice in child welfare is to plan from the very beginning of the case for the future of the child.

Moreover, formal drug treatment programs do not last as long as child welfare interventions in families. Much of recovery is done after treatment is completed. There is no "cure" for addiction. Drug addiction, especially crack addiction, is a "chronic, relapsing disorder." (Schottenfeld, 1994) Child welfare systems must develop the expertise to monitor progress in

recovery after formal treatment is completed. If the client is fortunate enough to receive treatment in an environment in which access to drugs is restricted, the child welfare worker must be careful not to assume that the client can sustain behaviors outside of the controlled environment. (DSM IV) The client's behavior must be measured and carefully monitored once she leaves the restricted setting, and the "clean time" in the restricted setting, while important, must not be over-relied upon.

To reconcile these fundamental differences in orientation is no easy task. To best serve children, however, collaboration must occur. Substance abuse programs that receive public funds to serve child welfare clients must redefine treatment success to include improving the client's ability to function competently as a parent. Child welfare programs must share expertise and information with the treatment provider to help measure progress, and both systems must reach out and form tight linkage with other critical community resources, such as developmental services for children, and maternal and child health care services, including family planning.

2. **The best way to keep clients in treatment is to provide continuity of care -- that is, the ability to move among levels of care within a single treatment agency.** There are few long-term substance abuse treatment programs. Inpatient treatment beds are being reduced, and the length of most publicly funded in-patient programs has been reduced from six months to anywhere from 21 days to 90 days. American Society of Addiction Medicine (ASAM) criteria require periodic evaluations for appropriate levels of care. Best practice dictates placing the parent in an appropriate level of care, based on assessment. Providing continuous treatment requires "stepping down" from higher levels of care to lower levels of care, and providing an aftercare plan upon discharge. Aftercare is not treatment at all, but rather an individualized discharge plan which directs the client to seek treatment for other needs, such as mental health and vocational rehabilitation, and provides a plan for "relapse prevention". This prevention plan outlines strategies for coping with the stress of post-acute withdrawal, dealing with the client's "triggers" (the people, places and things that trigger use) and engaging in social interactions which will support the client's sobriety, such as AA, NA, church or community activities. A client with a long-standing and severe substance abuse problem is likely initially to require an inpatient or intensive outpatient program, eventually stepping down to a 25 hour regular outpatient program, then moving to aftercare. In addition, some clients will need transitional housing or drug-free apartments.

Child welfare clients referred to programs receiving special funds through the DCFS-DASA Initiative are guaranteed treatment, but not necessarily at their assessed level of care. If the client needs inpatient care, there is usually a waiting list, so the client may be referred into a 25-hour regular outpatient slot until a bed becomes available. Those familiar with the Initiative report to the OIG it is often difficult to retain a client in a lower level of care than that for which she has been assessed. (The current evaluation of the Initiative may shed more light on the extent of this problem.)

Each time a client must move between programs in order to receive the appropriate level of care,

she is extremely vulnerable. Individuals in the early stages of recovery rely heavily on familiar routines. The treatment process requires that a participant begin to reveal him- or herself and to develop trusting relationships with others in treatment. Transition to another level of care, if it requires transferring to another facility, places the participant at risk of relapse and/or dropping out of treatment. Research and experience tell us that the best way to keep a client in treatment is to provide continuity of care - that is, the ability to move among levels of care within a single treatment agency.

Moreover, when a child is involved, and the agency is working with the mother and child together, keeping the parent in one agency should result in improved monitoring of the parent's ability to appropriately care for the child and the child's developmental progress. Once the professionals and paraprofessionals in an agency know the mother and child, it is more likely that they will notice if the condition either is worsening or improving.

3. **Comprehensive treatment, or one-stop shopping, for substance affected families must include integrated child welfare and substance abuse treatment services.** A better model also offers additional services, such as maternal and child health services, including family planning services, protective day care and early childhood interventions (such as Headstart, Zero to Three, and state Pre-Kindergarten), housing and employment referrals, linkage to aftercare programs, and groups for men, such as batterers groups, men's NA and AA groups.

Research supports the notion that "co-location" of services -- combining key services in a single treatment setting -- is the most efficient and effective way of delivering a comprehensive range of services. (Zuckerman, 1994) It is unrealistic, however, to expect drug treatment programs to develop the expertise to competently provide a full range of child welfare services. In other words, drug treatment programs should not be encouraged to "go it alone". Historically, the substance abuse treatment system has focused on treating individual problems and has been dominated by treatment models favoring the needs of men. (Azzi-Lessing and Olsen) Across the nation, there are very few treatment programs which approach women as mothers as well as individuals, or deal with matters of parenting and the well-being of children. Even fewer allow mothers to bring children into treatment with them. (Gustavsson 1991) Rarely do treatment center staff have training in parenting skills, recognizing or treating child maltreatment, or on child welfare issues. Family reunification and long-term family functioning are rarely if ever dealt with during substance abuse treatment. (Tracy, 1994) Typically, treatment programs define success strictly in terms of abstinence and sobriety. Treatment staff have little or no contact with their client's child welfare workers; too frequently the staff support their clients' unrealistic expectations that once treatment is completed all their children should be returned to them regardless of the length of time the child has been out of the home, the nature of the parent-child relationship, and the potential for relapse by returning too many children too soon.

Cook County is extremely fortunate to have several programs which already focus on the woman in her role as mother as well as on the child. These programs have indicated the willingness to

develop better strategies for working with the entire extended family. Moreover, these programs have indicated an eagerness to develop the capacity for comprehensive treatment by collaborating with other agencies, such as Public Health and DCFS intact family, foster care or reunification programs.

Proposals for Change

The following proposals include recommendations for initiating new efforts, as well as discussion of projects the OIG already has begun implementing. The first seven proposals are specific to cases where substance abuse is involved; the remainder of recommendations concern child welfare practice regardless of the presenting problems. but clearly are applicable to substance abuse cases.

1. Collaborative service planning between substance abuse treatment and child welfare programs - a new approach

A 1995 survey conducted by the OIG found that chemically dependent child welfare clients who were in residential treatment had unrealistic expectations regarding the return of all of their children. Their expectation of return home was based on their participation in treatment, regardless of the length of time the children had been in foster care. Moreover, despite residing in stable treatment, many of the mothers had little contact with their caseworkers.

In May 1996, the OIG began field testing a model of collaborative service planning which involves substance abuse providers, child welfare workers, parents, the child's out-of home care giver, and the extended kinship network. Child welfare and chemical dependence professionals were trained together. The model requires caseworkers to convene a series of preparatory meetings with the various participants, leading to a conference at which all parties are present and the following occurs:

- The clients, extended family and chemical dependence providers are provided with a realistic picture of the case and the permanency plan for each child.
- The need to involve family members in child welfare decision making and in the chemical dependence treatment process is discussed.
- A process of early and ongoing collaboration between the child welfare and chemical dependence program is established, including an agreement on frequency of communication and joint case planning to assure consistent expectations for the parent's progress.

The results of the field trial are encouraging. The conferences have resulted in better communication, more information sharing, and more coordinated case plans. Based on this experience, the OIG recommends that a collaborative service planning conference be held in both intact family and substitute care cases at the point that the parent has stabilized in treatment. Additional staffings involving the relevant professionals (including mental health workers) and the parent should be held at critical transitions in the level of care. DCFS and DASA should work together to train both public and private child welfare and chemical dependence providers in this conference mode; [redacted] should be used to

develop a model of training which will help workers be able to facilitate these conferences.

2. Specialized intact family services for substance abusing families

Currently, DCFS funds a variety of generic intact family programs which are not targeted to the specific subsets of the population of DCFS clients. Programs receive between $4,500 to $5,000 per case. Because of a lack of knowledge regarding substance abusing families, many of these programs are ineffective. We recommend that DCFS create an RFP process to solicit proposals for specialized intact family services for substance abusing families. This recommendation would not cost additional money, but would rather reconfigure existing contract money.

These programs should have the following attributes:

- Integrated child welfare and chemical dependence treatment services. This integration can be achieved either through co-location of both services in a single agency or through a partnership among two agencies. Integration of services will be marked by collaborative service planning, frequent joint case staffings, and ongoing interdisciplinary assessment and consultation.

- Families should be treated by teams which include an M.S.W. supervisor, a chemical dependence professional, and a paraprofessional. The experience of Project Safe programs is that persistent, caring outreach by paraprofessionals, who live in the community and are often recovering addicts themselves, is often the key to getting the parent into treatment. Paraprofessionals also can provide transportation, support to parents during treatment and recovery, and can schedule collaborative service conferences.

- Mandatory 12-18 months of service delivery for intact family cases, unless temporary custody is taken during this time. Cases must be able to be kept open for up to 24 months when necessary. Brief in-home services do not square with the fact that the resolution of drug treatment and recovery takes at least one and frequently two years. (DSM IV; Barth, 1994)

- Housing referral - Families who are receiving Norman funds to secure housing should be assisted in finding housing in drug-free buildings. Paraprofessionals who understand the local drug culture can be enlisted to find such buildings. Chemical dependence programs that operate transitional housing programs find that landlords are very receptive to establishing drug-free buildings. The housing initiative we are recommending is not transitional housing, but rather a place where the client can live long-term: it makes sense to funnel Norman assistance into environments which promote recovery for the parents and safety for the children.

- The program must assure that the parent enroll each child in early childhood intervention,

state pre-Kindergarten. Headstart or school. The intact family program must also enter into an agreement with the early childhood educational site that if the child is absent for more than two consecutive absences, an emergency call will be made to the intact family services worker. Intact family workers must treat these calls as identifying potentially high-risk situations requiring immediate home intervention.

- The program must provide for child care during treatment, crisis nurseries to provide short-term overnight care while parents are in detox, and respite care during times of parental illness. Along with early educational intervention, child care is the bedrock of services to protect children at home.

3. **Family planning services**

The anecdotal data on families being served by DCFS in which the primary presenting problem is chemical dependence is that these families are larger than the average family served by DCFS (see also Besharov, 1996). (The average DCFS family size varies among regions from 1.5 to 2.5 children.) Reducing the number of unplanned pregnancies among substance abusing mothers is an important way to limit the stress placed on a family and to prevent subsequent SEI births. A program in California in which women in substance abuse treatment programs are offered the opportunity to receive periodic Depo-Provera injections has been shown to be far more effective than other forms of family planning which require more planning and/or daily oral medication. The OIG has talked to the Chicago Department of Public Health and at least one women's treatment program; there is interest in exploring such a program. Drug treatment programs could open their door to Public Health nursing staff to run educational information seminars on family planning, and/or provide transportation for clients to public health clinics for an initial appointment. In Chicago, there is currently a sixty day wait for initial appointments, but the Chicago Public Health Department has offered to come out to the treatment facilities, educate clients on family planning options and schedule initial appointments. The OIG will explore this idea further in the next several months.

4. **Restriction of Medicaid cards for substance-abusing parents**

In a recent investigation, the OIG identified the potential for individuals to abuse prescription drugs by seeking treatment and prescriptions from multiple primary care providers and/or pharmacies. The Department of Public Assistance (IDPA) provides a process by which a Medicaid recipient's use of public aid cards can be restricted to a single designated primary care provider, doctor and/or pharmacist. The program, called the Recipient Restriction Program, is designed precisely to reduce overuse of services, including limiting abuse of prescription drugs.

The IDPA provides an administrative review process for determining the need for such a restriction. The review is initiated through a written request. Restricted recipients are entitled to appeal the decision. Should a restricted recipient access services through a provider other than the one he or she is restricted to, the ineligible provider will be fined.

The OIG will be working with the IDPA Medical Quality Assurance Department to make information about recipient restriction available to child welfare providers.

5. Memorandum of Agreement

The OIG has been concerned with the number of cases where a child is born substance exposed and/or born to a mother with a history of substance abuse. Frequently, these cases are referred to DCFS because of risk of harm. Some of these cases are appropriately referred to the Juvenile Court for a court order removing the child from the parents custody; other cases either are not opened by the DCFS, or opened but custody of the child is not taken. There are also cases where court involvement may not be required, but the parent temporarily may be unable to care for the child while he or she begins substance abuse treatment.

The OIG is working with the DCFS and at least two community organizations (one in Chicago and one in Champaign) that offer mediation services to encourage extended family involvement in decision making and participation in the protection and care plan of children who are at risk of being placed in the foster care system. The model, referred to as Family Conference, is based on the premise that families should be given and should take responsibility for creating a plan that will protect children and keep the family intact; the state and community should support and assist the family in creating an appropriate plan.

In cases involving substance abuse, this plan may allow the child to remain with the drug involved parent while the parent addresses the substance abuse problem; at other times it may require that the substance abusing parent temporarily relinquish parenting responsibility and participate in in-patient or out-patient substance abuse treatment. (See Attachment 1, decision making trees for use in the Family Conference.) The OIG is interested in adding a component to the Family Conference in those cases that involve substance abuse. The project would encourage a parent to enter into a memorandum of agreement with the child welfare agency serving the family. As part of the agreement, the parent commits to undergo substance abuse treatment at a program designated in the memorandum, agrees to the purposes for the treatment, as delineated in the memorandum, and agrees to sign consents for release of information forms in order for the child welfare agencies serving the family to be apprised of the parent's progress. The memorandum clearly informs the parent that his or her noncompliance with the agreement may result in the family being referred to the Juvenile Court for a hearing at which the children may be removed.

6. Short-Term Guardianship

The project described above also would encourage a parent to appoint another individual as public aid payee, and in appropriate cases, to sign a short term guardianship (or in some cases a standby guardianship) form allowing a family member (in some rare cases it may be a close family friend) to care for the child while the parent is in treatment. (The memorandum of agreement addresses these issues.) This arrangement would be used, for example, in cases where

the parent is undergoing detox, entering an inpatient program. or unable to care for the children while he or she works on getting the substance abuse under control. Under the short term guardianship law, the guardianship arrangement is for a period of up to 60 days, but it does not require court involvement. The standby guardianship provisions require that the court approve the arrangement within 60 days of the designated individual assuming guardianship responsibilities.

The OIG has contacted the IDPA to discuss an arrangement whereby a parent who signs a short term or standby guardianship form does not risk losing his or her Medicaid card and assistance, and thus the ability to pay for the substance abuse treatment and keep his or her housing. This result would defeat the entire aim of the program--to provide the opportunity for parents, without state intervention, to address their substance abuse problems in order to be able to care for their children. [redacted]

See Attachment 2 for summaries of the short term guardianship and standby guardianship laws, as well as drafts of the memorandum of agreement and consent for release of information forms we intend to use in this project.

7. Requirement that children be in school/Headstart or Zero to Three programs

All children who come from substance abusing home environments who are being served by DCFS in their own homes, should be in school or early childhood programs. To assure the child's continued safety and well-being while receiving intact family services, the educator should be asked to notify the child welfare worker if the child misses more than two consecutive days. When a child is being seen by a concerned educator, it reduces risk factors for the child and strengthens the safety net. The research on children from chemically dependent families is that they need stability, predictable environments and early childhood education to remedy or treat the effects of the chemically dependent family, which include a chaotic lifestyle and a lack of environmental stimulation. Children returning home from foster care should be enrolled in their new program prior to return home. The reunification plan can include extended visits on weekdays, during which the child can begin attending the new school program, and the child welfare worker and the educator can assess how the parent is handling the child being in the home and cooperating with the education program (e.g., child's attendance, volunteering at the Headstart site).

8. Fast track termination of parental rights.

In the majority of cases before the Juvenile Court, the child's need for a timely permanent placement is best served by aggressive casework and provision of services aimed at strengthening the child's biological family so that the child can return home. Even in cases where there is an open question about whether the family can make sufficient improvements to allow the child to be returned within a reasonable period of time, it is often wisest to provide a period of services to the family in order to answer the question about whether the family is

treatable. In some cases, however, a parent's conduct toward the child or the child's sibling has been so egregious that the behavior justifies termination of parental rights without giving parents another chance. In other cases, the parent's incapacity to care for the child, combined with an extremely poor prognosis for treatment or rehabilitation, justify a determination that the provision of rehabilitative services is unreasonable. For both classes of cases termination of parental rights should be an option early on in the case. Expedited termination in appropriate cases frees up valuable agency resources for establishing these children in other permanent families and for working with families who do have the capacity for change. Senate Bill 522, which has the support of a variety of organizations and agencies including the OIG, DCFS, Office of the Governor, Illinois Foster Parent Association, and the Office of the Presiding Judge for the Child Protection Division of the Circuit Court of Cook County, will allow for expedited termination of parental rights in appropriate cases. The bill is pending on the House floor; it is hoped it will pass the House and Senate during the January 6 and 7 session. (See Attachment 3 for Synopsis of SB 522 attached.)

9. Permanency decision-making - reunification; contingency planning

Beginning in January 1997, the OIG and DCFS will begin a new collaborative endeavor with the Child Care Association, and three of its member agencies, including Volunteers of America (VOA) and Lifelink/Bensenville Home Society (a third agency will be invited to join us). This project has been developed to test a series of best practice strategies for achieving a more timely permanent home in a less adversarial manner both for children who should be able to return home quickly and for children who are unlikely ever to be returned home.

The field test will involve children and families served by the three private agencies. A study group of children under the age of 12 who have been in foster care for one year or less will be assessed regarding the likelihood of reunification with their parent. Workers and supervisors will be trained in the use of two tools which have been developed by the Child Care Association. An interview protocol which will supplement existing assessment tools, and a decision-making matrix, called a Permanency Assessment Matrix are designed to be used by the supervisor and worker together to differentiate cases. The tools will assist in the identification of families at both ends of the substitute care continuum: families whose strengths are such that children are likely to be able to be reunified with the family within a period of five to eight months from time of entry into care, as well as families where the children are unlikely to be able to be reunified. Within the latter category (unlikely to be reunified), an additional distinction will be made between families for whom the prognosis for return home is so poor that an alternative permanency plan should be pursued immediately, and families where a reasonable cause exists for permitting the parent a final opportunity to engage and progress in services. For the latter families, *contingency planning* is recommended. *Contingency planning* is a model of practice in which parents are offered services with a clearly stated preferred goal of return home, but at the same time, other permanency options are being explored with full knowledge and, if possible, participation of the parents. If the parent has not made reasonable progress within a six to nine month time frame, the alternative permanency option is pursued. During the period of service

delivery, every attempt is made to place the child in a home which could become a permanent placement if the child cannot be returned to his/her parent(s).

If a case has been identified as a likely candidate for early reunification, the worker, with the assistance of a casework assistant, will schedule a meeting, called a *permanency conference*, with the parent, the extended kin, unrelated foster parent if applicable, and key service providers, such as substance abuse providers, who are currently involved in treatment of the parent. The permanency conference, based on the family conference model, will be facilitated by a trained family mediator whose services will be provided by the two participating agencies as an in-kind contribution to the project. If the case is an early reunification case, the purpose of the session will be to engage the participants in case planning for an early return. The goal will be to develop a service plan which maximizes the family's strengths, galvanizes support resources for the child's caretaker, and incrementally increases the parent's caretaking role over time so that at the end of the five to eight month period, the parent will have proven his or her ability to resume full-time caretaking. Training and consultation on strategies for successful reunification will be made available to workers and supervisors. Information learned in this project will be used to write a protocol for early reunification decision-making.

If the child is identified as *unlikely* to be reunified, the worker and casework assistant will likewise schedule a permanency conference involving the parent, kin and, where appropriate, the child's non-related foster parent and key service providers. Again, the worker's assessment of the case will be shared. If the recommendation is for immediate pursuit of an alternative permanent home with an identified caretaker, this information will be shared and the parent and the caretaker will be offered the opportunity to enter into mediation to explore the parent executing a specific consent for adoption. If this offer is accepted, the project will provide full mediation services through the agencies' trained mediators. If the parents do not wish to avail themselves of this less adversarial approach, the case will be screened for termination of parental rights and adoption planning.

If the agency's recommendation is for contingency planning, and the parent wishes to work toward reunification, the goal of the family conference will be to inform the parties of the intention to pursue contingency planning, what this means, and that, because children need stability and consistency, that the family is being asked at this point to consider where the child will live permanently if the child cannot be returned home. The service plan for the parent(s) and the time frames under which the parent's progress will be evaluated will be discussed. Typically, the family will be informed that a final decision will be made in the case no later than six to nine months from the date of the permanency conference.[3] During the period of service delivery, the

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[3]Two examples from cases currently under investigation because of the death of a child illustrates the need for contingency planning:

Eight months after a three year old girl was returned to her mother, she was

parent and extended family will be informed about the agency's assessment of the parent's progress. Also, if the desired alternative permanent plan would be adoption or subsidized guardianship by a relative, caseworkers will work with extended family members during the period of service delivery to help them come to decision about making this commitment to the child Follow-up conferences will be scheduled at the time of the final permanency decision to update the family. Again, if appropriate, the parent and family will be offered the opportunity to mediate a possible specific consent for adoption.

The project will provide training and ongoing consultation to workers and supervisors on the principles and techniques of contingency planning and will provide tools to assist in the documentation of the parent's and caseworkers' efforts and progress.

The application of the matrix, the process and outcome of the permanency conference and mediation sessions, and the process and outcome of contingency planning efforts will be

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> *drowned by her mother's boyfriend allegedly because she had wet her pants. The mother had eight children, five of whom have been in foster care for five years. The mother had a six year history of substance abuse, three cocaine exposed babies and two relapses. The little girl was the third cocaine exposed child.*

Another example is the case involving the death of a four year old who had recently been returned to his mother's care:

> *At the time the child was born, drug exposed, his older sister had already been in a non-related foster care for three years because of the mother's drug problem and during much of that time his mother had no contact with the agency or her daughter. Shortly after the child's birth, the mother failed to comply with an order of protection to enter treatment with the boy, and disappeared for nearly a year. For some of this time, the mother left the child with the putative father. After she was located and the boy placed in foster care, the mother did not engage in services or visit the child for four months. By this time, a petition to terminate the parental rights on the older daughter had been filed; this daughter was later adopted.*

Had contingency planning been done with either family at the time of the birth of the child who eventually died, or at the time of his placement into foster care, grounds for termination of parental rights would have been established long before the children were returned to their parents. Contingency planning allows the chemically dependent parent who has repeatedly failed to engage in treatment, resulting in long periods of foster care for a child's siblings, one last, time-limited chance to make significant progress in treatment. After that, the child's need for a permanent home takes precedence.

evaluated. In addition, where cases are referred for immediate termination of rights, the OIG will track these cases in the screening, Juvenile Court, and post-termination phases.

A manual will be developed which can serve as a guide to workers, supervisors, and administrators on how to put contingency planning into practice in Illinois.

10. Improved case monitoring

One of the problems which the OIG has discovered during the course of its investigations is the tendency of critical pieces of information to get "lost" in the case record, especially when there is worker turnover. The OIG has developed a case management information tool to allow workers to organize and systematize the flow of information in complex cases. The tool permits the concurrent and consecutive monitoring of multiple parental and familial problems. The tool allows the worker to track progress over time and to be able to get a visual picture of the history of the case. This instrument will be field tested in the contingency planning project discussed above.

11. Improved courtroom practice

The OIG has developed a two day training designed to develop caseworker skills in testifying in court. The training is a combination of lecture and moot court practice. The three hours of lecture covers both legal and social work issues; the social work portion focuses on best practice in substance abuse cases, including supervision, urine testing, relapse, and interviewing clients to monitor progress in recovery. The moot court portion of the training requires advance preparation on the part of the caseworker, who has the opportunity over the two days to practice skills, be critiqued, and receive suggestions for improving courtroom skills from attorneys from DCFS, the OIG, and the private bar. By June 30, 1997, 225 caseworkers and supervisors from DCFS and the private agencies will have been trained. (See Attachment 4 for the materials on substance abuse presented during the training.)

The OIG also is preparing a guide to proving chronic addiction in court which will be useful to caseworkers and attorneys.

12. Paternal involvement

It is recognized that many children grow up in families in which one parent abuses substances but the other parent or household member, such as a grandmother or aunt, is sober and provides stable caretaking. What is less widely acknowledged is that, even in households headed by a single mother or relative, fathers often play an important role in the lives of their children. (Zimmerman and Salem, 1995) Many child welfare workers overlook the potential for positive involvement of the child's biological father. The OIG will be working with University of Chicago Professor Waldo Johnson over the next six months to develop some guidelines and practice strategies for workers to engage fathers in the lives of their children.

13. CANTS and LEADS Checks

In the course of its investigations, the OIG has found that workers often fail to assess the risk posed by the presence of other adults in the child's household, including paramours. It is recommended that CANTS checks be completed for all adult members of a household where there is a history of substance abuse or violence, and that the LEADS protocol be followed (see Attachment 5, Leads Protocol). Where applicable, both LEADS and CANTS should be completed whenever an adult joins the household. Failure to do so can place both the child's safety and the recovering parent's sobriety at risk.

Discussion with the Cook County Office of the Public Guardian

On December 13, the OIG met with the Cook County Office of the Public Guardian to discuss proposals to improve child welfare practice, in the wake of the [redacted] case. Out of the discussion came the following recommendations. The first five are ones that should be fairly non-controversial and relatively easy to implement:

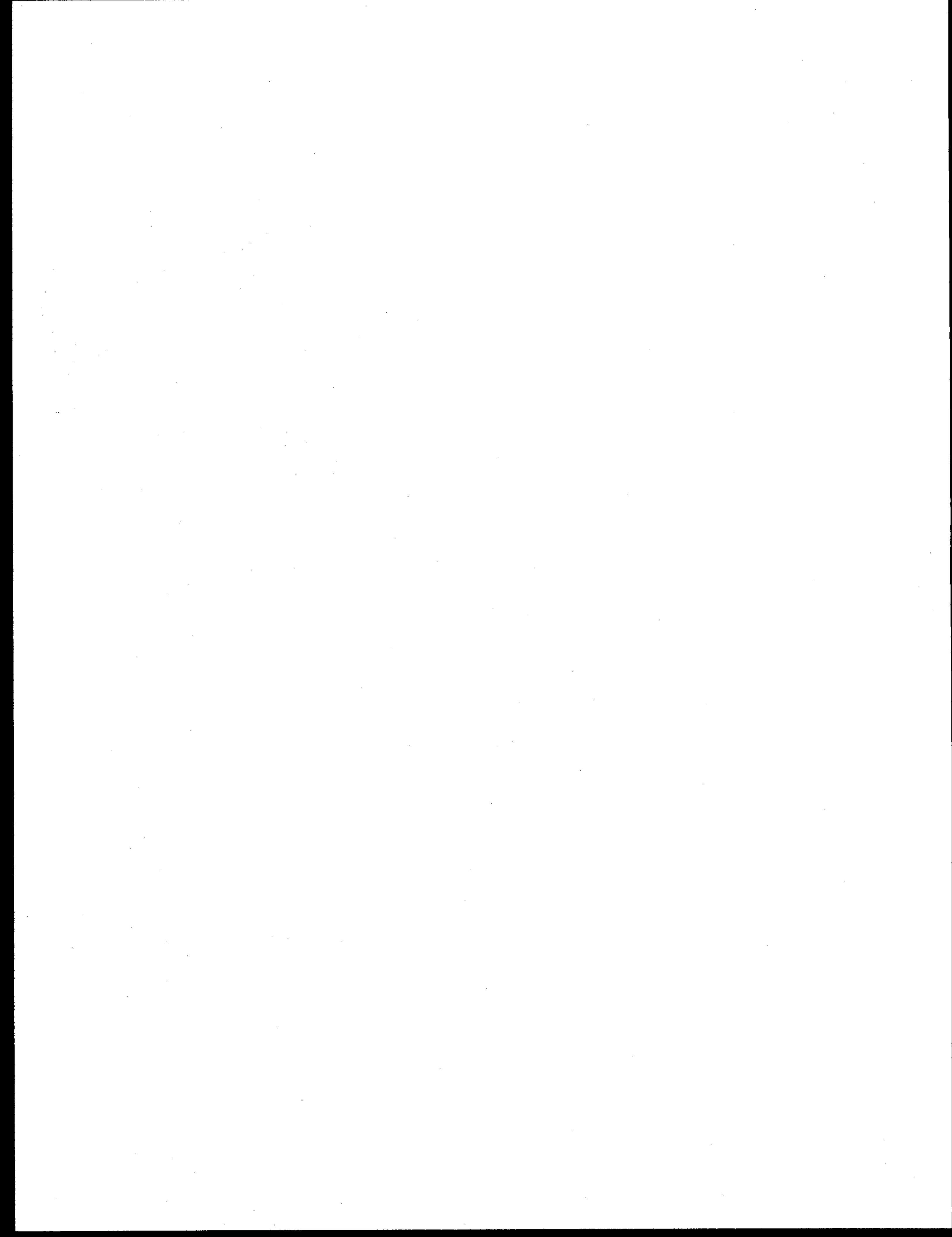
1. Once a client has had an evaluation completed by a psychologist, any referrals for subsequent evaluations should be to the same psychologist (unless there is reason to believe the first evaluation was of poor quality). ([redacted] first had a psychological completed by [redacted], and a subsequent one by [redacted] the two psychologicals were inconsistent; the [redacted] one was also much more thorough.) In addition, any evaluation should include a face sheet that identifies all reports that were reviewed in preparation for, and following, the evaluation.

2. Protocol should be developed for the information that must be provided to a psychologist prior to his or her conducting an evaluation, including client history, treatment history, facts leading to referral. ([redacted] appears not to have had a complete history on [redacted])

3. Workers should be required to bring the confirmation numbers for CANTS and LEADS checks to court so that the court or attorneys can confirm the results. (This may not assist in those cases where information is unavailable or unreliable regarding an individual's social security number, birth date, fingerprints.)

4. A court date should be scheduled within 45 days of a return home to check on services being in place and parent complying with services. (In the [redacted] case, the first court date following the September return home was scheduled for January.)

5. When an allegation is made that a child in foster care was abused or neglected by a parent during a visit, and there is a court hearing involving the allegation, the DCP worker, rather than the follow-up worker, should be required to testify at the court hearing. (In the [redacted], the GAL believes the DCFS worker testified about the allegation, not the DCP worker, and all parties accepted the DCFS worker's interpretation of what happened, i.e. [redacted] inflicted the injury.)



This annual report is dedicated to the memory of John M. Heath.

John was a respected and loved staff member of the OIG from 1993 until the time of his death on May 23, 1997. John served the State with integrity, honor, enthusiasm, dedication and hard work. His memory reminds all of us of the competence and effectiveness that we try to uphold in our jobs. John very proudly received a Bachelor of Science degree in Legal Inspection from Northeastern Illinois University just five days prior to his death.