OFFICE OF THE INSPECTOR GENERAL

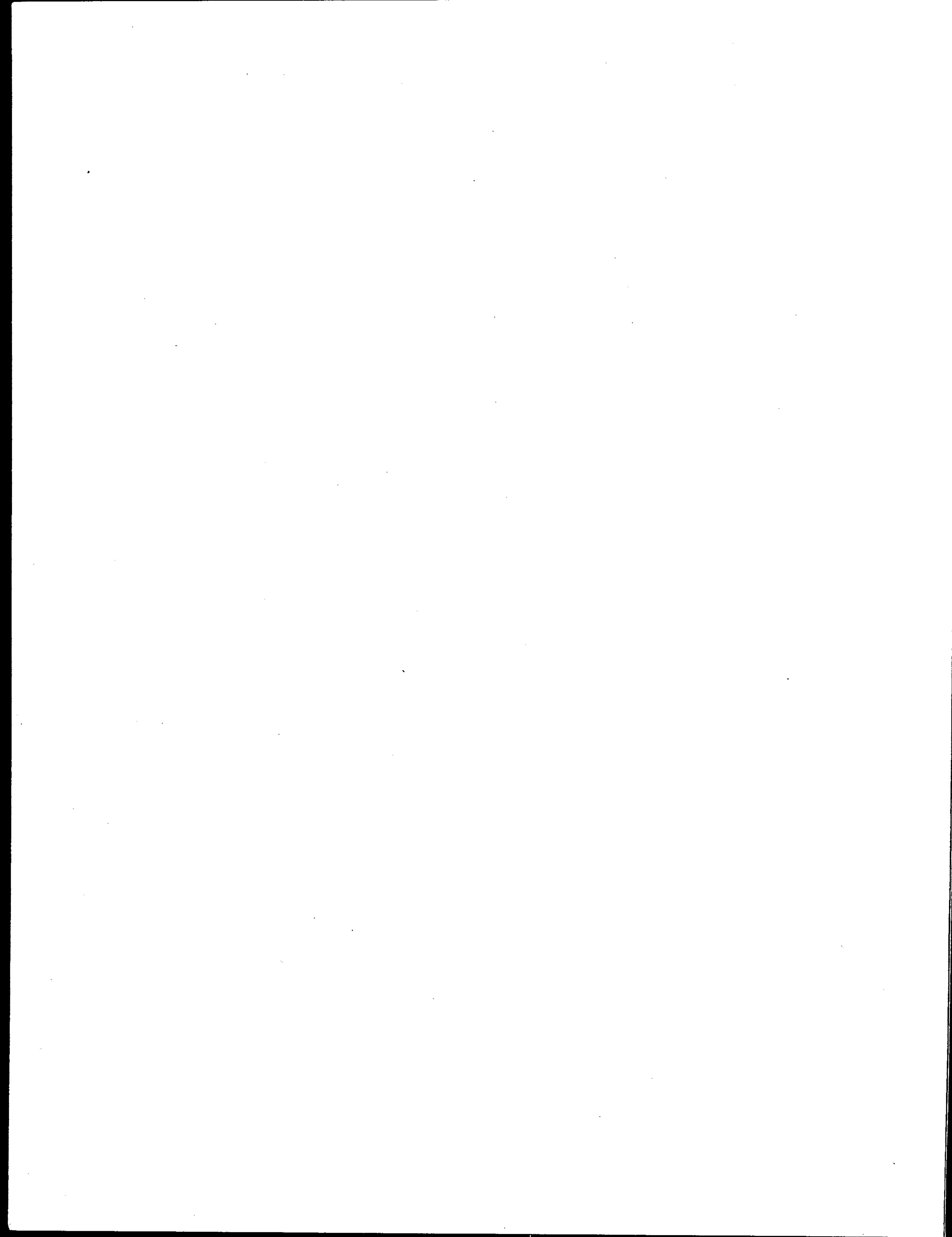
Illinois Department of Children and Family Services

REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY

Pursuant to 20 ILCS 505/35.5

January 2000

Denise Kane
Inspector General



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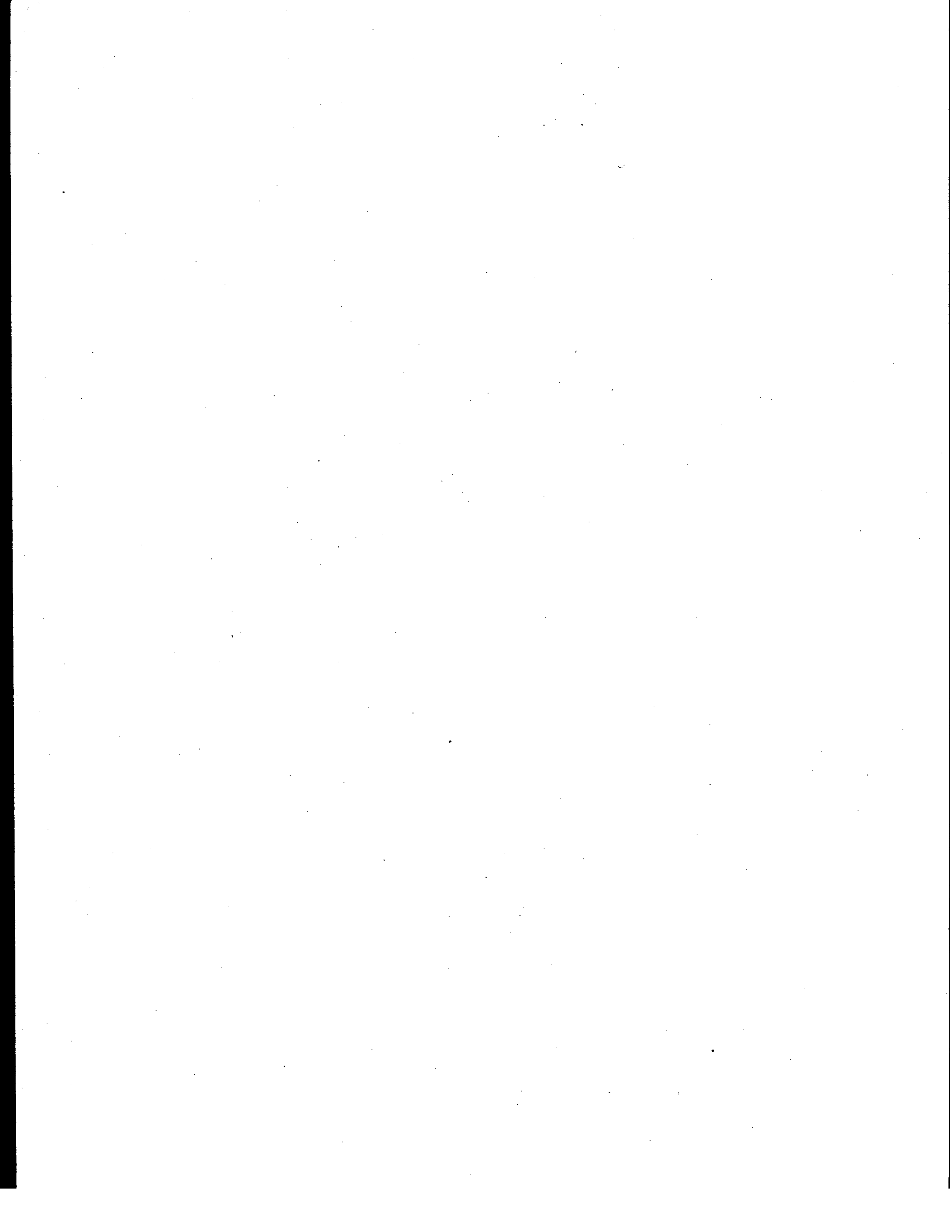


LETTER FROM THE INSPECTOR GENERAL

To the Governor and Members of the General Assembly:

Between my senior year in high school and college I placed an ad in the paper for summer employment. It was the summer of 1963. An Oak Park mother answered the ad. She needed someone to watch her children but couldn't discuss her situation over the telephone. She asked that I come to her house and meet her family. I met her two children, a son four years old and a daughter six years old. Her son had Downs Syndrome.

The mother was an older woman. She had served in World War II as a WAC and was one of the nurses who tended to the wounded after D-Day. She now stayed home full time to raise her children but wanted to return to nursing for the summer to save for her son's education. He would not be allowed into the public school system when he turned five. Because the family struggled on her husband's salary, she could not pay much for child care and was reluctant to leave her children unless she found the right person. For the next few months I arrived at her home at 7:00 a.m. and left at 5:00 p.m. I have never known a more dedicated and loving mother and I did not know that our society cared so little for some of its children.

By the 1970's the fundamental right of all of our children to have a free and appropriate education was established. Within the next twenty years, educational entitlement for children with disabilities broadened from the age of three through the age of twenty-one.

In 1999, however, the OIG investigated the murder of an adolescent girl who came into the State's care at the age of six. She had developmental disabilities and was entitled to special educational services until the age of twenty-one. Since the first grade she was in special education classes. Some of her most shining moments occurred at school. While in grammar school she won medals at the Special Olympics. Her local school reported she made friends in her classes. She loved school and often expressed her desire to graduate from high school. She had a sense of pride about school. At the age of seventeen she left a residential program and was placed into an independent living program where she lived for the last six months of her life. The independent living program was run by an agency that was paid over $400 a day to provide for her. There was an excellent special education high school within a few miles of where she lived. The agency never enrolled her in high school. Rather, the agency enrolled her for a few days in a "GED" class and then into a "literacy" class that met a few hours a week. Unlike the trials of my Oak Park family, it was not financial hardships or the lack of an accessible free education that prevented this girl's attendance at school. In spite of the fact that there are class size limitations for special education classes, the agency believed that the public school would be too large and unsafe. It did not envision its job to include advocating for special education entitlement.

Our lack of emphasis on the importance of education is broader than the special education arena. Recently, a ward came into the State's child welfare system. He was placed in foster care. Prior to coming into the State's care he was attending a parochial high school. His parent had been willing to pay his tuition after he performed poorly for two semesters at a public school. The youngster recently discovered that the State, unlike most level-headed parents, will place wards as young as seventeen into their own apartments. He wanted to go for it. He turned down one program because it required him to live in a dorm setting before transitioning to an apartment with a roommate. He opted for the program that would subsidize the full cost of an apartment without the bother of a roommate. It has not dawned on this young man, nor apparently on us, that even single working adults need roommates to afford apartment living.

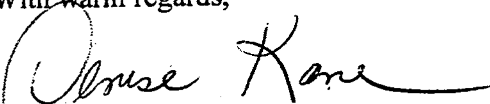
If I were a betting person I would bet on the probability that a seventeen year old in his own apartment is a recipe for school failure, not success. Children of high school age should not expect the State to move them into their own apartments or clubhouses, as the case may be. What they should see from us instead is the expectation of academic excellence. The pursuit of education requires strong parental support. For our older children, it requires strong agency and institutional support. The efforts are worth it. The Alternative School Network illustrates the strong relationship between self-sufficiency and education with the following example: A young woman dropped out of high school in the 1990's will make $5,600 a year. In her lifetime, she will make $260,000. With a high school degree, her lifetime earnings double. With a college degree, it increases fourfold. Young men who finish high school and college fare even better.

Presently, rather than being a John Hughes' "Uncle Buck" with our adolescents, agencies can comfortably choose, or say that the young person chose, a GED program for a few hours a week over the demands of high school. The youth get their own apartments and DCFS pays the private agencies rates of $198 to $298 per youth, per day for independent living programs. In contrast, most wards who pursue college are usually given a cash grant of $250 a month ($3,200 a year) and little or no agency support. The average cost of college room and board ranges from $3,000 to $6,000 a year. Most of the wards who forgo education are "set up" in their own apartments by independent living programs and given agency support. This practice is a topsy-turvy system that betrays our children. These programs subsidize rents that range from $400 to more than $600 a month ($4,800–$8,200 a year). Would it not make more sense for our taxpayers to subsidize the dorm expenses of our college bound students and likewise require our non–college bound adolescents to be enrolled in job or vocational training in similar college dorm–like settings?

To do so, however, would require that agencies, like parents, expect, promote and support educational attainments and teach the proprieties of social living. Until the State's child welfare system commits itself to educational excellence and guidance toward responsible independence it will be difficult for our children to achieve a productive place in society.

The Staff of the Office of the Inspector General and I wish you and your families the best in the dawn of the 21st Century.

With warm regards,



Denise Kane
Inspector General

The OIG had 926 requests for investigation in FY 99, 540 of which were requests for technical assistance.

Requests for investigation can lead to a full investigation, a partial investigation, technical assistance, referral to other resource, or closure without investigation.

I. OIG INVESTIGATIVE PROCESS

The Office of the Inspector General (OIG) is mandated by statute to be separate from the Department. Thus, OIG files are not accessible to the Department. Generally, information regarding OIG investigations will not be released while an investigation is pending.

The OIG investigative process begins when the State Central Register notifies the OIG of a child's death or when a Request for Investigation is filed with the Office. This past fiscal year, the OIG also began to review reports of serious injury. Complaints and death or serious injury investigations are screened to determine whether the facts suggest possible misconduct by a DCFS employee or private agency employee. If a complaint is accepted for full investigation, the OIG will fully review records and interview relevant witnesses. When the investigation is completed, the OIG reports to the Director of DCFS, and under certain circumstances to the Governor, with recommendations for discipline, systemic changes, or sanctions against private agencies. The OIG monitors the implementation of recommendations. When recommendations focus on a private agency, the OIG may work directly with the agency and its board of directors to ensure 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 Advocacy Office for Children and Families, formerly the Ombuds Office; or other state agencies such as the Department of Professional Regulation.

Confidentiality

A complainant to the OIG, or anyone providing information, may request that his or her identity be concealed from anyone outside the Office of the Inspector General. As the investigation proceeds it may become necessary to reveal such identity. In those cases, the OIG will approach the source to secure consent prior to releasing the information. In any event, both the OIG and the Department are mandated to ensure that no one will be retaliated against for making a complaint or providing information to the OIG.

The employee or private agency subject of the report may review the Report (with confidential information deleted) and respond to any factual inaccuracies prior to the imposition of any discipline or sanction, except where circumstances demand immediate action. In those cases, a sanction may be imposed on an interim basis while the Department and OIG weigh the response. 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 original Department or private agency records by the OIG. When files are impounded, the investigator leaves a receipt for impounded files with the office or agency. Important information may be copied by the worker during the impound 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 instituted a policy of making an additional copy of all files impounded in death investigations and returning originals to the DCFS Division of Legal Services to ensure that the Department maintains a central file for certain records.

Criminal Investigations

The OIG provides training and technical assistance to the Department and private agencies in performing criminal history checks. In FY 99, the OIG performed 2,911 requests for information from the Law Enforcement Agencies Database (LEADS). In addition, in the course of an investigation, 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 consistent with laws regarding confidentiality. 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

OIG 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 or private agency contact with the family. An analysis of the findings is provided along with recommendations.

When recommendations are made to a private agency, appropriate sections of the Report will also be submitted to the agency director and the board

of directors. The agency may submit a response to address any factual inaccuracies in the Report. In addition, the board and executive director will be given an opportunity to meet with the Inspector General to discuss the Report and recommendations.

The OIG uses certain reports as teaching/training tools. The reports are redacted to ensure confidentiality and then distributed to private agencies, the schools of social work, and DCFS libraries as a resource for child welfare professionals. A packet of redacted OIG reports is available by contacting the OIG at (312) 433-3000.

Monitoring

The OIG monitors implementation of OIG recommendations. 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 or private agency implementing recommendations which call 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 significant OIG recommendations are contained in this Annual Report.

Death Review

The OIG investigates all cases in Illinois in which a child has died while 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. The OIG received notification from the State Central Register (SCR) of 82 child deaths in FY 99. Death investigations which resulted in major report recommendations are included in the Investigations Section of this Report. The OIG is a member of Child Death Review teams around the state.

II. 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 a recommendation regarding discipline has been made, the OIG will present it to the Director of DCFS. If accepted, the Department will initiate disciplinary proceedings with the employee. The employee will have a chance to review the evidence and submit a response. After receiving the response, the Department will determine whether discipline is appropriate. If the Department determines discipline is appropriate, it will be administered and noted in the employee's personnel file. In addition, 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 99 are divided into two major categories: Death Investigations and General Investigations.

At the end of the report, systemic reform recommendations are 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.

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

III. 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 792 telephone calls in FY 99.

In FY 99, the OIG Foster Parent Hotline received 792 calls. Of those, 673 calls were for information and referrals, 59 calls were referred to the SCR hotline, and 60 calls were referred to the OIG for investigation.

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.

INVESTIGATIONS

Death Investigations

Death Investigation 1

ALLEGATION

In October 1998, a two year old ward died of scalding burns he received in a foster home. The child was scalded after being placed in a bathtub in which the water temperature was over 150°F. **OIG NOTE: It takes just one second for a child to sustain a third-degree burn from water that is 150°F.**

INVESTIGATION

The OIG investigation revealed that the child had been recently placed in a newly licensed foster home. The foster mother was young and inexperienced and had serious medical issues, including kidney failure. On the day the child was scalded, the foster mother was scheduled to be admitted to the hospital. The foster mother had contacted the agency that morning to arrange for temporary care for the two year old while she was in the hospital. Rather than arranging temporary care or inquiring into the reasons for the hospital admission, the private agency workers sought to convince the foster mother's mother to take the child. When that plan fell through and the worker arrived to pick up the child, he was already on his way to the emergency room as a result of the scalding. The police investigation did not result in any charges. The child protection investigation determined that the child was scalded because the foster mother had allowed her eleven year old child to bathe the ward. The foster mother was indicated for death by neglect, burns, inadequate supervision and malnutrition.

The foster mother was recommended for licensure by a private agency. A previous private agency had refused to license her because of her youth and inexperience. In order to receive her license, the foster mother was not required to disclose any information about her medical history. All that was required was a one-page form in which a doctor attests that the applicant has passed a tuberculosis screening and that the applicant is free of outward signs of communicable diseases. The private agency caseworker that was monitoring the home failed to respond proactively when he learned that the foster mother had serious kidney problems. He explained to the OIG that he believed it was his job to simply make notations (foster mother going into hospital), and that if follow-up was necessary, his supervisor would tell him what to do. The investigation also revealed that the filing practices of the agency were not conducive to good casework. The agency had a practice whereby caseworkers were not required to review, or even handle, the entire file but only to complete individual casenotes, which were forwarded on for filing. The workers, therefore, did not have historical or contextual case knowledge on which to base case decision making.

At the time of the ward's death, there was also a thirteen month old ward placed in the same home. A medical examination of the infant, after the first ward's death, revealed that the thirteen month old was malnourished and had abrasions on his feet, back and chin. The hospital noted that the child's upper arms were the circumference of a quarter. The private agency worker had failed to note the child's size during his monitoring visits. The foster mother was indicated for malnutrition and inadequate food as to this child. Also, after the first ward's death, the Department learned that the foster mother had been the victim of domestic abuse and had pled guilty to a charge of possession of a controlled substance, just prior to being licensed. The investigation revealed that the criminal history occurred after she had cleared a background check but before she was licensed. Although the Department had a procedure whereby the State Police were to notify the Department of any new criminal history information on foster parents, the system was loose and rarely worked in practice.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department must ensure that all licensing entities test water temperature prior to licensing and with any change in address. ***This mirrored a previous OIG recommendation that had been accepted by the Department but never implemented.***

The Department agreed. Digital thermometers have been received. These thermometers are being distributed to licensing workers in order to comply with policy that has been implemented regarding water temperature testing in foster homes.

2. The Department should implement use of a new medical form for prospective foster parents that would incorporate OIG recommendations made previously (mobility and ability assessed with respect to children placed or to be placed), and also require disclosure of prescription medications and specified serious medical conditions that could impact on the ability to continuously care for children. In addition, the form must be completed by either a) a doctor with whom the patient has a treatment history of at least one year, or b) a doctor from an approved list to be developed by the Department.

The Department agreed. Executive staff are currently reviewing the revised forms.

3. The agency must consider appropriate discipline for the workers involved with this case. In addition, the OIG strongly recommends that the agency reconsider its decision to move one of the workers into the position of Licensing Representative.

The Department stated that all of the individuals have resigned from the agency.

4. The agency must institute a training program within six months for caseworkers and licensing staff which includes critical analysis, developmental tracking, follow-up on critical issues, communication between divisions and specific problems identified through this investigation.

The Department stated that the agency has expanded its Case Manager Pre-Service training to include these recommendations. In addition, all staff participated in "Critical Decisions" training that was conducted by the Department in March 1999.

5. The agency must document within six months that it has adequate foster care respite homes available.

The Department stated that by April 2000, the agency will maintain three licensed respite homes for use in its home of relative and traditional foster care programs. At present, the agency utilizes six licensed respite homes in its Specialized/Treatment Foster Care and Comprehensive Community Based Youth Services program. In addition, the agency will adopt a policy on emergency respite services to foster parents in home of relative and traditional foster care programs and provide training on this policy.

6. The agency must modify its file maintenance procedures within six months to facilitate contextual and integrated casework practice.

The Department stated that the agency has begun a three-phase process to improve its file maintenance process that will be implemented by June 2000.

7. The Department should ensure that DCFS Licensing has adequate staff to process new arrest information. DCFS Licensing should be commended for its responsiveness in addressing several of the systemic problems identified in this case.

The Department agreed. The Department is working on improving the flow of information between the Department and the Illinois State Police.

8. The Department should reexamine its position regarding outside income for foster parents. If it determines to retain current policy requiring outside income, it needs to retrain on and enforce the policy; if it determines outside income is not necessary, it should delete the requirement.

The Department agreed. The Department's position is that an individual's outside income is a relevant factor in determining placement of children in the home. DCFS will retrain on this issue.

Death Investigation 2

ALLEGATION

A woman whose family case was being served by the Department since 1991 found her three month old daughter unresponsive in her crib. She brought the child to the hospital where she was pronounced dead of an undetermined cause.

INVESTIGATION

The mother told hospital staff that she had fed her daughter around 7:30 a.m. At 9 a.m., she found the baby motionless in the crib, went to a neighbor's house and called 911. Doctors attending to the child found no external signs of abuse or neglect. They did report that the baby had a heart condition which required her to be on an apnea monitor at night. The mother stated she had turned it off that morning because it "made her paranoid." Staff at the hospital reported the mother appeared to be high when she arrived. She later admitted to them that she had been out all night smoking cocaine and had a beer in the morning.

The OIG reviewed the case history and found a pattern of inconsistent compliance with services on the part of the mother. Since her initial involvement with the Department in 1991, she demonstrated only intermittant periods of dedication to the plans outlined by DCFS that would allow for the return of her children. The relationship between the mother and the private agency servicing her case was contentious. The agency was never able to fully engage the client in the process. Although the mother was referred to numerous substance abuse programs, her level of participation fluctuated and the most successful experiences resulted only in a temporary change in behavior.

Following the indicated reports which led to her four oldest children being removed, the mother became pregnant again. The mother's uncooperative behavior had minimized her contact with the private agency. When the hotline was called upon the child's birth, the agency was unprepared to construct an effective safety plan or provide pertinent historical information to the Division of Child Protection. The baby was sent home with her mother with a less than adequate safety plan, despite the fact that the Department had determined that the mother's other children could not be returned to her care. The absence of a thorough clinical staffing prevented all involved service providers from developing a complete picture of the mother's ability to parent.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. In this case there seemed to be a lack of communication between the private agency and the Division of Child Protection (DCP). The worker was not available and the administrator acting as a liaison seemed to have little knowledge of the case. The private agency has addressed this problem by establishing a schedule of case staffings. Each case is staffed at least once a year by a Licensed Clinical Social Worker (LCSW), caseworker, supervisor, licensing representative, crisis manager and other involved parties including therapist, treatment staff and family members. In addition they have established a critical issues staffing rule in which a staffing can be called at any time and should be held within 24 hours. The critical issues staffing is attended by an LCSW, crisis manager, caseworker, supervisor, licensing representative and other involved parties. Agency Performance Teams should ensure that other agencies have similar procedures in place. This will help to ensure that when a hotline call comes in on a family that has children already in the system, the agency serving that family can provide a history of family involvement to DCP. If the agency is not able to provide the history in a timely manner, the agency performance liaison should become involved in obtaining the information.

The Department agreed that communication can be improved between private agencies and the Division of Child Protection. During fiscal year 1999, the Substance Affected Family (SAF) policy was implemented and will serve as a guide to DCFS and POS workers making critical decisions on Substance Exposed Infant (SEI) cases. The policy requires that a multidisciplinary staffing be conducted on all SEI cases. Further, Agency Performance Team (APT) liaisons have been instructed to contact the agencies to ensure they have a protocol in place that reflects these procedures.

2. *Substance Exposed Infants and Their Families: A Protocol for Clinical Practice and Collaborative Intervention* indicates a need for interagency collaboration when there is a substance exposed infant. This call for collaboration should be followed in family cases where other substance exposed infants have been born and a subsequent birth finds the mother currently in treatment or where chronic substance abuse is an issue. Communication, treatment planning and monitoring between DCFS, treatment agencies and other involved parties will help to ensure the safety of the child and better engagement in treatment. Any child who has siblings in the system but is discharged to the mother should have a safety plan that has been staffed and developed by caseworker, supervisor, administrator and appropriate others (therapist, treatment staff, family members). The mother should have a list of outside support people and caregivers, including family members, who should then be contacted by the caseworker. Criminal history (LEADS) and prior abuse and neglect (CANTS) checks should be done on any alternate caregivers.

The Department agreed. As previously indicated, in fiscal year 1999, the SAF policy was developed. The SAF policy requires staff from the Department of Children and Family Services, the Department of Public Health and the Office of Alcohol and Substance Abuse to staff all SEI cases. The SAF policy guide requires that a safety plan be developed on all SEI cases. In addition, the SAF policy requires that CANTS and LEADS be done on all alternative caregivers.

3. DCP was expected to decide whether the child should be screened into placement. Often, DCP is relied upon for making these decisions rather than private agencies having to decide on the safety of the child. It appears, in communicating with several agencies, that some agencies are not aware they can screen a case into court and the process for doing so. Private agencies should be informed and retrained on the process of screening cases into court so as to better prepare for mothers on their caseload who are currently pregnant or experiencing difficulties. The possibility of a database code alerting workers that a mother with children in the system is pregnant should be explored.

The Department agreed to make information available and to provide training to private agencies on the appropriate process for screening cases into court. This information will specifically target clients who are currently pregnant or experiencing difficulties.

4. The Department should work with state and local Departments of Public Health on the issue of family planning, especially with mothers who have previously given birth to substance exposed infants. This should include education on options for family planning and access to services including transportation to clinics. DCFS must also assure access to clients served by purchase of service agencies whose religious affiliation might prohibit direct assistance in this regard. Treatment programs should also be included in this inter-agency cooperative effort. As suggested in the Intact Family Recovery Model, the programs could invite Public Health Nursing staff to run educational programs on family planning and/or provide transportation for clients to public health clinics for the initial appointment. Frontline workers should be trained on exploring the issue of family planning with their clients and have resources available to offer their clients.

The Department agreed. The Department has worked in collaboration with the Department of Public Health (DPH) to address the issue of family planning and religion. In the Substance Exposed Infant (SEI) protocol, DPH Family Care Nurses are required to discuss family planning issues with all SEI families as a postpartum service. DCFS requires staff to document that these discussions have taken place, the family's response and any follow-up with DPH.

5. A child left in the care of the mother is essentially an intact case but currently the child is monitored by the worker already servicing the family. The Department should explore whether the foster care caseworker can most appropriately monitor the family. High risk cases may be better served by bringing in an intact worker to concentrate on the family and work with the other caseworker on coordinating services. A foster care caseworker, because of sibling and parent visits and time spent in court, may not have the time to devote the intensity of service and monitoring that is associated with success.

The Department is piloting an aggressive case management program in Cook County. In June 1999, TASC, an independent case management organization, began assigning "Recovery Coaches" to new SEI cases in Cook County. The program currently has approximately 50 open cases and is growing. The Recovery Coach is to do home visits, coordinate care with the substance abuse treatment agency, conduct outreach should the parent drop out of treatment and help the Department assess the potential risk to a child because of parental substance abuse. The Recovery Coach component is the basis for the Department's second IV-E Waiver.

6. Throughout the history of this case, the mother participated in a number of services, generally not completing full service plans, but portions of plans (for example, parenting classes). Even though the mother had completed these classes or participated in services the resultant behavior and information from psychological testing indicate that these services were not completely effective in addressing her problems. She was unable to integrate the knowledge and skills from the services into her actions or attitude. DCFS and private agencies should make more use of clinical consultants to help identify issues.

The Department agreed. The Department has a number of protocols that are being developed to ensure outcome-based practice. The Substance Affected Families policy guide now requires that the Guide to Assess Risk Factors evaluate services. In addition, the Department has increased the number of specialty consultants in each region of the state in child sexual victimization, mental health and psychological services. The Department is looking to provide additional consultative services in developmental disabilities and domestic violence in fiscal year 2000.

7. The private agency did not engage the mother in treatment, appeared to rely on the mother to follow through with referrals, did not provide other agencies with pertinent information and failed to plan for the birth of the child who died. Even after the birth, the agency did not ensure that the worker assigned monitored the case as it should have been monitored nor did the agency assist the worker in doing so. The private agency has put in place some corrective actions:

a) Each case will be staffed at least annually and critical issues staffings can be called at any time by any involved person and will be held within 24 hours.
b) Caseload levels have been lowered; the agency is attempting to maintain caseloads of around twenty cases per worker.
c) The agency has hired an in-house educational liaison to assist both workers and schools in keeping abreast of the status of children and families involved with the agency.
d) The agency has written a new training syllabus for workers and foster parents. Additionally, they are holding ongoing in-house training for staff in regard to changes in DCFS policy.

The Agency Performance Team should review and monitor these new practices at the agency. In addition, the agency should have more clinical trainings and use more clinical consultants.

The Department, through APT, is closely reviewing the corrective action plan and monitoring new practices at the private agency. In addition, the private agency has hired more clinical consultants and redesigned its in-service training program.

Death Investigation 3

ALLEGATION

A seventeen year old developmentally disabled girl, who had been a ward of the Department since she was eight, was sexually assaulted and murdered while she was placed in a supervised independent living program.

INVESTIGATION

At the time of her death, the girl had been in a supervised independent living program for six months. Her previous placement determined her disabilities interfered with her ability to comprehend the program. The girl was raised in a rural community and had never experienced a large metropolitan setting like the one where the independent living program was located. The girl's placement options were limited, in part, because she had been labeled as sexually aggressive, based on minor incidents which were not adequately investigated and which failed to take account of the girl's disability. Soon after her placement, the girl began engaging in sex acts with numerous men from the surrounding area. Sometime before her death, the private agency determined she required 24 hour one-on-one supervision. On the night of her death, the girl left the agency without her one-on-one supervisor. Prior to being placed in the independent living program, the girl had enjoyed attending high school. The agency failed to ensure that she continue in a local high school, even though she had an existing individual education plan which would have required the high school to provide her with special education classes. Instead she was enrolled in a GED class.

The OIG determined that she should never have been placed in an independent living program and that the Department and private agency failed to provide necessary services to address the girl's disability and deprived her of her educational entitlement. In addition, the OIG investigation revealed that the independent living program included several youth who were juvenile sexual offenders. Many of these youth were housed in community YMCAs, which also housed licensed daycare settings and children's programs, or other individual living situations without adequate supervision to ensure community safety.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department needs to replace the administrator in this case with a strong proactive administrator who not only has expertise and experience in the field of adolescent developmental disabilities and mental illness but who also has the commitment to advocate for the youth's educational entitlement.

DCFS has recently revised its Placement Review Team (PRT) Protocol to require clinical participation and review of developmentally disabled, mentally ill and children designated as Sexually Aggressive Children and Youth (SACY). An outside contractor assessed all children in the independent living program. In addition, a different administrator has been assigned to work on children with developmental disabilities for the Division of Operations.

2. The Department should reconsider its top administrators' piecemeal strategies and strive for a coherent and integrated system of critical thinking and problem solving. The public expects top DCFS administrators to comprehend fiduciary duties.

The Department agreed. The Department takes these concerns seriously and adjustments have been made.

3. The Department should discipline DCFS staff for their failure to forward critical information, of which they had knowledge, to the Court.

The Department agreed. The workers were counseled for their participation in this case.

OIG Response: The Department discussed the issues with staff but failed to institute official discipline.

4. The Department should phase out the supervised independent living contract involved in this case. In its stead, the Department should reconfigure its monies to:

> **A) Work with the University of Illinois, Institute on Disability and Human Development and a multi-disciplinary team to build an empirically-based community social skill training (including sexuality) and clinical consultation program that would work in partnership with agencies to develop supportive living arrangements for older adolescents with developmental disabilities (in the mild range of retardation). Partnering agencies would be obligated to cooperate with the Institute on Disability and Human Development in measuring the efficacies of their interventions and the social significance of their outcomes. The Department should develop these resources in cooperation with the Department of Human Services (DHS) to assure a smooth transition of these wards into adult services;**
>
> **B) Explore the development of halfway houses with extended day programming to clinically assist appropriate older adolescent juvenile sexual offenders from Cook County who have successfully completed a treatment program at a secure facility to transition safely into the community. A restorative justice model should be integrated into the programming; and**
>
> **C) Youth who are judged to still present high risk to re-offend should be kept in secure out-of-state facilities until Illinois begins to operate its own secure facilities.**

The Department has closed intake to the independent living program to those children with a developmental disability and those children designated as SACY. Instead, the focus of the program will be to provide independent living services to a less challenging population. In addition, the Department has worked with the private agency to fine-tune their program by asking them to enhance their policy and procedures for the program, provide training to staff around SACY issues and to work with the Infant Parent Institute around Medicaid issues. An independent consultant, Illinois Alternatives Network, has been hired to assist in implementing the changes and report progress back to the Department.

The Department agreed with the OIG's recommendations for needed resources/collaboration with experts in the developmental disabilities field. Currently, the Department is working with the University of Illinois Department of Psychiatry staff to identify resources nationally which treat an adolescent developmentally disabled and/or mentally ill population both inpatient and in the community.

The Department is currently reviewing a proposal to develop halfway houses. The Department agrees that children who are at the highest risk of re-offending should be kept in an environment with security commensurate with their needs and risks to the community.

5. To prevent the minimization of the behaviors exhibited by wards in independent living programs (ILP), the Department should counsel and re-emphasize with all ILPs that Unusual Incident Reports (UIRs) must be filed with the Department in a timely fashion. The Department should institute an analysis of the UIRs in order to baseline expected behaviors from wards in these programs and determine proper services and assure that courts and ACRs are fully informed. The Department should develop a protocol for ILPs to understand that fully informing the court and the Department means informing them of the ward's sexual acting out, victimization, runaways, education programs, progress in developing independence skills, pregnancies, arrests or police detentions, etc.

A) All ILPs should be re-notified to complete and turn over all UIRs to ensure they are entered into the computer system; and

B) The Department should designate an accountable individual to review and analyze the records of all wards in ILPs to ensure both community and ward safety and appropriate placement of wards.

The Department agreed. All ILPs will be notified to complete and turn over all UIR to ensure they are entered into the computer system. In addition, the Deputy Director of Education and Transition services will review and analyze the records of all wards in ILPs to ensure both community and ward safety and appropriate placement of wards.

6. The Department and the Illinois State Board of Education should jointly address the need for consistent surrogate parent involvement during the transition of special education adolescents across school districts. The Department should immediately notify DCFS and private agency personnel that GED is not an alternative education plan for wards that are developmentally disabled.

The Department is implementing a federal rule change that allows foster parents to serve as "parents" for purposes of special education. In addition, the Illinois State Board of Education has agreed that as long as a foster parent is a trained "surrogate" parent, the parent can continue to serve as a surrogate for the child should the child leave the foster home to be placed in a residential facility. The Department will notify DCFS and private agency personnel that GED is not an alternative education plan for wards that are developmentally disabled.

7. The Department should require that all Placement Review Team summaries contain comprehensive information on the child or youth reviewed.

The Department agreed. The Placement Review Team Packet was revised to include this recommendation.

8. There is concern regarding the girl being labeled SACY and sex offender treatment becoming the main focus of services for her. The OIG is working on a general review of the SACY process and procedures.

No action necessary.

9. Portions of this report should be shared with the private agencies involved for their consideration of program changes or staff re-training around servicing developmentally disabled and/or sexually aggressive youth.

No action necessary.

OIG REPLY

The OIG disagrees with the Department's decision to continue contracting with the independent living program at issue. The program had a capacity of 40 wards. In fiscal year 1999, it was awarded a contract for $2.9 million. In September 1999, the agency billed $284.00 per day, per child for 25 residents, $198 per day for one resident and $412 per day for one resident. It was developed to prepare wards returning from out-of-state institutional placements for independent living. The OIG investigation revealed that the population of wards at the supervised independent living program included both developmentally disabled youth and juvenile sexual offenders. It was highly unlikely that some of the developmentally disabled youth could ever live independently. Many of the sexual offenders needed far more supervision to ensure community safety (including the safety of other program residents), than was being provided by the program. At the time of the OIG investigation, as many as six juvenile sex offenders had been placed by the supervised independent living program in community YMCAs, with licensed daycare centers. In addition, a majority of the wards were not in high school, although many had been enrolled and were attending high school prior to entering the program.

During the course of the investigation, the OIG advised the Director of DCFS that federal educational entitlements were being denied to developmentally disabled children. In response, the Director commissioned consultants to assess the program services to developmentally disabled residents. In June 1999, the consultants reported to the Director, confirming the OIG's conclusions that developmentally disabled wards were not being adequately serviced or protected.

In August 1999, the Department asked sexual a assault consultant to review the program to determine whether it provided adequate supervision and treatment of DCFS wards with sexual behavior problems. On September 27, 1999, the contractor reported to the Department that eight out of the ten sexually aggressive [SACY] designated residents reviewed were not appropriate for admission to the supervised independent living program. The report determined that "the structure of [the supervised independent living program] doesn't allow for sufficient supervision to occur as demanded by the severity of the offenses committed by the clients in the program." On November 5, 1999, a DCFS clinical manager reviewed the program. Her report was also consistent with the OIG's findings. The report noted that one of the youth, who was a juvenile sexual offender, was inappropriate for the program. The report recommended that this same youth be removed immediately. The contractor reported that this youth "is currently reporting ongoing fantasies of sex with young girls and is not participating in treatment." It was not clear from the contractor's report that they were aware that this ward was living in a YMCA which also housed a licensed day care center. When the Inspector General received the clinical manager's report on November 17th, she contacted the YMCA and learned that no one from the Department or the private agency had yet notified the YMCA of the risk that this youth posed. Once informed, the YMCA notified the agency to immediately remove the youth from its residence.

All of the professionals who evaluated or investigated the supervised independent living program did so without the benefit of each other's findings and concerns. No decisive action was taken despite these multiple reports, which all came to the same conclusions regarding the inability of the program to provide basic services and protections. The separate evaluations provide an inter-reliability of findings that cannot be ignored.

The Department's response to the OIG was that, rather than discontinuing the contract, it wants to bring in a fifth set of consultants to "fine-tune" the program and to "enhance" program policies and procedures. The OIG finds this response unacceptable. In presenting the findings of the OIG report to management at the private agency, the Inspector General was struck by the tendency of management to minimize the problems identified and blame deficiencies on others. Neither the Department nor management appear to understand the fundamental nature of the problems identified. The DCFS Agency Performance monitor who was delegated the responsibility to work through problems at the program had not received copies of the OIG report or the report of the first consultants.

Although the Department has continued to express agreement with the OIG's statement of the problem, the OIG has yet to see a genuine shift in resources to assure appropriate fit between "step-downs" from institutional care into community care. "Identifying national resources" simply forestalls necessary institutional rearrangements to safely protect our communities while providing adequate services to our most difficult or vulnerable older adolescents. To continue to pay this agency at least $102,384 a year for each of these wards is unconscionable. With the strong support of taxpayers' dollars, this agency has produced a dismal program that betrays the decency of affording basic educational entitlements of our wards and basic protections to our community's young children entrusted into the care of state-licensed daycare settings.

Death Investigation 4

ALLEGATION

A five month old boy was found dead in his mother's apartment. His mentally ill mother, a ward of the state, left him alone for 48 hours. The medical examiner ruled the cause of death as undetermined. The private agency servicing the case failed to provide appropriate services to ensure the safety of the ward and her infant in their supervised independent living program.

INVESTIGATION

The mother became a ward of the Department when she was living with her first child in her step-grandmother's house along with her mother, step-father and five younger siblings. The mother, who was diagnosed as being mildly mentally retarded, had a conflictual, often violent relationship with her parents which led to behavioral problems and frequent running away. She had attempted suicide at least three times, including one attempt to self-abort her first child by drinking bleach. The mother was known to have unprotected sexual relations with several partners and had been diagnosed with three sexually transmitted diseases. She also suffered from chronic severe headaches which physicians identified as possible residual effects from a past closed head injury.

The Department placed the mother in an independent living program to develop the necessary parenting and living skills to care for her two and a half year old son; however she was soon transferred to a more structured program. Three days after entering the new program, the mother left her child with her step-grandmother for the weekend. When the mother returned, the grandmother refused to return the child because she believed the mother was high on drugs. The mother ultimately agreed that the child should be cared for by the grandmother. The program, however, failed to provide recommended services and instead offered "cookie cutter" services based on the standard framework of their program.

Two weeks after entering the placement, the mother informed staff she was pregnant. The child, born eight months later, tested positive for syphilis and remained in the hospital for treatment. Soon after the baby was released, the mother told workers she felt overwhelmed with caretaking responsibilities and thought she would harm her daughter. A hotline call was made. The mother was indicated for risk of harm and the child was placed with a relative. Two months after her daughter was removed from her care, the mother related to staff she was pregnant again.

During her third pregnancy, the mother attended almost none of the programs in which she was expected to participate. She would arrive to claim her checks and then leave. The mother's third child tested positive for syphilis upon his birth and remained in the hospital to be treated for the condition. Hospital staff were hesitant to send the child home because the mother tested positive for cocaine and again stated her fear of hurting the child. The staff, however, did not call the hotline.

Two months after the boy was born, his mother was evicted from her program-sponsored apartment because of assaultive behavior. The agency placed her and her son in an unsupervised independent living program without developing child care or safety plans. Instead, the agency simply reported that the mother intended to rely upon a casual network of relatives to ensure her son was cared for. The mother left her apartment and none of the mother's relatives cared for the child. The boy was found dead in the home. No charges have been filed in the case.

Throughout the course of her stay in the independent living program, the mother's behavior continued to worsen but accurate reports of the mother's condition were never communicated to the Department or the Court. Progress notes minimized her shortcomings and were conveyed in such a way as to make the mother seem capable of raising her children. There was no indication in the case file that integrated the information into a cohesive representation of the mother's situation or critically evaluated the context in which her behavior occured. The information compiled by the agency was not used to determine the mother's needs, the appropriateness of services provided to her or the effectiveness of the program. The agency's lack of critical thinking points to the problem of a "one size fits all" approach to independent living programs, especially those involving mentally ill wards who are pregnant or caring for children.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should consult on the development of a protocol for wards with potential residual effects of closed head injuries.

The Department agreed. The Department has consulted regarding the development of a protocol for wards with potential residual effects of closed head injuries. The consultant has determined that his protocol for a child with a brain injury from a closed head injury is no different from the protocol for a child with a brain injury because of any other cause. Based on this research, the Department agrees that no specific protocol is warranted. The Department will use the consultant's protocol for head injuries.

2. The Department should request that a consultant review the clinical records of parenting wards who have multiple diagnoses of mental illness, developmental delay and substance abuse to ensure the appropriateness and efficacy of services.

The Department agreed. Currently, the consultant is reviewing the clinical records.

3. Through consent or court order, the Department should obtain SSI evaluations/reports of pregnant and parenting wards to be reviewed by the Office of the Guardian.

The Department agreed. No consent or court order is necessary. The Bureau of Disability Determination Services has agreed to send the Department copies of all psychological evaluations done on children in the custody of the State of Illinois. Those psychological evaluations will be forwarded to the appropriate caseworker to add to the child's case file.

4. The service provider should convene a meeting with family members to evaluate the support system and, if appropriate, develop a safety plan to include an agreement that the care giver will accept the child for care at any time with the understanding that the care giver can page the agency. The purpose is to develop a baseline of the frequency and circumstances under which the child is left, and the length of stay. The agency will be available to assist the care giver.

The Department agreed. Policy Guide 98.1 addresses this issue.

5. The Department should consider the use of paraprofessionals in a training program for mentally retarded parents.

The Department is exploring the use of paraprofessionals in a training program for mentally retarded parents.

6. All service providers must maintain at least one central record that is comprehensive, containing all information applicable to the case.

The Department agreed. All contracts for Independent Living have been amended to require that the service providers must maintain at least one central record that contains all information applicable to the case.

Death Investigation 5

ALLEGATION

The OIG investigated the homicide of a two month old boy in a foster home. The home consisted of newly licensed foster parents, their two children (ages two and four), the dead child's two year old sibling and a fifteen year old foster child with a significant mental health history, including incidents of violence against foster siblings.

INVESTIGATION

The day after the child's death, the DCFS Guardian hired attorneys to represent the fifteen year old and a neighbor foster child. Special screening and assessment records concerning the fifteen year old were unavailable because the agency did not retain copies of the records. The fifteen year old's therapist had recommended that she be placed in a home in which she was the only foster child. The therapist, however, had not been given the entire mental health history of the girl. In addition, the foster parents were not given full information about the girl's mental health history. After placing the fifteen year old in a foster home against the therapist's recommendation, the caseworker failed to monitor the home in a meaningful way. The OIG determined that the failure was based, in part, on additional demands on the caseworker's time by the Department, such as a national accreditation process, and adoption initiatives, in conjunction with lack of adequate supervision. In addition, the case management was deficient in that the department failed to provide full information either to the foster parents or to the evaluators charged with assessing the fifteen year old. Only the caseworker and her supervisor had full information on the child and they did not have sufficient expertise to manage the case of a severely emotionally disturbed adolescent. Soon after the OIG investigation began, the ward had to be institutionalized. She was transferred to a second institution soon after that when the Department learned that the first institution did not have an educational component.

The supervisor of the fifteen year old's caseworker was instructed by DCFS Legal that the girl's case record could not be shared with DCFS child protective investigators who were charged with determining whether the child died as a result of abuse and neglect and, if so, who was responsible.

The child was killed in September of 1998. As of November 1999, both the child protective and criminal investigations are still pending.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The foster child should be referred for a neurological evaluation.

The Department agreed. The fifteen year old received a neurological evaluation in October/November 1998.

2. The OIG was unable to access the foster child's Screening Assessment and Support Services (SASS) records. SASS agencies provide crisis intervention to stabilize children who are experiencing severe emotional or behavioral problems. It is critical that complete records be maintained for all children who undergo SASS evaluations. All SASS evaluators must be required to maintain a master file of their SASS evaluations.

The Department agreed. Any agency contracted by the Department is required to maintain a master file of their SASS evaluations.

3. The caseworker failed to visit the foster child after she had taken on the responsibility of placing this emotionally disturbed adolescent into a relatively new foster home with young children and young and inexperienced foster parents. This was a critical failure of the caseworker's professional and ethical obligations. This failure, however, has to be viewed within the context of the reported climate that was created by pressure for workers to meet Council On Accreditation (COA) and Permanency Initiative requirements, the DCFS standards requiring minimal visitation in a foster home, and the fact that she was not directed by her supervisor to provide increased supervision of the foster home. Nonetheless, the caseworker and her supervisor should be disciplined for failure to ensure compliance with the therapist's recommendation. In addition, the OIG recommends that this report should be shared with the caseworker and her supervisor as a teaching tool.

The Department agreed. Appropriate disciplinary action is being pursued.

4. The foster child must not be placed in a home in which any young children are residing. In the event that she is placed in a foster home, the Regional Administrator should ensure that the home is capable of being in compliance with all recommendations involving the foster child's placement and continue to monitor its status. In addition, the Placement Clearance Desk should be contacted to ensure that no additional foster children are placed in the home.

The Department agreed. The fifteen year old is currently in placement in a residential treatment center and will not be placed in a foster home with any other children.

Systemic Issues

1. A work group is currently reviewing the issue of referrals to treatment providers. The Department should develop a protocol to be used by caseworkers when they provide referrals to treatment providers. This protocol should spell out the records that should be sent to the providers. These records, at a minimum, must include all hospitalizations, all psychological and psychiatric evaluations, and all Unusual Incident Reports. The protocol should include a requirement that workers document in the file the records that have been forwarded to treatment providers.

The Department agreed. The recommendations will be incorporated into Best Practice.

2. Caseworkers lack clinical expertise to manage the complex issues presented by wards with mental illnesses. This case illustrates the need to develop special case units to address the particular needs of severely emotionally disturbed children and adolescents. A similar recommendation was made by the OIG in a report submitted to the Director on December 30, 1996, although this recommendation was directed toward parents with mental illness.

The Department contracts with psychiatrists and psychologists who have expertise in treating children with mental illnesses and developmental delays. In addition, the Department has field teachers who have backgrounds and experience in working with children with serious mental illness. These field teachers regularly staff cases and serve as consultants to caseworkers and investigators.

3. The Department should develop a protocol that caseworkers can use when sharing information about a child with the foster parent. A record should be kept documenting the information that is given to the foster parent. The information must be factually detailed - not merely diagnoses. This document should be signed by all parties at the placement staffing and a copy given to the foster parents.

The Department agreed. This recommendation will be incorporated into Best Practice.

4. The Department must always allow its own child protective investigators to have free access to any information in its control relative to the safety of children.

The Department agreed. The Division of Child Protection is allowed access to information relative to the safety of children. As for mental health records, the Department has requested an official opinion from the Attorney General's Office relating to this issue.

5. The Department should develop more mentor foster homes. The Department should provide annual ongoing training for mentor parents, retain the 24 hours a day/7 days a week availability of mentor consultants, and ensure that mentor payments are commensurate with duties expected of the foster parents compared to those in other programs.

In general, the Department agreed with this recommendation. The Department is currently researching this issue.

6. The Department must develop and consistently apply new guidelines for appointment of counsel for wards. The current procedures do not address appointing counsel prior to indictment and current practice is uneven in terms of which wards get counsel and which do not. New procedures should include a provision for conflicts checks to ensure that an attorney representing a ward will not have an actual, potential or apparent conflict of interest.

The Department agreed. The Department assesses the need for legal representation for wards on a case by case basis. Procedures 327.4 Guardianship Services addresses the obligation of the Guardianship Administrator to provide for children's legal needs. Currently, the Department is revising and clarifying these procedures, pursuant to this recommendation.

7. The OIG strongly disagrees with Department policy that, in this case, prohibited sharing important mental health information between divisions of DCFS. The Inspector General and the Department agreed to refer the matter to the Attorney General for an opinion. The matter was referred to the Attorney General in March 1999.

The Department has requested an official opinion from the Attorney General's Office relating to this issue.

8. The Department should develop a policy guide to cover situations in which DCFS Legal provides counsel to accompany workers to police interviews. The guide should include a requirement that both the worker and the police are made aware of the precise nature of legal representation and should include instructions that information should be withheld from the police only when the Department is prohibited by law from releasing such information to law enforcement.

The Department agreed. Currently, the Department is revising and clarifying these procedures, pursuant to this recommendation. When the procedures are completed, a copy will be sent to the Inspector General.

9. Prior to placing a school-age ward in any residential facility, the Department should ensure that the facility has an operating educational component.

The Department agreed. All residential facilities that serve DCFS youth have fully operating educational components. The Department has established a system of gatekeepers and contracted monitors who visit facilities regularly and assure that all programs are fully functioning, including their educational components.

Death Investigation 6

ALLEGATION

A five and a half year old boy was beaten to death by two of his foster mother's biological sons. The forced transfer of the family's case from a closing agency, substandard management by both agencies involved and improper agency licensing practices by Department employees contributed to the boy and his five siblings being placed in an unsafe environment.

INVESTIGATION

The boy and his brothers and sisters were picked up from their licensed foster home by their caseworker to be taken to a visit with their mother. The boy was sleepy, feverish and nauseous throughout the afternoon. Upon returning him home, the worker told the foster parent to take the child to the doctor if he did not feel better in the morning. The next day, the boy rose briefly, drank some water and went back to bed. Two hours later, he was found unresponsive in his bed. He was then taken to the hospital where he was pronounced dead. The Medical Examiner documented numerous recent internal and external injuries and ruled the death a homicide resulting from blunt force trauma because of assault. The ensuing investigation revealed two of the foster parent's sons, ages nine and fourteen, had allegedly pushed the boy up against a wall, punched him repeatedly in the stomach, and hit him in the face and back with a belt because he had vomited and some of it had gotten on one of them. The two boys had first-degree murder petitions filed against them in juvenile court.

An OIG review of the case history found the private agency originally charged with providing services to the family was improperly licensed by a Department licensing representative. A license was issued to an agency that had never been incorporated. The Department representative also failed to issue the required six month permit prior to licensure. Instead, the representative issued an initial two year license without having completed reviews of personnel, children or foster home records. Seven months later, she issued the agency, which had not yet received children for services, a four year license. The new license was approved and signed by another Department employee in the capacity of Licensing Coordinator even though he did not hold that position.

The agency's executive director did not have a master's degree from an accredited school and therefore was not qualified to hold his position. A review of the agency by another licensing representative conducted during monitoring visits found several deficiencies in the agency, including incomplete records and the agency's lack of a qualified case management supervisor and a foster home licensing worker. The reviewer also attempted, but was unable, to verify the executive director's degrees, which were never questioned by the initial licensing representative. Although these findings were discussed with the agency's administrators, they were not shared with other members of the Department.

An Agency Performance Team (APT) review was initiated by the Department following the death of a six year old boy who was one of nine children in a foster home licensed by the same private agency. The APT report noted serious licensing violations, overcrowding, safety concerns, and questionable decision-making regarding numerous foster homes licensed and monitored by the agency. When the OIG learned that the Department was going to devise a corrective action plan with the agency, the OIG addressed a letter to the Director informing him the Department had sufficient evidence to terminate its contract with the agency and that failure to do so would threaten the health, safety, and well-being of children for whom the Department was responsible. The contract was terminated and the agency's cases were transferred by the Department to twelve other private agencies. Over one half of the closing agency's foster homes (and accompanying children) were transferred to four "new" agencies; three of the four new agencies' contracts were terminated by the Department within the next nine months. None of the receiving agencies were advised by the Department of any of the licensing violations, safety concerns, and questionable decision-making by the agency that were noted by APT.

The family's case was delegated to one of the new private agencies as a result of the mass transfer. The agency assuming responsibility for the case exhibited many of the same shortcomings as the previous agency. The executive director did not meet the Department's requirements to hold the position. The agency had no full-time social work supervisor and the employee who served as bookkeeper and case manager had inadequate accounting skills and had misrepresented her educational background to DCFS Licensing. The executive director's father served as Chairman of the Board of Directors until he was advised by the Department of the inherent conflict of interest in his holding the job, at which time he resigned and was hired as a case aide. In his personnel record, he reported he was a convicted felon. The agency had received an initial six month permit that was followed by the pro-forma issuance of a license before it had serviced any children. DCFS Licensing representatives made their last visit to the agency before it had received any cases and did not return until the day after the boy's death almost two years later.

While the family case was with the second agency, placement stabilization services were requested for the oldest child who was exhibiting behavior problems. The worker from the placement stabilization service provider documented contacts with the child and foster family that, based on the facts, could not have occurred as documented. For example, the worker reported that the foster child's behavior was improving after the boy's death and the girl's removal from the home. The matter was referred to the State's Attorney, who declined to prosecute because the worker was not a "public employee" according to statute. The OIG informed the agency of the worker's actions and she was dismissed by the agency.

Neither of the private agencies provided adequate supervision to the foster home and both failed to ensure that the six siblings, ages two months to eight years, were placed in a safe, nurturing home environment. Following their brother's death, the children told investigators they had been physically abused in the home by the foster mother, her sons, and her boyfriend, whom she had presented to workers as her brother-in-law. The foster mother's failure to care for the siblings or restrain her own sons from taking part in the beating of the children resulted in the boy's death.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The OIG and the DCFS Legal Division jointly developed a memorandum form to be used when cases are transferred from a closed agency.

The Department agreed. The Memorandum Regarding Transfer of Case Files Due to Agency Downsizing or Closure is currently being utilized.

2. According to APT documents, APT can recommend whether case managers of a closing agency should transfer with cases to receiving agencies. Because this constitutes a hiring recommendation by APT, this practice should be discontinued for the following reasons: a) APT liaisons are unlikely to have reliable information pertaining to backgrounds and performances of the employees; and b) such recommendations can be misconstrued by receiving agencies as a requirement. Employees of closing agencies should independently apply for positions at child welfare agencies of their choosing and the decision to hire an individual should be at the discretion of the employer.

The Department agreed. The practice of transferring caseworkers from a closed agency to a new agency with their caseload occured only once. In that case, a private agency's contract was terminated in February of 1997. A decision was made to send workers with their caseloads to the agencies receiving the cases to ensure that the cases were covered. This practice was not repeated again in any other foster care contract termination.

3. APT staff must be able to identify clinical problems and have the authority to enforce resolution of identified problems. Therefore, the Department should:
a) ensure that all APT staff are trained to the utmost in relevant clinical issues and comprehend that their jobs require substantive monitoring of the agency's interventions with our children, their foster parents, and their biological families; and
b) institute a process of communication between APT and Licensing and Contracting Divisions (similar to Critical and Chronic Alerts used in the Administrative Case Review process), that will result in actual sanctions to private agencies for poor practice and failure to respond to identified problems.

The Department agreed. Agency Performance staff have been attending Clinical Retraining. Currently, weekly meetings are held to discuss the performance of foster care agencies. In attendance are the Division of POS Monitoring Deputy, Associate Deputy, Agency Performance Field Service Managers, a Court Facilitator, Agency and Institution Licensing and the Chief of African-American Services. Sanctions already exist and are in the attached protocol.

4. The OIG referred the placement stabilization worker's falsification of records to the State's Attorney's Office. It was rejected for prosecution because she was not a "public employee" as defined by 720 ILCS 5/2-17. The OIG brought the matter to the attention of the agency's administration and the worker is no longer employed by the agency.

No action necessary.

5. The OIG previously recommended that DCFS terminate its foster care contract with the first private agency based on its Agency Performance Team findings.

No further action necessary because the agency's contract was terminated.

6. The Department should initiate license revocation proceedings on the second private agency.

The Department agreed. The Department attempted to initiate license revocation. However, the agency is no longer operating at the address at which they had been licensed, therefore invalidating their license.

Death Investigation 7

ALLEGATION

A fourteen year old girl with an extensive history of running away was murdered while on run from shelter care.

INVESTIGATION

The girl, who had lived with her father since she was molested by her mother's paramour when she was five, had begun acting out and engaging in self-destructive activities following her father's marriage two years prior to her becoming active with the Department. She was taken into protective custody by the Department after her father refused to take her home when she was expelled from a residential drug treatment program for twice running away. Her father allowed the Department to take temporary custody because of his concern that he would be unable to manage her behavior but he wanted to be involved throughout her treatment.

The Department placed the girl in a temporary shelter. Staff identified depression and suicidal tendencies coupled with her admitted drug use as their primary concerns. She left the shelter without permission nine times, spending 29 of the 44 days she was in the custody of the Department on runaway status. Despite fleeing so often, she always returned voluntarily, either by returning to the shelter directly or turning herself in to a local police department. After she ran away for the seventh time, staff at the shelter asked for permission to use restraints to prevent her from leaving again. The request was denied by the Emergency Reception Center supervisor but supervision was increased. Nonetheless, the girl ran away two more times in her last two days at the shelter.

As time passed following the last time the girl ran away, her parents and staff at the shelter became increasingly concerned. Her picture and information was registered with several national databases for missing children, a juvenile arrest warrant was issued and her father contacted her friends hoping to find clues as to her whereabouts, to no avail. When her caseworker followed up with the Chicago Police Department a month after the girl's disappearance, she learned that a missing persons report had not been filed for the last runaway. The report number being used was actually from one of the previous times the girl had run away. The case worker made the official report which was reviewed by CPD every 30 days at first, then every six months.

Seventeen months after she disappeared, the girl's information was forwarded by National Missing and Exploited Children to a police department in Wisconsin where the body of a teenager fitting the girl's description had been found in a forest preserve just two weeks after she ran away. The cause of death was asphyxiation, most likely suffocation with a black garbage bag found over her head. The town had held a funeral service for the unknown girl and buried her in a local cemetary. She was identified from dental records as the girl who had run away from the shelter in Chicago.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The OIG recommended the use of a communication form containing vital information that would assist law enforcement in tracking down runaway children as quickly as possible. The form should be filled out completely and included with a placement package when any child is placed in a foster home, residential placement or shelter. It would be most helpful to have the information for teenagers.

The Department agreed. This will be included in the soon to be released policy on runaway children.

2. Pictures of all wards, such as school pictures, should be taken on a regular basis, dated and provided to placement providers or foster parents. The Department should pay for school pictures.

The Department agreed with the need for pictures and current identifying information on all wards. The Department is identifying an appropriate process to accomplish this for all wards.

3. The time and date of a ward's runaway and the place from which the ward ran should be clearly stated on the Unusual Incident Report and distinguished from the date on which the report is being made. Also included should be the number of the police report, which means the runaway has to be reported to the local police department before the UIR is prepared.

The Department agreed. The Department is in the process of revising the Unusual Incident Report system. The revision will allow the Department to track the date and time of a ward's run and include the police report number.

4. Once a ward has been absent for 30 days and on runaway status and the whereabouts of the ward remain unknown, the Guardian's Office should report the child to the following national agencies: National Missing and Exploited Children Hotline, Missing Children Hotline, Child Find and the Runaway Hotline. It was after the girl was reported to these organizations that she was identified.

The Department agreed. A policy guide has been drafted providing guidelines for the immediate reporting of runaways to national centers for missing children.

5. When dealing with an adolescent whose behavior is self-destructive and uncooperative, but who is also using drugs, the Department should consider filing a petition on the minor as an Addicted Minor (ILCS 705, 405/4-1 et sec) to make use of the authority of the court in servicing the youth.

The Department agreed. When appropriate, the Department will consider using the Addicted Minor law to deflect children from coming into foster care.

6. The Department should retrain supervisory Emergency Reception Center (ERC) staff as to when it may be proper to allow children to be restrained from running away.

The Department agreed. ERC has retrained all supervisory staff as to when it is appropriate to restrain a child.

Death Investigation 8

ALLEGATION

A sixteen month old girl died as a result of abuse by her parents. The Department had unfounded an abuse charge made against the parents two months before.

INVESTIGATION

Two months before she died, the girl had been brought to a hospital emergency room by her parents for treatment of a rash. A hotline call was made after an attending nurse noticed what appeared to be bruises caused by fingertips along the child's jawline. The investigator from the Division of Child Protection learned that local police had recently been to the home after the mother was seen being carried from her house by three people. The mother had been taken to the hospital and treated for an overdose. The worker reviewed the hospital records from the child's emergency room visit and interviewed staff who had treated her. He also spoke to the maternal grandmother, who said her daughter was very good with the baby, and the administrative assistant of the mother's housing complex who told him she had never received any complaints or witnessed any abuse of the child. The investigator did not speak to the mother until a month after the call was made because the mother did not respond to numerous attempts to contact her. When he did see her, she told him her daughter was injured when she had fallen into a coffee table. She also stated that her boyfriend, the child's father, did not live with her but only came to visit periodically. The investigator accepted the mother's story and unfounded the allegation. One month later, the parents again brought the child to the emergency room where she was pronounced dead. The hospital called the hotline and filed a report of death by abuse.

The investigator did not follow up the report of the mother's hospitalization for an overdose. Hospital records of that incident showed the treating physician believed the overdose to be a suicide attempt and obtained a consult with a psychologist. The records also reported the mother had been drinking and had been in a fight with the child's father before the overdose. When he met with the mother, the investigator did not question why she had not returned his calls. He also did not pursue the issue of the boyfriend's presence when both she and her daughter required emergency room treatment even though he reportedly did not live with them.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. This case should be used in training DCP investigators as to why it is sometimes necessary to look below the surface and explore any indicators or red flags before determining the level of risk to a child.

The Department agreed. This case will be used as a training tool for DCP investigators.

2. This report should be shared with the DCP investigator.

The Department agreed. The report was shared with the investigator.

Death Investigation 9

ALLEGATION

An eight month old girl who was placed in a licensed foster home by the Department died. Although her death was ultimately determined to be the result of Sudden Infant Death Syndrome (SIDS), an investigation of her death raised questions about her care and conditions in the foster home.

INVESTIGATION

The eight month old baby was found unresponsive in her crib by her foster mother who stated that she was afraid the baby may have suffocated on a pillow in her crib. An examination of the baby revealed that she had a pacifier held in her mouth by tying a shoe string around her neck. The Cook County Medical Examiner's Office ultimately found that the baby's death was due to SIDS and a DCFS Division of Child Protection (DCP) investigation of the infant's death was unfounded on that basis. DCP did not share the concerns about the infant's care with the Division of Licensing. The OIG notified the Cook South Resource Development Manager for Licensing of the concerns regarding the infant's care and advised that a licensing representative should discuss them with the foster parents prior to any more infants being placed in the home. Licensing sent the OIG verification that it did so and that, in addition, it had advised the foster parents not to accept any more infants in their home.

The OIG later learned from the Cook County Medical Examiner's Office that a standard scene investigation of the baby's death revealed that all of the interior doors in the foster home had either chain or key locks or both; even the closet door in the deceased infant's room had a chain lock. When asked about the locks, the foster parent stated that the locks had been in place when the home was purchased and that they had not been removed. The Medical Examiner's investigator noted that this explanation seemed evasive. The OIG spoke with the foster parents' licensing representative about the locks. The licensing representative stated that she never noticed the locks, but that she would go to the home and investigate. The licensing representative sent the OIG a letter stating that the foster parent explained that the locks were for privacy and to lock adults out and that the lock on the door of the bedroom where the children sleep had been removed. This response from Licensing was unsatisfactory.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. A thorough review of the records of this foster home should be conducted.

The Department agreed. The Cook South Resource Development Manager supervised a thorough review of the foster home records. Because of the foster father's prior criminal conviction for carrying a concealed weapon, the foster home license was not renewed. However, the foster mother's grandson remains in her care.

2. The foster family should be interviewed to answer outstanding questions about the locks on the doors, as well as any concerns based on the review of the foster home records. The foster parents should be required to remove all of the internal door locks which do not serve a reasonable purpose.

The Department agreed. The concerns were addressed with the foster parents and the locks have been removed from all interior doors.

3. A review should be conducted of the actions/inactions of the licensing representative assigned to the foster home and any appropriate follow-up measures should be taken.

The Department agreed. The Licensing Representative received counseling for her actions/inactions regarding the foster home. In addition, the licensing representative has received additional training in licensing and documentation.

4. The caseworkers for the children currently placed in the foster home should interview their clients regarding their treatment in the home and provide summaries of the interviews to the Cook South Resource Development Manager.

Because of the non-renewal of the foster home license, all unrelated foster children were removed from the home.

5. The recommendation that the foster parents should not accept infants in their home should be formalized and should include toddlers as well.

The foster parents were instructed not to accept infants into their home. Because the foster home license was not renewed, this recommendation is now moot.

Death Investigation 10

ALLEGATION

A sixteen year old mother was indicated for abuse after admitting she dragged her toddler across the carpet because she was angry with her boyfriend. The child had special needs in that she had been born at 25 weeks gestation weighing only one and a half pounds and had respiratory problems that necessitated a tracheostomy, which both her mother and grandmother were trained to manage. Although the child died of natural causes at age two and a half, it appeared the family was not receiving services to ensure the safety of the child.

INVESTIGATION

The hospital arranged for medical services and supplies to be provided to the child in the home. The Division of Child Protection (DCP) had recommended anger management counseling for the mother and the case was assigned to an intact family worker. The worker never secured the anger management counseling recommended by DCP.

During the first nine months of services, the worker's case notes record only one home visit and two telephone conversations with the mother. The worker had no knowledge that, during that time, the mother was hospitalized and the child had to be hospitalized as well since there was no trained caretaker to attend to the tracheostomy. The worker had no knowledge of these events as they occurred and never formally assessed the family, yet she completed Client Service Plans, rating all objectives satisfactory. A DCFS nurse who visited the home noted a host of environmental concerns and offered an extensive list of recommendations, but assignment of responsibility and timelines for completion were not documented. The service plans were not signed by the worker's supervisor.

In her interview with the OIG, the worker's supervisor related that she had serious ongoing concerns about the worker's performance on this and other cases; however, the supervisor demonstrated a lack of understanding of how to use the progressive disciplinary process.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Labor Relations and Quality Assurance should assist the supervisor with a comprehensive review of the worker's currently assigned cases to evaluate her capability to perform her job responsibilities. Based on an assessment of the worker's overall performance, Labor Relations needs to determine appropriate disciplinary action and consider transferring her out of Intact Family Services where many children remain in homes where abuse occurred. The worker's poor performance significantly increases the existing level of risk in these families.

The Department agreed. The Department completed a thorough review of the caseworker's performance on June 17, 1999. The Department believes transitioning this employee to another division is not feasible and appropriate disciplinary action is being reviewed.

2. DCFS nurses' care plans should include time lines for dates of completion, assigned person responsible for implementing each recommendation, and formal follow up of recommendations. Care plans should be typed to avoid the problem of illegibility.

The Department agreed. DCFS nurses were instructed to include timelines for dates of completion of care plans, assigned person responsible for the plans and to follow up on each recommendation.

Death Investigation 11

ALLEGATION

A fifteen year old boy died from complications of a severe form of muscular dystrophy that also affected three of his ten siblings. Despite the family's history of involvement with DCFS, the Department never provided adequate support to ensure the children's needs were met.

INVESTIGATION

The family first came to the attention of the Department in 1987 when the manager of the building they lived in called the hotline to report the poor condition of the family's residence. The mother was indicated for environmental neglect and the father, who acknowledged having an alcohol problem, was prohibited from having unsupervised contact with the children. The case was referred to Intact Family Services. The case was closed a year later based on improvements made in the home and the availability of family members to assist with cleaning, repairs and paying bills. There was no evidence that workers attempted to get the parents to enroll the younger children in preschool or addressed the needs of the family in light of the children's medical requirements.

In 1993, another hotline call was made by the children's school for medical neglect of the siblings afflicted with muscular dystrophy. The mother was not indicated for medical neglect but was again indicated for environmental neglect because of the condition of the home. The Family Assessment Factor Worksheet Summary noted that the mother appeared overwhelmed by the responsibility of caring for all of her children. The eldest son was later the subject of a hotline call for physically abusing his siblings and was subsequently removed from the home. The family's case was again closed.

In 1995, the children's school called the hotline to report the parents were overwhelmed trying to care for their ten children. The ensuing Division of Child Protection (DCP) investigation found the family's home was again in a state of disrepair and the children were not regularly attending school. The father was arrested for domestic battery, although the incident was not documented by DCFS. A Law Enforcement Agency Data System (LEADS) check conducted by the OIG showed the father had been arrested at least six times for domestic battery. The Department referred the mother to a private health care service to provide in-home care for the children with muscular dystrophy. When the mother did not follow through with the referral, DCFS closed the case.

In 1997, a DCFS follow-up worker called the hotline to report environmental and medical neglect. The father admitted to the worker he had an alcohol problem and told him the family's only sources of income were public aid and social security disability checks. The investigator recommended the family for Intact Family Services. The fifteen year old died prior to an Intact Family worker being assigned.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Intact Family Services should be specifically tailored to address the issues individual families face. The OIG is especially concerned that medically complex children receive appropriate and timely attention from agencies with medical expertise.

The Department agreed. The Department is in the process of identifying medically complex/medically involved children within the system. A new data system, Health Care Information System, is in the developmental phase and will be implemented in Cook County by the end of calendar year 2000. In addition, a policy guide is currently being drafted and will be sent to the field delineating the procedures for informing DCFS regional nurses of all medically complex/medically involved children.

Death Investigation 12

ALLEGATION

A woman with a history of drug use and two prior DCFS indicated reports gave birth to a premature daughter who died an hour later. The mother tested positive for cocaine at the time of the baby's birth. The infant was not tested; however, a report to the hotline alleged that the mother's drug use caused the infant's death.

INVESTIGATION

The mother had two surviving children, a six year old daughter and a four year old son. The mother had two hotline reports indicated against her around the time of her second child's birth. The first report was indicated for inadequate supervision for leaving her daughter with her grandmother without a care plan while she went off to use drugs. The second report was indicated for substance exposure to her newborn son. DCFS offered to provide services to the mother, including drug treatment; however, the mother refused services and a service case was never opened by the Department.

The report alleging that the mother's drug use caused her infant daughter's death was unfounded based on the obstetrician's opinion that the infant's death was a result of the mother's untreated hypertension. Thus, a service case was not opened on the family. The OIG reviewed the family's records and found areas of concern, particularly the mother's substance abuse that has continued over a period of at least four years. She has used drugs during two of her pregnancies and has delivered at least one substance-exposed infant. Her hypertension could have life-threatening consequences should she continue to use drugs and get pregnant again. At the time of her baby's death, the mother was experiencing stress because of marriage difficulties and the daily care of her children. Her mother, who looks after the children while she works, lacked important emergency medical information about the children, as well as a means of contacting the mother at work.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. A child welfare case should have been opened by the Department following the infant's death. The Department should now offer services to the family. The OIG recommends that the following child welfare services (or assessment of such services) be offered to the family:

a. **Family support services to the biological mother and grandmother, including services to ensure that the maternal grandmother receives necessary emergency and medical information from the mother;**
b. **Substance abuse treatment for the mother;**
c. **Family planning;**
d. **Assessment for family bereavement counseling;**
e. **Enroll the youngest sibling in a pre-school program;**
f. **Assessment of the father of the children; and**
g. **Family counseling to assess and/or address various family issues including marital, family planning, the mother's medical condition (hypertension with drug use and risk of pregnancy and ensuing complications), and the exploration of voluntary guardianship to the maternal grandparents, or stand-by guardianship if the parents should be unable to care for the children in the future.**

The Department agreed and child welfare services were offered to the family.

Death Investigation 13

ALLEGATION

A twelve year old boy was accidentally shot and killed by an acquaintance after running away from his placement in a group home.

INVESTIGATION

The boy, a ward of the Department, was the youngest of five children whose family first came to the attention of DCFS in 1987. He was committed to the Department after being charged three times with delinquency for possession of a controlled substance stemming from his involvement with dealing drugs for a street gang. While in the group home, the boy attended school and participated in counseling sessions. One Unusual Incident Report was filed concerning the use of restraints on the boy, but his time in the group home appeared otherwise uneventful.

On December 3, 1998, he ran away from school, apparently upset at not being allowed to return home for Thanksgiving. The school immediately notified the group home who, in turn, contacted the Department and Chicago Police while initiating their own search for him. Two days later, the boy was shot by an acquaintance who was playing with a gun in a playground near the boy's home.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

The group home responded promptly and responsibly to the report that one of their charges had run away. No recommendations were made.

General Investigation 1

ALLEGATIONS

The investigation of the Sexually Aggressive Children and Youth (SACY) program by the OIG was an outgrowth of an investigation conducted at the request of a licensed private agency foster parent. The initial complaint questioned removing a developmentally disabled, six year old foster child and placing him in a residential treatment center for pre-adolescent sex offenders. The foster mother reported that her foster child had been placed with her by the private agency in June 1998, but then removed in August 1998 and placed at a residential home for sexually aggressive children. The six year old child had been designated a SACY ward because of reports of sexually inappropriate behavior exhibited in a previous foster home. The foster mother did not believe that placement in a residential treatment center for sexually aggressive children was warranted for the child. Rather, he required a nurturing, loving and stable home since he had been moved six times in less than three years.

In her request for an investigation, the foster mother raised two additional concerns: (1) whether race was a factor in the child's removal from her home (she is African-American and her foster child is Caucasian), which would be a violation of the Multi-Ethnic Placement Act (MEPA), and (2) whether the emotional environment of the treatment center would be detrimental to a child of such a young age. The foster mother explained that when she visited the child at the residential placement, he was told that he could not sit on her lap or display any type of physical affection toward her. Although the foster mother and child had developed a warm and affectionate relationship and it was not uncommon for them to exchange hugs, this behavior was discouraged by the staff because "sex offenders" were not supposed to engage in any type of physical touching. The foster mother was appalled by the attitude of the staff at the facility, but when she objected, she was labeled by the staff as a hindrance to the child's progress. She believed that the staff were creating obstacles to her attempts to remain close and protective of her foster child. The OIG discovered that the child had been labeled sexually aggressive without analysis of the context of his behavior. The OIG also learned that adult offense/treatment models were routinely imposed on children below the age of eight. As a result, the OIG undertook a comprehensive review of SACY labeling and treatment of wards under eight years old.

INVESTIGATION

In the early 1990s, the Legal Assistance Foundation of Chicago (LAF) identified that the state provided few resources or treatment to DCFS wards who sexually abused other children. In response, the Department began to develop programs to identify children with sexual behaviors and provide them with properly focused services. It appeared that traditional case management and/or traditional therapeutic measures were not effective in helping these children. The Department contracted with a victim advocacy group in 1994 to create a new program. The result was the SACY program. The goals of the program were to identify children with sexual behavior problems, provide them with treatment services to address their specific sexually related issues, and monitor them via a statewide database.

The Inspector General's investigation revealed that the SACY program has developed into a system which designates and labels children, some as young as 2 1/2 years old, as sexual offenders. These children are treated for the potential threat of "re-offending," as if they were adult sexual predators. The standards of measuring sexually aggressive behavior, which closely resemble the adult/adolescent sexual assault model, are applied to very young children. In the majority of cases, children are labeled and placed on this database after only one incident of sexual behavior which in many cases does not reach a high level of severity. There is often no investigation of the facts surrounding the incident, no complete review of the child's history, and children are often placed on the database based solely on a single phone call. The designation fails to consider the developmental capacity of the child or other traumas in his/her life which may have contributed to behavior problems. These minimal procedures can play into a tendency on the part of some adults who are overly alarmed by any behaviors with sexual overtones.

In fact, in the majority of cases, behavior problems such as physical aggression or poor impulse control were the more salient issues. However, these issues were largely ignored or interpreted solely from a sexual perspective without identification of developmental status, socialization history, appreciation of sexual reactivity. A SACY label precedes the child in nearly everything he or she does including school, recreational activities and home life, because all adults in a supervisory position with a child must be notified of the SACY status. In addition, it often affects the range of placements available to wards.

In the Inspector General's sample of 27 children age seven and under labeled SACY in Cook County, nearly half of the children had developmental and/or learning delays. Fifty-one percent of the children in the sample were known to have been physically or sexually abused, 44% exhibited non-sexual physical aggression, 48% came from a drug environment (i.e., born drug exposed, had a sibling born drug exposed or a parent having drug use monitored) and 70% were labeled after only one or two incidents. In spite of these critical facts, the SACY Standards use the measure of "usual and expected" to determine problematic sexual behavior. What is usual and expected for a "normal" child likely differs from behavior that a child might exhibit after having experienced serious life traumas or being developmentally delayed.

Perhaps the most harmful aspect of the SACY program is the assumption of incurability: "there is no cure for sexual abuse and behavior must *always* be managed."[1] This lends itself to a view of very young children as unredeemable.

Finally, the SACY program failed to monitor its own standards of treatment. As a result, children had been retained on the database for years without appropriate services or review. The casual labeling of a young child as sexually aggressive can have detrimental and long-lasting effects. In many cases, siblings have been separated, placements have been denied, children have been alienated from their peers, and adoptions have been held up in court based largely on the weight of the SACY label.

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[1] SACY Standards, 1999.

OIG RECOMMENDATIONS/ DEPARTMENT RESPONSES

1. The Department should prohibit sexual labeling of small children or subjecting them to therapy primarily or exclusively aimed at the label. While children seven and under may benefit from home-based treatment that addresses problematic behavior, there is no need to label such children as sexually aggressive and place them on the SACY database. The OIG investigation revealed they are likely to be harmed from such labeling. Reports of inappropriate sexual behavior should be analyzed with a developmental perspective recognizing that many of our wards may exhibit age-inappropriate behavior because of deprived environments, under-socialization or exposures to overly adult sexual behaviors or lifestyles associated with drug usage. Behavior should be analyzed in context, with anti-bias techniques to avoid cultural biases. Then, if still considered sexual, the behaviors should be seen as only a part of the child's needs and should not supercede developmental and educational needs. The American Psychological Association guidelines prohibit the reduction of any individual to a label.

The Department agreed. All names of children under the age of eight have been deleted from the SACY database. Each child's case will be reviewed to ensure that developmentally appropriate intervention is being provided.

2. DCFS's contract with the private contractor should be amended to exclude children aged seven and under, and to reallocate the funds for monitoring and follow-up of adolescents with serious aberrant behavior.

The Department is currently reviewing its contract with the contractor. Responsibility for management and oversight of young children exhibiting sexualized behavior has been delegated to regional clinical staff. The contractor will work with the liaisons in a consulting role.

3. The Inspector General should convene a multi-disciplinary panel to review the few cases of children seven and under that portend serious injury to others.

The Department agreed. A multi-disciplinary panel has been established and the first meeting was convened on October 22, 1999.

4. The Department should develop an early childhood clinic for young children whose presumed sexual transgressions are part of larger developmental problems, social skills deficits, aggression management, and other inappropriate behavior. Children and foster families would be referred there for observation, assessment, time-limited educational sessions, and subsequent home-based behavior management programs.

The Department is undertaking a serious review of the mental health needs of young children, including abnormal sexual behavior. The Department will keep the Office of the Inspector General apprised of developments in this area.

5. Whenever possible, young children with mild verified sexual behavior problems should be treated at home with their foster parents, and should also be enrolled in early enrichment programs. There should be education for foster parents regarding what is normal and expected sexual development for children of a young age, as well as what might be expected from wards who have experienced traumatic events. No treatment plan should be devised for any of our children without full knowledge and consideration of their history and input from the current caretaker.

The Department agreed. The draft training curriculum for foster parents will emphasize early enrichment programs for young children with sexualized behaviors. The requirement for a complete review of the child's history and input from the caretaker in developing a treatment plan will be included in the standards for young children.

6. The Department should abandon the trappings of the adult criminal justice model of treatment with its punitive language and attitude when treating or describing children aged seven and under. The Department should keep in mind its commitment to helping these young children toward better lives. Some were born substance-exposed, experientially retarded, or developmentally delayed, and approximately half have been sexually abused. Staff should see them as tender-aged victims, rather than as "scary," "perps" or "offenders." Like all DCFS wards, they deserve respect and compassion.

The Department agreed. The names of young children will no longer be entered in the SACY database and the names of children age seven or younger have been deleted. Clinical staff have been established in each region who are responsible for reviewing all cases presenting sexual behaviors and consulting around appropriate treatment and service planning. Any language or references to young children in the SACY training curriculum have been deleted.

OIG REPLY

The Department intends to use the contracting agency in a consulting role and has requested that the contractor be a member of the multi-disciplinary panel. The OIG investigation revealed that the contractor classified our young wards (age seven and under) as "incurable," which was detrimental to their well-being and treatment. This same problem was identified and confirmed by a study of the program performed by Illinois State University for the DCFS Research Institute. The study noted "not a single expert agreed at all with the assumption that there is no 'cure' for sexually aggressive behavior in children."

Because the OIG, the Department and the study commissioned by the Research Institute all agree that a developmental approach is critical to our children, age seven and under who exhibit sexualized behavior, the OIG does not agree that using a consultant who does not specialize in child development is an appropriate allocation of DCFS funds.

The Department has commitments from several consultants who have offered to serve the Department without pay to remedy the harm caused by the program in the past. These consultants include a nationally renowned psychologist who specializes in child development, a leading mental health advocate and a pediatrician.

Most importantly, it is unethical to have a consultant review its own work — especially when the conclusion of that review could result in financial gain for the consultant. The OIG suggests that the contractor present its conclusions and opinions to the multi-disciplinary panel in lieu of being a member of the panel.

General Investigation 2

ALLEGATIONS

Three asthma related deaths prompted an OIG investigation and research into case management of children with asthma. One child had an active DCFS case and the other two were investigated by Child Protective Services for possible medical neglect and supervision. The investigations found no neglect. All three children had acute fatal asthma attacks during early morning hours and died en route or shortly after arrival to hospital emergency rooms. Their deaths were ruled "Death by natural causes- Bronchial Asthma." The OIG investigated the deaths to evaluate what, if anything, could have been done to prevent these deaths.

INVESTIGATION

Asthma is a chronic lung disease characterized by airway inflammation and increased sensitivity to stimuli and allergens that cause constriction of the bronchiole tubes of the lung. Additionally, swelling of the bronchial tube lining and the mucus secretions that it produces can block the airways, making breathing even more difficult. Asthma attacks are generally reversible and preventable, but the disease requires education as well as understanding and avoidance of triggers, allergies and stimuli that induce asthma attacks. The cause of asthma is unknown.

The rate of asthma among young people ages five to fifteen has increased 74% between 1980 and 1994, and the rate among preschool children increased 160%. Asthma is the most common chronic illness leading to school absenteeism, accounting for more than ten million missed school days annually. Asthma is the third leading cause of hospitalization in children under age fifteen. Inner city children with asthma, particularly African Americans and Hispanics, may have a three to five times greater asthma mortality rate. Many of these deaths are probably avoidable. Over the past ten years, asthma morbidity and mortality have risen due to under diagnosis of asthma and insufficient treatment, increased environmental exposure to allergens and pollutants, and lack of access to primary care providers and specialists, especially in indigent patient populations. Although asthma attacks are seldom fatal, deaths from asthma do occur. There are over 5,000 deaths annually because of asthma. Asthma related deaths among children five to fourteen years of age more than doubled from 1979 to 1995. A high percentage of deaths occur either in the night or early morning hours.

Several problems were identified by reviewing these deaths. The Department does not have a database system that currently can identify serious medical needs of wards of the State. It is critical that the Department find a way to identify its wards with asthma and other serious or chronic illnesses. The National Academy of Pediatrics and the National Heart Lung and Blood Institute(NHLBI), through the National Asthma Education and Prevention Program, have established comprehensive guidelines for the diagnosis, treatment and education of children suffering from asthma. These guidelines could provide a basis for the establishment of an identification system for afflicted wards in the State of Illinois.

Based on statistics, we can expect that at least fifteen percent of our wards have asthma. The importance of identifying these children is to ensure that basic follow-up measures are taken to: (1) establish the severity of the child's asthma; (2) ensure that the child has an Asthma Action Plan and Peak Flow Meter; and (3) educate foster parents and parents about asthma, asthma triggers and how to remove them. Training should emphasize the importance of asthma action plans and peak flow measurements.

It is important that the Department know whether children's physicians are following the National Institute of Health guidelines for the treatment of asthma and to advocate for adherence to those guidelines. This is particularly critical for children whose severe asthma might make them more prone to fatal attacks. Caseworkers and DCFS nurses have a pivotal role in raising awareness and promoting asthma education. Research studies show continuous asthma education is critical in order to get a child's asthma under control and manage the disease.

OIG RECOMMENDATIONS/ DEPARTMENT RESPONSES

1. The Department should develop a central data base identifying children with asthma and other chronic illnesses, and hospital admissions and discharges. Establish a point person to maintain current asthma data and literature and available resources such as asthma clinics and classes, and local support groups.

The Department agreed. A survey is being developed to send to all caseworkers to identify children with various chronic diseases. Also, the Department will utilize the Department of Public Aid claims data to identify children with asthma. DCFS regional nurses will accompany caseworkers on home visits to children with severe asthma based on the DPA claims data on hospitalization/ER visits due to asthma. Phase two of the upcoming Healthcare Information System will track different kinds of major diagnoses using ICD-09 codes. The Healthcare Information System will be incorporated into the Statewide Automated Child Welfare Information System (SACWIS). The Division of Health Policy will serve as the centrally located resource for regional nurses to obtain the most up to date information on asthma literature and data.

2. The Department should establish protocol to case manage children with asthma and adopt current medical standards and guidelines for the treatment of asthma:

a) Assess the severity of asthma of each child. Identify children who have fatality-prone asthma and replicate the Red Alert Program for these cases.

b) All wards diagnosed with asthma must be allergy tested to help determine their triggers. Before placement, the child's prospective environment should be assessed for the existence of their known triggers and allergens.

c) Establish an asthma education program to provide caregivers with adequate and current knowledge and skills in effective management of a child with asthma, i.e., medications, triggers, signs and symptoms of asthma onset. Educate foster parents about available resources. Prospective foster parents should attend asthma classes before accepting their first foster child with asthma.

d) Ensure that all wards with asthma have Asthma Action Plans and Peak Flow Meters. Require written copy of asthma management treatment plans; one copy would reflect daily treatment and one copy would reflect emergency treatment. Copies should be updated as needed.

e) Coordinate caregiver's role in the management of a child's asthma: ensure that caregiver has a written Asthma Action Plan, evaluate his or her skills and knowledge of asthma management and medications, ensure ready access to medication (some children need medications kept at school, day care center, etc.), ensure follow-up with medical appointments, and assess caregiver's transportation needs.

f) Ensure minimal school absences because of asthma episodes, doctor appointments, and testing. Work with caregivers to coordinate appointments with caseworkers, therapists, doctors, home health professionals, etc., to avoid over scheduling in the same week or day; and ensure timely sharing of pertinent information for continuity of care.

g) Educate caseworkers and DCFS nurses on asthma management, including the National Heart Lung and Blood Institute (NHLBI) standards for treatment of asthma to ensure that doctors caring for our asthmatic wards are following the NHLBI guidelines. Caseworkers should utilize the consultation and expertise of DCFS nurses regarding medications, disease process, current pediatric asthma management regimen, and assessing suspected medical neglect.

The Department agreed with the need for a protocol and will develop one by February 1, 2000 for case management of DCFS wards with asthma.

3. DCFS should coordinate with other state agencies and community-based agencies on the management and service of asthma. The Department should ensure that medications, equipment, supplies, and training are covered by Medicaid and/or other primary health insurance.

The Department agreed. The Division of Health Policy staff serves on the Department of Public Health's Asthma Planning Workgroup (formed in 1998). Other members of the workgroup include representatives from the Department of Public Health, DCFS, Illinois Health Cost Containment Counsel, the Illinois Environmental Protection Agency, University of Illinois' Division of Specialized Care for Children and The American Lung Association of Illinois. Although the Department has no jurisdiction over insurance coverage, the Department recognizes its responsibility to ensure children have medications, equipment, supplies and training.

4. The Department should evaluate implementation and efficacy of the protocol. This would make for valuable research for the Department. There are sources of funding for research, i.e. NHLBI, to study asthma among wards of the state.

The Department agreed. Evaluation of the implementation and efficacy of the protocol will be done.

General Investigation 3

ALLEGATIONS

The OIG investigated allegations of inadequate supervision and inadequate medical care in a residential treatment facility for emotionally disturbed children after three separate incidents of injuries occurred in the facility.

INVESTIGATION

The OIG concluded that, while the facility had adequate policies in place to protect the children in its care, workers failed to properly implement these policies in all three instances. In the first incident, a staff member restraining a child failed to properly adhere to the facility's internal policies requiring two-person restraints. The child suffered a black eye and a fractured wrist.

In the second incident, the staff-to-resident ratio policy was violated. The facility had a policy requiring 24-hour supervision of the residents, as well as ensuring there is one staff person for every three residents on the 3:00 p.m. to 11:00 p.m. shift, when the children are going to bed. One evening the facility was one staff person short during that shift. Further, the staff member on duty that evening stepped outside of the dormitory and left the children alone for a few seconds. One of the children in the dormitory alleged that he was sexually assaulted by another child during the time the worker was out of the room. The OIG noted that security cameras had been removed because they are against the policy of the Council on Accreditation.

In the third incident, the facility hired a Licensed Practical Nurse (LPN) instead of a Registered Nurse. An LPN does not have adequate training to ensure that children receive proper medical treatment when needed. This resulted in two residents receiving delayed medical treatment. One of the residents suffered from testicular torsion. He was not brought into the hospital until 72 hours after the onset of symptoms. The delay in medical care resulted in the removal of the testicle.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The OIG concurs with the agency's corrective action in the hiring of a registered nurse to adequately manage the health needs of the residents. As the medical journals advise, the agency should instruct the registered nurse to refer any youngster with trauma to the scrotum or pain or swelling in this area for immediate medical attention.

The Department agreed. The agency has been unable to hire a full-time RN. Currently, the agency has two contractual half-time nurses.

2. The newly-hired registered nurse should conduct training sessions for the agency's staff on when it would be appropriate to get medical attention, especially following a restraint. It is not uncommon for children to be harmed during a restraint. The newly hired registered nurse should also educate staff on common health issues, male physiology, and the issues regarding excessive masturbation.

The Department stated that the agency will provide training for staff. Upon completion of the training, documentation will be provided to the Department.

3. The agency and other residential treatment facilities need to utilize a behavior management committee, as required by Department of Children and Family Services Rule 384.

The agency is forming an inter-agency behavioral management committee.

4. The Licensing Division of DCFS should enforce Rule 384.

The Department agreed. DCFS Rule 384 is currently under revision.

5. Unusual Incident Reports should contain more specific and detailed information on the circumstances surrounding the event, i.e., who, what, where, and when. If multiple children are involved in an incident, their names, initials, or identification numbers should be noted in the report so that they can be contacted in follow-up investigations. Residential treatment facilities should consider whether training on this issue is necessary to carry out this recommendation.

The Department agreed. The Department is in the process of revising the Unusual Incident Report system. The revision will allow for more specific information on incidents to be entered and updated.

6. The facility should assure that its policy of having one residential counselor for every three children is followed. Therefore, the facility should make sure that there is a third staff person available in the dormitory in the event that there is an emergency situation. It is not sufficient to rely on the services of a roaming supervisor, who is to continue roaming and ensuring the safety of the other children when incidents arise.

The Department stated that the agency has been informed of the recommendation and has indicated that they would remain vigilant on staff issues.

7. The Department should conduct an investigation for inadequate supervision in any situation where there is a question of child safety being compromised.

The Department agreed. Depending on the nature and severity of the complaint, the investigation may be conducted by any or all of the following parties: Gatekeeper and regional operations staff, Agency and Institution Licensing representative and/or Division of Child Protection.

8. The facility should retrain the worker involved in the first incident about the policy of using more than one individual to restrain children.[2]

The Department stated that the worker has been retrained on the policy of using more than one person to restrain children.

9. Staff working together on the same shift (on a regular basis) should be trained in applying restraints together. Staff should be familiarized with employing restraints with fellow staff of differing sizes and genders.

The Department stated that facility officials have indicated that they are reviewing their restraint training policy.

10. The facility should implement a mechanism for formal review of incident reports to determine how staff, including supervisors, handled the incidents, how specifically the report was written, and whether staff that handled the incident need to be retrained or disciplined.[3]

The Department stated that facility officials have indicated that they have a formal system to routinely review all incidents as part of their ongoing management and quality review system.

11. The OIG recommends discipline for the following individuals:

a) The workers involved in the first incident should be disciplined for failing to follow agency policy and employ a two-person restraint. The workers' discipline should take into consideration certain mitigating factors. For example, the workers were not trained together as a team to conduct a restraint, and one of them had just been transferred to the unit.

b) The Vice-President of Program Services should be disciplined for the following reasons: She failed to recognize the LPN's limitations and failed to adequately supervise her. The LPN did not discharge her duties in accordance with agency policy by not reviewing the medication log. The Vice-President also failed to ensure that the LPN entered into the medication logs records of the medications she distributed to the residents and failed to supervise the LPN as to appropriate specification and documentation of medical concerns to physicians.

c) Although the LPN resigned her position as the school nurse, she should have documentation of her inadequate discharge of her duties in her previous position placed in her personnel file.[4]

Agency officials do not believe discipline is warranted for any of their staff. As an alternative, staff has received additional training and coaching.

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[2] According to an agency official, the agency has already reviewed its CPI procedures and has conducted training sessions for all staff on proper restraint procedures.

[3] According to an agency official, the incident reporting system has been revised, and rules for reporting incidents have been distributed. The official provided the OIG with documentation to this effect.

[4] The OIG concurs with the discipline the agency gave to the worker involved in the second incident. The worker told the OIG that he had received a written warning about his conduct. The OIG received written documentation of this from the agency.

12. The Department needs to raise the issue of using security cameras in residential treatment facilities, taking steps to ensure privacy as much as possible, and should explore the feasibility of amending this Council On Accreditation (COA) policy.

The Department agreed and will follow up with COA concerning the use of security cameras in resident living areas.

13. Given the nature of the highly structured facility/routines of these wards, officials from the agency and the Office of the Public Guardian should meet to work out the terms and procedures that will be employed when the Public Guardian's Office wants to meet with one of its clients who is a resident at the agency's facility.

The Department stated that the facility officials have agreed to revisit this issue with the Office of the Public Guardian.

14. Attached to this report in Exhibit A are the OIG's recommendations for changes to Rule 384.

The Department has incorporated the appropriate recommendations in the revisions to Rule 384. The rule is currently being prepared for first notice.

General Investigation 4

ALLEGATIONS

A couple's ten year old biological son was indicated for sexually abusing a five year old foster child living in their home. The foster parents alleged the Division of Child Protection (DCP) worker who conducted the investigation behaved in an improper and unprofessional manner.

INVESTIGATION

The foster child, who had been in the home for four months, reportedly told his babysitter that he had sucked the ten year old's penis while they bathed together. This information was relayed to the foster father, who questioned the boys. The five year old denied anything had happened while the ten year old said the younger boy had attempted to touch his penis. During a monitoring visit, the foster mother told a private agency worker about the situation. The caseworker called the hotline which took the call as "information only." Two weeks later, the five year old told another agency worker that the ten year old had forced him to suck his penis. The worker called the hotline and the case was assigned to a DCP investigator.

DCP notes show that prior to interviewing either of the boys, the investigator referred to the ten year old as the "perpetrator" to both the foster mother and his supervisor. At one point during his interview with the ten year old son, the investigator told the boy, "God would want [him] to tell the truth." The boys' statements were in conflict with each other and, in the case of the five year old, inconsistent with what he had previously reported. The investigator failed to ask the boys fundamental questions about the circumstances of the incident to establish a basis in fact or consider possible alternative explanations for any of his findings. After drawing his own conclusions from limited investigative effort, the investigator filed a delinquency petition against the ten year old without supervisory consultation or approval. After an administrative review of the investigator's findings by DCP, the indicated finding against the ten year old was overturned by the Department.

The DCP investigator is also a private investigator/polygraph examiner in the small town where the family lives and has many interactions with law enforcement officials in both capacities. Local police deferred their investigation to DCP, a common practice in many smaller communities. The investigator relied heavily on his interpretation of body language to arrive at his conclusion that the foster child had been abused by the ten year old. In his interview with the OIG, the investigator said he, "knew [he] had a victim here," because of the way the foster son sat and positioned his head at various times. Likewise, he believed the ten year old adopted a defensive stance during their interview and displayed other behavior which convinced him the boy had committed the abuse. The investigator explained his training in the REID interviewing technique allowed him to make confident judgments in this case.

The REID Interviewing Technique was developed to assist law enforcement in making credibility determinations. While it may provide an investigator with hints or signs that may suggest relevant areas of inquiry, its reliability as an ultimate indicator of guilt or innocence is highly questionable, especially when used with children under fifteen.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department needs to review the use of the once popular REID Method of interviewing, and review its use when interviewing children.

The Department agreed. The Division of Child Protection is in the process of reviewing the REID method of interviewing, particularly as it relates to child interviews.

2. The DCP sub-region manager should meet with local police and DCP field offices in order to delineate the roles of law enforcement and DCP.

The Department agreed. The DCP Manager met with local authorities to discuss appropriate roles and responsibilities, particularly in regard to police initiation of child protective investigations. The roles and responsibilities have been clarified and police initiation of child protective investigations is only approved in emergency situations.

3. Because of the small population of the city and the limited number of law enforcement and court personnel, there is a potential conflict of interest in the DCP investigator's professional roles. Because the investigator may interface with the same officials both as a child protective investigator and private investigator/polygraph examiner, there is a conflict in that some officials may not always be able to distinguish between the Department employee's work as a State employee and a private investigator/polygraph examiner. The investigator also faces a possible conflict between his interests as a private investigator and his judgment as a DCFS employee. This should be evaluated by the DCFS Conflict of Interest Panel.

The Department agreed. A memo from the Office of Internal Audits on 10/28/98 recommends that Child Protective Investigators be permitted to work in investigative or law enforcement functions only in counties other than the one served by the field office to which they are assigned.

4. The DCP investigator should be counseled not to mention God or discuss religion during investigations, especially with children.

The Department agreed. The investigator was counseled and resigned effective June 30, 1999.

5. The DCP sub-region manager should manage supervisors' prudent filing of delinquent petitions and work with local law enforcement. DCP should file delinquent petitions only with supervisory approval and DCP field manager review.

The Department agreed. In general, DCFS does not file delinquency petitions. Delinquency petitions may only be filed with supervisory approval. A reminder will be sent to staff that they must have supervisory sign off. In addition, there are ongoing collaborative meetings with the DCP supervisor and the State's Attorney's Office to maximize effective communication.

6. The Sexually Aggressive Children and Youth (SACY) program needs to develop guidelines for sexually inappropriate and sexually aggressive behavior of non-wards who live in foster homes (ie., biological children of foster parents). The protocol should be included in future SACY training for Department staff.

The Department agreed. Revised SACY Standards will reflect that a DCFS ward cannot be placed in relative or substitute care or remain in such a placement with a non-ward exhibiting sexually problematic behavior without a protective plan. This will also be included in SACY training.

General Investigation 5

ALLEGATIONS

A sixteen year old boy was indicated for sexual molestation and sexual penetration following a Division of Child Protection (DCP) investigation that employed a polygraph test. The boy's father stated he was not allowed to accompany his son into the polygraph examination.

INVESTIGATION

The boy's ten year old sister told her babysitter that her brother had touched her vagina. The babysitter related the girl's story to local police who took the girl into custody and called the hotline. The Child Protective Investigator assigned to the case was informed by police of another alleged victim, an eleven year old girl. In his interview with the sixteen year old, the investigator asked him if he would take a polygraph test. He agreed, and the boy, his father, and the investigator went to the crime lab where the boy's father signed a consent form allowing his son to be examined. The OIG determined that Rules and Procedures had been followed and the indicated finding was appropriate based on the information gathered.

The OIG noted that DCFS Rules and Procedures do not prohibit or limit the use of polygraph examinations in DCP investigations. While the Illinois Child Protective Services Handbook states polygraph test results should not be documented in the case file, it does not clarify that polygraph test results should not be used as evidence of guilt. The DCP Child Protection Handbook states polygraph testing should only be considered when requested by law enforcement or a subject of the case. However, many investigators are trained in the REID interviewing technique, which includes offering the subject the opportunity to take a polygraph test as part of the process.

This investigation also looked at situations in which workers are unable to transport children to a Child Advocacy Center to conduct Victim Sensitive Interviews (VSI). In these instances, VSIs typically are not conducted. The VSI protocol limits the number of times an alleged child victim is interviewed about the alleged abuse in order to reduce the child's anxiety during the collection of forensic evidence.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should specify the role of polygraph examinations of minors in DCP investigations. (In all cases involving wards, the DCFS Guardianship Administrator should be consulted.) The Department should not be the agency recommending polygraph examinations because of validity problems; such recommendations should fall into the purview of law enforcement.

The Department agreed. This recommendation is included in the revisions to the investigative process that will be included in the Child Protection Investigation Handbook and the Best Practice model for comprehensive investigations.

2. The Department should retrain DCP investigators on the restricted use of polygraph examinations in their investigations. A memo should be sent to Child Protective Investigators (CPI), DCP supervisors, Field Managers and Regional Administrators delineating: the restricted use of polygraphs in DCP investigations; and restrictions on the documentation, recommendations, and consultation of polygraph examination in DCP investigations. The Department will have to give special consideration to CPIs trained in the REID interviewing technique, because the questioning includes the suggestion of a polygraph examination. The REID technique has not been proven reliable with minors.

The Department agreed and will provide training to all Division of Child Protection (DCP) staff after the revisions to the investigative process are completed.

3. In circumstances where the victim is unable to get to a Child Advocacy Center, the Victim Sensitive Interview (VSI) protocol should be used. The regional field service managers and administrators should collaborate with local law enforcement and the Assistant State's Attorney to effectively implement the protocol.

The Department agreed. The Attorney General's Office has taken the lead in establishing VSI Protocols in counties where Child Advocacy Centers do not exist.

General Investigation 6

ALLEGATIONS

A four month old girl was admitted to a hospital with extreme malnutrition, hypothermia, severe dehydration and multiple broken bones. Two DCFS Child Protective Investigators had seen the child in the preceding weeks but had left her in her mother's custody. The complaint stated the investigators failed to adequately assess the situation and provide for the safety of the four month-old and her two siblings.

INVESTIGATION

The Department first became involved with this family when the maternal grandmother called the hotline concerned that her daughter had left two of the children at home alone. The following day, the mandate investigator for the case (an investigator required by law to see the alleged victim within 24 hours) went to the home and found the children in the care of their uncle who appeared lethargic and under the influence of drugs or alcohol. The four month old and her one year old sister were dirty and wearing soiled diapers. A ten year old cousin who was also present in the home was able to find some diapers and changed the infants. The investigator noted the four month old, who was wrapped in a blanket, looked more like a newborn but did not examine the child further. When the children's aunt (the mother of the ten year old cousin) arrived, the mandate investigator agreed to send the children home with her and developed a protective plan which stated the children were not likely to be in immediate danger.

Ten days later the Child Protective Follow-up Investigator visited the family. The mother told the investigator that she never left the children alone because she had many relatives who lived nearby and that the children all received medical attention from a local clinic. The follow-up investigator also observed the four month old to be undersized but did not examine the baby. A week later the grandmother called the Department again to report the four month old was in serious need of care. The grandmother took the baby to the hospital and another investigator was dispatched to meet her there. The attending physician told the third investigator that the child weighed only five ounces more than when she was born and suffered from several other maladies all directly attributable to extreme abuse and neglect. Warrants were issued for the mother and her boyfriend. After she turned herself in, the mother admitted to police that she had stopped properly caring for her daughter almost two months before.

In their interviews with the OIG, both initial investigators expressed their beliefs that they held relatively minor roles in handling the case and that the other was responsible for the more significant fact finding work. The mandate investigator stated she did not speak with the follow-up investigator because her notes reflected her concerns. However her notes were not explicit in outlining her observations in the home and allowed room for various interpretations on the part of the follow-up investigator. The follow-up investigator told the OIG she believed she had spoken to the mandate investigator but could not recall when or what they had talked about. She stated that because the mandate investigator had already seen the children, filed an inadequate supervision allegation and established a safety plan, all she needed to do was talk to the mother. Each investigator relied on the other to do the most critical tasks, yet neither communicated with the other to verify that their understanding of the situation was accurate.

After the child had been in the hospital for eight days, the follow-up investigator, who was not assigned to investigate the most recent allegations, called a DCFS nurse to ask whether it would be possible for an infant who already appeared small to lose a significant amount of weight in ten days. The nurse answered in the affirmative. She also stated that a child that had gained substantial weight quickly could lose it quickly if feeding stopped. The nurse never had any first-hand interaction with the child and appeared to be contacted by the follow-up investigator in order to provide a possible explanation for the investigator's inaction on the case. Medical professionals who examined the child stated that her malnutrition was extreme and had been going on for an extended period of time.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The mandate investigator and the follow-up investigator should be disciplined for their poor work in this case.

- **The mandate investigator failed to adequately document her observations, concerns and professional assessments.**
- **The mandate investigator did not seek to communicate concerns with the investigator who was then assigned the case.**
- **The mandate investigator allowed children to take on the adult responsibility of changing the babies' diapers while she was present in the home.**
- **The mandate investigator, in forming a safety plan, essentially placed three children in the care of a relative without taking protective custody, informing the parent, or further assessing the appropriateness of the potential caregiver.**
- **The mandate investigator did not assess the situation or the family adequately, nor did she follow up on the indication that the child was extremely small for her age.**
- **The follow-up investigator failed to closely read the notes that the mandate investigator had written about her visit, so as to realize that the reporter had not been contacted.**
- **The follow-up investigator failed to seek out any substantial communication with the mandate investigator regarding her visit.**
- **The follow-up investigator made assumptions about the case and failed to confirm any information given to her by the mother.**
- **The follow-up investigator failed to contact the reporter or any collateral contacts within a reasonable time frame.**
- **The follow-up investigator failed to follow up on important medical information given to her by the mother.**
- **The follow-up investigator failed to move the case quickly to indicate and open services.**
- **The follow-up investigator failed to gather information for a social history or for further interviews.**
- **The follow-up investigator did not follow up on her observation of the child's small size, an indication of neglect.**

The Department agreed. Appropriate discipline is being reviewed.

2. Child Protective Investigators should receive more training on developmental milestones, including those of infants. Growth charts should be made available for review and considered for possible use in investigations.

The Department agreed. The Office of Health Policy, in conjunction with the Department's Medical Director, is currently developing a package of training materials. These materials will be used to train Child Protective Investigators in developmental milestones.

3. Although there were indications that there were further problems than inadequate supervision neither investigator investigated or added other allegations. Child Protective Investigators should be reminded during CERAP training that their assessment should not be limited only to the allegation called in if there are indications of other abuse or neglect.

The Department agreed. The Division of Training has been notified to ensure CERAP training includes an added reminder that Child Protective Investigators are not limited to assessing only the allegations reported. In addition, a memo has been sent from the Deputy Director, Division of Child Protection, to all child protection managers with reference to this. Furthermore, this recommendation is also included in the revisions to the investigative process that will be included in the Child Protection Investigation Handbook and the Best Practice model for comprehensive investigations.

4. DCFS nurses should give their opinions within the context of actual cases. DCFS nurses should review records and speak to treating physicians before offering professional consultation to workers.

The Department agreed. DCFS nurses will be directed to review records and consult with treating physicians before offering professional consultation to workers.

General Investigation 7

ALLEGATIONS

A complaint alleged that a 21 year old mother was not receiving services that would enable her to be reunified with her three year old son.

INVESTIGATION

The three year old child was in foster care since the age of two months. The private agency assigned to the child's case did little to effectively service the family. A review by the OIG of the family's history with DCFS revealed that two children were born to this mother and her boyfriend while both were teen wards of the state. The couple's first child, a girl, died at the age of three months. Nine days earlier the teens had taken the baby to the doctor because she seemed uncomfortable when touched. The couple did not follow the advice of their doctor, or their caseworker, to take their daughter for x-rays because of the possibility that she had broken ribs. An autopsy of the baby revealed that she had six healing rib fractures. The cause and manner of the baby's death were undetermined by the Cook County Medical Examiner's Office because, "the presence of the rib fractures and two separate and different explanations provided by the family for these fractures raise suspicions of foul play." A finding of SIDS (Sudden Infant Death Syndrome) was ruled out as a cause of death. After an investigation by DCFS, both parents were indicated as perpetrators of abuse. Ten months later, the couple's second child, a two month old boy, was taken to the emergency room with a broken leg. Again, the parents' explanation for the cause of the injury did not make sense. In addition, further examination of the two month old revealed a fractured clavicle and multiple fractured ribs in various stages of healing. The baby was taken into custody by DCFS and placed with a maternal aunt.

The agency servicing the family maintained a permanency goal of return home to mother for this child for almost two years, despite the high risk nature of the case and the mother's failure to take responsibility for her actions and change her behavior. Agency workers measured progress based on their impressions of the mother rather than on a critical analysis of available information. Over the course of the 21 months that the agency had the case it was assigned to five different workers. The workers did not comprehensively and consistently document contacts with the family and what services were being provided. The agency did not follow recommendations it had sought for services. It did not furnish service providers, such as evaluators and counselors, with historical information about the case, but instead allowed the mother to self-report. This resulted in invalid assessments and ineffective counseling. During a court-ordered psychological evaluation by Forensic Clinical Services of the Circuit Court of Cook County, in January 1998, the mother minimized her son's injuries and stated that her daughter died from SIDS. Based on the mother's positive reports of her current functioning, the evaluator recommended that she be granted brief unsupervised visits with a view toward ultimately returning her son to her care. After the OIG provided the evaluator with accurate historical information, including the Cook County Medical Examiner's reports of the baby girl's death, the evaluator prepared an addendum to his evaluation recommending that consideration be given to changing the DCFS goal to termination of the mother's parental rights so that the boy could be adopted by his aunt.

OIG RECOMMENDATIONS/ DEPARTMENT RESPONSE

1. The private agency should be instructed to pre-screen this case with DCFS's Office of Legal Services.

The Department agreed. This case passed legal screening on May 20, 1999.

2. The OIG should be the liaison between Forensic Clinical Services of the Circuit Court of Cook County and the Cook County Medical Examiner's Office. The OIG has informed Forensic Clinical Services that it will assist the office in retrieving medical examiner reports in cases involving the deaths of children, where the agency requesting the evaluation has not provided the information.

The Department agreed.

3. DCFS's Office of Legal Services should reconsider whether a parenting assessment of the mother is still necessary in light of the doctor's psychological evaluation report recommending termination of parental rights. If the evaluation proceeds, Legal Services should ensure that the parenting assessment team has all critical historical information.

A parenting assessment is unnecessary because of the change of goal to termination of parental rights.

OIG Comment: DCFS Legal, in conjunction with the Office of the Public Guardian, decided to go forward with the parenting assessment. The OIG provided the Parenting Assessment Team with all critical historical information regarding the family. The PAT concluded that termination of parental rights was appropriate in this case.

General Investigation 8

ALLEGATIONS

A four year old girl was adopted by her foster parents after the court terminated her biological parents' rights. The girl's adoptive mother believed the assigned caseworker exhibited unprofessional behavior throughout the period of her involvement and lied under oath at the termination of parental rights hearing.

INVESTIGATION

The OIG received a complaint outlining 19 separate allegations of inappropriate or unethical statements or actions of the caseworker. The complainant alleged that the worker misrepresented facts to the court, failed to contradict false statements to the court, colluded with the defense (the biological mother's attorney) in order to steer the outcome of the hearing and made untrue and defamatory statements about the foster parents to the court and the biological mother. The complainant also claimed to have knowledge of past acts of misfeasance by the worker involving attempts to persuade fellow workers not to indicate reports of abuse against biological parents. She believed the worker was biased in favor of biological parents and acted to preserve their custodial rights, regardless of the child's best interest.

The OIG reviewed court transcripts of the termination hearing and the child's DCFS record for evidence supporting the complaints. The record showed the caseworker answered all questions asked of her honestly to the best of her knowledge. Because the presiding judge cleared the courtroom of potential witnesses while other witnesses were testifying, the worker had no knowledge of the content of other witnesses' testimony, preventing her from refuting any false or incorrect statements presented to the court. The worker was called as a defense witness and had neither a role in determining the defense's course of action nor a choice in taking the stand. Interviews with co-workers and others familiar with the case did not provide support for the complainant's allegations.

This case was complicated by the fact that both the adoptive mother and father held administrative positions with decision making authority in state agencies. During the course of the investigation, statements made to the OIG by the caseworker and others involved with the case alleged that the adoptive parents had attempted to intimidate them in order to influence their professional decisions. The Ethics Panel reviewed the matter and concluded that the OIG had the authority to review the actions of a complainant when it was in the best interests of children. This conclusion resulted in a change in the OIG intake form.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. To avoid the perception of bias: (a) All matters arising from this Adoption Unit shall be directed to the Regional Administrator and should not be sent through the complainant; and (b) For five years from the date of this report, any of the workers mentioned in this report should have the right to seek immediate review of any DCFS action pertaining to this report that the worker perceives to be punitive or disciplinary in nature. Such review shall be conducted by a different administrator or other neutral third party. A notation to this effect shall be placed in the workers' personnel files. Upon the Director's approval of this recommendation the Regional Administrator shall notify these workers of this right.

The Department agreed. In any of these instances, the Regional Administrator will be responsible for any necessary review or action. A notation to this effect has been placed in the workers' personnel files.

2. DCFS rules need to be amended to acknowledge that licensing state employees (not employed by DCFS) to be foster parents can create conflict of interest situations. The rules should be amended to say that state employees in management positions should be licensed as foster parents through private agencies.

The Department agreed. All DCFS Rules and Procedures will be amended to reflect that all state employees who apply for foster care licensure must do so through a private agency.

General Investigation 9

ALLEGATIONS

Both the biological and foster parents of a two year old girl registered complaints against the Department worker handling their case, stating he was rude and unprofessional.

INVESTIGATION

At the time this case was assigned to the worker, the biological parents of the two year old were divorcing. Because of their involvement with DCFS, the father had been attending parenting and anger management classes while the mother was a resident at an in-patient alcohol rehabilitation program.

At a status hearing, the caseworker arrived without a report requested by the DCFS Office of Legal Services. The caseworker's testimony provided little useful information and provoked an admonishment from the presiding judge. According to the mother, after the hearing the worker drove the two of them in a state car to go out for lunch. The mother stated the worker offered her alcoholic beverages at the restaurant which she declined. The worker denied offering the mother drinks, but did acknowledge consuming two himself.

There is no documentation in the case file that the caseworker followed up with any of the agencies providing services to the parents. Both the mother and the foster parents said the worker was consistently late with visitation and failed to make some scheduled appointments. Although the mother asserts that some visits took place, there is no documentation in the case notes of any mother/child visits.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The caseworker should be disciplined for failure to provide services or monitor the progress of the child's biological parents. He did not provide court ordered visitation which impeded the progress of the child's goal of return home. There is no documentation of any case work performed on behalf of the father and the case notes are generally incomplete. The worker also violated DCFS Employee Rule 3.7.1 which prohibits employees from drinking alcohol while on the job and Rule 3.7.4 for driving a state car after having consumed alcohol.

The Department agreed. The worker was discharged from the Department effective July 8, 1999.

General Investigation 10

ALLEGATIONS

A private agency operating two group homes for boys had several administrative and financial issues as well as serious conflicts of interest among employees and board members.

INVESTIGATION

The OIG investigation into the practices of this agency found significant leadership and management problems that were disrupting an otherwise productive organization. The Director received a salary of $65,000 as a full-time employee although he also held a full-time position with the Chicago Public Schools. The Director did not provide staff with his work schedule and when the OIG visited, agency time sheets were available for all employees but him. The Director told the OIG he gave his time to the agency on nights and weekends and was on 24-hour call, however the time sheets he eventually provided for review and the group home's log book did not substantiate his claims. While agency phone logs listed calls to other staff members for assistance in problem solving, there was no record of any calls being made to his residence for consultation.

The man who owns the two properties in which the group homes are operated helped found the program in 1981 and holds the title of Coordinator, fulfilling several obligations managing the agency's finances. While he has maintained the property and arranged for repairs and improvements to be made, he has received $10,000 per month in rent for space in the two buildings since 1992. A real estate broker and a residential appraiser consulted by the OIG stated this sum was not commensurate with values of the surrounding areas and was at least double the market rate.

A majority of the agency's employees and board members are related. These relationships contributed to the development of two factions within the agency and a struggle for control. Criminal history checks were not performed on some employees. There are appearances of conflict of interest, confusion of roles and misplaced authority. A group of employees filed a lawsuit against the Coordinator, who managed the agency's finances, seeking over $18,000 in wages which they ultimately were awarded in a default judgement. The attorney for the employees, a former Program Director, was one of the plaintiffs and is married to a current supervisor.

In spite of the problems plaguing the organization's upper management, the OIG found the agency's client records to be comprehensive and in good order. Each record reviewed contained adequate information pertaining to the minor's medical, school, social and psychological background and their families. Both homes were found to be clean, comfortable and nicely furnished, although the OIG did advise staff that deadbolt locks on interior doors in the homes needed to be removed.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The field audit of the agency to be performed by the Department should include: (a) an evaluation of the fair market value of each home (the agency should have appraisals performed on the two properties with consideration given to the intended use of the properties to arrive at reasonable rental amounts) and (b) changing current financial management practices to acceptable standards of practice.

The Department agreed. A copy of the final audit was forwarded to the Office of the Inspector General.

2. The Department should introduce independent mediation to help remedy the internal conflicts that exist within the organization with the goal of preserving the group home programs. Two possible mediation resources are the Center for Conflict Resolution and Judicial Dispute Resolution (JDR).

The Department determined that preserving the group home programs was not a viable option. The original group home is closed. The license for the second group home was revoked. The agency is appealing that decision. As of October 7, 1999, the Department is locating alternative placements for the remaining children.

3. The Executive Director's actual work hours and responsibilities should be reviewed by the Board of Directors and mediated, if needed, to achieve acceptable conditions of employment and responsibilities.

See response # 2.

4. Criminal history checks must be immediately completed on all employees.

Criminal history checks were completed on all employees.

5. The Department should arrange for a fire inspection of each group home by the State Fire Marshal to ensure their compliance with fire code regulations and the removal of all deadbolt locks.

Admissions were frozen and, as of October 7, 1999, the Department is locating alternative placements for the remaining children.

INVESTIGATIVE REFERRAL

The OIG referred the audit to the Illinois State Police for further investigation.

General Investigation 11

ALLEGATIONS

Four men were arrested while driving a state-owned vehicle. They claimed to be members of a gang that had an arrangement with a DCFS employee who allowed them to use state vehicles in exchange for money and drugs.

INVESTIGATION

The blue minivan was registered to the State of Illinois. The van was damaged on the driver's side and had a bullet hole in the rear. One of the suspects told police he had rented the van from a DCFS employee for $20. The suspect further stated that he had rented several different vehicles from this man in the past and that the employee had made similar arrangements with members of the street gang that supplied the employee with narcotics.

The employee named had effective control over a state van housed at his DCFS office. The OIG's investigation found that the employee had reported the same minivan stolen the previous month. A few days later he reported to the Chicago Police Department that he had recovered the vehicle undamaged at an address that turned out to be one block away from his residence. When questioned about the second incident where the police had stopped the men driving the van, the employee told the OIG he had last used the vehicle a week before the suspects were stopped by police and that there were two witnesses who could corroborate his story. However, police recovered a gas receipt signed by the employee dated three days after he claimed to have last seen the van and, in interviews with the OIG, the two witnesses gave accounts that contradicted the employee's story. It was also learned that the employee's Illinois drivers license had been suspended for over a year though he was required to possess a valid license in order to perform his duties. Furthermore, the reimbursement requests made by the employee in his travel voucher reports appeared to greatly exceed the amounts necessary to cover his actual expenses. The employee resigned his position before the investigation was concluded citing harassment by the OIG and the Department in general. The OIG referred the investigation to law enforcement for possible criminal prosecution. The Illinois State Police determined there was insufficient evidence to take the case to the State's Attorney's Office for prosecution.

The minivan was designated by the Department for the use of an Administrator for the purpose of transporting case records, equipment and large items between offices. The Administrator told the OIG he frequently "loaned out" the vehicle to other Department units. There was no system in place to record where the van was at any given time nor were any measures taken to control the distribution of keys to the vehicle.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Administrator should implement a system of recording who, when and which unit requests to use the van. All requests should be made to the Administrator in writing three days prior to the date of actual use. Any use of the van should be documented in a log book. The log book should be safely secured and in the possession of the Administrator. The log book should be made accessible to other unit heads so that they may thoroughly review travel vouchers submitted for reimbursement of all their employees.

The Department agreed. Procedures for use of the Department van assigned to the Cook County Administrative Unit have been developed and implemented.

2. The Administrator should collect and account for all keys to the van. There should be only two keys, an original and a copy, kept in the sole possession of the Administrator. He should ensure that the keys are imprinted with "do not duplicate".

The Department agreed. The ignition tumblers on the van were changed and two new sets of keys were made. These keys were stamped "Do Not Duplicate."

3. The employee's supervisor should be counseled for his failure to determine whether his worker's travel vouchers were supported by legitimate job requirements.

The Department addressed this issue with the employee's supervisor.

4. This report should be shared with law enforcement, the Unit heads and the Regional Administrator.

The Department agreed. The report was shared with the individuals recommended in the report.

5. Management should ensure that a "do not rehire" notation is placed in the employee's personnel file.

The Department agreed. The employee was discharged and therefore would not be eligible for rehire with the Department.

General Investigation 12

ALLEGATIONS

A private agency employee attempted to use her position to obtain information to which she was not entitled.

INVESTIGATION

The private agency worker arrived at an elementary school, identified herself as a caseworker and stated she was following up on a hotline call. The worker asked the school counselor for information on the current placement of two children. The counselor refused and contacted the DCFS Education Liaison who informed her that the children had no involvement with the Department. The administrator of the worker's agency was contacted. The worker admitted she had sought the information as a favor to a friend of hers, the children's father. The agency suspended the worker, placed a formal reprimand in her personnel file and counseled the worker about misuse of her position. The agency told the OIG it did not terminate the worker because they did not believe her actions were malicious.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The case scenario contained in this report is a good example of misuse of authority for use in training both DCFS and private agency personnel.

The Department agreed. The case scenario will be used in training for both DCFS and private agency personnel in conjunction with New Employee Orientation and Clinical Practice Training.

2. The OIG offered the agency an ethics training, which they agreed would be very useful. The training was conducted on February 23, 1999.

No action needed.

General Investigation 13

ALLEGATIONS

In March 1998, a worker in a DCFS field office discovered an activated listening device planted behind a bookcase in the office.

INVESTIGATION

The OIG enlisted the aid of the Illinois State Police in order to determine who placed the device and if there were any more recording devices in the office. The State Police conducted a sweep of the building and found no other monitors or transmitters. The equipment that was found was the property of the Department and had been used by workers in the office for supervised visitations until it disappeared in September of 1997.

The State Police questioned a Department employee who had been placed on leave from that field office in September of 1997. The worker admitted that he had taken the monitor and bugged his supervisor's office. The supervisor stated the worker had been placed on leave as a result of continuing unstable behavior. The worker was subsequently observed loitering in the building's parking lot on several occasions, prompting the field office to change the locks on all doors. Because of the employee's psychological problems, the State's Attorney's Office declined to pursue possible criminal charges related to the eavesdropping.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. As a result of his actions, the worker should receive a form of discipline to be determined by Labor Relations.

The Department agreed. Given the nature of the worker's mental health issues, it was determined the Department would be better served by placing him on permanent disability leave. The Department, AFSCME and the worker's attorney have negotiated an agreement that will be implemented once it is signed by the Director.

General Investigation 14

ALLEGATIONS

A Department caseworker assigned to assist a mother and her two teenage sons achieve reunification did minimal casework and was reported to be intoxicated on several occasions.

INVESTIGATION

An Assistant Public Defender stated to the OIG that the caseworker, who was scheduled to testify in juvenile court that day, was intoxicated. He said other officers of the court had made similar observations and requested that an OIG staff member return to court with him to observe the worker. By the time OIG staff reached the courthouse, the caseworker had left. The Assistant State's Attorney and the Guardian Ad Litem told the OIG that the caseworker had been under the influence of alcohol. All three attorneys complained that the worker had done almost nothing to service the case and was argumentative when questioned about his apparent lack of effort. The mother and the worker from her group home both stated they had had previous encounters with the worker where they believed he was intoxicated. One of the boys told the OIG the worker never had time for his case and always told him it was because he had another big case he had to work on.

The DCFS attorney on this case disagreed with the other lawyers, saying he did not believe the worker was drunk. When court resumed, the presiding judge held a sidebar, without the DCFS attorney present, and decided the worker should be removed from the case. A new worker was assigned to the case within a week.

The worker told the OIG he had not been intoxicated in court and did not have any problem with alcohol. His personnel file did not contain reports of any incidents of alcohol use or referrals to treatment. The worker admitted to doing very minimal work on the case and cited another, high profile case he was working on as a factor, although he was unable to give the name of the case or any significant facts about it.

The worker passed away four months after the OIG interviewed him.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department of Children and Family Services should develop a protocol that would set out objective facts that create reasonable suspicion such that a drug and alcohol test would be required. The Department should develop guidelines for utilizing the tests. The Department should look to other agencies or governmental bodies, such as the City of Chicago in developing their protocol. As demonstrated by the City in developing their policy, it is essential that DCFS negotiate with and secure the support of the Union. Aspects of the City of Chicago policy that should be incorporated by DCFS include:

a) The ability to test an employee when there is reasonable suspicion by two supervisors that the employee has used alcohol or drugs at work or is under the influence of drugs or alcohol at work (note: for purposes of suspicion of use at court hearings, the individuals able to assert reasonable suspicion may need to be defined as Department employees acting in a supervisory capacity or in a position in which they represent the Department to the court - e.g., the courtroom liaison or Department attorney).
b) The requirement that a supervisor or Department representative at court drive the employee to the testing site and remain with them during the testing process.
c) The ability to test for the presence of drugs or alcohol following an accident or other serious injury during work hours.
d) The ability to order reluctant employees to be tested and to terminate employees who refuse to be tested.
e) The requirement that the results of tests go to Personnel and the Regional Administrator for review.
f) The ability to seek assistance through the Department's Employee Assistance Program.

In general, the Department agreed with the OIG's intent in this recommendation. Due to the many different groups involved and their representatives, it will take some time to work through all the implementation issues.

2. The Department should require through contracts that purchase of service agencies have a testing mechanism that is at least as stringent as that developed by the Department; the Department should monitor the utilization and effectiveness of those policies.

The Department agreed. See response to recommendation # 1.

General Investigation 15

ALLEGATIONS

A homeless couple and their two young children arrived at the Emergency Reception Center (ERC) in hopes of finding shelter. They were directed to the local police station which, after calling the State Central Register, referred them back to the ERC.

INVESTIGATION

After being asked to leave the home of a friend they had been staying with, the family went to the ERC before regular operating hours. The intake worker informed the couple that the children could not stay at the shelter unless they were DCFS wards. The worker directed the family to the police station. The commander of the youth division had his officers contact the ERC and the parents decided to turn their children over to the Department so they could stay in the shelter.

The supervisor of the ERC Screening Unit, which provides referrals and services to anyone who calls or walks in during business hours, told the OIG that they utilize a "quick list" of phone numbers and a comprehensive resource/referral book to assist in directing families in need of appropriate services. The supervisor stated the book has an entire section of family shelters and that one operates nearby the ERC. Visitors seeking shelter should not be referred to the police. Also, procedure requires that intake workers who receive visits during non-operative hours document the contact and turn the information over to the Screening Unit in the morning. In this instance, the worker neither consulted the resource materials available to assist the family, nor documented the contact for the benefit of the Screening Unit.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Develop protocol and train ERC intake workers to use the referral resources available from the Screening Unit, including Child Welfare Service referrals and Norman funds.

The Department agreed. A protocol was developed and implemented and is continuously reinforced at regularly scheduled staff meetings for ERC intake workers.

2. Install an off-hours log book at the ERC Intake Desk to record all walk-in clients to help ensure clear and complete communication between the off-hours ERC Intake Desk and the Screening Unit.

The Department agreed. The off-hours log book was installed January 1999.

General Investigation 16

ALLEGATIONS

Media reports involving the neglect of a child involved with the Department prompted the OIG to initiate an inquiry into the status of the family's case.

INVESTIGATION

The family consisted of eight children, their mother and the biological father of six of the children. From 1992 to 1998 there were 14 reports made to SCR, six of which were indicated. The Department attempted to keep this family together, opening an intact family case so they could receive services. They remained as an open intact family case for five years despite the mother's lack of compliance with DCFS guidelines and failure to meet minimum parenting standards. Workers frequently observed evidence of alcohol consumption in the home but did not document evidence of drug use. Although the mother submitted to drug screens, she was never tested for alcohol use. On at least 13 occasions the mother was referred to substance abuse treatment and either failed to attend or dropped out within days of enrolling. Caseworkers repeatedly found the home to be dirty and determined the parents were ambivalent about correcting its condition. Homemaker services were initiated in January 1995 but were terminated soon after because the mother was uncooperative. After it was learned the two eldest children were not in school, a caseworker was able to persuade the parents to enroll them, however, their attendance was sporadic at best. The eldest son was absent too often in the second half of that year to receive grades. Despite these shortcomings, the family case was closed because DCFS and private agency workers concluded the mother had met the minimum parenting standards established by the Department.

The eldest son was the named perpetrator of an indicated report in 1995 when he was ten years old. It was alleged he had sexually molested one of his sisters. The boy lived in this chaotic environment with only a protective plan and without follow-up services. An independent review of the evidence used by DCP found insufficient cause to indicate the boy for sexual molestation.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department should ensure that its contractors for urine toxicology and substance abuse treatment routinely test for alcohol in random urine screens and/or have breathalysers available to test for alcohol. In addition caseworkers should be trained to use and have access to portable breath testers and/or saliva testers.

In general, the Department agreed with the OIG's intent in this recommendation. Due to the many different groups involved and their representatives, it will take some time to work through all the implementation issues.

2. The Department should develop observable and measurable discharge criteria over time (which are not available in the definition of minimum parenting standard) for the Intact Family Services/Family Preservation program. For example, the definition requires that parents, "provide children with education..." One criterion would be, when applicable, "the child regularly attends school."

The Department agreed. This recommendation will be incorporated into the Best Practice Reunification that is currently being drafted.

3. Proceedings should be initiated to expunge the eldest son's indicated finding of sexual molestation. The DCFS Guardianship Administrator should act on his behalf to ensure that his indicated finding is expunged and his Sexually Aggressive Children and Youth (SACY) designation is deleted and removed from all records pertaining to him. It is recommended that the boy's case record contain a notification from SACY that any reference to a SACY designation is an error.

The Department agreed. The boy's indicated finding of sexual molestation was expunged from the State Central Register. His SACY designation was also deleted. There is no information in any DCFS data system identifying him as a perpetrator of sexual molestation. The boy's case record contains notification that any reference to a SACY designation is in error.

4. SACY standards should be developed to screen out labeling of young children for single incidents, especially those that occur in substance abusing households.

The Department agreed. SACY standards are being revised to require diagnostic services for children zero to seven exhibiting sexualized behavior. DCFS is developing a tracking system for child victims of sexual abuse that will ensure age appropriate intervention and treatment.

5. The Department should develop standards for referral to child welfare, educational and/or mental health services instead of indicating abuse reports against young children and vulnerable children with cognitive disabilities. The standards should include recognition of environmental factors that may accompany a caretaker's drug lifestyle.

The Department agreed. The newly revised SACY standards will include a section that will address intervention and services for children with developmental disabilities. Also, see response # 4.

6. The independent review of the DCP investigation which indicated the boy should be shared with the child protective investigator and her supervisor.

The Department agreed. The investigator resigned from DCFS effective 12/31/98 and the supervisor resigned effective 3/13/99.

General Investigation 17

ALLEGATIONS

A three and a half year old girl was going to be returned home to live with her biological parents three years after her father was convicted of aggravated battery for throwing her into a piece of furniture, resulting in a skull fracture. The complaint alleged the girl was being returned home too soon without the completion of adequate assessments and services.

INVESTIGATION

Following the initial incident, the child was placed with her paternal grandparents. Her father admitted to the abuse and was sentenced to three years' probation. Her mother was initially indicated for neglect but the allegation was later expunged because of her cooperation with the Department. Two children were born to the couple after their daughter was removed. One of them has special needs. The couple participated in parenting classes and counseling and participated in a number of assessments with various service professionals. The father, however, did not participate as fully as the mother and did not complete all service requirements. The general conclusion among professionals involved with the parents was that the couple was compliant and willing to adhere to Department requirements in order to secure the return home of their daughter. Visitation between both parents and their daughter occurred from the time the child was taken into custody. As time passed, a rift developed between the parents and grandparents over the frequency of visits and quality of services, although both sides recognized the importance of positive contact and were willing to work together.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The child should be referred for a developmental assessment. Although, according to her grandparents, she seems developmentally on target, her severe head injury necessitates an assessment. After the assessment, the child should be enrolled in Head Start or state pre-kindergarten if the need is indicated.

The Department agreed. The girl's biological mother took her for a developmental assessment on April, 17, 1999. The child is eligible for pre-kindergarten and will begin in the fall.

2. The parents and grandparents should be offered professional mediation services through DCFS. Both the parents and grandparents are important figures in the child's life. Further, the grandparents have been a strong source of support to the parents and this support will still be needed with more children in the household. The Department should increase its efforts to engage the extended family in planning.

The Department agreed. Mediation services are being offered through the family's therapist.

3. The current worker on the case should receive supervisory and administrative assistance.

The Department agreed. The field service manager and the supervisor are providing supervisory and administrative assistance on this case.

General Investigation 18

ALLEGATIONS

Foster parents who hoped to adopt a four year old boy filed a complaint after the child was placed with his maternal aunt in California. The foster parents believed the caseworker misled them and failed to act in the best interests of the child.

INVESTIGATION

The boy was born cocaine exposed and was removed from his parents' custody twice as a result of their failure to comply with Department requirements. A Master Adoptive Parent contacted a couple with whom she was familiar and asked them about their interest in accepting the child. The couple was concerned with the possibility of having the boy placed in their home and later being removed to live with a relative. The foster parents stated the caseworker informed them that the boy had no relatives who were either willing or able to care for him. The caseworker said his impression after speaking with the boy's biological mother was that relative placement was not an option. However, in interviews with the OIG, both the caseworker and the Master Adoptive Parent said the foster parents understood the boy was a legal risk placement and was not legally free at that time.

After the boy was placed in the foster home, contact between the caseworker and foster parents was infrequent. The caseworker explained that he was overburdened by his heavy caseload at that time and had to stress certain cases over others. While workers are not to have more than 20 cases at a time, DCFS records show this worker was handling 31 cases when the boy's case was assigned to him. The caseworker also said the relationship between himself and the foster mother was strained because she would call him crying or making angry demands. The worker said this behavior caused him to become frustrated and further complicated effective communication.

After four months with the couple, the caseworker called the foster parents to inform them that the boy's aunt in California had requested he be placed with her family. However, the caseworker told the OIG he was first contacted by these relatives shortly after the boy was placed in the couple's foster home. The worker was instructed by his supervisor to arrange a bonding assessment between the boy and his foster parents even though his removal was imminent. While the boy had been scheduled for a developmental assessment because of his substance-exposed birth, his foster mother canceled it because she did not feel it was necessary. The adoption supervisor did not advocate a rescheduling or impart to the prospective adoptive relatives the need for such an assessment. After several trips to Illinois for visits and interviews, the aunt and uncle from California ultimately were granted custody of the child, ten months after his placement in the foster home. On their own initiative, they later requested a thorough developmental assessment to determine if the boy required special help or learning remediation.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The caseworker should be disciplined for his lack of forthrightness in failing to immediately inform the foster parents of the California relatives' interest in the child. His uneasiness in working with "angry" foster parents does not preclude his duty to be honest with them.

The Department agreed. The worker received specific counseling regarding his failure to inform the foster parents in a timely manner of the relatives' interest in adopting the child.

2. The adoption supervisor should be disciplined for failing to advocate with the adoptive relatives for a developmental assessment of this special needs child.

The Department agreed. The adoption supervisor received counseling regarding the need to recommend a developmental assessment for this special needs child.

3. The California relatives should be reimbursed for the travel expenses accrued traveling between their home state and Illinois while going through the process of having the boy placed with them.

The Department agreed. The Department is working with the family to assist with obtaining reimbursement for travel expenses incurred.

General Investigation 19

ALLEGATIONS

The OIG received a complaint from a private agency alleging that DCFS was pressuring the agency to place a child with his aunt in a potentially unsafe home. The private agency believed that the child should not be placed with his aunt. The Department believed the agency was biased against the aunt because of her race.

INVESTIGATION

In 1993, the child came into the system when his mother brought him to his maternal grandmother's for a visit and never returned. The grandmother did not want the responsibility of the child, however the maternal aunt who lived with the grandmother wanted to take the boy. The private agency was concerned because of the apparent lack of concern and feeling demonstrated by the maternal aunt. The agency's concerns were magnified because the child had special emotional needs. The agency did not believe the maternal aunt and the boy would be a good match. The Department notified the agency that it would no longer be allowed to service the case because of the clinical disagreement.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The clinical disagreement should be mediated. The dispute was resolved through mediation.

General Investigation 20

ALLEGATIONS

The foster parents of a one year old girl who had hoped to adopt her felt they were misled by the Department after the court ruled the child should be placed with her paternal aunt and uncle. At the time of the complaint to the OIG, the girl was living with her paternal aunt and uncle.

INVESTIGATION

The child's biological mother suffered from uncontrolled epileptic seizures which caused brain damage resulting in mental health problems, sudden mood swings and violent outbursts, that precluded the infant being released into her custody. The biological father had a history of drug and alcohol abuse and was not considered a candidate to care for the child. Because the mother had previously told her therapist that her father had sexually abused her as a child, the maternal grandparents were ruled out as possible guardians. The Department did not investigate the father's relatives as prospective caregivers. After spending two weeks in the hospital because of medical complications, the child was released and placed in a traditional foster home.

Upon learning the child was in DCFS custody, the infant's paternal aunt and uncle contacted the Department and expressed their interest in having the baby placed in their home. Although the couple reached the Department within ten days of her placement in a foster home they did not receive a response. Six weeks later, the relatives contacted the private agency handling the case and informed them of their desire to have the child placed in their home. At various times the agency's caseworker told both the foster mother and the aunt it was unlikely the baby would be placed with relatives because the biological parents could have access to the child.

The aunt and uncle continued to petition the court to consider them as an option. Eventually, after a home study was completed, the presiding judge ordered visitation with the paternal aunt and uncle to begin with the goal of placing the child in their home. The foster parents opposed the decision and attempted to prevent the girl from being moved by enlisting the aid of DCFS administrators and attorneys who, in turn, asked lawyers from the Attorney General's Office to become involved in the case. The Department, which had supported placing the child with her relatives, changed its position and advocated leaving her with the foster parents. However the court insisted the private agency work toward the relative placement which was ultimately achieved. The OIG investigation confirmed that placement of the girl with the relatives was appropriate.

Because of the child's various health problems, a DCFS nurse was involved with both families during the course of the custody dispute. Both the foster parents and the girl's relatives felt the nurse acted in an unfriendly and unprofessional manner toward them and further complicated an already difficult situation. The relatives reported to DCFS immediately that the child seemed hungry all the time and that the amount of food the foster parents instructed them to give her seemed insufficient. The nurse did not investigate the relative's claims and failed to baseline the amount of food and formula the child was receiving. DCFS' nurses had previously been part of Clinical Services. In a reorganization, the DCFS nurses temporarily became part of the Office of Health Policy.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The temporary arrangement of placing the Department's Chief Nurse and the DCFS Regional Nurses under the Office of Health Policy should be made permanent. It is a logical arrangement and should lead to better coordination in providing services to children between Healthworks, Public Health, APORS and the Zero to Three Program.

This recommendation is still under consideration.

2. DCFS should adopt and train its staff to use a failure to thrive protocol prepared by Rush Presbyterian Medical Center.

The Department agreed. DCFS issued policy guide 99.2, Failure to Thrive Protocol, on January 8, 1999. The Department's Chief Nurse will attend the next available protocol training offered by Rush Presbyterian Medical Center. The Chief Nurse will be trained as a certified instructor and will train the regional nurses on the Failure to Thrive Protocol.

3. The nurse involved with this case should be counseled by the Chief Nurse regarding her interpersonal relationships with clients. In this case, both families felt very uncomfortable about the nurse's approach to them.

The Department agreed. The DCFS nurse was counseled on August 23, 1999.

4. This report should be shared with DCFS Legal. There were numerous attorneys involved in this case. At one court hearing at least 27 people were present for the hearing, 11 from or representing the Department. At another hearing there were three attorneys from the Attorney General's Office as well as several DCFS attorneys present. The Department must be cognizant of the public's perception of a case with excessive numbers of attorneys representing and/or acting on behalf of the Department.

The Department agreed. The report was shared with DCFS Legal on August 12, 1999.

5. The OIG is requesting permission to discuss and share this report with the local Attorney General's Office involved with this case.

The Department agreed.

General Investigation 21

ALLEGATIONS

A complaint alleged the worker handling a family case involving three siblings put the children at risk by failing to provide timely services and allowing them to remain in the home despite a high number of indicated reports against their mother.

INVESTIGATION

The children first became involved with the Department in January 1993, when the mother was indicated for cuts, bruises and welts and risk of harm to the middle child. A second report was indicated for environmental neglect in November of that year and the case was opened for services through a private agency. Between January 1993 and February 1996, a total of 14 hotline reports were made against the mother, six of which were indicated. Most of the calls involved physical injuries. The girls denied their mother abused them and provided explanations of varying degrees of credibility for their injuries. The caseworker believed the girl's explanation.

The middle sister was removed for a period of time during 1995 and placed in a relative foster home. At that time, her mother admitted to a counselor that she sometimes impulsively hit her daughter when she was angry. The mother's psychological evaluator concluded she was, "severely depressed, anxious and overwhelmed by the demands of her world." Medical personnel who examined the girl on various occasions expressed concern over the girl's low weight and suggested the child might need attention for failure to thrive. However, the worker advocated the girl be returned home because her mother was doing so well and the child had not gained weight while in foster care. She did not relate the findings of the psychological evaluation with other involved workers until two months after the girl was returned home. The girl was removed again after another indicated report against her mother for abusing her. The Department took custody of the other two children two months later after yet another report, the N sequence, was indicated. The sisters went to live with their biological father and their younger brother was placed with his maternal grandmother.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. This case should be used as a case study tool and shared with the head of DCFS nurses to determine if nursing intervention would have been helpful in the resolution of this case.

The Department agreed. A redacted copy of the report will be used as a teaching tool.

General Investigation 22

ALLEGATIONS

The Department asked the OIG to investigate the apparent theft of gifts donated to the Department's Toys for Tots campaign.

INVESTIGATION

The OIG found several administrative problems which compromised the effectiveness of the Department's Toys for Tots campaign. There were two coordinators from different organizations vying for control of the program which created an absence of central leadership and provided for little or no supervision over who had access to the toys once they were collected. A meeting regarding the need for additional space to house the toys produced a decision to transport a portion of the donated items to a storage facility, a move one of the coordinators strongly opposed, leading to her resignation from the program. A security guard at a site where toys were being stored stated that on one occasion he saw the same coordinator, along with her husband and others, loading boxes of toys into personal vehicles. The guard thought nothing of it at the time because of the coordinator's position of authority in the program.

Security guards at another storage site informed their manager they had witnessed workers from the moving company hired to move the goods loading boxes and bags of toys into their personal vehicles. The guards said the movers were allowed access to the toys without any supervision. When a request was made to see warehouse sign-in sheets for review, the OIG was told the sheets had been lost or misplaced. The DCFS employee asked to oversee the program delegated that responsibility to subordinates who did not have expertise in warehousing and distributing goods.

An estimated 5,000 to 7,000 of the 40,000 toys donated to the program were lost. The Department employee in charge of overseeing the program had ordered workers not to inform police of the suspected theft out of fear that it would bring negative publicity to the program.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. The Department has no experience in the warehousing and distribution of goods. That is not its area of expertise. The Department should not continue to operate the Toys for Tots program. It should be coordinated and run by personnel skilled in the fields of warehousing and distribution of goods. Each stage of the project should be overseen and controlled by persons with expertise in those areas. All phases of the operation should be documented and fully supervised. It has been demonstrated that the Department was unable to handle such a project. It is beyond the primary duties of the Department and the time and efforts of the Department's personnel should be spent on their primary responsibilities.

The Department agreed. The Halas-Payton Foundation will be managing the holiday program through Alliance for Children.

General Investigation 23

ALLEGATIONS

A woman and her daughter filed a complaint alleging they were assured they would receive a day care center license by a Department Day Care Center Licensing Representative. Instead, the Department denied the license and the applicants suffered a financial loss.

INVESTIGATION

The complainants submitted pre-orientation correspondence and attended a licensing orientation session. At the session, the women filled out documents indicating they planned to be the on-site directors of an infant day care center and that both women were registered nurses, licensed in Illinois. The licensing representative assigned to the applicants assisted them in completing a fire inspection and several other steps in the licensing process. On a visit to the site, the licensing representative told the women the facility would have to be rehabbed before it could be licensed. The licensing representative told the applicants she believed they were eligible to serve as directors, assuming the information they had provided was accurate and verifiable. The women interpreted the licensing representative's reassurances as a guarantee of licensure and proceeded to invest over $4500 in renovations to the site. The licensing representative's supervisor raised questions about the accreditation of the nursing school the women attended and determined they were ineligible to serve as directors according to Department guidelines. Although the exact content of the conversation between the licensing representative and the applicants is unclear, miscommunication between the two sides resulted in expensive renovations being undertaken by the prospective agency well before other steps necessary for licensure had been completed.

The nursing school the complainants attended was accredited by the National Accreditation Council. The program was a 26 month program. In addition, both women had taken college credit courses and completed pediatric rotations at Children's Memorial Hospital. The Department's licensing representatives used a set of licensing procedures that have been in "draft" form since 1990. Examination of the school's status and current Department regulations showed the women either qualified or were very close to meeting qualifications to serve as directors. The OIG also learned Department licensing staff are not required to attend a licensing orientation, yet they are expected to verify, clarify and interpret information shared at the orientation. The absence of cohesive, permanent regulations for determining licensing eligibility leaves a great deal of the process dependent upon worker's perceptions of proper policy, which are not always accurate.

OIG RECOMMENDATIONS / DEPARTMENT RESPONSES

1. Rule 407 Day Care Center Licensing Standards was recently amended and put into effect. Day care center licensing procedures should be immediately developed and published in final form along with staff training. Procedures should a) cover all phases of license application and renewal processes; b) require an evaluation of academic credentials and work experience; and c) expect that all significant documents and tasks critical to the licensing process will be dated upon receipt and completion, and maintained in the license record, and that critical information verbally exchanged between licensing staff and license applicants and licensees be confirmed in writing. The license application process and procedures should be reorganized to prevent the purchase or leasing of facilities or facility renovation prior to other critical clearances of applicants.

The Department agreed. Comprehensive procedures for Rule 407 are currently being drafted and the draft will be available for review by the Licensing Coalition by early January 2000.

2. The Day Care Center Licensing orientation should be evaluated and developed in accordance with the amended licensing standards. Relevant and updated information should be incorporated into the orientation session on an ongoing basis including information about the Americans with Disabilities Act (ADA) and its application to day care facilities and programs. DCFS licensing staff should receive training on ADA legislation in order to intelligently discuss and guide license applicants and license holders in this area. Free training and informational resources include: the Department of Rehabilitation Services, City of Chicago's Office for People with Disabilities, and many disability serving non-profit agencies, i.e., Access Living.

The Department agreed. The Department is in the process of hiring six regional Day Care Quality Assurance managers for day care licensing activities. One of the primary responsibilities of these staff will be to evaluate current orientation and training programs for day care applicants/providers and day care licensing staff.

3. All licensing representatives should be required to attend at least one licensing orientation session in order to hear the same things heard by prospective license applicants attending these sessions.

The Department agreed. All day care licensing representatives are required to attend at least one licensing orientation session.

4. The Department should clarify its position regarding a) accredited educational institutions, such as schools of nursing, that are not colleges or universities but are accredited and require college credited courses, and b) inclusion of experience in a pediatric setting at a hospital to meet the clock hours requirement.

The Department will raise these issues with the Licensing Coalition for consideration. Additionally, there is a process whereby the Office of Child and Family Policy is asked to issue an interpretation for a specific section of the rule. Also a new Declaratory Ruling process contained in the revised Rule 407 allows an applicant or licensee to see a declaratory ruling about the application of any part of the rule to the specific circumstances of the requestor.

5. The Department should evaluate the academic and work history of the applicants to determine their level of compliance with Rule 407.11 prior to the recent amendment. Should either license applicant qualify to be a day care center director, license application proceedings should be initiated with the understanding that compliance with the amended Rule must be achieved within the first licensing period. (One of the applicants has expressed a continued interest in becoming a day care provider.) Should either applicant meet the required hours in courses prior to the recent amendment, the OIG recommends the applicant be granted a waiver, if possible.

The Department agreed. The Cook County Licensing office has offered to evaluate the academic and work history of both applicants. The Department cannot, however, allow an applicant who is not qualified under the current version of the licensing standards a full licensing period to become qualified. The Department is prepared to offer a reasonable corrective plan for a period not to exceed one year.

CHILD DEATHS

The Office of the Inspector General (OIG) tracks, reviews and investigates deaths of children whose families have been involved with DCFS at the time of their death or within one year of their death. During Fiscal Year 1999 (FY 99), the OIG received reports of 82 deaths of children meeting these criteria. A categorization of death reports received by the OIG according to cause and manner follows.[5]

Parental drug use continues to be a precipitating factor for involvement with DCFS. Many of the deceased children reported to the OIG are affected by parental drug use. Twenty-two of the deceased children reported to the OIG were born with drugs in their systems. Eight of these twenty-two cases were comprehensively reviewed by the OIG. With one exception, all of the babies were born premature. Three were stillborn. Five died from SIDS; two within a month of their births, and three at about two months.

Common threads found among the cases included the following:

- seven of the mothers had prior involvement with DCFS;
- six of the mothers had never completed a drug treatment program;
- support services to promote successful drug treatment were not provided;
- safety plans, including a support system of non-drug users, were not utilized;
- prenatal and postnatal health care was inadequate;
- SIDS prevention education was not provided to families.

Many of the issues identified by the OIG review and brought to the attention of the Director are currently being addressed by the Department. On November 17, 1999, Director McDonald distributed Policy Guide 99.13, *Services for Substance Affected Families*. The policy guide addresses the importance of drug treatment, client contact, and health maintenance. Specifically, the guide addresses how caseworkers should initiate treatment, continue to encourage the client to enter treatment if he or she refuses, and coordinate care with other service providers. The policy guide notes the importance of contact with Public Health nurses and referrals to the Adverse Pregnancy Outcome Referral Service (APORS). Finally, the guide educates caseworkers regarding continuing care, recovery, and relapse prevention. By providing a resource for caseworkers and supervisors, DCFS had laid the foundation for continued improvement in addressing the needs of substance affected families.

Database
In Fiscal Year 2000, the OIG will continue its investigations of the deaths of children involved with DCFS. In conjunction with the University of Chicago, the OIG, in FY 99, developed a death investigation database. The OIG is tracking trends in child deaths and will attempt to generate large data-based reports on the types

[5]To give the reader an idea of the number of deaths reported to SCR in a given year, according to the DCFS Office of Quality Assurance, in Fiscal Year 99, the State Central Register ("SCR") received 143 reports of child fatalities in which abuse or neglect was suspected. 111 of these reports were A sequence reports or first time reports to DCFS. The remaining thirty-two reports had some prior indicated report with DCFS. The Division of Child Protection investigated the reports and indicated the reports in 66 of the cases. Sixteen reports are still pending and the remainder have been unfounded. Not included in these numbers are the deaths of children with DCFS involvement where there is no suspicion of abuse or neglect, such as deaths due to chronic medical conditions.

of deaths commonly seen in children who have been involved with DCFS. Information obtained from the child death investigation database will be combined with current research to guide and support policy and practice recommendations. The major goals of the database project are to develop a clearer understanding of the factors that are correlated with or may cause the deaths of children and to devise strategies for the prevention of child deaths.

The children who have died while involved with DCFS serve as a constant reminder of the need for our continuing commitment to prevent deaths of other children. Yet, not all of our children's deaths can be prevented. The majority of caseworkers do their best to ensure that the children on their case loads receive the care and attention every child should. When a child on their case load dies, it is a painful experience. This past year a DCFS caseworker related a story about an eleven-year-old girl whose medical problems were so severe she could not speak. The caseworker visited the girl regularly, noting that her face and mostly her smile expressed what the child could not say. The girl died this year, but she lived longer than doctors expected. The child's biological family did not visit or attend her funeral. Her funeral was attended only by her DCFS caseworker and the care facility staff - the people who loved this child, the "family" this child had known.

Fiscal Year 1999
Death Reports Received

In fiscal year 99 the OIG received reports of 82 deaths of children who were involved with DCFS or whose family had DCFS involvement within the last year. Following is the general categories of deaths by cause and manner.

Sudden Infant Death Syndrome

20 total SIDS deaths, manner is natural
14 substance exposed infants
6 non-exposed infants

Stillborn

4 total stillborn babies, manner is natural
3 substance exposed
1 non-exposed

Homicide

16 total homicides, specific causes noted below
5 killed from gunshot wounds (all by non-relative perpetrators, four of these children exhibited repeat runaway behavior)
4 killed by mother's paramour (2 blunt head trauma, 1 Shaken Baby Syndrome and trauma, and 1 multiple injuries)
2 killed by mother (1 head injury by mother who is a ward, and 1 intentional water immersion burns)
1 killed by stepmother (head trauma)
1 death due to complications as a result of Shaken Baby Syndrome inflicted earlier (parents suspected but never charged)
1 killed by his older siblings (multiple injuries)
1 killed by a hit to the chest with a piece of concrete while engaged in a gang fight
1 killed in a foster home by an unknown perpetrator (blunt head trauma)

Natural

29 total deaths where the manner of death was natural and the cause was not SIDS or stillborn

6 multiple medical issues
6 respiratory problems (reactive airway disease and other complications)
3 bronchial asthma
3 cardiac problems
2 cardiac arrest
3 complications due to prematurity (all were substance exposed infants)
1 terminal brain tumor
1 viral infection
1 sickle cell anemia complications
1 AIDS

Natural, continued

1 congestion/severe dehydration (possible medical neglect by caretaker)
1 obstruction of airway (possible medical neglect)

Accidental

6 total deaths ruled accidental in manner

1 drowning in bathtub (neglect involved, mom left child alone)
1 drowning in bucket (neglect involved, child left alone)
1 fall out of a window (possible neglect)
1 smoke inhalation from a house fire (possible neglect, four year old playing with matches)
1 asphyxiation (head caught between the bars of a crib that had been recalled)
1 car accident

Burns/Undetermined

1 death as a result of water immersion burns, manner undetermined

Methadone Ingestion/Undetermined

1 death as a result of a child drinking orange juice that had methadone in it

Undetermined/Undetermined

4 total deaths were ruled undetermined cause/undetermined manner (these generally are suspicious for foul play)

2 substance exposed infants
1 likely to have been signed out SIDS, but mother had lost a previous baby to SIDS
1 likely to have been signed out SIDS, but mother did not cooperate with a mandatory medical examiner death scene investigation (the ruling could be changed if mother decides to cooperate)

Pending

1 death where cause and manner are still pending

1 cause is a cardiac problem, but manner is pending (may have been exacerbated by sexual abuse)

CONCURRENT PLANNING / PARTNERING WITH FAMILIES FOR PERMANENCY

The OIG is wrapping up a three year project to design and test a series of best practice strategies for achieving timely permanency in a less adversarial manner for children under age 12 who either: 1) based on significant family strengths, should be able to return home quickly; or 2) are unlikely ever to be returned home. This latter assessment is made based on the seriousness of the abuse, conditions which are generally unamenable to treatment, or previous failures to make progress despite reasonable efforts by a child welfare agency. The project attempted to test a matrix and interview protocol designed by the Child Care Association to help workers assess the likelihood of reunification early in the case, to avoid a "one size fits all" approach to families.

Results

The mean length of time of the children in the project was 18 months, with a range of between 7 and 23 months. Of the 48 children for whom final status information was available, either reunification or adoption had been achieved or appeared likely to be achieved for 31 (65%) of the children. Adoption was planned for 4 children but no legal action had been initiated. One child achieved permanency through private guardianship. Reunification was planned for 2 additional children but progress was not good. One child had a goal of independent living. No permanency decision had been made for 9 (19%) of the children.

Lessons Learned

We believe that the strategies of early differential assessment, full disclosure to families, and involving the extended family in the case plan are entirely compatible with the Department's permanency initiatives, including performance contracting. Timing is important, however, and as the Department implements concurrent planning more broadly it will benefit from having these other initiatives well underway.

This project was unique in that it tested concurrent planning with relatives as opposed to specially recruited and trained foster parents which were studied in the initial small study in Washington state. Acknowledging our small sample size and the developmental nature of our field test, we nonetheless answer the question "can concurrent planning be done with relatives?" with a cautious "yes". This is an important first step as so many of the children DCFS serves are in relative placement.

For the full report of the Concurrent Planning Project, see Appendix C.

ETHICS

The Ethics staff was involved in a number of projects this year. With the assistance of Professor Eileen Gambrill,[6] the Ethics staff completed the first volume of a two-volume handbook on ethical issues facing child welfare professionals. This 200-page volume, entitled *Ethical Child Welfare Practice: A Companion Handbook to the Code of Ethics for Child Welfare Professionals*, Volume I: Clinical Issues, was written, edited, printed and distributed this fiscal year. Chapters in this book include Ethical

[6]Gambrill is a Professor in the School of Social Welfare at University of California at Berkeley. She is the author of numerous books and articles on social work, including *Social Work Practice: A Critical Thinker's Guide*, (c) 1997 Oxford University Press, Inc.

Decision-Making; Integrity; Self-Determination and Informed Consent; Confidentiality; Conflicts of Interest; Competence; Responsibilities to the Court; Termination and Transfer and When Others Act Unethically. The Handbook contains numerous helpful features, including hypothetical examples, Ask Yourself test questions, and a glossary of terms.

Continuing its commitment to the development of child welfare ethics, the OIG, in partnership with the Park Ridge Center for the Study of Faith, Health and Ethics, initiated a two-day meeting. The partnership brought together child welfare professionals, social workers and ethicists to discuss the historical development of child welfare in Illinois and the ethics problems that were created in the wake of various reforms. This group of individuals will continue to meet in fiscal year 2000, discussing additional ethics problems. The culmination of these meetings will be the production of a training video for child welfare professionals with accompanying instructional materials for trainers and participants' manuals.

The Ethics staff also continues to coordinate the meetings of the Child Welfare Ethics Advisory Board. Michael Davis, Ph.D. of the Illinois Institute of Technology's Center for the Study of Ethics in the Professions, joined the Ethics Board.[7] Professor Davis is a nationally recognized specialist in ethics and the author of over 100 publications on professional ethics. The Ethics Board addressed inquiries made by the Inspector General and by child welfare professionals throughout the State of Illinois. In 1999 the board guided the OIG on a number of issues:

(1) Ethical Obligations in Child Protection Investigations

The Board reviewed an inquiry regarding the obligations of child protective investigators when there is police involvement in a child protective investigation. The inquiry specifically focused on the differential ethics between child welfare workers and police. While child welfare ethics oblige a worker to be honest, police tactics allow for deception. Since police officers often use deception when questioning suspects, the board addressed the question of a child protective investigator's obligations when the caseworker is present during a deceptive interview. Appealing to the *Code of Ethics for Child Welfare Professionals*, the Board strongly emphasized the child welfare professional's obligation to "treat those with whom they have professional relationships in a(n)... honest and fair manner" (Code, 1.01).

(2) Confidentiality

The OIG investigated a case in which a teen ward was suspected of murdering a foster sibling (See Death Investigation #5). The attorney that DCFS hired to represent the ward instructed her not to speak with the police or her therapist about the incident. The Legal Division of DCFS then instructed the follow-up supervisor not to share her case file with the DCFS child

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[7] As of July 1, 1999, the members of the Child Welfare ethics Advisory Board were:
Roberta Bartik, J.D., Commander, Youth Investigations Division, Chicago Police Department
Michael Bennett, Ph.D., Director, Msgr. John J. Egan Urban Center, DePaul University
Dorothy L. Carpenter, M.Ed., Child Care Services, Chicago Housing Authority
Michael Davis, Ph.D., Illinois Institute of Technology's Center for the Study of Ethics in the Professions
Esther Jenkins, Ph.D., Department of Psychology, Chicago State University
Anthony Marchlewski, M.D., Great Lakes Psychiatric Center
David Ozar, Ph.D., Director, Center for Ethic, Loyola University Chicago
Ada Skyles, Ph.D., J.D., Chapin Hall Center for Children, University of Chicago (Chair)
Eugene Svebakken, MSW, Executive Director & CEO, Lutheran Child & Family Services

protective investigator. The OIG referred this case to the Board to determine whether it is ethically defensible for one division of DCFS to refuse to disclose information to another division of the Department based on concerns of confidentiality. The Board concluded that since DCFS was the guardian for the teen, it should be able to freely share information within DCFS without any concern of violating confidentiality.

(3) The OIG Intake Form

Following an investigation in which the complainant in an OIG investigation became the focus of the investigation, the OIG asked the Board about the ethical implications of investigating the complainant. The complainant disclosed the information believing that the information would be used to investigate the substance of the complaint. The Board insisted that the OIG had an obligation, regardless of the source of the information, to investigate any circumstance that appeared to violate standards of clinical practice, administration and or fiscal propriety. The Board did, however, assist the OIG in rewriting the OIG intake form to reflect this commitment.

(4) The Ethics Handbook

The Board also reviewed chapters and offered helpful direction in the writing of *Ethical Child Welfare Practice: A Companion Handbook to the Code of Ethics for Child Welfare Professionals*, Volume I: Clinical Issues.

Additionally, the OIG's Ethics staff conducted a number of trainings for various child welfare professionals. These trainings included presentations on confidentiality and conflicts of interest. The Ethics staff is also involved in presenting information on child welfare professionals' ethical obligations at the DCFS New Employee Orientation. The OIG Ethics staff also answered several informal phone inquiries from child welfare professionals and also participated in the DCFS Conflict of Interest Panel, addressing conflict of interest inquiries from DCFS employees.

Denise Kane, the Inspector General, continued in her role as the Ethics Officer for DCFS. Therefore, the ethics staff had the responsibility of collecting and reviewing 200 copies of Statements of Economic Interest from top-level DCFS employees. Based upon individuals' responses, the Ethics staff devised, distributed and collected follow-up questionnaires to probe more deeply into the economic activities of DCFS employees to ensure that no conflicts of interest were left unaddressed.

INTACT FAMILY RECOVERY

The Intact Family Recovery (IFR) project was developed in response to OIG investigations which highlighted the tragic consequences of providing too few services to substance affected families. Through a number of investigations, the OIG determined that generic intact services for families with substance affected infants provided little contact with the families (on average 2 visits per month), workers and supervisors lacked substance abuse knowledge, and there was poor communication and follow through with treatment providers. Further, service provision periods for intact families typically lasted 12 months or less. Outcomes of these generic services included cases being closed by the Department without a clear understanding of whether the parent had completed substance abuse treatment, as well as births of subsequent substance exposed infants, eventually resulting in placement. These findings prompted the OIG to develop, through its Best Practice Project, the IFR model.

The IFR model integrates a child welfare/substance abuse approach to providing intact family services to families who have delivered a first or second substance exposed infant in an effort to increase child safety and the family's capacity to effectively participate in substance abuse treatment. These services are designed to last for a period of 18 to 24 months. Basic tenets of the model include increased communication and collaboration between child welfare and substance abuse treatment workers; comprehensive services offered to the entire family; intensive home visits by both child welfare and substance abuse providers; and cross training in both disciplines. Further, the model implements graduated sanctions in an effort to increase compliance in substance abuse treatment. These graduated sanctions include the use of a Memorandum of Agreement or contract between the workers and parent(s) listing conditions and consequences for noncompliance; pre-screening or reviewing the case with the Cook County State's Attorneys Office; and obtaining Orders of Protection mandating treatment compliance. Early data suggests that the use of such sanctions have been effective in compelling parents to complete significant courses of substance abuse treatment.

In March 1998, three child welfare and three substance abuse treatment agencies from each Cook region were chosen to partner and implement the model. Currently, these agencies include Lutheran Social Services of Illinois (LSSI) and Gateway Foundation serving the South Cook region; Lutheran Children and Family Services of Illinois (LCFS) and The Women's Treatment Center, serving the Cook Central region; and LSSI and Recovery Point, serving the Cook North region. These partnerships began receiving referrals in June 1998 and to date 147 families had been referred into the program.

Since referrals began, the IFR project has contributed to notable changes in practice. One such change includes improved communication and collaboration with the Department's child protective investigators surrounding hand-offs. Hand-offs, or the initial meeting in which the case is officially transferred from the investigator to the IFR team, have increased from approximately 30% at the beginning of the program to 90% currently. In addition to increased frequency, the content of these hand-offs have improved to include the presentation of a united front to the family and to clearly state expectations for cooperation and compliance. Further, the IFR teams have worked to reduce the risk associated with substance abusing parents by ensuring that all families have a crib or playpen. Currently, the program has supplied cribs or playpens to approximately 40% of the families.

The OIG will continue to monitor and report on notable changes in practice and significant data throughout the course of the project. Significant data to date from the project's first 147 families includes the following:

- 54 or 37% of the families are court involved;
- 18 or 13% of the families have IFR initiated Orders of Protection;
- 13 or 72% of the 18 families issued Orders of Protection entered treatment within one month of the Order and completed a significant course of treatment;
- 9 or 69% of the 13 families who complied with treatment following an Order of Protection remained intact throughout the case. Three of the four families who lost custody (for subsequent non-compliance or child safety issues) were reunited within a relatively short period of time.
- 39 or 26% of both court and non-court involved families have had children placed in Temporary Custody and were transferred from the IFR; and
- 7 or 5% of the mothers have become pregnant while in the program;
- The average number of children per family is 4.

PATERNAL INVOLVEMENT PROJECT

Overview

The Office of the Inspector General's Best Practice Division is working with the Paternal Involvement Project[8], the Illinois Department of Children and Family Services (DCFS), and the Cook County Public Defender to conduct a field test designed to increase the involvement of fathers with their children who have recently been placed in foster care. The project has two goals: first, to allow able fathers to take custody of their children, thereby reducing the child's length of stay in foster care; or in the alternative, to enhance the father's ability to act as a support to the child in the custody of the mother or relatives.

Services Offered

Each father in the pilot is assessed to identify services needed for reunification. The following services are offered to fathers through the Paternal Involvement Project:

- Parenting Classes
- Educational and vocational assessments
- Job referral, placement and retention services
- Professional counseling and peer support
- Legal advocacy, including paternity establishment
- Case management
- Referral for substance abuse services
- Monthly father-child activities
- Participation in a paternal involvement alumni/support group
- Housing referrals

Throughout the case, the progress and utilization of services is measured as well as the father's benefit from those services. In addition to the father's individual treatment, the father's support system is identified and involved in his treatment plan.

Tracking & Findings

Each father's case is closely tracked in order to identify systematic and individual barriers to reunification. Meetings are held at the time that the father is assessed, when the father completes formal services, and additionally as needed. Invited to these meetings are the biological father (and mother if planning for reunification together), any members of the father's support system, the foster care case worker, any additional community service providers, the paternal involvement case coordinator and OIG Best Practice staff. Each meeting is held with the purpose of building relationships, identifying and discussing the goals of the case and how the goals will be achieved, and monitoring the father's progress toward reunification.

The OIG is using early experience of the field test to identify gaps in policies and practice in the child welfare field. After reviewing the case files of the referred fathers, it was discovered that many of the foster care case files did not have service plans for the fathers.

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[8]The Paternal Involvement Project is a community agency located at Kennedy-King College on Chicago's South side. The Project, which began as a public/private venture funded collaboratively by the Woods Charitable Trust and the Illinois Department of Public Aid, focuses on reconnecting non-resident fathers with their children.

The following are among the issues which have been identified through the pilot project, feedback received from training, and discussions with offices involved with the court:

- Workers and administrative case reviewers identify concerns about violating the mother's confidentiality as a barrier to working with fathers and the father's family. Workers need training about the what is and is not confidential and how fathers can be informed about their children without violating confidentiality of treatment records.
- Workers have difficulty identifying appropriate services for non-custodial fathers who were not involved in the incidents that led to the child's placement in foster care. Targeted services, such as extended supervised visitation or parent coaching for inexperienced fathers, need to be developed.
- It was found that many fathers did not have a clear understanding of their service plan and what is being asked of them to be reunified with their child(ren).
- Fathers did not have a clear understanding of the court process and reasons why their children were removed.
- A number of the fathers assessed through the project are in need of comprehensive substance abuse treatment services. DCFS has recently made DCFS-Office of Alcohol and Substance Abuse Initiative treatment slots available for fathers. Workers need to be educated about this important new resource.
- During many of our meetings there were apparent adversarial relationships between the foster care workers and the parents, which prohibited effective communication and reunification efforts. In the cases where this was apparent, there was a strong emphasis placed on building a working relationship between the parents and case workers during the meetings. At the end of these meetings both case workers and parents expressed a greater understanding of either the father's situation and involvement in the project or the case worker's reasoning behind the decisions and recommendations made about the case.

Research and Evaluation

In addition to data collected on each father's participation in the field test, fathers are asked to complete a detailed social history interview conducted by Dr. Waldo Johnson from the University of Chicago School of Social Services Administration, a well-known researcher in paternal involvement. Another aspect of the OIG's paternal involvement efforts is to study caseworkers and practices regarding fathers. This study, along with the findings from the field test will give the OIG material to provide excellent training on paternal involvement for the child welfare field.

Collaboration and Training

The OIG's Paternal Involvement Field Test is working with specific aspects of child welfare, such as the Teen Parenting Service Network (TPSN) and the Intact Family Recovery (IFR) Project. The TPSN's supervisors are undergoing training on paternal involvement issues with a goal of training all TPSN case workers and setting up a Paternal Involvement Project satellite office to focus on services for teen fathers. The workers on the IFR Project have been trained on paternal involvement and are being worked with closely to identify barriers encountered when attempting to promote paternal involvement.

Additionally, to build a referral base and to bring awareness of the project to professionals in the child welfare field who have interaction with the fathers, training on the developing model has been delivered to child protection judges, public defenders in the child protection unit, private bar attorneys, public guardians,

and DCFS administrative case reviewers. Information about the project with an encouragement for referrals was sent to private agencies and the DCFS best practice work group participants.

Assistance to the Paternal Involvement Project

In addition to the fathers in the pilot, extensive background information on all DCFS involved fathers utilizing services at the Paternal Involvement Project is obtained by the OIG. Information such as criminal history, child abuse/neglect charges, court records, caseworker information and information on the child(ren) is gathered and used for the Paternal Involvement Project to effectively service involved clients.

SPECIFIC CONSENTS FOR ADOPTION

The Inspector General began working to normalize "specific consent" taking in 1994. Today this procedure is a part of permanency practice. A "specific consent" allows a birth parent to agree to adoption by a specific individual. The child/ren must have lived in the current foster parent home for a year or longer and DCFS must agree that the adoption is the best interest of the child.

The OIG worked with the Department and many others to pass legislation would solidify the practice of taking specific consents from birth parents during FY '97 (Senate Bill 522).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. The process has been centralized within the Legal Office of DCFS. During 1998, 749 specific consents were signed by birth parents and 431 of these resulted in adoption actions.

RECOMMENDATIONS FOR REFORM and DISCIPLINE

The recommendations made by the OIG this fiscal year are organized according to the function of the child welfare system that the recommendation is designed to strengthen.

DISCIPLINE

The OIG recommended that DCFS or private agency staff be disciplined for the following misconduct:

- Failing to notify the court that a young girl was inappropriate for the independent living program, because of her developmental disabilities, that she was not enrolled in special education services and that she was engaging in indiscriminate sexual behaviors on the street which placed her at imminent risk of harm
- Placing a severely emotionally disturbed adolescent in a foster home with other foster children despite her therapist's recommendation that she be placed in a foster home in which she would be the only foster child
- Falsifying case entry notes
- Failing to follow private agency protocol when physically restraining a ward
- Using religion to manipulate a child during a child protection investigative interview
- Failing to adequately document concerns raised during the initial child protection investigation, allowing a child to take adult responsibilities during an interview, failing to notify the parent, placing children without adequately assessing capability of the caregiver, improperly assessing safety and ignoring obvious health concerns
- Failing to properly investigate allegations
- Failing to provide services or monitor the progress of the child's biological parents
- Failing to provide court ordered visitation
- Failing to provide services to the father
- Consuming alcohol while on the job
- Failing to properly review supervisee's travel vouchers
- Selling state property to gang members in exchange for drugs and money (the OIG recommended a "do not rehire" letter be placed in an employee's personnel file after he had resigned while being investigated for these allegations)
- Falsely claiming to be acting on behalf of the private agency in accessing children's school records for a friend
- Failing to timely inform foster parents of relatives' interest in adopting their foster child
- Failing to ensure that a necessary developmental assessment was performed for a special needs child
- Hiding a listening device in his supervisor's office
- Failure of a licensing representative to raise concerns when she noticed chain locks on all the bedroom doors
- Failing to provide adequate casework services (In this OIG investigation, the casework appeared significantly deficient and the worker's supervisor stated that she had concerns about all the worker's cases, the OIG recommended Labor Relations and Quality Assurance assist the supervisor with a comprehensive review of the worker's currently assigned cases to evaluate her capability to perform her job responsibilities.

SANCTIONS / PRIVATE AGENCY REFORM

- The Department should terminate its foster care contract with two private agencies with wholly unqualified management, who had falsified credentials in order to receive a license. In addition, both agencies had unqualified staff who had violated numerous Department regulations.

- The Department should phase out a private agency's supervised independent living contract after it learned that the agency failed to ensure youths entrusted to it were enrolled in appropriate education, failed to notify the Department or the Court that a ward in its program was probably incapable of learning sufficient independent living skills, allowed wards who were juvenile sexual offenders to live independently in the community without adequate supervision and specifically placed many sexually offending youth at a YMCA that also housed a daycare center, without informing the YMCA.

- The Department should implement a corrective action for a private agency that failed to ensure the mother was in treatment, appeared to rely on the mother to follow through with phone numbers she was given for referrals, did not provide other agencies with pertinent information and failed to plan for the birth of a child that died. Even after she was born, the agency did not ensure that the assigned worker properly monitored the case.

- The Department should implement corrective action after a death investigation in which there was a lack of communication between the private agency and the Division of Child Protection (DCP). The worker was not available and the administrator acting as a liaison seemed to have little knowledge of the case. The private agency has addressed this problem by establishing a schedule of case staffings. Each case is staffed at least once a year by a Licensed Clinical Social Worker (LCSW), caseworker, supervisor, licensing representative, crisis manager and other involved parties including therapist, treatment staff and family members. In addition they have established a critical issues staffing rule in which a staffing can be called at any time and should be held within 24 hours. The critical issues staffing is attended by an LCSW, crisis manager, caseworker, supervisor, licensing representative and other involved parties. Agency Performance Teams should ensure that other agencies have similar procedures in place. This will help ensure that when a hotline call comes in on a family that has children already in the system, the agency serving that family can provide a history of family involvement to DCP. If the agency is not able to provide the history in a timely manner, the agency performance liaison should be contacted and involved in obtaining the information.

- The Department should exclude tracking wards age 7 and under who had exhibited sexualized behavior from a contract with a private contractor whose expertise was sexual assault.

COMMUNICATION BETWEEN DIVISIONS

- The Department must always allow its own child protective investigators to have free access to any information in its control relative to the safety of children. The OIG strongly disagrees with Department policy which, in this case, prohibited sharing important mental health information between divisions of DCFS.

- The Department should formalize communication between Agency Performance Teams and Licensing and Contracting Divisions that will result in actual sanctions to private agencies for poor practice and failure to respond to identified problems.

COMMUNITY SAFETY

- The Department should explore the development of halfway houses with extended day programming to clinically assist appropriate older adolescent juvenile sexual offenders from Cook County who have successfully completed a treatment program at a secure facility to transition safely into the community. A restorative justice model was recommended.

- Youth who are judged to still present a high risk to re-offend should be kept in secure out-of-state facilities until Illinois begins to operate its own secure facilities.

SAFETY

- The Department should explore whether a foster care caseworker can appropriately monitor a family that has children in foster care and, subsequently, the mother gives birth to another child. Such high risk cases may be better served by bringing in an intact worker to concentrate on the family and work with the other caseworker on coordinating services. A foster care caseworker, because of sibling and parent visits and time spent in court, may not have the time to provide the intensity of service and monitoring which is associated with success.

- The Department needs to raise the issue of using security cameras in residential treatment facilities and should explore the possibility of amending accreditation guidelines to allow for this use.

- In FY 98, the OIG investigated the serious beating of a three month old boy, who was allowed to remain in his home after it appeared that the father had broken his leg. The family was being serviced through the Department's Intensive Family Preservation Services Unit. The OIG investigation discovered that the Unit operated without effective screening guidelines that would preclude offering intensive services in high risk cases or in cases in which the risk factors could not be monitored. The OIG recommended that the administrator be removed and that a genuine screening protocol adopted.

MANAGEMENT

- The Department should replace the DCFS administrator charged with managing wards with developmental disabilities with a strong proactive administrator who not only has expertise and experience in the field of adolescent developmental disabilities and mental illness but who also has the commitment to advocate for these youths' educational entitlements.

- The Department should develop a policy guide to cover situations in which DCFS Legal provides attorneys to accompany workers to police interviews. The guide should include a requirement that both the worker and the police are made aware of the precise nature of the representation and should include instructions that information should be withheld from the police only when the Department is prohibited by law from releasing such information to law enforcement.

- The Department should not continue to operate the Toys for Tots program. The Department has no experience in the warehousing and distribution of goods. That is not its area of expertise. The program should be coordinated and run by personnel skilled in the fields of warehousing and distribution of goods. Each stage of the project should be overseen and controlled by persons with expertise in those areas. All phases of the operation should be documented and fully supervised. It has been demonstrated that the Department was unable to handle such a project. It is beyond the primary duties of the Department and the time and efforts of the Department's personnel should be spent on their primary responsibilities.

- The Department must be cognizant of the public's perception of a case with excessive numbers of attorneys representing and/or acting on behalf of the Department. In a particularly contested case, at least 27 people were present for a court hearing, 11 from or representing the Department. At another hearing there were three attorneys from the Attorney General's Office as well as several DCFS attorneys present.

- The DCFS Administrator who is responsible for a state van must implement a system of recording who, when and which unit requests to use the van. All requests should be made to the Administrator in writing three days prior to the date of actual use. Any use of the van should be documented in a log book. The log book should be safely secured and in the possession of the Administrator. The log book should be made accessible to other unit heads so that they may thoroughly review travel vouchers submitted for reimbursement of all their employees.

- The DCFS Administrator who is responsible for a state van must collect and account for all keys to the van. There should be only two keys, an original and a copy, kept in the sole possession of the Administrator. He should ensure that the keys are imprinted with "do not duplicate."

EDUCATIONAL ENTITLEMENT

- The Department and the Illinois State Board of Education should jointly address the need for consistent surrogate involvement during the transition of special education adolescents across school districts.

- The Department should immediately notify DCFS and private agency personnel that obtaining a GED is not an alternative education plan for wards that are developmentally disabled.

REFERRALS/ASSESSMENT

- The Department should require workers to provide designated records to treatment providers that receive referrals. These records, at a minimum, must include all hospitalizations, all psychological and psychiatric evaluations, and all Unusual Incident Reports. The protocol should include a requirement that workers document in the file the records that have been forwarded to treatment providers.

- Monitoring staff must be able to identify clinical problems and have the authority to enforce resolution of identified problems. Therefore, the Department should ensure that all private agency monitors are trained to the utmost in relevant clinical issues and comprehend that their jobs require substantive monitoring of the agency's interventions with our children, their foster parents, and their biological families

- The Department should develop observable and measurable discharge criteria over time (which are not available in the definition of minimum parenting standard) for the Intact Family Services/Family Preservation program. For example, the definition requires that parents, "provide children with education..." One criterion would be, when applicable, "the child regularly attends school."

- Sexually Aggressive Children and Youth standards should be developed to screen out labeling of young children for single incidents, especially those that occur in substance abusing households

MENTALLY ILL WARDS

- The Department should develop special case units to address the particular needs of severely emotionally disturbed children and adolescents. Caseworkers lack clinical expertise to manage the complex issues presented by wards with mental illnesses. A similar recommendation was made by

the OIG in a report submitted to the Director on December 30, 1996, although this recommendation was directed toward parents with mental illness.

FOSTER PARENTS

- The Department should develop a protocol that caseworkers can use when sharing information about a child with the foster parent. A record should be kept documenting the information that is given to the foster parent. The information must be factually detailed - not merely diagnoses. This document should be signed by all parties at the placement staffing and a copy given to the foster parent.

SERVICES

- The Department should develop more mentor foster homes. The Department should provide annual ongoing training for mentor parents, retain the 24 hours a day/7 days a week availability of mentor consultants, and ensure that mentor payments are commensurate with duties expected of the foster parents compared to those in other programs.

- The Department should request that a consultant review the clinical records of parenting wards who have multiple diagnoses of mental illness, developmental delay and substance abuse to ensure the appropriateness and efficacy of services.

- The Department should prohibit sexual labeling of small children or subjecting them to therapy primarily or exclusively aimed at the label. While children seven and under may benefit from home-based treatment that addresses problematic behavior, there is no need to label such children as sexually aggressive and place them on the SACY database. Children are likely to be harmed by such labeling. Reports of inappropriate sexual behavior should be analyzed with a developmental perspective recognizing that many of our wards may exhibit age-inappropriate behavior because of deprived environments, under-socialization or exposures to overly adult sexual behaviors or lifestyles associated with drug usage. Behavior should be analyzed in context, with anti-bias techniques to avoid cultural biases. Then, if still considered sexual, the behaviors should be seen as only a part of the child's needs and should not supersede developmental and educational needs. The American Psychological Association guidelines prohibit the reduction of any individual to a label.

- The Inspector General should convene a multi-disciplinary panel to review the few cases of children seven and under that exhibit sexualized behaviors and that portend serious injury to others.

- The Department should develop an early childhood clinic for young children whose presumed sexual transgressions are part of larger developmental problems, social skills deficits, aggression management, and other inappropriate behavior. Children and foster families would be referred there for observation, assessment, time-limited educational sessions, and subsequent home-based behavior management programs.

- Whenever possible, young children with mild verified sexual behavior problems should be treated at home with their foster parents, and should also be enrolled in early enrichment programs. There should be education for foster parents regarding what is normal and expected sexual development for children of a young age, as well as what might be expected from wards who have experienced traumatic events. No treatment plan should be devised for any of our children without full knowledge and consideration of their history and input from the current caretaker.

- The Department should abandon the trappings of the adult criminal justice model of treatment with its punitive language and attitude when treating or describing children aged seven and under. The Department should keep in mind its commitment to helping these young children toward better lives. Some were born substance-exposed, experientially retarded, developmentally delayed, and approximately half have been sexually abused. Staff should see them as tender-aged victims rather than as "scary," "perps" or "offenders." Like all DCFS wards, they deserve respect and compassion.

- The Sexually Aggressive Children and Youth (SACY) program needs to develop guidelines for sexually inappropriate and sexually aggressive behavior of non-wards who live in foster homes (specifically, biological children of foster parents). The protocol should be included in future SACY training for Department staff.

SUBSTANCE ABUSE

- The IFR model integrates a child welfare/substance abuse approach to providing intact family services to families who have delivered a first or second substance exposed infant in an effort to increase child safety and the family's capacity to effectively participate in substance abuse treatment. These services are designed to last for a period of 18 to 24 months. Basic tenets of the model include increased communication and collaboration between child welfare and substance abuse treatment workers; comprehensive services offered to the entire family; intensive home visits by both child welfare and substance abuse providers; and cross training in both disciplines. Further, the model implements graduated sanctions in an effort to increase compliance in substance abuse treatment. These graduated sanctions include the use of a Memorandum of Agreement or contract between the workers and parent(s) listing conditions and consequences for noncompliance

- Collaboration between the Department and agencies treating the parent for substance abuse should occur in family cases where other substance exposed infants have been born and a subsequent birth finds the mother currently in treatment or where chronic substance abuse is an issue. Communication, treatment planning and monitoring between DCFS, treatment agencies and other involved parties will help to ensure the safety of the child and better engagement in treatment. Any child who has siblings in the system but is discharged to the mother should have a safety plan that has been staffed and developed by caseworker, supervisor, administrator and appropriate others (therapist, treatment staff, family members). The mother should have a list of outside support people and caregivers, including family members, who should then be contacted by the caseworker. Criminal history (LEADS) and prior abuse and neglect (CANTS) checks should be done on any alternate caregivers.

- Private agencies should be informed and retrained on the process of screening cases into court, which allows the State to take custody of children when circumstances begin to raise safety concerns. Agencies can then better prepare for mothers on their caseload who are currently pregnant or experiencing difficulties. The possibility of implementing a database code alerting workers that a mother with children in the system is pregnant should be explored.

- The Department should work with state and local Departments of Public Health on the issue of family planning, especially with mothers who have previously given birth to substance exposed infants, including education on options for family planning and access to services including transportation to clinics. DCFS must also assure access to clients served by purchase of service agencies whose religious affiliation might prohibit direct assistance in this regard. Treatment programs should also be included in this inter-agency cooperative effort. As suggested in the Intact Family Recovery Model, the programs could invite Public Health Nursing staff to run educational programs on family planning and/or provide transportation for clients to public health clinics for the

initial appointment. Frontline workers should be trained on exploring the issue of family planning with their clients and have resources available to offer their clients.

- The Department should ensure that its contractors for urine toxicology and substance abuse treatment routinely test for alcohol in random urine screens and/or have breathalysers available to test for alcohol. In addition caseworkers should be trained to use and have access to portable breath testers and/or saliva testers.

DEPARTMENT COORDINATION WITH PRIVATE AGENCIES

- The Department should adopt a standard memorandum to be used when transferring case files because of agency downsizing or closure. The memorandum will inform an accepting agency that it is receiving a case because the Department terminated its contract with the prior agency. It will state the major problems identified in the former agency so that the new agency can be more vigilant and understand the particular pitfalls that may be waiting.

TRANSITIONING WARDS TO ADULTHOOD

- The Department should work with a division of a state university that specializes in human development and a multi disciplinary team to build an empirically based community social skill training (including sexuality) and clinical consultation program that would work in partnership with agencies to develop supportive living arrangements for older adolescents with developmental disabilities (in the mild range of retardation). Partnering agencies would be obligated to cooperate with the state university in measuring the efficacies of their interventions and the social significance of their outcomes. The Department should develop these resources in cooperation with the Department of Human Services (DHS) to assure a smooth transition of these wards into adult services.

GUARDIANSHIP ADMINISTRATOR

- The Department must develop and consistently apply guidelines for appointment of counsel for wards. The current procedures do not address appointing counsel prior to indictment and current practice is uneven in terms of which wards get counsel and which do not. New procedures should include a provision for conflicts checks to ensure that an attorney representing a ward will not have an actual, potential or apparent conflict of interest.

- The Department should use a form containing vital information that would assist law enforcement in tracking down runaway children as quickly as possible. The form should be filled out completely and included with a placement package when any child is placed in a foster home, residential placement or shelter. It would be most helpful to have the information for teenagers.

- Pictures of all wards, such as school pictures, should be taken on a regular basis, dated and provided to placement providers or foster parents. The Department should pay for school pictures.

- The time and date of a ward's runaway and the place from which the ward ran should be clearly stated on the Unusual Incident Report and distinguished from the date on which the report is being made. Also included should be the number of the police report, which means the runaway has to be reported to the local police department before the Unusual Incident Report form is prepared.

- Once a ward has been absent for 30 days and on runaway status and the whereabouts of the ward remain unknown, the Guardian's office should report the child to the following national agencies: National Missing and Exploited Children Hotline, Missing Children Hotline, Child Find and the Runaway Hotline.

- Through consent or court order, the Department should obtain SSI evaluations/reports of pregnant and parenting wards to be reviewed by the Office of the Guardian.

RESTRAINTS

- The Department should retrain supervisory Emergency Reception Center staff as to when it may be proper to allow children to be restrained from running away.

- A private agency should comply with DCFS requirements by utilizing a behavior management committee.

MEDICAL

- DCFS nurses' care plans should include time lines for dates of completion, the assigned person responsible for implementing each recommendation, and formal follow up of recommendations. Care plans should be typed to avoid the problem of illegibility.

- The Department should consult on the development of a protocol for wards with potential residual effects of closed head injuries.

- A residential treatment facility should hire a registered nurse (as opposed to a licensed practical nurse) to care for the residents and to conduct training sessions for staff on such issues as when it would be appropriate to seek medical attention.

- DCFS nurses should not offer professional consultations to workers in serious matters without reviewing records and speaking to treating physicians.

- The temporary arrangement of placing the Department's Chief Nurse and the DCFS Regional Nurses under the Office of Health Policy should be made permanent. It is a logical arrangement and should lead to better coordination in providing services to children between Healthworks, Public Health, Adverse Pregnancy Outcome Referral Service and the Zero to Three Program.

- DCFS should adopt and train its staff to use a failure to thrive protocol prepared by Rush Presbyterian Medical Center.

CHILD ABUSE/NEGLECT INVESTIGATIONS

- The Department needs to clarify whether and when it is appropriate to use the once popular REID Method of interviewing, and review its use when interviewing children.

- The Division of Child Protection (DCP) sub-region manager should manage supervisors' prudent filing of delinquent petitions and work with local law enforcement. DCP should file delinquent petitions only with supervisory approval and DCP field manager review.

- Child Protective Investigators should receive more training on developmental milestones, including those of infants. Growth charts should be made available for review and considered for possible use in investigations.

- Child Protective Investigators should be reminded during training that their assessment should not be limited only to the hotline allegation if there are indications of other abuse or neglect.
- The Department should develop standards for referral to child welfare, educational and/or mental health services instead of indicating abuse reports against young children and vulnerable children

with cognitive disabilities. The standards should include recognition of environmental factors that may accompany a caretaker's drug lifestyle.

ADDITIONAL OIG FUNCTIONS

- The OIG should be the liaison between Forensic Clinical Services of the Circuit Court of Cook County and the Cook County Medical Examiner's Office. The OIG has informed Forensic Clinical Services that it will assist the office in retrieving medical examiner reports in cases involving the deaths of children, where the agency requesting the evaluation has not provided the information.

ETHICS

- DCFS rules need to be amended to acknowledge that licensing state employees (not employed by DCFS) to be foster parents can create conflict of interest situations. The rules should be amended to say that state employees in management positions should be licensed as foster parents through private agencies.

- The Ethics staff completed the first volume of a two-volume handbook on ethical issues facing child welfare professionals. This 200-page volume, entitled *Ethical Child Welfare Practice: A Companion Handbook to the Code of Ethics for Child Welfare Professionals*, Volume I: Clinical Issues, was written, edited, printed and distributed this fiscal year.

- The OIG's Ethics staff conducted a number of trainings for various child welfare professionals. These trainings included presentations on confidentiality and conflicts of interest.

PERSONNEL

- The Department of Children and Family Services should develop a protocol that would set out objective facts that create reasonable suspicion such that a drug and alcohol test would be required. The Department should develop guidelines for utilizing the tests. The Department should look to other agencies or governmental bodies, such as the City of Chicago in developing its protocol. As demonstrated by the City in developing its policy, it is essential that DCFS negotiate with and secure the support of the Union. Aspects of the City of Chicago policy that should be incorporated by DCFS include:

  - The ability to test an employee when there is reasonable suspicion by two supervisors that the employee has used alcohol or drugs at work or is under the influence of drugs or alcohol at work (note: for purposes of suspicion of use at court hearings, the individuals able to assert reasonable suspicion may need to be defined as Department employees acting in a supervisory capacity or in a position in which they represent the Department to the court - e.g., the courtroom liaison or Department attorney);
  - The requirement that a supervisor or Department representative at court drive the employee to the testing site and remain with them during the testing process;
  - The ability to test for the presence of drugs or alcohol following an accident or other serious injury during work hours;
  - The ability to order reluctant employees to be tested and to terminate employees who refuse to be tested;
  - The requirement that the results of tests go to personnel and the Regional Administrator for review;
  - The ability to seek assistance through the Department's Employee Assistance Program;

- The Department should require in its contracts that purchase of service agencies have a testing mechanism that is at least as stringent as that developed by the Department; the Department should monitor the utilization and effectiveness of those policies.

- In May of 1995, the Inspector General submitted a Report to the Director regarding an investigation into practices of photographing children at a local DCFS field office. The OIG Report found the following:

  - In a particular neglect investigation, just prior to a temporary custody hearing a foster mother additionally alleged that a two year old child had been burned by her mother. The foster parent noticed a mark on the child while changing the child's diaper. The child's brother told the foster mother that his mother had burned his sister with a curling iron. The mother had a previous indicated finding for burning the child with a cigarette. The DCP supervisor and the investigator did not advise the court of the additional allegation, did not take the child to a doctor, did not complete a body chart noting the alleged burn, and did not note the additional allegation to the Department's State's Central Register. Rather, after the court hearing, the investigator and her supervisor had the child disrobe and lie on the floor of the supervisor's office with her legs spread while the investigator photographed the two year old. The office had full length open windows, from which the child was visible to passers-by in the adjacent parking lot. The burn allegation was never added to the allegations to be indicated and there was no documentation that the child was ever taken to a doctor for medical treatment. The alleged burn shows up in the photograph as a small whitish mark below the diaper line. A doctor interviewed by the OIG stated that the photograph would not enable him to testify that the child had been burned. Two co-workers stated to the OIG that after the photographing began, the child's father showed up and angrily stated, "what is this, a freak show?" In addition the investigation revealed that children's photographs were maintained without labels and therefore useless for evidential purposes. The pictures were also kept separate from the investigatory files.

  - The Report concluded that the child was photographed in an insensitive manner, and that the supervisor, failed to supervise in any meaningful way.

The Report recommended that the supervisor be disciplined for her failure to supervise, and that the investigator be prohibited from photographing child victims. The report also recommended that the investigator should have a new supervisor. These recommendations were accepted by the Department.

In June 1998, the OIG discovered a newspaper article, which pictured the investigator and supervisor, still working together as supervisee and supervisor. The newspaper article had been arranged through the DCFS Office of Communications. The OIG Monitor contacted the Director's office and was informed that the Department had been unable to disrupt the supervisory relationship, but that the two had been disciplined.

The OIG retrieved copies of the investigator's and the supervisor's personnel files. No discipline was apparent in either file and all evaluations covering the period of time relevant to the report were positive, without reflecting any of the problems noted in the report.

LICENSING

- Rule 407 Day Care Center Licensing Standards was recently amended and put into effect. Day care center licensing procedures should be immediately developed and published in final form along with staff training to comply with Rule 407. Procedures should 1) cover all phases of license application and renewal processes; 2) require an evaluation of academic credentials and work experience; and 3) expect that all significant documents and tasks critical to the licensing process will be dated upon receipt and completion, and maintained in the license record, and that critical information verbally exchanged between licensing staff and license applicants and licensees be confirmed in writing. The license application process and procedures should be reorganized to prevent the purchase or leasing of facilities or facility renovation prior to other critical clearances of applicants.

- The Day Care Center Licensing orientation should be evaluated and developed in accordance with the amended licensing standards. Relevant and updated information should be incorporated into the orientation session on an ongoing basis including information about the Americans with Disabilities Act (ADA) and its application to day care facilities and programs. DCFS licensing staff should receive training on the ADA law in order to intelligently discuss and guide license applicants and license holders in this area. Free training and informational resources include: the Department of Rehabilitation Services, City of Chicago's Office for People with Disabilities, and many disability serving non-profit agencies, i.e., Access Living.

- All DCFS licensing representatives should be required to attend at least one licensing orientation session in order to hear the same things heard by prospective license applicants attending these sessions.

CONCLUDING REMARKS

Over the last five years, the Office of the Inspector General has conducted major investigations in three key areas; the state's adoption practices, child welfare practices with substance abusing families and case practice after children are returned to their parents. Determining that non-feasance and bad practices existed in these arenas was an easier task then determining the appropriate remedy for these harms. The Director's, and subsequently the Department's, perseverance in remedying these harms was an act of courage. Systems reform can be merely an illusion of appearances or a substantive change. There have been substantive changes in the Department's state of affairs. A historical review confirms this.

Adoption

In FY 1995, the Inspector General issued a report that addressed complaints from several foster parents concerning the barriers they faced in adopting their foster children. These barriers included a failure by DCFS staff to follow existing adoption Rules and Procedures, allegations of racial discrimination, and a general failure to understand the significance of permanence in a child's life. Gross violations of good social work practice had occurred on a regular basis, such as overuse of bonding assessments, casual disruption of children's placements, and under use of the adoption resources of the Department. In this climate, relative foster parents were rarely asked if they had considered adopting the children in their care.

In order to create a sense of permanence for children in foster homes, the Inspector General recommended a series of corrective measures that have contributed to the permanency initiatives that the Department has implemented over the last five years. These measures include: Convening Extended Family Conferences to develop a permanency plan (OIG Annual Report, FY 94); adding clauses in private agency contracts for adoption conversion (OIG Annual Report, FY 94); discontinuing extensive psychological or bonding assessments when children have lived with foster parents successfully over an extended period of time (OIG Annual Report, FY 94); agreeing to identify more children who are appropriate for adoption, and to move them more quickly to permanency. In March 1996, at the request of the Director, the OIG began to work with Cook County adoption supervisors to design a new system for facilitating adoption in Cook County regions (OIG Annual Report, FY 96). Illinois has become a national leader in leading children to permanency.

Practice After Returning Children Home

Beginning with its first report to the Director in 1993, the OIG identified serious shortcomings with case practice and follow-up after abused or neglected children were returned home. This year saw the introduction of extensive reunification guidelines to address many of the problems identified in OIG reports over the years. In addition, the Department has reached out to other sectors of the system, such as the courts and other state agencies, to help solve some of our most difficult problems.

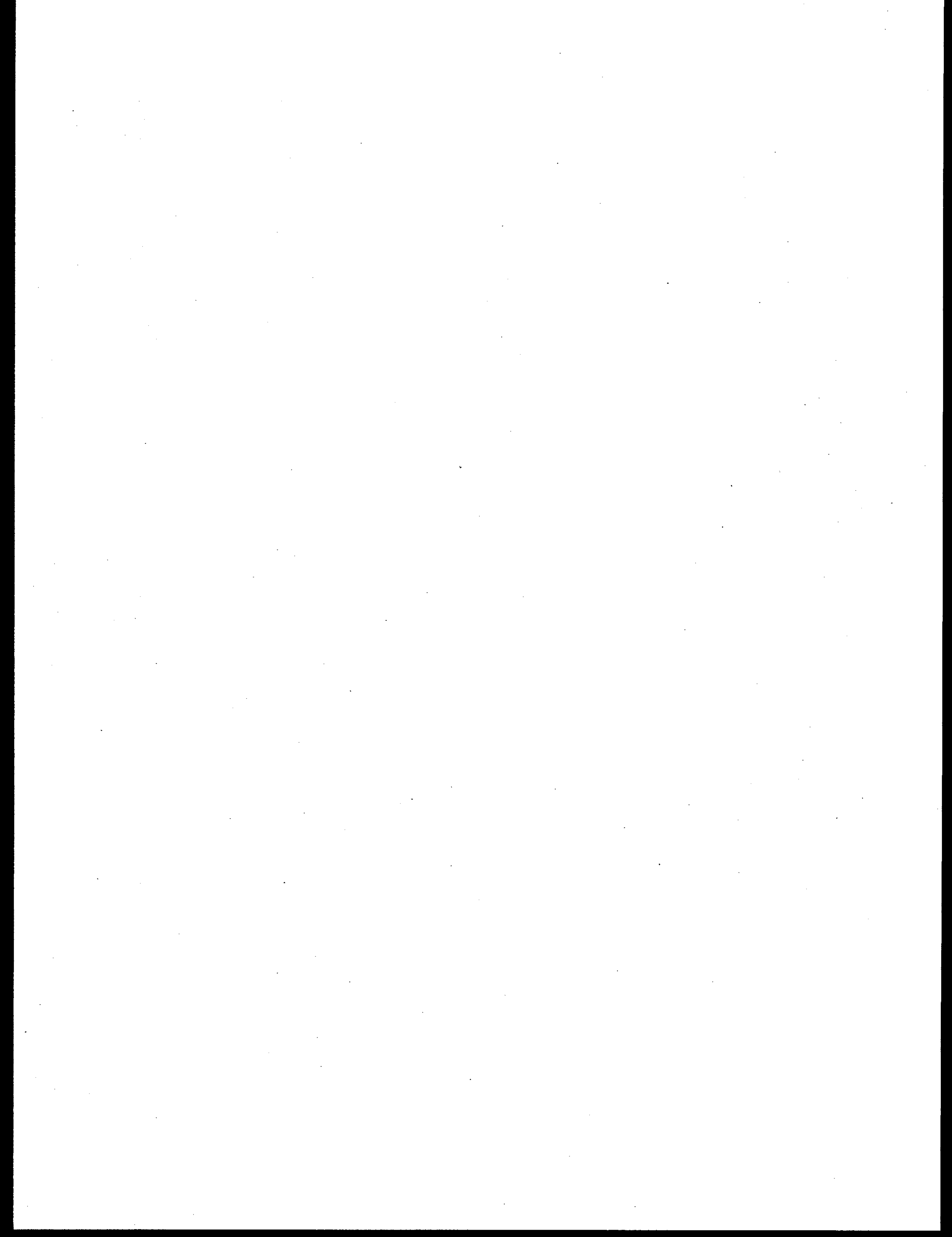
Substance Abuse

In FY 1998, the Office of Inspector General issued a special report with recommendations for improving child welfare response to families affected by parental substance abuse. Over the previous years our death investigations pointed to a trend of multiple births of substance exposed infants to mothers who retained custody of their child or children despite their noncompliance with drug treatment. Intact family involvement that was too short lived combined with uninformed practice, produced tragic consequences to our children. Parents' and caretakers' arrests and convictions related to drugs or violence were not considered in the family's assessment. In spite of protocols, available law enforcement data (LEADS) information was not used to obtain an appropriate level of substance abuse services or to inform decisions such as whether to remove children from the home. For example, a parent with an arrest record for drug sales or prostitution that spans ten years requires a more intensive level of drug treatment to succeed than a parent with no drug

related criminal history and only a recent history of drug usage. Although management initiated coordination with the Division of Drug and Alcohol Substance Abuse in 1995, the field practice continued to painfully lag. Procedures for determining whether clients had substance abuse issues was overly dependent on self-reports.

In the last fiscal year, the Department has made admirable strides in attacking these problems. In November of this year, the Department issued a new and comprehensive policy guide on services for substance exposed families. The Department's new Health Policy Division used investigative knowledge and labors to help remedy problems and bring the Department and the private agencies into a state of the art approach towards substance abuse. Presently, the Department is using feedback from the Lawndale Family Conference Program, the Intact Family Recovery program and its Healthy Fit data to shape empirically-based family rehabilitation programs for the growing population of heroin exposed families. Also this year, the Department implemented a LEADS protocol to formalize use of criminal history information in critical decision-making by workers. The Department also issued comprehensive rules and procedures to assist workers in assessing the level of drug dependency in families.

These reform efforts take commitment, good faith, and a great deal of work. The Director and the Department should be commended for the products of their labor. Our adoptive and recovering intact families have benefitted from these efforts. It is the strengths of these families that will carry our children safely into the 21st century.



Department of Children and Family Services
2240 West Ogden Avenue
Chicago, Illinois 60612
(312) 433-3000

Office of the Inspector General

REDACTED REPORT

This report is being released by the OIG for teaching/training purposes. To ensure the confidentiality of all persons and service providers involved in the case, all identifying information has been changed. All names are fictitious.

AN INVESTIGATION OF CURRENT PRACTICES WITH VERY YOUNG CHILDREN DESIGNATED AS SEXUALLY AGGRESSIVE

Submitted to the Director June 30, 1999
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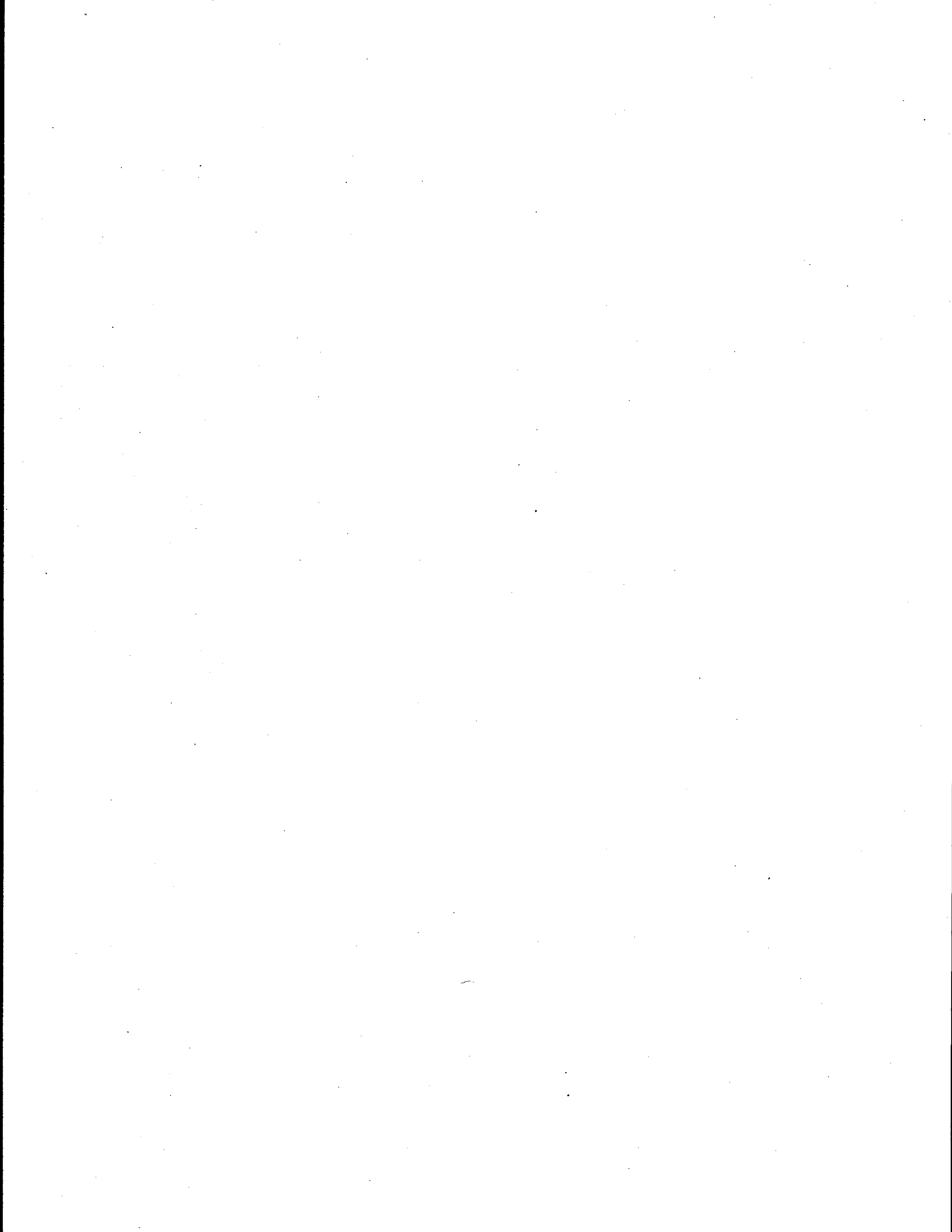
APPENDIX A



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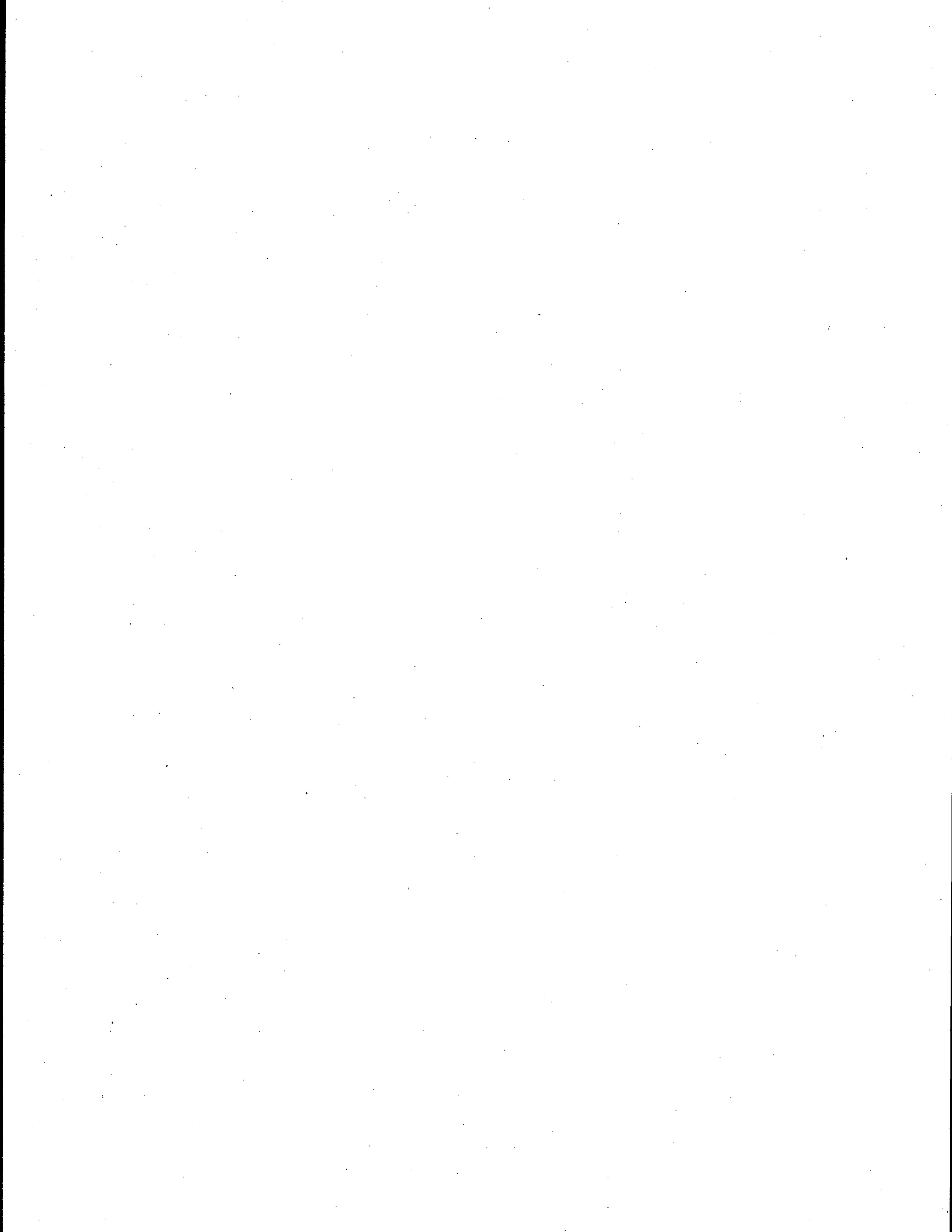


EXECUTIVE SUMMARY

The Sexually Aggressive Children and Youth (SACY) program of the Illinois Department of Children and Family Services (DCFS) assesses children who have allegedly exhibited sexual behaviors. Once identified, the SACY program recommends treatment for these children, and maintains their names on a permanent database. There is no clinical basis for treating sexually aggressive behavior in young children separately from treating generally aggressive behavior.

Complaints to the Office of the Inspector General (OIG) in the fall of 1998 concerning the SACY program's practice of labeling young children prompted the OIG to investigate the program's policies and procedures. The Department has labeled 70 children in Cook County, age six and under, as "sexually aggressive youth." The Inspector General investigated a random sample of 27 of these children, the results of which produced disturbing facts. Our investigation found that the Department's designation and treatment of children seven and under with presumed sexual behavior is deeply problematic. The Inspector General found that children as young as two-and-a-half have been designated as "sexually aggressive" and entered as such on the SACY program's permanent database. In most cases, the actual behavior rarely justified a separate therapeutic focus. Further, this program is focused primarily on protecting the alleged victim.

This report presents the data resulting from the Inspector General's investigation and recommendations for improvement and treatment of children **seven and under** who are labeled as "sexually aggressive." The appendix includes the history of each case investigated, a time line of important events that guided our analysis, and answers to specific questions. The results of this investigation cast doubt on the wisdom of continuing the SACY program's current policies and procedures with children **seven and under**. We, therefore, recommend policy and treatment changes.

Findings

- Programs and procedures developed from studying and treating criminal adult sexual offenders are not appropriate for small children displaying minor sexual behavior. These behaviors would be better handled through education within the home, with the involvement and education of caretakers.

- The overemphasis on any behavior of a "sexual" nature in small children results in ignoring more important developmental needs, such as education and socialization.

- Few case records reveal any attention focused on how to develop positive behaviors in the child, or on their educational needs. The focus is placed on treating only the sexual behavior. However, sexual aggression is not a recognized psychiatric diagnosis.

- Many of these young children have mental health deficits, most frequently hyperactivity, impulsivity and attention deficit disorder. Treatment that ignores these deficits is not likely to result in clinical progress.

- It is startling to note the use of criminal justice terms such as "perpetrator," "perp," and "re-offender" to label very small children who have not had the benefit of due process. These wards are far below the age that Illinois law considers one capable of crime.

- SACY labels are shared with all adults who may be in a supervisory position with the child, without apparent concern for the potentially slanderous and stigmatizing effect of the label, even when the risk potential of the particular child is low. Notification of the SACY designation could include school personnel, church staff or recreational leaders.

- Protective Plans are not individualized; they are developed without relating the act to the degree of isolation. In many cases, the same specific instructions and restrictions are listed in each child's Protective Plan.

- The SACY program's overreaching approach, which designates small children as sexually aggressive, opens these vulnerable children to the potential of further victimization. When children are very young, under-socialized and deprived, an educational and nurturing approach that fosters normal development would be more effective and less harmful. This could be achieved without unduly putting others at risk.

- In some cases, a SACY label has needlessly separated siblings, lost an adoption opportunity or caused the child to lose a nurturing foster parent. This is especially true since many of the behaviors for which the Department is currently labeling such children are pre-cognitive and occurred when the children were barely out of their toddler years.

- In the Inspector General's investigation, children designated as "sexually aggressive," who received SACY designated services, were significantly more likely to have additional reported incidents of sexual aggression than "SACY" children who did not receive SACY designated services.

Recommendations

1. **The Department should prohibit sexually labeling small children or subjecting them to therapy primarily or exclusively aimed at the label.** While children seven and under may benefit from home-based treatment that addresses problematic behavior, there is no need to label such children as sexually aggressive and place them on the SACY database. Our investigation revealed they are likely to be harmed from such labeling. Reports of inappropriate sexual behavior should be analyzed with a developmental perspective recognizing that many of our wards may exhibit age inappropriate behavior because of deprived environments, under-socialization or exposures to overly adult sexual behaviors or lifestyles associated with drug usage. Behavior should be analyzed in context, with anti-bias techniques to avoid cultural biases. Then, if still considered sexual, the behaviors should be seen as only a part of the child's needs and should not supercede developmental and educational needs. The American Psychological Association guidelines prohibit the reduction of any individual to a label.

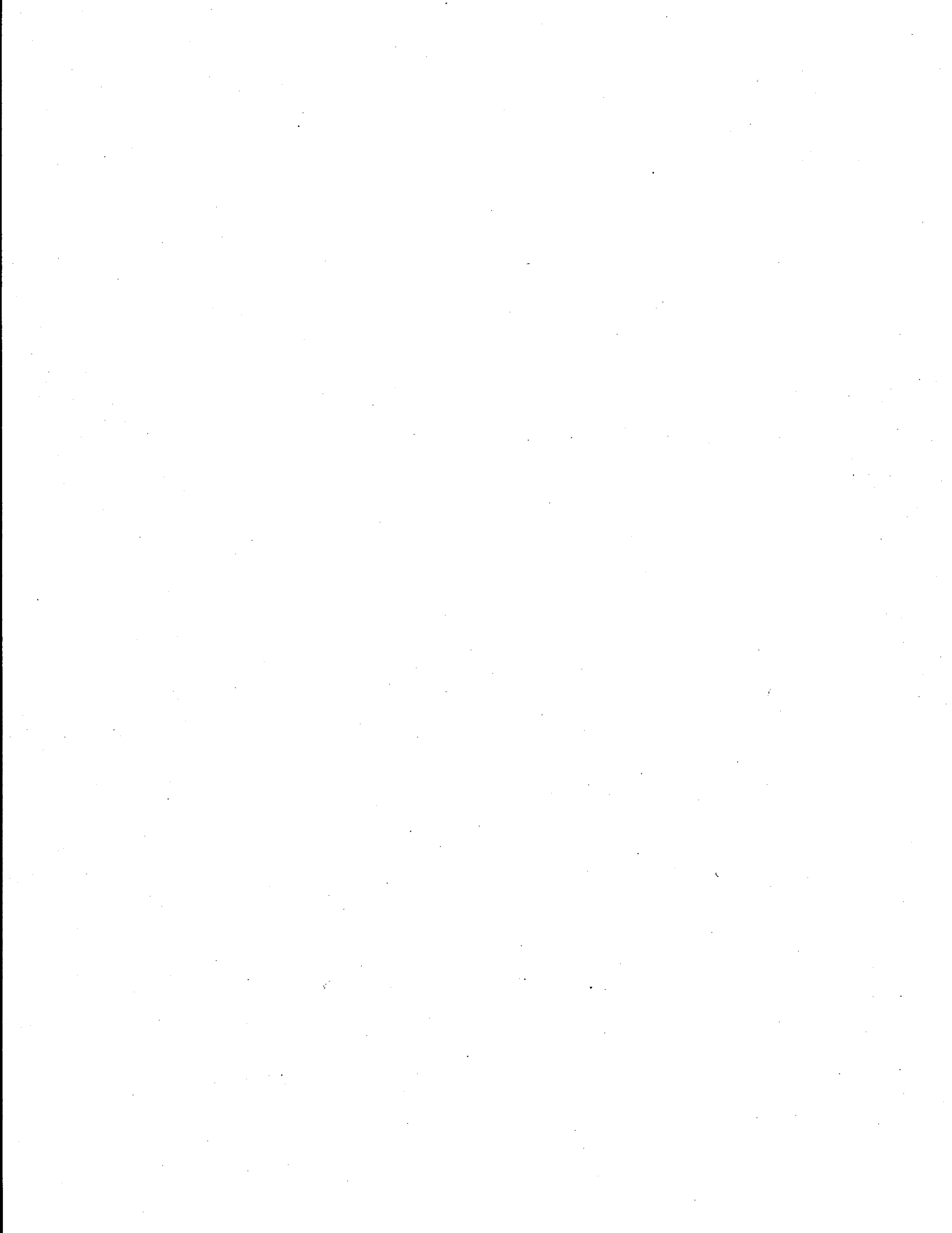
2. **DCFS' contract with the contracting private agency should be amended to exclude children aged seven and under, and to reallocate the funds for monitoring and follow-up of adolescents with serious aberrant behavior.**

3. **The Inspector General should convene a multi-disciplinary panel, similar to the Mental Health panel, to review the few cases of children seven and under that portend serious injury to others.**

4. **The Department should develop an early childhood clinic for young children whose presumed sexual transgressions are one part of larger developmental problems, social skills deficits, aggression management, and other inappropriate behavior.** Children and foster families would be referred there for observation, assessment, time-limited educational sessions, and subsequent home-based behavior management programs.

5. **Whenever possible, young children with mild, verified sexual behavior problems should be treated at home with their foster parents, and should also be enrolled in early enrichment programs.** There should be education for foster parents regarding what is normal and expected sexual development for children of a young age, as well as what might be expected from wards who have experienced traumatic events. **No treatment plan should be devised for any of our children without full knowledge and consideration of their history and input from the current caretaker.**

6. **The Department should abandon the trappings of the adult criminal justice model of treatment with its punitive language and attitude when treating or describing children aged seven and under.** The Department should keep in mind its commitment to helping these young children toward better lives. Some were born substance-exposed, experientially retarded, developmentally delayed, and approximately half have been sexually abused. Staff should see them as tender-aged victims rather than as "scary," "perps" or "offenders." Like all DCFS wards, they deserve respect and compassion.



INVESTIGATION

Information Used in this Investigation:

- A random sample of 27 DCFS case records of DCFS wards, ages six and under, from the 70 cases in Cook County labeled as sexually aggressive as of December 25, 1998.
- A review of the SACY program files for the 27 children in this investigative sample.
- Interview with Dr. Barbara Bonner, a leading researcher on children's sexual aggression from the University of Oklahoma Medical Center.
- Interview with Dr. William Friedrich, a leading researcher on the assessment of childhood sexual aggression from the Mayo Clinic.
- Interviews with caseworkers and current foster parents from each cases the Inspector General investigated.
- Interview with Dr. Peter Nierman, Clinical Director for Child and Adolescent Services for the Illinois Office of Mental Health.
- Interview with Statewide Coordinator, DCFS/SACY program
- Interviews with the Associate Director of the private agency overseeing the SACY program and Coordinator of the Cook County SACY program, and the private agency's SACY Supervisor.
- Interview with Dr. John Lyons, Northwestern University psychologist, who previously reviewed 168 SACY cases and recommended practice guidelines for caseworkers.
- Interviews with Mary Jo Barrett, therapist and Director of the Center for Contextual Change and Joe Cortese, therapist at the Center for Contextual Change.
- Interview with Erin Sorenson, Executive Director of Chicago Children's Advocacy Center.
- Interview with Dr. Michelle Lorand, Chair of Division of Child Protective Services for the Department of Pediatrics at Cook County Hospital.
- Interview with Scott Keenan, Detective, Chicago Police Department.

- Interview with Dr. Judith Becker, researcher of Juvenile Sexual Offenders at the University of Arizona, School of Medicine.

- Interview with Dr. Jon R. Conte, School of Social Work, The University of Washington-Seattle.

- Interview with Dr. Barbara W. Boat, University of Cincinnati, College of Medicine, Department of Psychiatry.

- "Standards for Intervention With Sexually Aggressive Children and Youth: Illinois DCFS and Private Agency Draft, 1995," " SACY Standards: Proposed Revisions, 1999," "DCFS Procedures for Intervention in SACY Cases," "Facing It: Sexual Abuse Among Children"- (DCFS/contracting private agency: Manual for Training on Sexually Abusive Youth), SACY Program Plan, 1999.

History of the Sexually Aggressive Child and Youth Program (SACY)

The SACY program was created to address the needs of DCFS wards who were exhibiting serious sexual behavior, because traditional case management and psychotherapeutic interventions did not help these children. Early in this decade, the Legal Assistance Foundation of Chicago (LAF) raised the issue of DCFS wards who sexually abused other children. The Department began to identify sexually aggressive youth and develop properly focused intervention programs. In 1994, DCFS asked an agency to develop a program to treat sexual aggression. The agency reviewed the Department's approach to sexual behavior problems and found problematic procedures for identifying, reporting, screening, evaluating, and treating this population. The Department and the agency created a new approach. They outlined the procedures Department personnel must follow in response to reports of a sexually problematic and aggressive ward. However, it was never the intent of the Legal Assistance Foundation to create a system in which children seven and under are viewed as sexual threats equivalent to adult/adolescent sexual offenders. Children seven and under should not be equated with more mature offenders.

Demographics of the Sample

The 27 children within the sample were younger than age seven when they received a "SACY" designation as sexually aggressive. The average age of the 27 children during the first "SACY" designation/plan was approximately 5 years, with a range of 2 years, 7 months to 6 years, 9 months. The average age at the time of the initial SACY related incident was 4 years 9 months,

with a range of 2 years, 2 months to 6 years, 9 months. The following table illustrates the age of each child at the time of the reported incident which led to the SACY designation.

Age of Child at the Time of SACY Related Incident

	2 years	3 years	4 years	5 years	6 years
# of children	5	2	6	8	6
% of the sample	18.5	7.4	22.2	29.6	22.2

In January 1999, when OIG investigators collected the case files, the average age of the sample was approximately 5 years, 9 months. The youngest child was 2 years, 9 months; the oldest child was 8 years, 1 month. Twenty-two of the children are African-American, 4 are Hispanic, 1 is Caucasian. Sixteen are male and eleven are female. The children's average number of foster-home placements was 2.85, ranging from 1 to 8 homes.

Four of the children were born with developmental disabilities. Eleven children were learning delayed (including the four born with developmental disabilities). The files suggest that many of the learning disabilities stemmed from environmental deficits.

In an effort to determine the time between referrals for SACY treatment and treatment start dates, case reviewers were able to locate only 16 referrals.[1] Of those 16, only 12 case files showed evidence that the children actually started therapy. However, many of the children who did not have specific SACY treatment referrals did address issues surrounding sexual aggression with therapists that they were already seeing. The average time between SACY treatment referrals and treatment start dates for the 12 cases with both dates was 3 months. The range was between 0 and 18 months.

In the course of our investigation, it was extremely difficult to determine the type and extent of therapy that each child received. More importantly, in many cases where it was reported that a child began therapy, further investigation revealed the therapy was often inconsistent. The SACY program files do not indicate whether therapy is taking place; it only indicates a recommendation for treatment. While on the surface it may appear that some children do receive treatment, the SACY program's lack of follow-up does not ensure that treatment occurs or is

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[1] SACY treatment refers to treatment that addresses sexual behavior problems. This does not necessarily refer to a SACY program certified therapist.

adequate. Only 1 child of the 12 who had a start date for therapy had a therapy report in the SACY program file within the last year.[2]

The numbers of sexual incidents occurring before and after the "SACY" designation were contrasting. Nineteen of the children (70%) were designated as "SACY" after one or two incidents. Seventeen children (62%) had no reported incidents of sexual aggression after they were designated as "SACY." Counting the number of incidents before a "SACY" designation was often made difficult by the fact that only one report was made to recount the presumably sexual incidents that had occurred in the past, as well as the current incident. Many of the DCFS case files contained no Unusual Incident Report (UIR) regarding sexual aggression. Descriptions of the past events that resulted in a "SACY" designation often relied on words such as "frequently," "often," or "several times," and made it difficult to determine the exact number of incidents. Most of the incidents reported within the DCFS case files were reported in Administrative Case Reviews (ACR), school reports, and case notes rather than UIRs.

The average number of incidents interpreted as sexual aggression before the "SACY" designation was 1.85. The average number so interpreted after the children were "SACY" labeled was .54. However, for those children who received SACY treatment, the average number of sexual incidents (after the initial designation) was 1.0, while the average number of incidents for those who did not receive SACY specific treatment was .23. The children who were receiving SACY treatment had been "SACY" designated for an average of 11.5 months while the children not receiving therapy have been "SACY" designated for only 5.3 months. Realizing that this difference in time may have been related to the number of incidents reported, the data was statistically controlled for time. However, the time variable only slightly changed the results (.82 for those children who were treated and .21 for those who were not treated).

A "SACY" designation resulted in several different types of therapy. Two children participated in family therapy; ten, play/art therapy; two, home therapy; one, task centered/behavioral therapy; and three, dynamic therapy. These therapies sometimes overlapped (especially in the cases of play therapy and dynamic therapy). Only 5 of the 25 children (20%) received services from a SACY certified provider. Seven of the case files contained no evidence that the children received any therapy related to their "SACY" status. Twelve children were referred for therapy for issues other than sexual aggression. Fourteen were physically or sexually abused. Twelve exhibited non-sexual aggression. Five were in specialized school programs. Thirteen children came from drug environments (born drug exposed, had a sibling born drug exposed or a parent having drug use monitored). Finally, each child saw, on average, three workers, with a range of one to nine workers.

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[2] This is especially disturbing in light of SACY's Program Plan, 1999, which states that the SACY team, "reviews treatment progress reports quarterly," and that there is, "Routine monitoring of each identified SACY ward's progress in treatment, and progression through the child welfare system."

Close examination of Protective Plans revealed that the majority of cases in our investigative sample do not have current and/or valid Plans. A current Plan refers to one that has been revised since a change in placement, in accordance with the SACY guidelines. A valid Plan refers to one that is signed by all of the required persons. Of the 27 children, only 1 child had a Plan that was both current and valid. Four of the 27 children (14%) in our investigative sample had no evidence of a Protective Plan in either their case files or their SACY program files.[3] Of the 22 children who did have a Plan, only 10 (45%) were completely signed, and were thereby valid, but not necessarily current.[4]

Major Problems with the SACY Program for Young Children

Introduction

The Inspector General's investigation has revealed several problems with the Department's SACY program. The SACY program presumes that behaviors of very young children, seven and under, are predictive of adolescent and adult predatory behavior. There is no basis in any clinical literature to support this presumption. Currently these small children are labeled as sexually aggressive, without the benefit of a thorough investigation, void of a developmental perspective and excluding a contextual analysis of the child's behavior. The SACY program overlays the adult/adolescent sexual assault model on the behaviors of these very young children using stigmatizing language that over-relies on the criminal justice model.

The SACY program also uses the adult/adolescent treatment model with children seven years old and younger. This model is dependent on cognitive abilities beyond the scope of most children seven and under. The intervention/treatment plans with these young children tend to be restrictive rather than reinforcing of pro-social skills. These treatment models do not emphasize the role that care givers have in reinforcing desired behaviors. Protective Plans are over-inclusive, not individualized and they enforce a restrictive view of "supervision."

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[3] The data for the Protective Plans was taken from both the DCFS case files and the SACY program files.

[4] Although these Plans were valid, they were not current. This was usually because they were not revised after a placement change or because they had not been revised quarterly. In some cases, these two variables overlapped. Nonetheless, if a Plan is either not valid (because it is not signed) or not current (because it has not been revised) then it cannot be recognized as an acceptable Protective Plan in accordance with the SACY Standards. The SACY program is not fulfilling its own requirements to review each case upon a change of placement. The ramifications of this particular issue are widespread, because if a Plan is not valid (which suggests that the case has not been reviewed,) there is a decreased possibility that a child will be removed from the database.

■ **Assumption of Incurability**

The SACY program's main focus is to identify and manage the sexually problematic behavior of children, which stems from the philosophy that "there is no cure for sexual abuse and behavior must *always* be managed."[5] The SACY program assumes that sexual aggression can never be cured, and places a great deal of importance on managing a "SACY" child's behavior to avoid occasion for a "re-offense." No study supports the assumption that sexualized behavior under age seven is correlated with adult or adolescent predatory behavior. Every expert interviewed in the course of the Inspector General's investigation concurs with this analysis.

With the SACY program's assumption of incurability comes the focus on containment rather than treatment. The reasons for labeling children as "SACY" are three-fold: 1) to protect victims from the "sexual perpetrator," 2) to provide treatment to the "perpetrator," and 3) for tracking purposes. In its effort to account for these three variables, the SACY program assesses very young children as sexually aggressive and places them on a database.

Labeling Process

The process by which the SACY program deals with children who exhibit sexual behaviors can be broken down into two parts: 1) identifying the behavior and 2) managing the behavior. Identifying the behavior refers to the initial referral to SACY and designating a child as "SACY." Managing the behavior refers to the implementation of Protective Plans, therapy, and any other special service referrals which are made to help control the child's sexual behavior.

Although there is a formal process outlined in the SACY Standards for initial designation of children as "SACY," in the majority of cases common practice does not follow the prescribed process.[6] A caseworker may call a SACY Specialist directly rather than the State Central

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[5] SACY Standards, 1999

[6] Ideally, practice should reflect the formal standards; however, our investigation has revealed that the opposite frequently occurs. The SACY Standards outline the formal process: Upon hearing of sexually problematic behavior either by direct observation or from a second source (foster parent or teacher etc), the caseworker calls the State Central Register (SCR). SCR then E-mails an Unusual Incident Report (UIR) to seven sites: Supervisor of the unit, SACY Specialist, Clinical Services Coordinator, Regional Program Manager, Regional Administrator, Statewide SACY Coordinator, and the Agency Performance Team (if the child is serviced by a private agency). The SACY Specialist forwards a copy of the UIR to the child's worker, and the caseworkers of other children in the same placement. The SACY Standards require that if the hotline call results in a CANTS report, a copy will be forwarded to the Statewide SACY Coordinator, and to DCP for an investigation.

The caseworker completes a Protective Plan and initiates a placement review within 24 hours. An internal SACY staffing occurs within three weeks, at which time the incident is determined to be either "usual and expected," or "unusual and problematic," considering the child's age. If the behavior is problematic, the child's name is entered into the SACY database and is referred for therapy that will address the sexual behavior.

This report will continue to footnote the SACY Standards. While the SACY Project does not currently follow the Standards, the Inspector General does not endorse their procedures either in current practice or in the Standards. This report is limited to recommendations for children seven years old and younger labeled "SACY." In subsequent reports, the Inspector General will make recommendations regarding the SACY Standards in conjunction with investigating children who are 8 to 21 years old.

Register (SCR). If SCR is not involved, there will be no Unusual Incident Report (UIR) or Child Abuse and Neglect Tracking System report (CANTS) or investigation. If a caseworker calls a SACY Specialist directly, the child can be labeled as sexually aggressive as a result of a single phone call, in contrast to the thorough investigation both prescribed and appropriate with the DCP process. The DCP process might allow a more considered view of the incident. Our investigation found that 21 of 27 children (77%) were labeled as "SACY" by a phone call.

- **Lack of Distinction Between Serious and Minor Incidents**

When called by a caseworker reporting an incident, the SACY Specialist completes a "SACY Phone Screening" form. This worksheet pre-screens the child's sexually problematic behavior. It reports who was involved; explains the nature of their involvement, and describes the sexual behavior; and designates an "aggressor" and a "victim."[7]

The SACY Specialists bring the "Phone Screen" worksheets to weekly internal staffings where a final decision is made about the severity of the child's behavior. The case is then designated as "SACY," "Non-SACY" or "Victim." Cases are not staffed if it is apparent from the phone screen that the child is a victim. In those cases, the child is referred for victim services.

When a case is staffed, the SACY "Screening Summary and Staffing Conclusions" worksheet is used to describe the behavior, by way of a checklist of possible child behaviors. The questions are broad in scope and pertain only to the alleged incident. The SACY program does not establish the severity of the reported behavior, and they do not allow for any explanation. The SACY Specialist is instructed to "check all that apply." The checklist categorizes behavior, and suggests that it should be generalized into major areas of "offenses," such as "Bribes, trickery, intimidation or other coercion." The difference between a child saying, "don't tell," versus making frightening threats or using a weapon is lost in the generalization of the behavior. An illustration of the worksheet follows.

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[7] The SACY Program Plan, 1999, states that in addition to completing the phone screen form, the specialist contacts the reporter of the incident, the caseworker, the therapist (if the child is already in counseling), and review any other documents regarding sexual behavior by the child. The Program Plan says that, the team gathers "*enough*" information to make a preliminary determination regarding whether the sexual behavior is "usual and expected," or abusive. What constitutes "enough" information is not clear.

Rationale for SACY Determination[8]

The ward is determined to be engaging in sexually problematic or aggressive behavior because he/she is determined to be the aggressor in the sexual incident(s) being screened and the following were involved. (Check all that apply):

- Fondling
- Public masturbation, exhibitionism or voyeurism
- Force, threat of force or use of a weapon
- Lack of consent
- Bribes, trickery, intimidation or other coercion
- Use of photography, videotape or other sexually explicit media
- Group or gang activity
- An unequal power relationship that is based on a difference in age, size, physical ability, mental capacity, family relationship, or position or authority.
- Sex with animals
- Voyeurism
- Frottage
- Simulated sexual intercourse
- Anal, oral, vaginal penetration
- Indiscriminate sexual activity with others unknown to the ward.
- Other: ____________________________________

- **Lack of Factual and Contextual Investigations**

Our investigation reveled that the SACY program does not review the child's history or consult with the foster parent, the child or the person who observed the incident (if it was not the caseworker). It is unrealistic to think that a clear picture of the context of the incident can be determined without reviewing the case record or consulting with people who are so integral in the child's life. The caseworker's report of the alleged behavior to a SACY Specialist is often the only source of information about the child's behavior. This is particularly troubling if the caseworker did not directly observe the incident, but instead received the information second hand. The practice of making a designation based on the interpretation of one individual, without exploring any other facts, is extremely disturbing considering the severity and long term consequences of a "SACY" label. Without an objective, contextual investigation, labeling has little reliability. In addition, the lack of an investigation allows subjective interpretations to guide the process, which can in turn, lead to cultural and other biases.

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[8] "Screening Summary and Staffing Conclusions" worksheet.

According to the SACY Specialist the primary criterion for the "SACY" designation is supposed to rest on whether the behavior could be considered as "usual and expected" for the age and development of the child. SACY program administrators told OIG investigators that "each child's presenting behavior is evaluated by whether the behavior is 'usual and expected' for a child of that age." However, our investigation revealed that their determination of what is "usual and expected" is subjective. Contextual issues, history, mental capacity, culture or situation are not considered. Behaviors that may have accompanied the reported incident are not reviewed, nor is an attempt made to relate the incident to other events in the child's life. SACY program representatives confirm that the SACY program's forms only call for context regarding the sexual incident, because regardless of the context, or mental capacity, the "victim" was harmed.

The importance of a contextual analysis prior to labeling cannot be overemphasized. Children experience traumatic disruptions of their lives with removal from their biological families and placement disruptions. It is commonly accepted that behavioral problems, including sexual acting out, are associated with such stressful events, and should, in fact, be anticipated. Children should not be labeled when their behavior is associated with traumatic events which do not recur. Context is also important in understanding the population of DCFS wards. SACY labeling is based on a comparison of the act to "normal and expected" childhood development. Many of our wards come from environments in which they were exposed to words, acts and treatment far beyond their years; therefore, their behavior may be expected to be out of sync with "normal" expectations, until appropriate services have been offered to address these problems. Everson and Boat (1990) researched the frequency of explicit sexualized play with anatomically correct dolls used in sexual abuse evaluations with children who have not been sexually abused. They found that the knowledge of the mechanics of sexual intercourse and the expression of that sexual knowledge was significantly related to the demographic characteristics of children and their families.[9] A deprived environment may also cause the onset of inappropriate behaviors. Again, until a child is offered enrichment opportunities and redirection, the child should not be labeled for exhibiting inappropriate behaviors.

Carol Mason was designated as sexually aggressive at age four because it was reported that she had engaged in mutual fondling and sexual conversations with another female foster child in the home. However, the case file indicates that both children who had engaged in the fondling had been exposed to pornographic materials in their home as well as frequent sexually explicit conversation. Further, Carol had been sexually abused. These factors impacted Carol's behavior but they were ignored and she was labeled by the SACY program as a sexual predator. Carol could have received appropriate educational and redirective services to address her problematic behavior—without being labeled and without future risk of harm to others.

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[9] 67% of the children who engaged in such behavior were from low socioeconomic backgrounds. All of those children were African-American. While African-American children represented only 32% of the sample, they made up 75% of the children who demonstrated clear knowledge of sexual intercourse. Overall, the children who exhibited the knowledge of the mechanics of sexual intercourse tended to be older African-American males in the sample (i.e. 5 years old) who were of low socioeconomic status.

The Department has an obligation to address these reactions and restore a more balanced and appropriate approach to childhood behaviors. Research shows that cultural ideologies are becoming incorporated into psychosexual definitions of normality in preschool children. (Gunderson, Melas and Skor 1981; Cantwell 1988 in Vizard, Monck and Misch 1995). One example is the commonplace use of sexually explicit language, such as "freaking," that is used in popular television networks. On the more restrictive end of the spectrum, an OIG investigation involved an 18-month-old child with a diaper rash who pushed his foster mother's hand away as she attempted to apply ointment. The foster mother interpreted this behavior as evidence that the child had previously been sexually abused. What is more troubling than the foster mother's immediate assumption is that the evaluating psychologist made no attempt to correct her misconception.

Without a description of context and history, no one can determine the nature, severity and future risk of the behavior cited in these reports. There is no room on the SACY "Screening Summary and Staffing Conclusions" worksheet for, or reference to context, medical history, mental capacity, cultural background, or the history of placements. SACY representatives emphasize the importance of redirection, i.e., the care givers ability to stop the behavior and prevent the behavior from reoccurring. The risk of repeated future actions is especially disturbing in light of cases involving learning disabled persons who cannot immediately be redirected from problematic behavior. There is no distinction made between a child with developmental disabilities (who therefore is not immediately responsive to redirection,) and a child who may be exhibiting legitimate sexual aggression. That is, one child may have problematic behavior, which happens to be sexual in nature, as a function of a learning disability; intervention should target the learning disability rather than the sexual nature of the problematic behavior.

Roberto Munoz was designated as sexually aggressive at age two because it was reported that he attempted twice to "penetrate" his sister's anus with a toy. The SACY Specialist found this behavior to be exceptionally problematic because Roberto was redirected once, and engaged in the behavior a second time in the same night. Roberto, age two, was further described as engaging in public masturbation and trying to grab at his sister's breasts. The SACY "Phone Screen" worksheet emphasizes the fact that Roberto was unable to be redirected from this sexual behavior. However, the SACY worksheet also notes that "Roberto is delayed, and practically non-verbal." Further, Roberto's current foster parent reported to OIG investigators that Roberto has low fine motor skills, and she questions the validity of the report. No consideration was given to the fact that much of the reason that Roberto did not respond to redirection was because he was severely learning delayed and two years old. No SACY Specialist ever spoke with Roberto's foster mother in an effort to understand Roberto's history or the context of his behavior As a result of these incidents, Roberto was separated from his sister, placed in a new home, and his name is on the SACY database.

As Roberto's case illustrates, the SACY program has not considered any factors except for the sexual behavior. In fact, many of the cases investigated show treatment focused solely on sexual

issues, to the exclusion of pro-social skill development, educational needs, aggression issues or learning disabilities.[10]

Nicole Tibbetts who was designated as sexually aggressive at age two demonstrates an example of the SACY program's lack of developmental perspective.[11] *Nicole, age 2, was labeled as the result of one incident where she allegedly attempted to remove her younger sibling's diaper, and reports that she would fondle her own genitals. The SACY report of Nicole's attempt to remove the diaper was not precise in description or context. Nicole's Protective Plan stated that Nicole had engaged in "public masturbation/exhibitionism," and "lack of consent." A psychological assessment determined that Nicole did not exhibit evidence of sexual aggression and that masturbation was normal for a two-year-old child. Nonetheless, Nicole was placed on the SACY database.*

Several important contextual factors were ignored in this case. First, Nicole was in a foster home with her younger sister. The foster parent made it very clear that she did not want to care for Nicole, but did want to continue caring for Nicole's younger sibling. This attitude could have influenced her description of Nicole's behavior. It is also very possible that the foster mother's rejections and attitude toward Nicole had a negative effect on Nicole's sense of security and emotional well being. It is not unreasonable to consider that Nicole was engaging in self-comfort through her behaviors. Second, when Nicole was finally moved to a new foster home, it was discovered that she had a full body rash. This was ignored as a contributing factor to her alleged excessive self-touching, and is a critical example of the SACY program's disregard for context. Nicole was labeled as "SACY" at age two, and this designation as sexually aggressive has made it difficult for Nicole's adoption proceedings to move forward.

In addition to the disregard of contextual, cultural issues and developmental perspective, the investigation found a failure to appreciate lack of stimulation in the environment as a potential cause of a child's inappropriate behavior. In homes where parents are drug addicted, there is often a lack of adequate supervision, consistent parenting and positive role models for the children. In the Inspector General's sample, 50% of the children were exposed to a drug environment. Oftentimes, children from drug environments are exposed to inappropriate sexual behavior by adults. They may even sleep in the same bed with adults and other siblings where they can see or feel the adults having sex. They may imitate sexual touching or soothe each other through sexual behaviors. The home environment is often a chaotic place where older

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[10] This is contradictory to the SACY Program Plan, 1999, which speaks to the relevance of considering the holistic child when they state that, "All case planning and monitoring are suited to the child's developmental functioning and the total constellation of clinical needs that may be present, *not just the problematic or aggressive behavior.*"

[11] For explanation of developmental perspective, see Recommendation (1) on page 4.

children are caring for younger children. If children who are exposed to these conditions appear to lag behind their peers who have better social and cognitive skills, it is a reasonable premise that remedial skills training should be the prudent course of action by the caretaking agency.

Demetrius Powers was designated as sexually aggressive at age four. One of the behaviors that Demetrius engaged in occurred while he was in respite foster care. Demetrius crawled into bed with other members of the household and tried to kiss them. While this behavior is sexual, it is understandable given Demetrius' history. Demetrius came from a chaotic home with drug addicted parents where it was normal for several members of the family to sleep in the same bed, as is often the case in homes with drug addicted parents. These factors should have been taken into consideration before determining that Demetrius exhibited sexually predatory behavior.

Negative stereotyping or labeling of a young child (as is the case with SACY) because of inappropriate learned social behavior before the child is given enriched opportunities to learn pro-social skills within a reinforcing environment is clinically unsound and ethically problematic. Instead of engaging the child in positive situations where he/she may be able to learn the pro-social skills that would replace the sexualized behavior, the "SACY" label characterizes the child as a "perpetrator," which stigmatizes the child throughout the community as a sexual offender.

Despite the SACY program's claim that they can differentiate normal or appropriate childhood sexual behavior from aggressive sexual behavior, the Inspector General's investigation found otherwise. There is a failure to distinguish between serious behaviors, such as rape, and less serious behaviors such as fondling over clothing. In addition, the failure to account for contextual factors, deprived environment, and exposure to sexuality makes the SACY program's designation of very young children as sexual predators even more objectionable.

An example of the referral process and its consequences follows. *When Danien Estelle was five years old, he touched the buttocks of another child in the bathroom at his preschool. He had also touched his own genitals at naptime. Danien is a severely learning-disabled child who receives SSI and lives in a pre-adoptive home with his sister. These two touches, without any consideration of his developmental disabilities, got Danien labeled as "sexually aggressive" at age five.*

Danien's SACY "Screening Summary" worksheet cites Danien's sexual behaviors as problematic or aggressive. The specific behaviors checked off were "fondling" and "public masturbation." Next to "fondling" were the hand-written words, "constant attempts at," and next to "masturbation" was the notation "excessive." Where the form asks, "Is the current placement appropriate for the ward?" the option for "provisional" is checked with the hand-written words, "placement with sister must be evaluated," to indicate that Danien perhaps should not be placed

with other children, even his sister. As mentioned earlier, during the course of reviewing a case, the SACY program does not consider the history and cultural backgrounds of a child. There is no mention of the fact that Danien is not circumcised, and had not been taught to keep his genitals clean so he would not itch; and there was no mention of the fact that the bathroom touching incident was observed only once.

The month Danien turned five, he received the "SACY" label after a phone call from his caseworker to the SACY Specialist. There were no further incidents, yet both Danien and his foster father were required to attend six assessment sessions for sexually aggressive children at the Center for Contextual Change. Danien is on Illinois' list of sexually aggressive children and youth. He is likely to remain there for at least two years, because he did something that would earn a non-ward no more than a parental instruction that it was inappropriate. Danien's "SACY" label has led a court to delay his adoption because of his "sexual reactivity." Even without any allegation that Danien had ever been sexually abused, the judge ordered that Danien undergo additional therapy before the adoption could proceed; such is the power of a "SACY" designation. Danien's pre-adoptive parents are presently so frustrated and upset with the delays in the adoption, that they were unwilling to discuss the matter any further.

- **Comparison Between the SCR and the SACY Program's Investigation Processes**

The differences between the SCR process for evaluating an incident and the SACY process are disturbing. Both are tracking systems; yet, SCR has criteria that discourage indicating a report for a child under 10, and takes into account a developmental perspective. SCR also requires an extensive investigation prior to indicating and provides a detailed administrative appeal process. On the other hand, the SACY process advocates the designation of very young children, does not require any objective investigation; and provides no appeal process or review. What is especially troubling is that the stigma associated with a "SACY" label may be greater than a CANTS indication. The Protective Plan requires notification of the "SACY" designation to any adult who may supervise the child. This could include school personnel, church staff, or recreational leaders. The caseworker will share information about the child's sexual problematic behavior and the requirements of the Plan. Everyone in the child's life is informed of his or her behavior. Further the Department puts a "hold" on a foster home in which there is a "SACY" ward so that no other children will be placed at risk by interacting with the "SACY" child. To quickly take such actions without regard to the young age of a child being classified as sexually aggressive fails to recognize what researchers describe as the bedeviling problem of what is inappropriate behavior among children (Breen and Turk, 1993).

Protective Plans

The SACY program's guidelines for Protective Plans require caseworkers to take all necessary precautions to "ensure the well-being and safety of the alleged victim, and to prevent harm to

other children."[12] The degree of restriction in a Protective Plan can vary. Some Plans outline very specific restrictions, such as escorts to and from the bathroom; while others vaguely call for 24-hour adult supervision. When "SACY" children are placed in a residential setting with a highly restrictive Protective Plan, their behavior may be restricted to a point near social isolation to prevent a "re-offense." Restrictions included in some Protective Plans include: a bell on the bedroom door to alert the foster parent that the child has opened the door, sleeping in a separate bedroom isolated from other children, and *Rene Coleman, who was designated as "SACY" at age three, had a Protective Plan which stated that because of "excessive masturbation" she was supposed to sleep with her hands outside of the covers.* In an adult group home setting, these same restrictions are considered so severe that before implementing them, they would require special approval from both a behavior management committee and a human rights committee. However, in the development of the SACY Protective Plans there is no comparable consideration.

While some very aggressive children may need a more extensive Protective Plan, all children are entitled to a Safety Plan designed to focus on their safety rather than on protecting other children from them, and all children require 24 hour adult supervision.[13] When dealing with aggressive children, supervision should include engaging and stimulating activities rather than serving primarily as a restrictive and punitive measure.

SACY program administrators say that they will request a Protective Plan immediately after the phone screening if they feel that a child is probably going to be designated as "SACY" in the staffing. Yet, they assume no role in ensuring that a Plan is ever completed, relying solely on the caseworker's follow through. The Inspector General's investigation shows a very low rate of compliance with the requirement to file and revise Protective Plans. Without a valid Plan in place, there can in fact be no effective follow-through.[14] Although when written, Protective

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[12] The Protective Plan details the specific risks the child presents, the services recommended for specific areas of the child's behavior, how the child will be supervised during all contact with other children or potentially vulnerable persons, and how all adults responsible for the child will be informed of the child's sexual behaviors. That requires constant supervision of the "child perpetrator," to prevent any future sexual aggression. Constant supervision requires external controls over the child, i.e., restrictions. The SACY Standards say that the caseworker is responsible for the development of a Protective Plan, but other people should be involved: the supervisor, primary caregiver, SACY Specialist, the treatment provider (if the child is already in therapy) and the child, if over the age of 12. The Protective Plan cites details about the amount and type of supervision, and time lines for completion of services. Once the Plan is approved by a SACY Specialist, it is signed by the Specialist, the ward (if over age 12) the caregiver, caseworker, supervisor and any adult who will be in a supervisory position. After it has been signed, a copy is placed in the case record and forwarded to the primary caregiver, the regional SACY Specialist, case worker, supervisor, Regional Administrator, Statewide SACY coordinator, and every other person involved in its implementation. Protective Plans are to be revised quarterly, and each time that there is a placement change, UIR, completion of treatment or if there have been no observed incidents of sexual behavior within a 12 month period (accompanied by a therapist documenting therapeutic gains indicating the need for "less monitoring and supervision.")

[13] *"Fostering Illinois"*, 1999, Late Spring.

[14] In spite of SACY's Program Plan, 1999, which states that a SACY Project Coordinator reviews all narrative and data reports monthly, recent statistics indicate a very low rate of Protective Plan compliance. The SACY Project Monthly Report for December, 1998 for all of Cook County reported that for 1,490 SACY wards, there were only 561 Protective Plans on file, a compliance rate of only 38% For 181 pending SACY wards, there are only 20 Protective Plans on file, a compliance rate of 11%, (a pending ward still requires a Protective Plan). Our investigation revealed that in many cases the Protective Plans were either incomplete, out of date, or did not exist at all. For example, only

Plans are often harsh and unreasonably restrictive, the fact that they are infrequently done leaves the SACY child alone with his or her label and without support.

Failure to Monitor

During the course of our investigation, it has become apparent that the SACY program has inadequate procedure for follow-up. That is, once a child is designated as "SACY," there is a failure to monitor the case to ensure that the proper therapeutic services are in place, that Protective Plans are current and appropriate for the child, and that a period of time with no further unusual incidents results in removal from the database. The failure to monitor is one of the most troubling and obvious issues that has arisen.

Carl Campbell, who was designated as sexually aggressive at age four, helps to illustrate the SACY program's lack of follow-up. Carl was first referred to SACY on October 23, 1997. His Protective Plan was not written until six months later, on May 6, 1998. This Plan was not valid, as it was signed only by Carl's caseworker. In the space for the primary care giver's signature, there is a notation that, "Foster parent has been alerted." This clearly does not meet the SACY program's criteria for a valid Plan. Further, it notes on the Protective Plan that, "Carl was previously a victim of sexual molestation by other youth." Carl has been in eight different foster homes since January, 1995; at least two of which were severely physically abusive. In January, 1999 it was discovered that Carl and his sister Colleen were being sexually and physically abused in their foster home. At that time, Carl and his sister were separated.

The incidents for which Carl was designated as "SACY" included a foster parent observing Carl and another foster child running after Carl's younger sister while her diaper was hanging off and the boys pants were unzipped. There was no reported physical contact. Other reports included conversations of a sexual nature overheard by the same foster parent between the same two boys. The behavior in these incidents was determined by the SACY program to involve: "Lack of consent; Force of threat or use of weapon; Group activity, gangs or ritual abuse." The SACY program recommended that Carl be removed from the foster home so that he would not be in placement with any younger children. There were no services put into place for Carl.

Since the time of the initial Plan, Carl has changed placement and caseworker several times, yet he still does not have an updated, signed Protective Plan. Carl's current caseworker stated in a phone interview with OIG investigators that when she received Carl's case in January, 1999, she contacted SACY regarding Carl's Plan, because she could not tell from the incomplete file whether he was even considered "SACY." The SACY Specialist indicated to the worker that there should be another Plan, even though there had been no reported incidents for almost two years. The SACY Specialist communicated that a reassessment of whether or not a Plan was needed was not necessary. According to Carl's caseworker, the SACY Specialist also stated that the last

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1 child of the 27 in our sample had a current and valid Plan.

Plan was not signed because SACY did not approve of Carl's placement, but that according to the SACY program it was valid even though it was unsigned. The SACY Specialist further indicated that a previous worker was told to revise and resubmit the Plan to SACY. However, there were several caseworker changes, and the SACY program failed to follow up. The result of the SACY program's disregard for effective procedure is that Carl Campbell, now age six, has been on the SACY database for nearly two years without any re-evaluation and has only recently begun therapy.[15] In addition, in spite of Carl's SACY label, his current foster mother reported to OIG investigators that she had never been spoken to about the SACY program. She stated that while Carl did have some understandably aggressive behaviors (as a result of all of the traumas in his life,) she has not observed any sexual behavior in the six months since Carl has been placed in her home.

- **Removal from the SACY Database**

The Inspector General attempted to obtain a list of all children who have been removed from the database. SACY program administrators said that they could not provide such a list because the option for removal is a new policy, which has not yet been approved.[16] Thus, the SACY program has not yet begun the process of removing children from their database. Any child that has been labeled as "SACY," regardless of the circumstances, currently remains on the database without respect to any services they have received, or the lack of subsequent incidents of sexual behavior. SACY program administrators argue that in the past, deletions from the database were difficult because many of their cases were older children who were not likely to be successfully managed, so they should stay in the database. Now, with more young children labeled as "SACY," the program is finally creating "opportunities and criteria" for removing a child from the database.[17]

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[15] Because the SACY program places all of the responsibility on the caseworkers, and does not follow up on cases, adequate services and care are not provided to children who are labeled "SACY."

[16] SACY Standards state that a SACY ward will have a Protective Plan as long as he/she is a ward of DCFS. If Department custody is terminated, but later reinstated, a Protective Plan shall be reestablished. Therefore, once a child's name is in the SACY database, it is very difficult to remove.

[17] Currently the proposed Standards state that a name can be removed from the database in two ways: 1) a discovery that the original report and screening were inaccurate, or 2) a therapist's determination that the child does not pose a threat to other children and has completed treatment. The second option is frequently inaccurate because the SACY program does not closely monitor therapy; if a child is not in therapy, there is no therapist to make the determination. As for the possibility of finding that the initial report was inaccurate, we must remember that the child's designation as SACY is often based only on the word of the caseworker. Since the worker makes the report, and SACY Specialists do not talk with the person who observed the behavior (if it was not the worker) there is no way to verify the information. Thus, any removal of a name from the SACY database because of misinformation would have to be the result of the discovery of a technical error in reporting. There is no possibility of removing a name from the database if the original incident involved animals, weapons, ritual abuse, gangs, violence, at least a five year difference between the abuser and the victim, or a history of adjudicated sexual offenses.

Our investigation found two cases in particular that reveal the difficulty of removing a child from the database. *Chloe Wallace was labeled as "SACY" at age three. A UIR reports sexual abuse by her older brother. Chloe was cited as the victim. A SACY "Phone Screen" worksheet two days later mis-reports that "Chloe sucked the penis of her two-year-old brother." It also reports that during a home visit, Chloe continually tried to kiss the caseworker on the mouth and was not able to be redirected. Soon after the report was made, the caseworker resigned. However, before doing so, the worker wrote a detailed letter to the SACY program about her concerns with the sexualized behavior of Chloe and her older sibling. The letter, however, is focused not on Chloe, but the other children, and the report of Chloe's behavior with her younger brother appears to be information from Chloe's 6 year old sister. There was never a verification of the facts. As a result of the reports of sexual behavior, Chloe was labeled as "sexually aggressive" at age three. There have been no further reports of sexual behavior, yet well over a year later, Chloe remains on the SACY database as a "sexual perpetrator."*

James Clark was labeled "SACY" at age two and one-half. This was the result of a report by his foster mother, Ms. Armstrong, who stated that James had gotten on top of his four and one-half year old brother, Javier, and tried to play with his penis. Ms. Armstrong initially reported that the behavior had occurred ten times. The caseworker wrote in the case notes that she was "uncertain as to the true frequency and extent of the incidents since this was never reported before." When Ms. Armstrong changed her story, stating that the behavior only occurred once, the caseworker speculated that the foster parent was "misconstruing or exaggerating events in order to increase her monthly income."[18] Later case notes state the agency was unable to determine the validity of these reports. Every SACY Protective Plan cites Ms. Armstrong's observation of James on top of Javier, pulling down his pants and touching Javier's penis, even after her reliability was seriously questioned. In a subsequent foster home, the foster mother, Ms. Jackson, reported that she overheard James saying, "Stop Javier." She observed James lying on his back with his brother Javier leaning over him on his hands and knees. Ms. Jackson separated the children. The UIR contained in James' SACY file lists Javier as the "perpetrator."

Both James and Javier have been in therapy to address aggression. The therapist reported in April 1997 that, "throughout the duration of therapy with James and Javier, this therapist has not observed any sexualized behavior on either brother's part." Even though the validity of the initial report of James's sexual behavior has been questioned, a report in which his older brother has been labeled the "perpetrator" has been made, and a therapist has seen no evidence of sexualized behavior, James continues to have a "SACY" designation.

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[18] DCFS case notes

Treatment Issues

The designation of very young children as sexually aggressive and their subsequent treatment is deeply problematic. The SACY program advocates and refers children for treatment which has not clinically shown to improve aggressive behavior and which may even aggravate it. Dr. John Lyons, reporting on 168 SACY wards, wrote, "Over the past decade, societal awareness of and sensitivity to issues of sexual aggression has increased. During this time, the definition of what constitutes aggressive sexual behavior also has expanded beyond sexual behavior with physical force and threat, to include issues of coercion and manipulation or hierarchical relationships. This increased attention to these issues also has influenced how we view sexual behavior by children and adolescents." Labeling and tracking children as "sexually aggressive" presumes an intent and purpose which may be wholly lacking in children seven and under. Intent is very difficult to prove in a child less than six (personal communication, Barbara Bonner, 1999). Lucy Berliner, a leading researcher of children's sexual aggression, points out, "I am opposed to conceptualizing sexual misbehavior in children primarily as crimes. As you know, states set the age below which children are presumed incapable of forming the intent to commit a crime and the age above which it is a rebuttable assumption. The ages vary. But the more important point is that when children twelve and under are the focus, in general, misconduct should be primarily considered a behavior problem not a crime. Just as this is true for non-sexual aggressive behavior, it should be true for sexually aggressive behavior."

The Inspector General questions whether a "SACY" designation for very young children leads to effective treatment and leads therapists to address the more basic need to develop the child's pro-social skills. Our investigation shows that "SACY" designated children age seven and under were treated by therapists who addressed primarily the sexual behavior of these young children. Sexual aggression is frequently only one aspect of a larger problem of aggression. To focus exclusively on the young child's sexual misbehavior at the expense of other more important areas is bad policy, harmful, and unlikely to result in treatment gains.

SACY's treatment manual outlines essentially an adult treatment program for serious adult sexual offenders. It is too complex for young children. It prescribes "breaking through" denials of their behavior and its seriousness. The SACY program advocates helping children "take ownership" of their deviant arousal patterns, as if they were adults. Our investigation shows that this adult treatment model has been generalized to very young children without any evidence that it can help them. In fact, it may ultimately harm them because often their cognitive incapability to "own" their behavior is misinterpreted as denial. In many cases, a "SACY" designated child is forced to address interpretations of abnormal sexual behavior that happened several years earlier.

The adult treatment model requires the offender to admit and repeat the details of the offense and process learned responses. Some of the children involved in this investigation had problematic

behaviors so early in their lives that the experience was probably pre-cognitive. *For example, one of Demetrius Powers' therapists in a residential facility reported that Demetrius, age six, is in denial of his past sexual behaviors, which allegedly occurred when he was two-and-a-half. His therapist believed his treatment would be successful only if this denial could be overcome. Whether Demetrius responded to treatment would depend on his level of denial. Demetrius' therapist recommended play therapy, to allow him to recover his memory of those early childhood events. A behavior checklist, completed by Demetrius' foster mother, indicates a very low level of problematic sexual behavior; instead, he is highly aggressive and impulsive. But no treatment plan was designed to address these issues.* To foist upon these small children, an adult/adolescent sexual offender model with its focus on "ownership" of their sexual behaviors is inappropriate and an egregious re-victimization. Based on their empirical research in treatment, experts interviewed in this investigation in the field of child sexual behavior confirmed that therapists should not force a child to confront and talk about early, sometimes pre-cognitive, incidents of sexual misbehavior as if that could lead to treatment gains.

During the course of this investigation, OIG investigators consulted several leading experts in the field of treatment for childhood sexual behavior problems. Dr. Barbara Bonner felt that forcing Demetrius to confront and talk about early sexual behavior, behaviors he may truly not even remember, would not be helpful and may even be detrimental. Dr. Bonner argues that repeated talk of an experience makes it more ingrained and unhelpful. She would not force him to own his behavior, and she might not even press him to agree that it happened. Dr. Bonner felt that Demetrius should simply be taught sexual-behavior rules, and that his foster parents should reinforce these rules.

It is clear that there is a vast difference between what is formally outlined by the SACY program, and what is common practice.[19] Social, educational and medical needs are assessed *only* for their impact on the child's sexual behavior, and are not compiled to make a complete view of the child's overall functioning. Consequently, the child's strengths in these areas are never identified, and critical contextual, historical and environmental factors are ignored. The sole focus is on negative behavior and how to prevent a "re-offense."

For example, Demetrius, like Nicole Tibbetts, needed speech therapy; however, these problems were not readily addressed. The treatment focus was on sexual behavior rather than communication deficits. Research shows that certain adolescent sex offenders have communication deficits which may increase their tendencies to engage in "acting out" behaviors,

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[19] The SACY Standards say treatment should begin by evaluating the ward's overall functioning, and assessing the extent of the child's sexual aggression. Their 1999 Program Plan says that the child is assessed holistically and that, "Special attention is given to the developmental/clinical needs of the child and the importance of the family/support network involvement in treatment."

(Epps,1991). Therefore, with children who exhibit aggressive behavior and who have speech deficits, measures should be taken to address and develop those communication skills.

In the case of three year old Chloe, she was referred to a SACY certified provider for therapy to address her sexual aggression and the sexual abuse that she had experienced from her older brother. Therapy sessions were office-based and occurred during the school day. Chloe, who attended a specialized Headstart because of her educational delays, missed most of a school day each week to be transported to and from her SACY treatment provider. The treating therapists never contacted her school, never coordinated their service with Chloe's Individual Education Plan (IEP), nor worked on behavior issues identified by Chloe's foster parent.

Research strongly indicates that a major, long-term developmental consequence of child sexual abuse is lower educational attainment, i.e. poor school performance and achievement (Trickett & Putnam 1998). Chloe, who was sexually abused, is certainly in this population. Therefore, in addition to treatment for her sexual abuse, a major focus should have been to enhance stimulation in the school setting rather than reducing her exposure and disrupting her education by removing her from the classroom. One should expect, at a minimum, that certified SACY providers would be aware of these empirical findings, and incorporate them in their efforts to treat a child. Instead, the therapy sessions were scheduled for the convenience of the provider, not for Chloe's benefit. The SACY program should not deprive a youngster with educational deficits from the daily benefits of Head Start. When asked about in-home treatment, the therapist stated that "in-home services belonged to the providers and homemakers, not the psychologists."

The SACY program has certified therapists in 24 practices as trained to provide therapy specific to sexual aggression.[20] While the SACY program advocates treatment that develops appropriate behavior, the children in our sample were not receiving that form of therapy. The SACY program advocates developing a behavior-management program within the child's social environment, yet our investigation has revealed that no parents or foster parents were ever instructed to do that. One therapist who was interviewed said flatly that she only does therapy in her office, and perhaps we could get a homemaker to go to the home.

The treatment that the SACY program prescribes is both inappropriate and ineffective for children of a very young age. The SACY Standards prescribe objective tests in addition to clinical interviews, but recommend the Thematic Apperception Test and the Rorschach Inkblot Test for children under twelve. These are *not* objective clinical measures. They require *interpretation* by a trained clinician and their validity for children under twelve is doubtful. The

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[20] This investigation shows that SACY-certified practitioners are not following the treatment guidelines outlined by SACY. Probably, they are not trained to use these procedures.

Achenbach scale is also recommended, but, according to Dr. Bonner, it is not a useful clinical measure for sexual behavior, because it contains very few questions regarding such behavior.

It is important that therapy for children who exhibit sexual behavior include caretakers. This is especially true for children who have been sexually abused. Very young children, because of their less than mature thinking, see themselves as responsible for their own abuse. Since these youngsters may be at high risk of displaying inappropriate sexual behavior, it is critical that their caretakers be engaged in providing a nurturing and shaping environment that models adaptive coping behaviors (Deblinger et al 1990). Behavioral parent intervention in the treatment of aggressive children may be the most potent intervention for children with sexual behavioral difficulties, because of its success in decreasing behavior that is resistant to change (Deblinger, Lippmann & Steer 1996; Kazadin 1987; McMahon & Wells 1989; Lanktree & Briere 1995; Nelki & Waters 1988; Cohen & Mannarino 1998). While the SACY program's treatment plan addresses some cognitive concerns, it ignores the other half of the equation: the development of behavioral patterns. Using the cognitive approach in isolation will fail with young children. To stabilize these patterns, therapeutic techniques such as observation, modeling, positive reinforcement, extinction and discipline must be taught to the child's care givers. They should also be educated to use such disciplinary techniques as time outs, prerequisites for rewards, natural and logical consequences and withholding attention (Fleischman, Horne and Arthur, 1983).

The Inspector General concludes that the treatment approach advocated by the SACY program for children seven and under is inappropriate. Our investigation showed that treatment focused on bringing past behavior to the surface; little if any effort was expended to teach pro-social skills that would help manage behavioral problems that exist with most of the children in our investigative sample.

Our investigation revealed that children who did not receive treatment were less likely to "re-offend" than children who did receive therapy.[21] Traumatic sexualization of young children includes both inappropriate sexual conditioning and socialization. Children who are conditioned in this way tend to exhibit sexualized behavior. In many cases, anxiety or a sense of insecurity triggers these behaviors, and many of the sexual behaviors are self-soothing and are used to comfort. However, recent research has discovered that sexually abused children improve over time, whether they are in treatment or not (Becker & Bonner, 1998), and studies evaluating approaches like non-directive supportive therapy have not shown significant improvements for children (Finkelhor & Berliner, 1995). Further research suggests that abuse-related factors can be mitigated by family support for the child, with children showing recovery within a year (Kendall-Tackett, Bonner & Finkelhor 1993). Hewitt and Friedrich (1991) found that two thirds

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[21] See Demographics, page 9.

of ritualistically abused pre-schoolers showed improvement and move to the normal range within one year.

If appropriate treatment (cognitive with development of behavioral patterns) is needed then follow-up should be immediate and thorough. The SACY program's lack of follow-up is ultimately detrimental to the progress of the young child.[22] Our investigation has revealed that some children, referred for SACY treatment, never got therapy or got it months or years later. *For example, it was eight months before Chloe Wallace started therapy, and even when she did begin, her sessions were rarely consistent. Steven Drake, age four, never got treatment because his caseworker left the agency soon after he was designated by SACY. Steven's new caseworker did not become aware of his "SACY" status for several months and did not act on it.*

Treatment for children with sexual behavior problems should take a broad environmental approach. Young children with sexual behavior problems should be in state pre-kindergarten or Headstart programs that teach social skills. Any specialized treatment program should have empirical support before receiving referrals. Dr. Barbara Bonner developed one such program at the University of Oklahoma Medical Center. Dr. Bonner has recently evaluated a cognitive-behavioral group treatment program for children ages 6 to 12 and their caretakers. These children showed several inappropriate sexual behaviors, such as touching classmates on the buttocks, exposing genitals, excessive self-stimulation, or engaging animals in sexual acts. Her 12-session program reduced the children's inappropriate sexual behavior using a highly structured and directive form of therapy. Within a group, the children learned sexual behavior rules, and could identify when they had broken a rule. Treatment included sex education and impulse control.

The appropriate intervention for the majority of children in this investigation, is one that will teach care givers a simple treatment program to encourage and reinforce appropriate social behavior and address aggressive impulsive behaviors. Most often, care givers and other family members are not included in treatment plans. It is only when appropriate behaviors can be consistently reinforced in the home setting that behavior will be changed. Weekly visits to a therapist's office are not enough to effectively change behavior, especially when there is no other reinforcement. Sadly, sometimes therapists are not even aware of the child's family or environment. *In Demetrius' case, the residential staff asked him to draw a picture of his family including himself. When he drew his foster father, Jon, into the picture, the staff became disgruntled that Demetrius did not even know with whom he lived. In fact, the staff had a cultural and racial bias and simply assumed that Demetrius' foster mother was unmarried. They did not bother to become familiar with Demetrius' family composition.* The Inspector General recommends that parents should be highly involved in the treatment program. Dr. Bonner's

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[22] According to the SACY Standards, therapy should begin within 15 days after the SACY designation. However, that rarely occurs.

program includes parent sessions that teach parents to reinforce what their child has learned, by teaching the parents behavior-management techniques. The Inspector General has concluded that this is an example of empirically supported treatment for children with sexual-behavior problems. Dr. Bonner strongly advocates a structured behavior-management program for parents and their children. Behavioral parenting programs, such as those of Sheila Eyeberg and Patricia Durning, were highly recommended by Dr. Bonner because they teach the reinforcement of appropriate, desirable behavior as well as the reduction of inappropriate behavior, are time limited and work with caretakers as well as children.[23]

Conclusion and Future Actions

The Inspector General investigated complaints of the labeling of small children as sexually aggressive and the placement of these children on the SACY database. The Inspector General also investigated the effectiveness of purported treatment interventions with these children. The results of this investigation were troubling. What became clear from this investigation is that the SACY program lacks an appropriate developmental perspective with younger abused and neglected children. There was no functional or contextual analysis of the behavioral and developmental problems that the children and their families faced. While intervention and developmental research suggest that family support mitigates abuse and neglect factors, the caretakers of the children in our investigations were not closely involved in the treatment process. Services provided were not based on sound, empirically-based interventions for young children with behavioral problems and developmental deficits. Rather, these children were labeled and indiscriminately placed on a database that contains adolescent sexual offenders. The Inspector General's investigation concluded that these children were more likely to be harmed rather than helped by the SACY labeling process.

At the same time that the Inspector General was investigating the set of problems associated with the labeling of small children, other complaints and the death investigation of 17 year old Tracy Kline raised additional issues with the Department's SACY system. Tracy had severe learning vulnerabilities (Educable Mentally Handicapped) that were minimized because of an over-emphasis on her "SACY" label. Tracy's treatment by her last SACY Specialist was especially tragic since the acts she committed to earn her the "SACY" label were distant and fairly minimal; at the same time, the adolescent who sexually abused her and had far more predatory behavior, was viewed favorably by his SACY therapist because he was glib. Tracy's "SACY" label

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23 *"Parent-Child Interaction Therapy: Procedures Manual,"* The University of Florida, 1994.

prevented her from admittance to five separate facilities that would have addressed her more immediate needs. However, those facilities would not accept a child designated "SACY."

This reflexive response appears to be common. For example, in another complaint to the Inspector General, 14 year old Jesse Scott was designated sexually aggressive when his sister, who is six years younger, revealed to her therapist that Jesse had touched her on her "butt and vagina" one time, four years earlier. Based on this report, the therapist contacted SACY staff who determined that Jesse's behavior was problematic. Their reflexive response was to remove Jesse from his foster home because of the assumption that perpetrators and victims should not reside together. A psychological assessment determined that Jesse was not a patterned offender. SACY/DCFS administrators intervened and kept Jesse in the home that he had known for most of his life. Nonetheless, Jesse was labeled as "SACY" at age 14 because of a report of an isolated incident that occurred four years prior. The SACY program notified Jesse's high school of his "SACY" designation, and consequently the school considered Jesse a sexual offender to be closely monitored.

The Inspector General has concluded its investigation of "SACY" children age seven and under. The Inspector General has provided the Director with recommendations for the future treatment of these very young children. However, because of the frightening risk of harm created by the lack of monitoring with serious sexual offenders discovered during the Tracy Kline investigation and the lack of critical analysis and discrimination in the Scott case, the Inspector General is continuing her investigation of the SACY process as it applies to older children.

Illinois Department of Children and Family Services
2240 West Ogden Avenue
Chicago, Illinois 60612
(312) 433-3000

OFFICE OF THE INSPECTOR GENERAL

REDACTED REPORT

This report is being released by the OIG for teaching/training purposes. To ensure the confidentiality of all persons and service providers involved in the case, all identifying information has been changed. All names are fictitious.

File No.:	**97-1796, 97-1506, 97-1453**
Minors:	**Maria Jones, Johnny Smith, and Tom Anderson**
Subject:	**Asthma Management - Implications for Child Welfare Case Management**
Date:	**June 25, 1999**

I. Introduction

Three asthma death cases prompted an OIG investigation and research into case management of children with asthma. One case was an active DCFS case with several years of Department involvement. The other two cases had been investigated by Child Protective Services for possible medical neglect and supervision. Investigations found no neglect and DCFS services were provided to the families. All three children had an acute fatal asthma attack in the early morning hours and died enroute or shortly after arrival to hospital Emergency Rooms. Their deaths were ruled "Death by Natural Causes - Bronchial Asthma." Although the families were not charged with medical neglect, could these deaths have been prevented?

The OIG's review of the Department's 5+ Review of one private agency's foster homes, found four of six caregivers caring for children with health problems involved children with asthma. One foster parent was caring for four asthmatic children. In another home, the foster parent of eight children said she was waiting for her caseworker to get a nebulizer for her foster child. Although the 5+ Review was intended to ensure the safety of children in large foster home settings, not one reviewer looked at these homes and families in terms of the child's illness and placement needs to help keep them safe. Can DCFS and its contracted agencies do a better job of case management and follow up of cases with medically fragile children?

APPENDIX B

The Department does not have statistics for the number of wards with medical needs or wards with complex, chronic, or severe medical problems. A recent DCFS survey suggests that asthma affects an estimated 5400 cases or twelve percent of Illinois's wards. Other respiratory illnesses such as broncho pulmonary dysplaysia and reactive airway disease account for at least another twelve percent.[1] These numbers suggest that the Department should consider putting into place a system or protocol to adequately supervise the management of cases where children have a diagnosis of asthma, and to ensure proper delivery of services to prevent hospitalizations and fatalities from this common, chronic, but manageable lung disease.

Current guidelines for the treatment of asthma were established in 1997.[2] The management of pediatric asthma, the most common chronic ailment in children, has become an important focus for the American Academy of Allergy, Asthma, and Immunology (AAAAI) and the U.S. National Heart, Lung, and Blood Institute (NHBLI) through its National Asthma Education and Prevention Program (NAEPP). These organizations launched the "Pediatric Asthma Best Practice" initiative a year ago, with the primary focus to work closely with schools and practitioners to help manage asthma in school-aged children (Larkin, 1999). The outcome of this initiative was to establish new guidelines for the treatment of pediatric asthma.

This report incorporates recommendations from that initiative, as well as recommendations from recent literature and studies on the topic of asthma, which DCFS can consider when structuring a case management system for wards with asthma and other chronic diseases.

II. Summary of Asthma-related Death Cases

Maria Jones, age 11

The Jones/Wilson family first became involved with DCFS on September 20, 1990 for shaken baby syndrome and physical abuse, which had been inflicted on Maria's sibling, George Wilson. George subsequently died from complications of his physical abuse. Maria, who was mildly mentally retarded, had also suffered physical and sexual abuse by her caretakers. Additionally, Maria fell and severely lacerated her face in 1994. The Department became guardian of Maria and her sibling in August 1994. Since November 1994, Maria lived with her maternal grandmother.

It is unclear how long Maria had asthma or its level of severity. Maria required the use of inhalers at school and her control of asthma was "suboptimal" as determined by her physician in an October, 1997 clinic visit.[3] The purpose of the clinic visit was to complete a form to use albuterol at school. It was determined that Maria needed to use albuterol on "an as needed basis, several times a day."

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[1]In fiscal year 1999, the DCFS sent surveys to caseworkers to identify our wards who use and are in need of medical equipment; 581 completed surveys were received by the Department. Of the total surveys received, 74 or 12.7% listed asthma; 44 or 7.6% identified reactive airway disease; and 30 or 5.7% listed bronchopulmonary dysplaysia.

[2]A copy of "Summary of the Expert Panel Report 2: Guidelines for the Diagnosis and Management of Asthma" is attached to this report. These guidelines are currently used but they will be changing again this summer. The newest guidelines, "Pediatric Asthma: Promoting Best Practice" is in the last phase of approval and will be available later this summer.

[3]Johnson Clinic Progress Report, dated October 15, 1997.

Her physical assessment that day included a pulmonary function test, which revealed that she had *"suboptimal control, and that the patient was not aware of the correct method of using her MDI (inhaler)."* It was noted that during this visit, the assessment was "discussed at length." However, it was unclear with whom this was discussed -- with the 9-year old child alone, with the foster parent (her maternal grandmother who only spoke Spanish) or with the caseworker. The doctor scheduled "them" for asthma classes and demonstrated the use of an Aerochamber, which would permit better delivery of the inhaled medication. The records did not indicate whether Maria and her caregiver attended the classes or the content of the asthma classes.

Disturbingly, Maria's Healthworks of Illinois Passport did not mention her asthma under the Problems List. The last entry in the Immunization Record was dated May 29, 1997. Also, there was no mention of her facial scarring under the Problems List. Considering that her Passport was to be used to provide health information to various doctors, these omissions were significant because other health providers would not know anything about her medical conditions. At the end of a psychological assessment done in November 1997, Maria reported having some difficulty breathing because of her asthma. She had forgotten to bring her inhaler. Fortunately, she was able to complete the testing session without a severe asthma attack. *Despite hearing the child's report of breathing difficulty and knowing her history, the therapist did not mention asthma management as part of an educational plan or therapy plan for the child and caregiver.* When given that Maria was mildly retarded, it would seem that an adult advocate trained to help manage her asthma was needed.

The record of bi-monthly home visits by the POS agency caseworker made no mention of the child's asthma management or her attendance at the asthma classes. A home visit was made on October 16, 1997; just one day after Maria saw the doctor about her asthma management. The caseworker documented Maria's feelings about the upcoming facial surgery. Discussions about Maria's asthma management would have been more appropriate since the caseworker noted "medication training" and "medication monitoring" as categories to discuss, and that her control of asthma symptoms was important before her surgery.

Based on the POS agency case entries, Maria was doing fine after her facial surgeries in January 1998 - Maria looked healthy, scars healing. There was no mention of any breathing difficulties or symptoms of asthma. A case entry dated February 2, 1998, stated that Maria "indicated that today she feels a little tired." Her right eye was swollen from the surgery. A case entry of the last home visit before her death on February 13, 1998 mentions a child whose eye was less swollen and who could completely open her eye. The caseworker wrote that Maria "appeared to be in good health." On February 21, 1998, Maria was taken to the hospital emergency room after an acute asthma attack at home which had occurred around 4:00 a.m. Paramedics arrived at the home around 4:20 a.m. and Maria was pronounced dead on arrival at 4:40 a.m.

According to the POS agency's report, the school sent Maria home at 11:15 a.m. on Friday, February 20, 1998 because the child was complaining about her asthma. According to the grandmother, Maria appeared fine that evening and night. It is not known whether Maria used her inhaler to control her

asthma symptoms while at school or at home The case records give no indication as to how much the grandmother knew about asthma management and the use of Maria's medications.

Johnny Smith, age 7

Johnny died of respiratory and cardiac arrest after being discharged from St. Jude's Emergency Room where he had been treated for asthma and shortness of breath, and then returning there an hour later. Upon admission to the ER at l:30 a.m., he had a breathing rate of 48 breaths per minute with a heart rate of 145, blood pressure of 128/53. He was given three albuterol nebulizer treatments at the hospital to dilate his bronchial tubes. After his treatments, he had an oxygen saturation of 97% (expected range would be above 95%). He also received 40 mg Prednisone at 2:10 am. At 2:13 a.m. he had chest x-rays which were normal. At 4:00 a.m., the ER nurse assessed his oxygen saturation to be 100% and he had less wheezing. He was given treatment with two inhalers (Ventolin and Atrovent) at 4:00 am. Johnny's blood pressure was now 121/61, heart rate at 109, and breathing was 32 breaths per minute. According to the medical notes, at 4:10 a.m. Johnny stated to the nurse that he felt relief from the treatments and wanted to go home. Four medications were refilled, including his inhalers and steroids. The ER record showed that he was officially discharged at 4:10 a.m. on June 19, 1998. The nurse's last note was written at 4:15 a.m. indicating that Johnny was stable, in no apparent distress, and was "ambulating and playful."

Johnny went home but soon after arriving there, he developed a serious asthma attack. His mother drove him back to the hospital, arriving there at 4:58 a.m., where he collapsed in cardio-pulmonary arrest. He was successfully resuscitated, placed on a respirator, and admitted to the Pulmonary Intensive Care Unit at 5:30 a.m. Johnny's condition was critical. While awaiting transport, to be transferred to General Hospital at around 7:00 a.m., Johnny again went into cardiac arrest and subsequently died despite efforts to revive him with defibrillation and emergency medications.

There was a question about whether Johnny may have received too much steroids. According to the first ER visit report, the mother stated, "pt has not been getting his Flovent MDI (an inhaled corticosteroid) because 'mother has a hard time finding it.'" Yet, according to the Child Protective Investigator's (CPI) interview with the maternal aunt, the mother had given him a treatment of steroids (inhaler) (CPI interview dated 6/19/98). Clearly, there is confusion about whether the mother had given him his anti-inflammatory steroid via inhaler. She did give him his oral steroid that day.

The ER nurse gave Johnny a 40 mg Prednisone (an oral, systemic corticosteroid) pill at 2:10 am. According to the DCFS Office of Communications report issued June 19, 1998, the mother reportedly had given Johnny his daily dose of 10 mg Prednisone earlier that day. If one calculates the minimum and maximum dose a child can get (0.14 - 2.0 mg/kg/day), his total of 50 mg in a 24

hr period would not be considered an overdose.[4] In fact, the ER doctor prescribed an increased daily dose when Johnny was discharged (20 mg Prednisone two times a day for a total of 40 mg/day).

High dosing of corticosteroids for the treatment of status asthmaticus (severe asthma attack) is recommended (Merenstein et al, 1997; Journal of Allergy, 1995, NHLBI guidelines, 1997). If the patient does not respond to bronchodilation therapy within the first 2 hours, corticosteroids are given promptly -- at the equivalent dose of 2 mg/kg of Prednisone every 4-6 hours until a therapeutic response is obtained (Merenstein, et al, 1997). (Again, in Johnny's case, this would have meant up to 88 mg every 4-6 hours if he had not responded to the breathing treatments.) Then upon discharge, the high dose of Prednisone may continue temporarily, with a schedule of tapering to lower doses over the next 3-7 days.

Tom Anderson, age 15

On June 5, 1998, Tom was found unresponsive by his mother on the kitchen floor at 1:00 a.m. He was then taken to Washington Hospital Emergency Room where he died of asthma. Tom's death was reported as a B sequence, death by neglect report because of a pending A sequence report.[5] There was little history of Tom and his asthma in the DCP report. However, the CPI verified with Tom's doctors that his mother had been taking Tom to the doctor regularly (twice a month).

III. Statistics - Asthma in U.S. and Illinois

Asthma is a chronic lung disease characterized by airway inflammation and increased sensitivity to stimuli that results in reversible bronchoconstriction. This inflammation causes increased irritability (called hyper responsiveness) of the airways. Stimuli such as cold air, exercise, tobacco smoke trigger smooth muscle constriction which contributes to a narrowing and obstruction of the airways. Additionally, the swelling of the bronchial tube lining and the mucus secretions that are produced can block the airways, which makes breathing very difficult (Costa, 1998; Horner, 1998; NIH, 1998). The cause of asthma is unknown.

Asthma affects approximately 10 -15 million Americans (CDC, 1995; Horst, 1998). It affects approximately 5 - 6 million children in the U.S. (CDC, 1995; ALA, 1995, Walsh, 1999; NIH, 1998). Prevalence by age groups are: 0-4 years old = 1,280,000; 5-14 = 2,790,000; 15 - 34 years old = 4,050,000.

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[4]Johnny weighed 90 lbs. (40.9 kg) - minimum dose = 5.7 mg; maximum dose = 81.8 mg.

[5]An A sequence report made on April 9, 1998, alleged inadequate supervision by Tom's mother, Jane Anderson, on two unknown children ages 5 and 8. The report was unfounded.

The rate of asthma among young people ages 5 to 15 has increased 74% between 1980 and 1994; and the rate among preschool children increased 160% (NIH, 1995). Asthma is the most common chronic illness leading to school absenteeism, with more than 10 million missed school days annually (NIH, 1995). Asthma is the third leading cause of hospitalization in children under age 15 (NIH, 1995).

Low-income minorities are disproportionately affected by asthma. According to the National Health Interview Survey, asthma prevalence is 25% higher in black children compared with white children, and 14% higher in children who are in poverty compared to those who are not (Walsh, 1999). Two survey studies of children in Head Start Programs and schools revealed that 15 - 19% of the children enrolled had had symptoms of asthma in the past year (Walsh, 1999; CAC, 1997). A survey of 3,660 children in the Chicago public and catholic schools revealed that 16% reported a diagnosis of asthma; and that more than 18% had wheezed within the last year (CAC, 1997).

In Illinois, 1996 hospitalization discharges for patients aged 0-17 with the diagnosis of bronchitis and asthma numbered 16,604 (accounting for 52% of the total patients, both adults and children, who were hospitalized for asthma). Discharges also included deaths which numbered 271 for 1996. This number was increased from 248 from 1990. In Chicago alone, children with the diagnosis of bronchitis and asthma numbered 6,970, representing 58% of the total patients who were hospitalized with this same diagnosis (CAC, 1997)

The Illinois Health Cost Containment Council (IHCCC) just released a report entitled *Special Report: Child, statewide asthma hospital cases rise in Illinois* (Health Cost Update 1999, Illinois Health Care Cost Containment Council). The report is limited to data collected from inpatient hospitalization and discharges. The report does not contain any information about Emergency Room, doctor's offices, clinic or other outpatient settings. They are also prohibited from using death statistics. Using data from 1996 and 1997, the Council found that infants and adolescents accounted for 43% of the admissions, 33% of the total hospital charges and 34% of the total hospital days. The number of child asthma hospitalizations rose 11.5%. In contrast, adult hospitalizations for asthma decreased 3.9%. Illinois' total asthma discharges (25,347) rose 2.2% from 1996. Average charges for an asthma patient in Illinois were $7,255, which represented a 1.0 % decline from 1996. Average length of stay (3.1 days) represented an 8.8% decline from 3.4 days in 1996. Total charges ($183.9 million) were a 1.2% increase from 1996. Total Patient Days (80,615) were a 4.6% decline from1996.

When the IHCCC looked at the breakdown of pediatric hospitalizations by age group they found increases in most age groups. Children less than a year old saw an increase of 12.5% in the number of hospitalizations. The 1- 4 age group had a similar increase of 10.1% and the 5-12 age group had an increase of 17.5% in hospitalizations. Teenagers (ages 13-17) had a 1.2% decrease.

The IHCCC found that asthma's greatest impact has been felt in the city of Chicago.[6] More than 45% of the state's asthma hospitalizations occurred in Chicago hospitals. Fifty-three percent of Illinois' $183.9 million in total charges came from the Chicago area. Suburban Cook and DuPage counties saw one-fourth of the state's hospitalizations for asthma. Children 0-17 made up 44.4 % of the asthma discharges from the state of Illinois. That number represented a jump of 18.2% from 1996. This data appears to show that asthma is not well controlled in the state of Illinois.

This IHCCC report examines recent studies, conferences and literature on asthma and attempts to address why this controllable disease is not under control. There appears to be several reasons. For example, studies have shown an association of worsening asthma with elevations in ozone levels, but it is not clear as to the mechanism of interaction in this relationship. In some controlled studies, exposure to ozone alone did not always trigger asthma attacks. Likewise, when compared to exposure to allergens alone, asthmatics were more likely to have an exacerbation of symptoms when exposed to both ozone and allergens than just to allergens. It is more likely that ozone is acting as a marker for other pollutants in the atmosphere (Chicago Asthma Consortium, 1997).

Results of the NICAS study (Rosenstreich, et al, 1997), in which Chicago was one of eight inner cities investigated, demonstrated a high proportion of children in the inner city with skin sensitivity to cockroach antigen and high levels of cockroach antigen in their homes. These same groups of children also had more hospitalizations and unscheduled clinic visits as well as missed school days, episodes of wheezing and nighttime awakening. Cat dander and dust mites did not show similar strong associations. Nevertheless, finding a pest management approach that did not in itself cause asthma attacks can become a formidable challenge.[7]

A study published in the May 1997 issue of the New England Journal of Medicine looked at the presence of allergens in dust samples from the bedrooms of 476 inner city asthmatic children. Analysis reveals that cockroaches were the most common cause of the children's asthma. In the children's bedrooms, 50.2% had cockroach allergens, in comparison to 9.7% dust mite allergens and 12.6% cat allergens. Hospitalization rates were 3.4 times higher among children whose skin tested positive to cockroach allergens and whose bedrooms had high cockroach allergen levels. The same group also had 78% more visits to health care providers, experienced more wheezing and missed more school because of asthma (Rosenstreich, et al,1997).

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[6]The IHCCC divides the state into 11 Health Service Areas (HSA). The city of Chicago has its own HSA and Suburban Cook and DuPage counties are combined in another HSA.

[7]Other studies show that although cockroaches may be exterminated, the antigen is found in cockroach droppings, and this antigen can remain present for up to five years. Researchers are trying to develop a cockroach antigen kit that would allow homeowners to swab areas of their home to test for the presence of cockroach droppings. Once identified, a more thorough cleaning can be made and the cockroach droppings, and therefore the antigen can be removed from the living environment (Potera, 1997).

IV. Mortality in U.S. and Illinois

Although asthma attacks are seldom fatal, deaths from asthma do occur. There are over 5,000 deaths annually because of asthma. Asthma related deaths among children five to 14 years of age more than doubled from 1979 to 1995 (NIH, 1998). A high percentage of deaths occur during nocturnal and early morning periods because of decreased pulmonary function, hypoxemia, decreased mucus clearance, and circadian variations of histamine, epinephrine, and cortisol concentrations (Journal of Allergy Clinical Immunology, 1995).

Mortality data from death certificates between 1979 - 1996 showed a marked increase in the annual number of asthma deaths in Chicago, especially during the 1990's, averaging 126 deaths between 1993 and 1996. During 1979 and 1994, the death rates for asthma were higher among blacks than whites. The death rate for blacks in Illinois was twice as high as the national rate for blacks for most years from 1982 through 1991 (CDC, 1996). Non-Hispanic Blacks under age 35 had an average annual rate of 29 deaths, with an exceptional number of deaths in 1993 (34 deaths) and 1994 (37 deaths). Hispanics and whites for these same years numbered less than five deaths for each of these years (Chicago Asthma Coalition, 1997).

Inner city children with asthma, especially African Americans and Hispanics, may have a three to five times greater asthma mortality rate. Many of these deaths are probably avoidable. (American Lung Association.) Over the past ten years, asthma morbidity and mortality has risen due to:

- Underdiagnosis of asthma and insufficient treatment.
- Increased environmental exposure to allergens and pollutants.
- Lack of access to primary care providers and specialists, especially in indigent patient populations (Kowal, 1999).

V. Costs

Direct and indirect monetary costs related to asthma will total approximately $11.3 billion dollars in 1998 (NIH, 1998) Hospitalization costs average $2,040 per day in Illinois. This is based on the average length of stay in the hospital. Outside Chicago, the length of stay averaged 3.0 days with average costs of $5,746; and in Chicago, the average length of stay of 3.5 days, at a cost of $7,584 (Chicago Asthma Consortium, 1997). Emergency Room visits would increase the cost.

In 1992, the average cost of medication for a serious asthmatic could be $300 a month to pay for the three or four breathing treatments of inhaled medications and any necessary antibiotics. In addition, decongestant and antihistamine therapy is often advised and costs can vary from $5 - $10 depending on the brands and amount purchased. In addition, the cost of a home nebulizer can range from $250 - $400 (Horst, 1995). Finally, a peak flow meter can cost around $25.

A study of health care utilization and costs among children with asthma enrolled in a health care

maintenance organization showed, that these children incurred 88% more costs ($1060.32 vs. $563.8/yr), filled 2.77 times as many prescriptions (11.59 vs. 4.19/yr), made 65% more non-urgent outpatient visits (5.75 vs. 3.48/yr), and had twice as many inpatient days (.23 vs. .11/yr) compared with the general population of children (without asthma) using services. Two-thirds of the costs were towards non-urgent outpatient care and prescriptions ($615.71/yr), while the remaining third was for urgent care and hospitalizations (Lozano, et al, 1977). This study looked at 71,818 patients between age 1 to 17 years who were enrolled in the HMO program. This population represented fewer nonwhites and families of higher socioeconomic status than other metropolitan areas -- the costs may actually be higher, especially with respect to costs of urgent care utilization, i.e., Emergency Room visits.

Not only are there financial costs, but the psychological costs can be high for the patient and family coping with the disease. The patient (and the family) may deprive themselves of outdoor activities for fear of an asthma attack; in addition, there is the stress of managing the disease itself to prevent acute episodes. The family's belief in the nature of the disease and its treatment affect their decision-making and management of the condition. In some families, asthma management is seen as a burden to endure while others see it as a challenge to overcome and take control, not letting it take control of their quality of life (Hanson, 1998; Horner, 1998; Zimmerman, 1999). It is important to assess the family's (and child's) level of confidence (self-efficacy) as well as knowledge and skill levels in caring for a child with asthma.

VI. Self-Management Education

Families

Self-management programs for asthma management were developed in the 1980's to address the concerns and asthma related problems of children who experienced barriers like poverty, language, lack of access to medical care, and culturally based beliefs about health and illness (Hanson, 1998). Hanson studied self-efficacy in asthma self-management. Self-efficacy is the belief that one can actually perform the behaviors and skills that are believed to help (Hanson, 1998). The study also looked at how social support increased self-efficacy. The study compared parents who received a formal asthma self-management program plus home visits by a family educator, to a control group of parents who received only routine care and education. Results indicated that both groups increased in their confidence to manage asthma; that is, individual asthma education was as effective in increasing parental self-efficacy as group education. Parents were more comfortable in treating asthma episodes than in preventing episodes. Thus, clinicians should allow more opportunity for discussing and rehearsing techniques and strategies for preventing exacerbation (Hanson, 1998).

Another study looked at how families coped and managed their lives around children with asthma. It summarized that the tasks taken on by these families fall into three phrases: learning the ropes, dealing with asthma, and coming to terms with asthma to prevent the asthma (Horner, 1998). How long a family remained in a particular phase depended on the age of the child at diagnosis of asthma,

the frequency and severity of asthma, and in what developmental phase the child was and the family experiencing the illness.

Zimmerman and his colleagues tested a model of self-regulatory development. They studied families' cognitive beliefs and behavioral skills for managing asthma symptoms. They found that the families' beliefs and skills emerge in four successive phases of asthma management: asthma symptom avoidance, asthma acceptance, asthma compliance, and asthma self-regulation. Through the combined efforts of parents and children, along with their physician, a medical plan is implemented to manage the symptoms of the child's asthma. Using this model, they found that despite receiving primary care for asthma, 83% of the sample group were classified as precompliant. Self regulation is a complex developmental process rather than just an educational one. The authors created an assessment tool, the Asthma Self-Regulatory Development Interview (ASRDI), to determine the patient's/caregiver's readiness to manage asthma based on the phase in which their beliefs and skills emerge (Zimmerman, et al, 1999).

To adopt a preventative asthma regimen, a person must change daily routines, the home environment, interactions with others (including physicians), and his/her own identity from self-doubting to self-efficacious (Zimmerman, et al, 1999). This change is especially difficult for the poorly educated for several reasons including their limited knowledge about health and their tight economic resources. They often have fewer environmental options for change and they have various beliefs about not only their disease, but also the efficacy of medical treatments.

Zimmerman et al, recommended that a specially trained "change agent", a family coordinator who intervened early and consistently was key in helping the child/family move through the different phases in their asthma management. This family coordinator would work closely with the physician to provide the needed behavioral and resource supports in order to allow the family to develop their self-regulatory skills in asthma management.

Children[8]

A two-day conference was held in May of 1998 by the American Academy of Allergy, Asthma, and Immunology (AAAAI) with the U.S. National Heart, Lung, and Blood Institute (NHLBI) to launch the "Pediatric Asthma: Promoting Best Practice" initiative. Recommendations were outlined to enlist more support and involvement of schools in helping the asthmatic child manage his/her condition. A critical issue was allowing the child to have ready access to asthma medications, and the same tools at school as the child might have at home, namely, peak flow meters and spacers. It was hoped that this would promote and reinforce the goal of self-management of asthma. The conference recommended that school policies be changed to allow a child to carry his/her own

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[8]The OIG found that there are no established guidelines for the age of children and readiness to self-manage their asthma, and specifically, to self-medicate. Nevertheless, the literature and health organizations and professionals encourage children's self-management of their asthma.

inhaler in order to treat an asthma attack (Larkin, 1999).

According to the American Lung Association, the child with asthma should be taught about his/her treatment program. They should know about their medication, its use and how to administer it. Children will gain confidence in themselves as they learn to control their asthma. Qualities such as self-discipline and personal responsibility are frequently learned through struggles with any chronic illness. (American Lung Association) However, young children, because of their age, rely on others to take care of them when asthma symptoms are evidenced. When children are young, parents take on the primary responsibility for asthma care. As they grow and mature, the children must master self-management of a complex health problem (Horner, 1998). Older children should be responsible for their own treatment program as much as possible. The whole key with asthma is self-management -- to recognize early warning signs and take medicine right away (Larkin, 1999).

As previously mentioned, Horner found that besides frequency and severity of the asthma, the age of the child at diagnosis and the developmental phase that the child was in, affected how long a family remained in a particular phase of asthma management. As a consequence of dealing with asthma under parental guidance and increasing one's own competence, the children took on more responsibility for the daily management of asthma care. However, becoming responsible includes other aspects of daily activity, i.e., helping with chores or assisting parents in completing tasks. Children need to have the opportunity to master predictable developmental tasks to continue growing and developing. There is a natural progression in the complexity of responsibilities assigned to children as they mature. However, when a child has asthma, the frequency and severity of episodes may demand that the child exhibit far greater autonomy than would normally be expected of another child at the same age. Horner found that over time, asthmatic children discovered strategies for changing their response to asthma through self-medication and initiating behavioral strategies to alleviate asthma symtoms. As the children matured and became more proficient in self-care, they were able to initiate interventions earlier leading to a reduction in the frequency and/or severity of asthma attacks. One 12-year old child's mother indicated that his improved skill in taking care of his asthma had resulted in a decrease in hospital visits and hospital stays, which had been a regular occurrence when he was younger (Horner, 1998). Health care professionals and caregivers need to explore the child's understanding of asthma care and level of maturity to effectively support the child's developing automony in self-care.

Asthma Action Plan

The most vital communication tool for management of asthma is the individualized Asthma Action Plan that includes instructions for caregivers, school professionals, and day care workers on how to help the asthmatic child during an acute episode. For example, a school day Asthma Action Plan would include and specify "who is going to do what" at school (Larkin, 1999). At home, an Asthma Action Plan helps the caregiver and child with asthma learn how and when to use the different asthma medications that the child has been prescribed (JAMA, Asthma Information Center, 1999). Attached to this report is a copy of an Asthma Action Plan contained in the attached publication,

"What You and Your Family Can Do About Asthma." The handout is compiled from a report issued by the Global Stategy for Asthma Management and Prevention in association with the National Heart, Lung and Blood Institute and the World Health Organization. This type of asthma action plan is worked out between the physician and child/family. The plan is based on the Peak Flow Zone System or daily readings of peak flow meters which are recommended by the National Asthma Education and Prevention Program (Kowal, 1999).

As part of an Asthma Action Plan, children are given a peak flow meter and taught how to use it properly. A peak flow meter is a device that the child exhales into and it gives a measurement of the amount of air expelled from the child's lungs. This measurement gives the doctor, the child, and the caregiver an idea of how well the child's lungs are functioning at any particular time. Daily peak flow measurements are compared to the child's personal best peak flow measurements. Using the colors of a traffic light, the Asthma Action Plan then directs the child and caregiver to the appropriate amount and type of medications to be taken. It also directs the child and caregiver to any additional care if needed. For example:

> *Green Zone*--If a child's peak flow measurements are consistent with his personal best (measurements stay within 20% of the personal best peak flow), the Asthma Action Plan will tell the child to continue his/her medications as normal.
>
> *Yellow Zone*--If the peak flow measurements are off by 20% to 50% of the child's personal best, on any particular morning, then the Asthma Action Plan will direct the child to take additional asthma medication.
>
> *Red Zone*--If the child's peak flow measurement is off 50% or over, then the child is directed to take emergency medications and to seek immediate advice from either his/her doctor or a hospital Emergency Room.

The goal of the Asthma Action Plan is to get the child into the Green Zone and maintain him/her there. Children who consistently fall into the Yellow Zone may need adjustments in either their medications or their environment, i.e., new triggers exacerbating the child's asthma. Children who consistently fall in the Red Zone need immediate medical intervention to get their asthma under control. Children and caregivers are taught to keep a chart of their peak flow measurements. These measurements can then be reviewed with the child's doctor and adjustments to the child's Asthma Action Plan can be made if necessary.

VII. Coping Strategies and Behavior Change

Asthma is a chronic disease and with any chronic disease, there is a certain amount of non-compliance, which can be evidenced by under-use, overuse, or erratic use of prescribed medications. The most successful programs to improve patient compliance, use combined techniques of education, reinforcement, and family interactions. It is important to ascertain the patient/caregiver's

knowledge about asthma and its available therapies, as well as their perceptions about the disease and the benefits of intervention for them. It is also important to understand the relationship between the physician and the family as well as the complexity of the disease management, which includes frequency of visits, medications, and cost (Journal of Allergy Clinical Immunology, 1995).

Project Concern is a model for management of services to low income children with asthma, which was developed by a medical social worker. In Project Concern, a social worker coordinated program provides resources to low income working families with children who have specialized health care needs, but lack insurance or government assistance to help them. The social worker takes the responsibility of coordinating the necessary care in an often confusing and fragmented system (Horst, 1995). Project Concern offers a successful expanded case management role that can help to alleviate the physical problems and psychological stress experienced by children and their caregivers. DCFS may wish to consider this model for service coordination, which can also be used for other chronic illnesses.

A telephone survey of 220 parental caretakers of children ages two to twelve in an inner city who had been hospitalized with asthma, revealed that both clinician and caretaker practices were not following the guidelines of the National Heart, Lung, & Blood Institute. Only 30% of the families had peak flow meters to measure their child's pulmonary functioning, although more than 97% of them had equipment for inhalation of beta-agonists. Only 39% of the families gave their child anti-inflammatory steroids on a daily basis, as recommended by NHLBI. Although half of the families had received a written Asthma Action Plan, none of the families referred to a written plan when given a scenario that was outlined in their Asthma Action Plan. Less than 40% would give beta-agonists; and only 4% responded that they would contact a clinician. Interventions are needed to affect both clinician and caretaker practices (Warman, 1999).

A 1998 survey called, Asthma In America, by Schulman, Ronco and Bucuvalas, Inc., a national research firm specializing in health issues, showed that national treatment standards for asthma are falling short of their goals. Researchers interviewed 2,509 asthma sufferers, 512 doctors and 1,000 members of the general public on many aspects of the condition. The results of the survey showed that the goals for asthma treatment established by the National Heart, Lung and Blood Institute are currently not being met. One of the national goals was to have no missed school or work because of asthma. The survey showed that 49% of children with asthma and 25% of adults with asthma missed school or work due to asthma in the past year. Another goal was that asthma symptoms should not interrupt sleep. The survey showed that 30% of respondents awakened with a breathing problem at least once a week. Another national goal for asthma patients is that they maintain normal activity levels. The survey showed that 48% said that asthma limits their ability to take part in sports and recreation; 36% said it limits their normal physical exertion; and 25% of those surveyed said it interferes with their social activities.

The survey suggests that there is a communication gap between asthma patients and their health care providers:

- 70% of doctors say they use spirometry to measure a patient's airflow on an ongoing basis, but only 35% of patients reported having a lung-function test in the past year.
- 92% of doctors said that anti-inflammatory drugs were either essential or very important in the long-term management of persistent asthma, but only 28% of asthma patients reported using an ant-inflammatory medication in the past four weeks.
- 83% of doctors say they prescribe peak flow meters, but only 28% of patients reported having one and only 9 % reported using one at least once week.
- 70% of doctors say they prepare a written action plan for all, most or some of their patients, but only 27% of patients said that their doctor has developed a written action plan for them.

The survey also suggests that asthma patients have a misunderstanding of their conditions. Only 9% of the patient's could name "inflammation" as the underlying cause without being prompted. Half of the patients said it was possible to treat only asthma attacks and symptoms and not the underlying cause; 61% of those surveyed reported use of quick-relief inhalers more than three times a week. According to NHLBI guidelines, this level of frequency indicates a need for long-term control medicine. In contrast, the survey shows that fewer than one in five patients with persistent asthma take inhaled corticosteroids, yet the NHLBI guidelines say inhaled corticosteroids are "the most effective long-term control medication for asthma" for patients five years and older (Asthma in America, 1998).

A goal of a study by Ali and Osberg was to provide Massachusetts Medicaid with information to monitor management of its asthma patients under a managed care initiative. It provided the results of health services utilization prior to the managed care program by black and white Medicaid recipients. They also looked at follow up visits at two weeks, four weeks, and six months for patients who had been hospitalized with asthma. Results revealed that 90% of the 500 Medicaid children had not seen a physician in the two week period following hospitalization. Thirty percent did not see a physician at all; and 81% had not had a six-month follow up. The study showed that one in five children (21%) did not see any physician at all. Blacks were more likely than their white counterparts to have less follow up, although utilization of emergency rooms and hospitalization did not differ between the two groups. It was concluded that a combination of provider and patient factors was believed to be responsible for differences in the follow up care (Ali & Osberg, 1997). Was health care access less likely in black communities than in poor white communities? Were there cultural barriers? The study concluded that a better understanding of the effects of discrimination, segregation, and access issues is needed to help Medicaid design interventions to overcome such barriers (Ali & Osberg, 1997).

Mentioned earlier, self-management programs have been in effect since the 1980's with varying results of success in decreasing mortality and morbidity of asthma. However, preventative management is more than mere knowledge and initial commitment - it means regular assessment and monitoring, trigger avoidance, and the use of preventative medications (NHLBI).

Altering health behaviors is not simply information acquisition, it means changing patterns of health beliefs and behavioral styles of coping, such as a change in daily routine, home environment (ridding the home of pets, carpeting, indoor smoking, etc.), as well as changing how one interacts with others. Strong support systems have to be coordinated and put into place to assist a child/family in successful asthma management. (Zimmerman, 1999; Horner, 1999; Hanson, 1998).

VIII. Health Promotion and Maintenance

A study based nurse managed program known as the Red Alert Program offers a good case management model in asthma cases. The Red Alert Program focuses primarily on severe cases of asthma. The study subjects were classified as fatality prone asthmatics. Fatality prone asthmatics are identified by certain risk factors that make them statistically more prone to die from an asthma attack. Criteria for identifying those children at risk include a history of loss of consciousness, mechanical ventilation or ICU admission secondary to asthma. A history of more than three prior hospitalizations because of asthma, chronic or frequent systemic use of steroids and persistent moderate or severe airway obstruction while on medications also make asthma patients fatality prone. The study also describes various behaviors that put a child at risk. They include poor adherence to prescribed treatment, disregard of asthma symptoms by patient or family, depression, manipulative use of asthma, age inappropriate self-care, dysfunctional family, adolescence and parent/staff conflict over asthma management. Once the Red Alert Program identified the children at risk it embarked on an intensive education plan of the child, family, and other caregivers. The Red Alert Program worked to provide a community based emergency communication and response network and comprehensive interdisciplinary health care team for the child and the family suffering from severe asthma.

Children, with a history of an acute asthma episode resulting in respiratory failure, were invited to enroll in the Red Alert Program. An asthma education plan was individually developed to teach the child, the family, and the caregivers about the disease process, the medications, the identification of warning signs, and an appropriate management and action plan. Assessments were conducted to evaluate the child's/family's knowledge about asthma, family health beliefs, child's asthma history, child's environment, and socioeconomic factors.

The unique feature of the Red Alert Program was a coordinated rapid response network that provided the family with access to rapid and appropriate care. Details of the child's asthma history, medications, and response to acute asthma episodes were shared among all potential emergency care providers (local ER, ambulance service, doctors, school or day care, hospital, and pediatric pulmonary team). Written documentation of the child's fatality prone asthma and protocols were

given to each family to keep at all times and provide to emergency care workers. Likewise, written materials and protocols were given to caregivers without health care backgrounds so that they could also be trained to help initiate the coordination of services and serve as first contact in the care of the child's asthma episodes. Early access to services and communication among the members of the network were needed to ensure successful management of the child's asthma.

Beginning in September 1998, the National Asthma Education and Prevention Program and the American College of Chest Physicians joined with the Institute of Healthcare Improvement to focus on innovations in asthma care delivered by managed care organizations. Included in this project is improving management of high risk populations, coordinating care among emergency departments, primary care, specialists, patients, and families, and improving patient education and patient outcomes (Weiss, 1998).

An individualized care plan such as the Asthma Action Plan is a key tool to help manage asthma. Such a plan should become part of a focus in therapy and home visits by DCFS caseworkers to ensure that the child/caregiver understand the plan and know how to utilize the medications for asthma control. DCFS could also identify and coordinate a rapid response network to provide families with children who have severe asthma (fatality prone histories), a timesaving and life saving means to access quick medical attention for a child in asthma crisis. Finally, the key to effective case management is continued and consistent communication among all involved parties.

IX. Medical Best Practice

Physician perception of barriers to asthma management was studied by Lara, et al, in 1998. They interviewed 30 physicians in an inner city Latino neighborhood. The interview identified themes and summarized results to recommend policy actions. The physicians described two significant issues: access to, and quality of care in the provision of the best primary care for asthmatics. Ten policy recommendations were identified; foremost of which was making comprehensive health insurance available to the families not only through Medicaid, but also helping the family access other types of health insurance to help when Medicaid funds ended or when Medicaid would not cover the costs of certain medications, equipment, and supplies needed in an effective asthma management program. Physicians desired programs that would teach families about asthma and would help them understand that asthma is a chronic ailment that needs regular medications and regular follow up.

Several recommendations were directed at the quality of care and consistency of care provided by the medical community. Programs were deemed necessary to educate both new and practicing physicians about how to best assess and manage childhood asthma according to the NHLBI guidelines. Lastly, a means of tracking clinical progress and promoting continuity of care among different medical practitioners was seen as important, along with administrative systems to facilitate scheduling of appointments.

Practice parameters were detailed in the November 1995 issue of Journal of Allergy Clinical Immunology. The major recommendation was that the primary physician work cooperatively with an asthma specialist in treating patients with asthma. The active participation of an asthma specialist is associated with lower asthma morbidity, fewer emergency room visits, decreased hospitalization, reduced length of stay in hospitals, reduced number of days lost from school and work, and a reduction in costs in asthma care (Spector & Nicklas, 1995).

The diagnosis and evaluation of asthma should include a detailed medical and environmental history and focus on potential triggers to the asthma, i.e., stress, environment factors, dust mites, smoke, etc. Asthma severity should be accurately determined based on history, physical exam, and some measure of pulmonary function. For persons with severe asthma, some measure of pulmonary function may occur at each follow up visit.

Spirometry and peak expiratory flow rates are useful measures of airway function. Spirometry provides more detailed information than does peak flow rate. Spirometry helps differentiate obstructive from restrictive airway disease. Spirometry is the preferred diagnostic procedure (Kowal, 1999). A direct correlation exists between amount of improvement in pulmonary function measurement after four to six hours of treatment for acute asthma, the rate of overall recovery, and likelihood of relapse. High dose systemic corticosteroids should be continued for acute asthma until the patient has sufficiently improved as measured by clinical response and/or pulmonary function tests (Journal of Allergy Clinical Immunology, 1995). Objective measurement of pulmonary function with expiratory spirometry can be done with children as young as three to four years of age.

Treatment of children include the following: (1) environmental control; (2) use of appropriate medications; (3) immunotherapy when indicated; (4) education of patient, family, and caregivers; and (5) close monitoring and follow up (Spector & Nicklas, 1995). Responsibility of care may apply to all environments in which the child spends a lot of time, such as preschool, school, or day care. Medications need to be conveniently available at school, preschool or day care.

Among the recommendations of the "Pediatric Asthma: Promoting Best Practice" initiative was to work closely with schools. Several school-based asthma programs have begun this year to provide ongoing education to help young children and adolescents manage their asthma. A new school and home based asthma education program was recently launched by Zeneca Pharmaceuticals and the Magic Johnson Foundation. BREATHE (Bringing Education on Asthma to Homes Everywhere) has begun in urban centers nationwide this year. The program will provide free bilingual educational materials and peak flow meters to community based health organizations for distribution to inner city schools.

No single lab test or group of tests can conclusively establish the diagnosis of asthma. Severity of asthma is determined by a combination of subjective and objective criteria such as symptoms as well as duration of symptoms (day, night, persistence throughout the week), impairment of activities, pulmonary function, number of emergency room visits, number of hospitalizations, and medication

use (Spector & Nicklas, 1995). An Asthma Severity Table can guide therapeutic recommendations, incorporating clinical findings with daily medications to control symptoms (Kowal, 1999).

Treatment philosophies vary considerably. Oral corticosteroids are usually prescribed for patients with severe asthma and not for patients with mild asthma. Persons with fatality prone asthma require special planning to involve regular follow up visits, measurement of pulmonary function, monitoring, identification of a reliable advocate, involvement of community resources, crisis plan, and identification and notification of patients/parents of fatality prone status (Spector & Nicklas, 1995). The impetus for launching the "Pediatric Asthma: Promoting Best Practice" Initiative was to coordinate a nationwide program to implement the most up-to-date strategies for diagnosing and managing pediatric asthma. The program includes conferences and the publication of new guidelines, *Pediatric Asthma: Promoting Best Practice Guidelines for Managing Asthma in Children* which will be available in Summer 1999.

Effective asthma control reduces or eliminates chronic symptoms and reduces the frequency and severity of acute exacerbation of asthma. The best strategy for predicting and managing these episodes is early assessment of lung function, prompt communication with healthcare professionals, and appropriate use of medications (Kowal, 1999). The NAEPP recommends the Peak Flow Zone to assist patients in establishing baseline health, when they are at their personal best in health and without symptoms, and helping them guide the adjustment of medications and when to seek help when symptoms do occur (Kowal, 1999).[9]

X. Asthma Education

Hanson's research clearly shows that basic asthma education increases parent/caregiver self-efficacy in managing their child's asthma (Hanson, 1998). If parents/caregivers do not understand the problem of asthma, they cannot carry out the treatment program. Allergy management is important for the continued control of asthma but caregivers forget about allergy avoidance measures when the asthma is controlled with medication or allergy injections. The caregiver might buy a new pet or furniture to which the child is or becomes allergic. The caregiver might forget about house dust and mold control in the home. Poor compliance with other treatment measures (routine medicines, allergy injections, follow-up visits) also leads to uncontrolled asthma. Additionally, the child should be taught about his/her treatment program and the caregiver should work together with the child and doctor to help insure the effectiveness of asthma treatment (The American Lung Association).

Foster parents are expected to go the extra mile for the asthmatic child. They deserve to know

[9]An example of an Asthma Control Sheet is attached to this report. However, patients and their caregivers must understand that disease management is a continuous process with ongoing dialogue and sharing of information between patients and asthma specialists, looking at the disease, medications, and control of symptoms, as well as the patient's perception of care, quality of life, and functioning at home, at school, and at work. The goal is to allow patients to live fuller lives with a disease they can control. (Kowal,1999.)

whether a child has asthma before deciding whether to accept the child for placement. In order to make an informed decision, foster parents should receive basic information about the illness and the potential for changes in their homes and lifestyle. Likewise, the caseworker seeking a foster home placement for an asthmatic child will want foster parents who are able and willing to make reasonable but necessary adjustments in order to accomodate the child's needs. For example, it would not be a reasonable expectation of foster parents who regularly smoke cigarettes or cigars to quit smoking or maintain a smoke-free home in order to place an asthmatic child in their home. However, foster parents may be willing to eliminate or control environmental asthma triggers in their home, such as routine maintenance and cleaning of air conditioning and heating systems, monitoring for and correcting dust and mold problems, prohibiting animals that have fur or feathers, and keeping their home smoke-free. Moreover, asthma episodes can become a central focus of family life until the asthma is effectively managed. Before recruiting (and monitoring) a foster home, the caseworker needs to understand the problem of asthma in order to find a good fit for the child and foster family.

When children are involved in self-management of their asthma, we cannot be quick to point an accusatory finger at the caregiver when the child becomes ill because of problematic practice in self-management. While research encourages that children learn about their asthma and become proactive in self-care, the degree of self-management should be based on careful consideration of the child's development and age. Some children (as young as nine years old (Horner, 1998)) become quite proficient in self-care from awareness of possible triggers to self-medication and self-calming interventions, while other children may require reminders of possible triggers or to take medicines, or closer supervision of his/her self-treatment regimen. Each child should be assessed on an individual basis in determining his/her readiness to self manage their asthma. The assessment must consider the child's development and mental health status (Maria Jones was mildly mentally retarded) and abilities, i.e., self-medicate, while caregivers and families must learn to promote competence and confidence in children to manage their asthma.

Asthma cannot be cured, but it can be controlled and managed for most patients. The Department has an opportunity to support or supplement asthma education to caregivers, parents, and children, especially in the area of prevention. The goal of education is to prevent problems and encourage the child to live a full and productive life (Simkins, 1998). "Almost all asthma patients can become free of symptoms with proper treatment. Patients and their families should expect nothing less." (NIH, 1999).

XI. Closing Summary

Although the disease of asthma is not under control in Illinois, there are excellent programs that the Department can model as it establishes guidelines for wards of the state who suffer from asthma. A recent DCFS survey of our wards to identify their medical equipment needs will hopefully foster efforts to identify children with asthma and other chronic diseases. The importance of identifying our wards who have asthma is to ensure that basic follow-up measures are taken to: (1) establish the severity of the child's asthma; (2) ensure that the child has an Asthma Action Plan and Peak Flow

Meter; and (3) educate foster parents about asthma, asthma triggers and how to remove them, Asthma Action Plans, and peak flow meters. Considering the studies that detail the serious impact that cockroach allergens have on asthmatic children, it will be very important to teach caregivers about this trigger and assist them in removing this allergen as well as others from their foster children's environment.

It is critical that the Department try to identify children with severe asthma, especially those who can be identified as potentially fatality prone. As guardian of these children, it is obviously important to know whether or not the children's physicians are following the National Institute of Health guidelines for the treatment of asthma, and to advocate for adherence to those guidelines. Caseworkers and DCFS nurses will have a pivotal role in raising awareness and promoting asthma education. Research studies show that continuous asthma education is not only critical in order to get a child's asthma under control, but to keep it under control.

XI. Recommendations

1. Identify the number of wards with asthma and develop a centrally kept data base system that identifies children with asthma and other chronic illnesses, and hospital admissions and discharges. Centrally locate and establish a point person to manage a file on asthma literature and data, i.e., treatment guidelines, local support groups, area asthma classes, available research sites, and available resources such as names of asthma specialists, clinics, medical equipment suppliers, support systems, etc.

2. Establish protocol to case manage children with asthma and adopt current medical standards and guidelines for the treatment of asthma:

   - Assess the severity of each child's asthma. Particular attention should be given to identify children who have fatality prone cases of asthma. Replicate the Red Alert Program for any fatality prone asthma cases.

   -All wards diagnosed with asthma must be allergy tested to help determine their triggers and given that they move from one environment to another. Before placement of the child, their prospective environment should be assessed for the existence of their known triggers and allergens. Information should be provided to foster parents on the removal of allergens, e.g. dust mites, pets, cockroaches, pets, and smoking.

   -Establish asthma education program to ensure that caregivers have adequate and current knowledge and skills in management of a child's asthma, i.e., medications, triggers, signs and symptoms of asthma onset, emergency access, etc., in order to make informed placement decisions and to effectively manage the asthma. Education foster parents about the existence of asthma classes, support groups, and research studies that they can participate in. Prospective foster parents should attend asthma classes before placement.

-Ensure that all wards with asthma have Asthma Action Plans and Peak Flow Meters. Require written copy of child's/caregiver's asthma management treatment plan modeled after the Peak Flow Asthma Plan or something similar. (This plan is to be worked out between the physician, asthma specialist, or home health nurse.) There should be two plans: one for daily treatment and one for emergency treatment. Copies to be kept in DCFS files, POS files, health care provider files; and by caregivers (including school, day care, baby sitter) and parents. Copies should be updated as needed, especially when case reviews are done, or at the time of discharge from DCFS service intervention.

-Coordinate caregivers' role in the management of a child's asthma (ensure that all caregivers have a copy of a written Asthma Action Plan; evaluate their skills and knowledge regarding asthma management and medications; and ensure that they have ready access to medications). Some children may need medications to be kept on hand at school, day care center, etc.

-Ensure follow up with medical appointments. Assess caregiver's source of transportation needs, provide vouchers in a timely manner; arrange for transportation when needed. (It is especially crucial to have follow up within two weeks after a child's hospitalization for asthma.)

-Ensure minimal absence from school because of asthma episodes, doctor appointments, and testing. (Routine doctor visits should not increase absenteeism from school.) Work with caregivers to coordinate visitations/follow up visits with caseworkers, therapists, public health, doctors, home health professionals, etc., to avoid scheduling all appointments in the same week or on the same day. Ideally, one or two such visits in a given week to different service providers would ensure better monitoring and provide reinforcement and ongoing education of asthma treatment. Timely communication of these visits and sharing of pertinent information should be coordinated by the caseworker to ensure continuity of care.

-Educate caseworkers and DCFS nurses on asthma management, including the NHLBI standards for treatment of asthma to ensure that doctors caring for our asthmatic wards are following the NHLBI guidelines. Caseworkers should utilize the consultation and expertise of DCFS nurses regarding medications, disease process, current pediatric asthma management regimen, and to help determine the possibility of medical neglect if this is suspected. Caseworkers and DCFS nurses should encourage the assessment of parents, caregivers and wards for their commitment and readiness to manage the asthma using assessment instruments like the Asthma Self-Regulatory Development Interview. Assessments of children must consider the age and development of the child.

3. DCFS should coordinate with other state agencies and community-based agencies on the management and services of asthma. Ensure that medications, equipment, supplies, and training are covered by Medicaid and/or other primary health insurance.

4. Evaluate implementation and efficacy of the protocol. This would make for valuable research for the Department. There are sources of funding for research, i.e. NHLBI, to study asthma in wards of the state.

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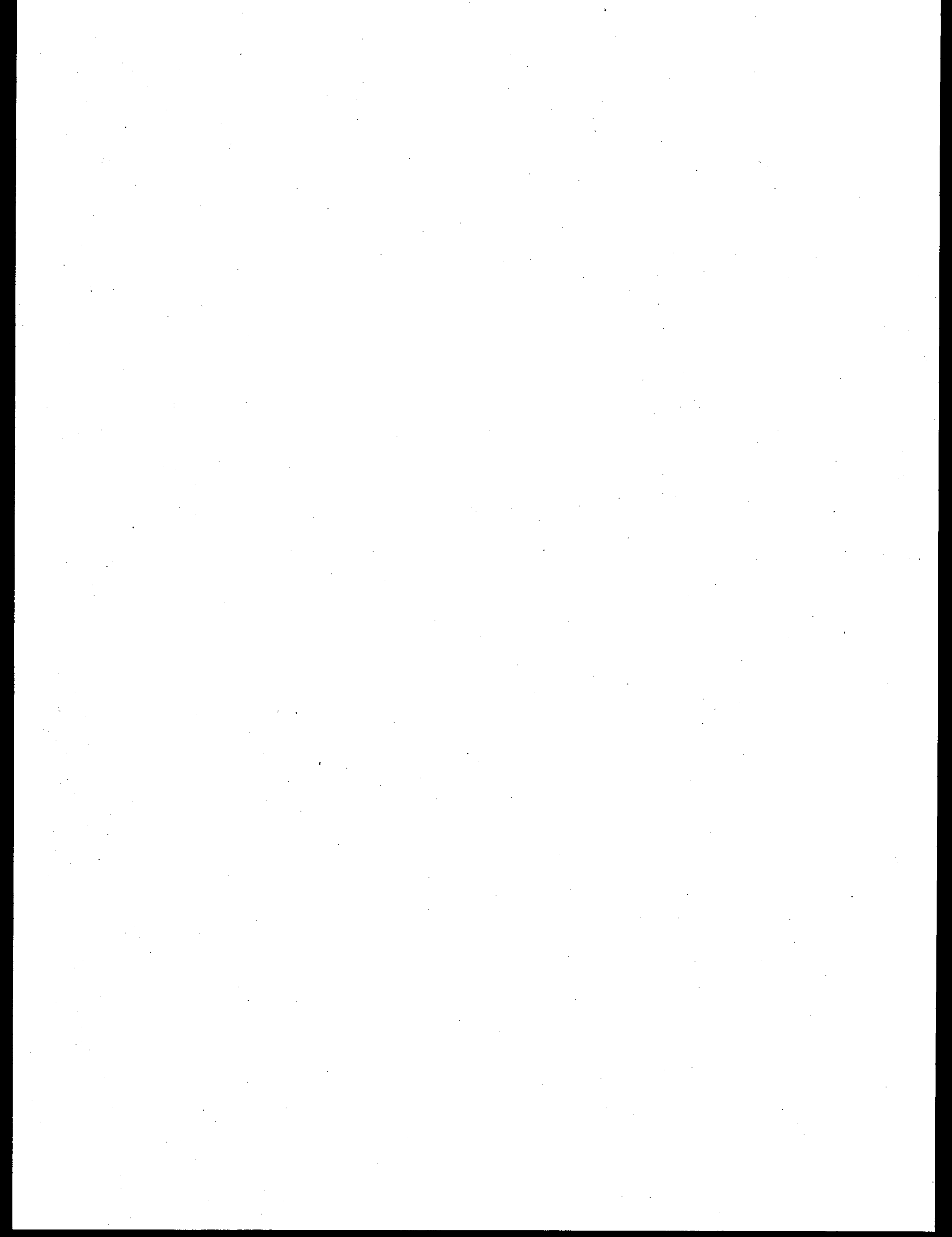


Asthma Management: A Handout for Foster Parents

Thank you for taking care of a child with asthma. The Department of Children and Family Services wants to ensure that optimal care is given to all of our children with asthma. Asthma is a chronic disease that can be potentially dangerous if it is not controlled and managed properly. No one knows how to cure asthma but doctors do know how to control it.

Please carefully read the following information and your handout. Your foster child should have an **Asthma Action Plan** that his/her doctor has developed specifically for your child. This plan should outline not only what to do on a daily basis to treat your child's asthma but also what to do if your child's asthma is becoming worse. Your foster child should have a **Peak Flow Meter** that will help tell you how well he/she is breathing. If you do not have a peak flow meter or if you are not sure how to use it, please contact your caseworker.

Many children have allergies to things in their environment that cause them to have asthma attacks. These allergens are called **asthma triggers**. Common asthma triggers include animals with fur, exposure to smoking, dust in beds, pillows, and carpeting, dust from sweeping, strong smells and sprays, pollen from trees and flowers, and changes in the weather. Common colds and the flu can trigger asthma, as can physical exercise like running, swimming and sports. It is important to learn what those allergies are and how to control them. Your child could have none, some or all of these triggers.

If your child has never been tested for allergies, or if no one knows what the child's allergies are, it is important that you find out. Your child's doctor can schedule your child for allergy testing. This is a blood test that can be performed in your doctor's office. If it turns out that your child does not have allergies, he/she can still have asthma attacks when exposed to certain triggers such as physical exercise. The latest research shows that in one study, 50% of inner city children with asthma have serious reactions to the presence of cockroaches in their environment. If your child has been exposed to cockroaches, ask the doctor to include this test in the allergy testing.

If your child's doctor does not think allergy testing is necessary, please tell your caseworker. If your child does not have allergy testing done, it is still very important to limit his/her exposure to common asthma triggers. Information on how to remove potential asthma triggers from your environment is included in your information packet. For additional help, please contact your caseworker.

How do you know if your child's asthma is well controlled?

Your child's doctor needs to know certain things in order to assess if your child's asthma is controlled or not. Below is a list of goals for the management of asthma. Put a checkmark next to each goal that you are meeting. Tell your doctor which goals you are meeting and which ones you are not. **Do this at every doctor visit.**

________ No symptoms or minor symptoms of asthma (symptoms include wheezing, coughing, shortness of breath, and chest tightness)

________ Sleeping through the night without asthma symptoms

________ No time off from school because of asthma

________ No Emergency Room visits or stays in the hospital

________ Little or no side effects from asthma medicine

Your child's doctor will use this information to prescribe medications and to come up with an **Asthma Action Plan** for your child. It is important that your child take the medication that the doctor prescribes. If your child experiences side effects, please tell the doctor. **Do not stop giving your child medication without the doctor's knowledge!**

The doctor will also give you a **Peak Flow Meter** which will help you measure how well the medications are working. The peak flow meter is a medical device that your child breathes deeply into and it gives you a measurement of how much air they can exhale from their lungs. The readings from the peak flow meter will tell you and the doctor how well your child's asthma is being controlled. The doctor or nurse will show you how to correctly use the peak flow meter. If you do not have a peak flow meter, please tell your caseworker.

Asthma is a chronic illness, which means it will be part of your foster child's life and it will be part of your family's life for the length of your foster child's placement. The goal of long term asthma treatment is to have good control over your child's asthma. There is a lot of free information about asthma available to you. The more you know about your foster child's asthma, the less frightening it becomes for you and your family. There are numerous support groups, asthma camps, asthma education classes and research studies in the Chicago area. A list of these services are enclosed. (For services elsewhere in Illinois, contact your caseworker.)

Reminders:

Do you have an **Asthma Action Plan** from your foster child's doctor?

Do you have a **Peak Flow Meter**?

Does your child have allergies? Do you know what they are? Has your child been allergy tested?

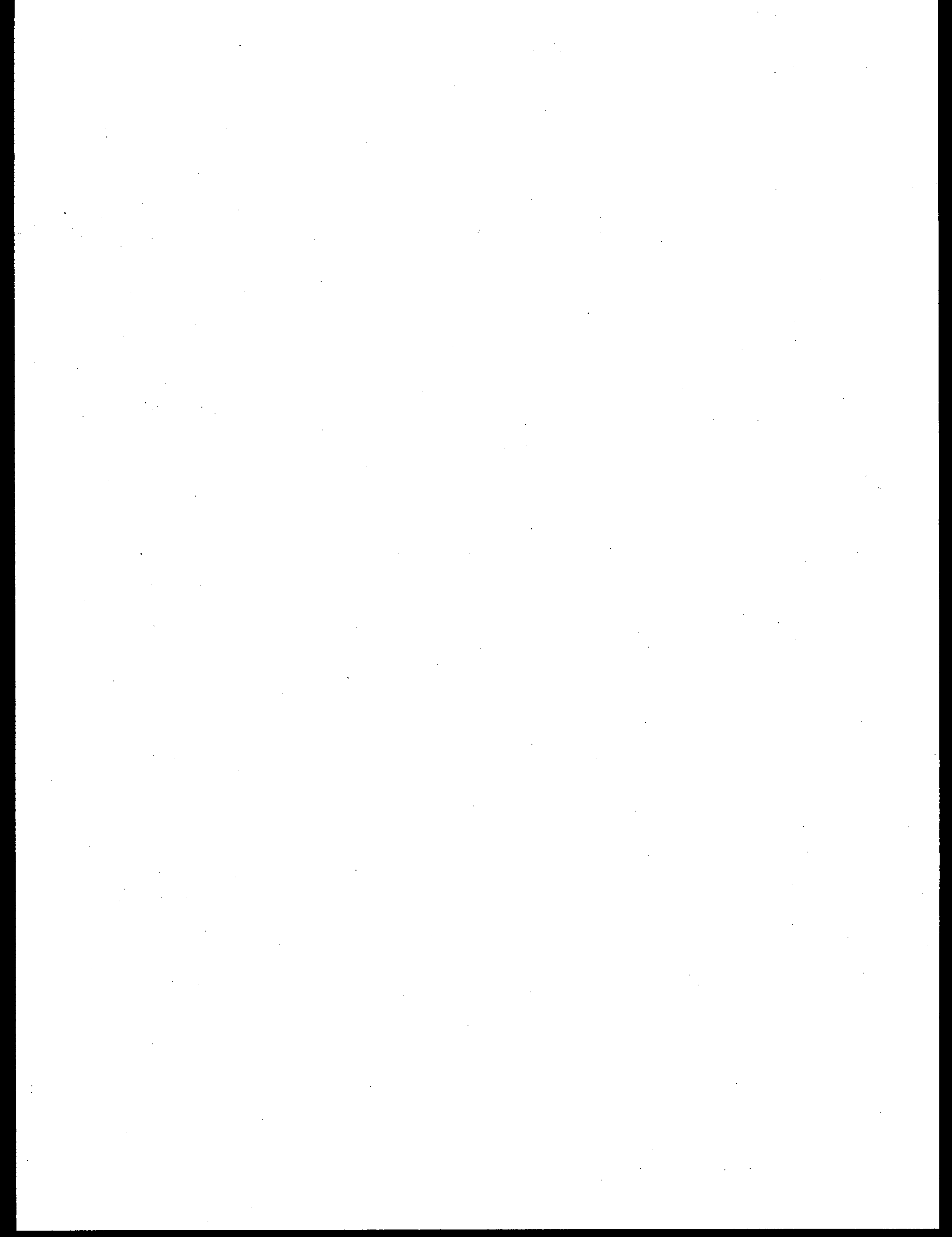
Have you eliminated **asthma triggers** from your child's environment?

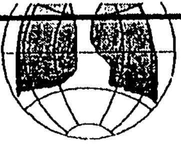
Is your child taking the medications that the doctor prescibed for him/her?

Does your child still have frequent symptoms of asthma? How controlled is your child's asthma?

Do you want more information about asthma?

(The enclosed handout has been compiled with permission from materials provided by the Global Strategy for Asthma Management and Prevention, a cooperative workshop between the National Heart, Lung, and Blood Institute (NHLBI) and the World Health Organization (WHO), revised 1998. Website: http://ginasthma.com/pocketguide/pocket.html)





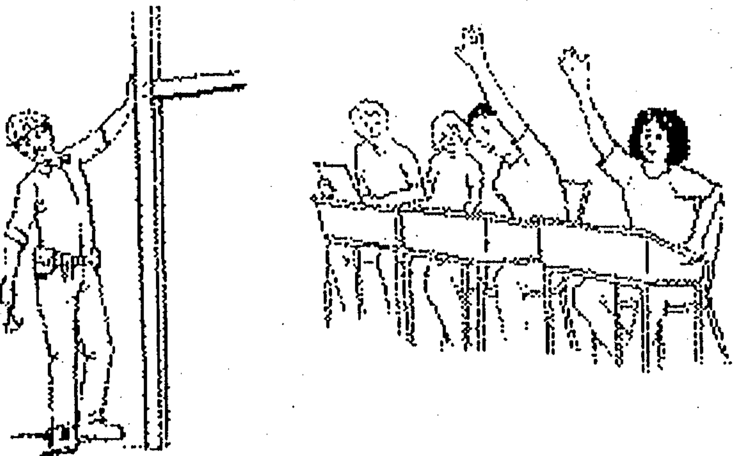
What You And Your Family Can Do About Asthma

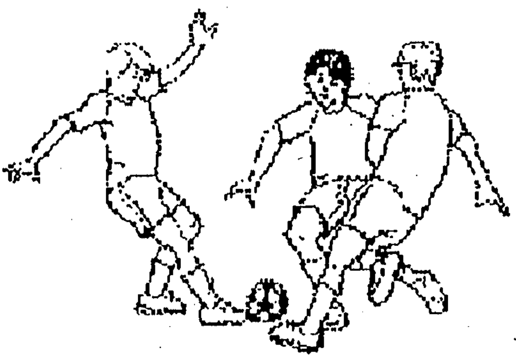
BASED ON THE GLOBAL STRATEGY FOR ASTHMA MANAGEMENT AND PREVENTION NHLBI/WHO WORKSHOP REPORT

National Institutes of Health
National Heart, Lung, and Blood Institute

You can not cure asthma,
but you can control asthma.

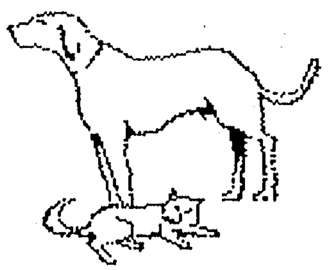
People with asthma can have normal, active lives when they learn to control their asthma. They can work, play, and go to school. They can sleep well at night.





Asthma is not a cause for shame.
All over the world, many people have asthma.

How to control your asthma and keep asthma attacks from starting:



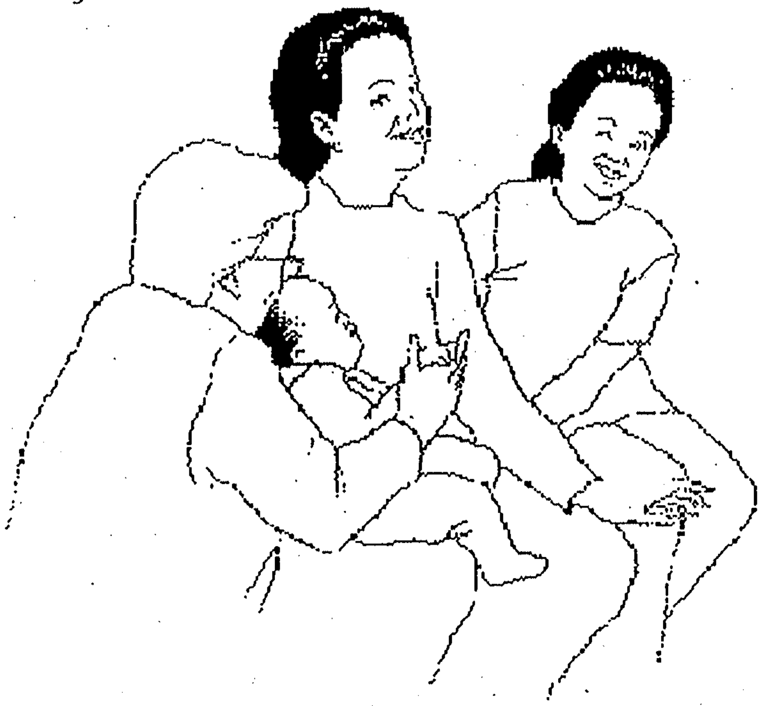
1. Stay away from things that start your asthma attacks.

2. Take asthma medicines the way the doctor says to take them.

3. Go to the doctor 2 or 3 times a year for check-ups. Go even when you feel fine and have no breathing problems.

When you know there is asthma in the family, you may be able to keep your baby from getting asthma.

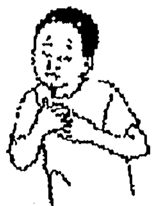
- When you are pregnant, do not smoke.
- Keep tobacco smoke away from the baby and out of your home.
- Put a special dust-proof cover on the baby's mattress.
- Keep cats and other animals with fur out of your home.



People have asthma for many years.

People with asthma can have trouble breathing. They have asthma attacks that come and go.

These are signs of an asthma attack.

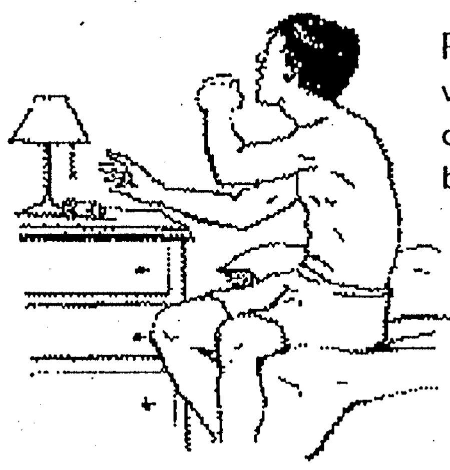


Tight Chest

Cough

Wheeze

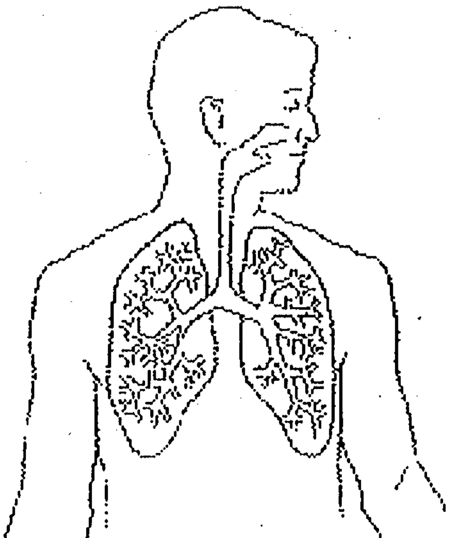
Some asthma attacks are mild. Some asthma attacks get very serious. People can die from a bad asthma attack.



People with asthma may wake up at night because of coughing or trouble breathing.

Asthma is a disease of the airways in the lungs.

You can get asthma at any age. You can not catch asthma from other people. Many times more than one person in the same family has asthma.

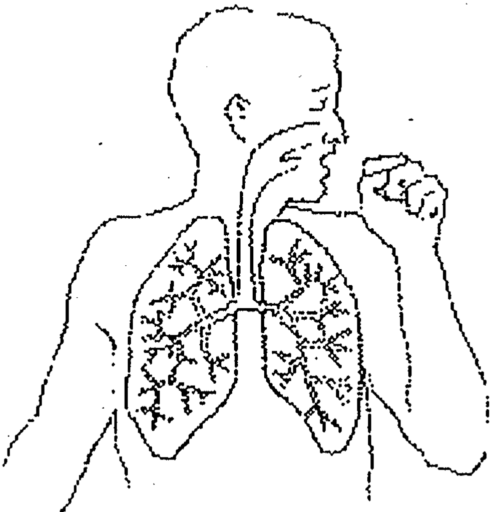


Airways carry air to the lungs. Airways get smaller and smaller like branches of a tree.

When asthma is under control, the airways are clear and air flows easily in and out.

Inside the airways, it looks like this.

When asthma is not under control, the sides of the airways in the lungs are always thick and swollen. An asthma attack can happen easily.



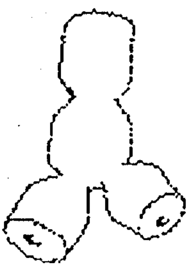
During an asthma attack, less air can get in and out of the lungs. People cough and wheeze. The chest feels tight.

During an asthma attack, it looks like this inside the airways of the lungs.

The sides of the airways get even more swollen.

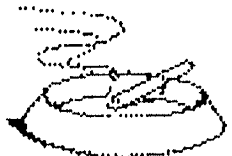
The airways get squeezed.

The airways make mucus.

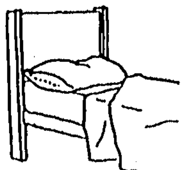


Many things can start asthma attacks.

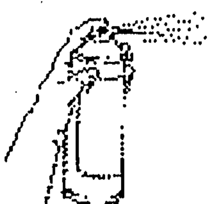
Animals with fur


Cigarette smoke

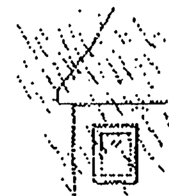
Smoke


Dust in beds and pillows

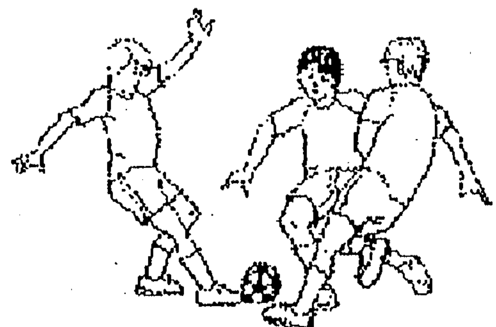
Dust from sweeping


Strong smells and sprays

Pollen from trees and flowers

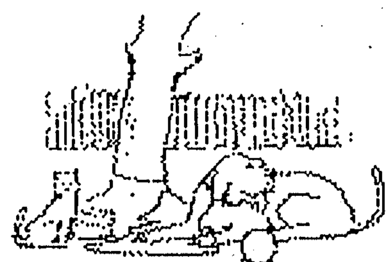

The weather

Colds

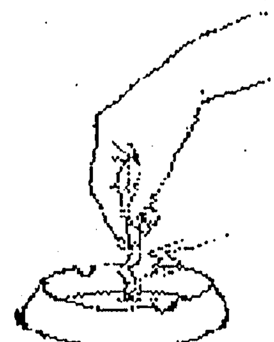

Running, sports, and working hard

Sometimes these things are called asthma triggers.

Keep things out of the home that start asthma attacks.



- Many people with asthma are allergic to animals with fur. Keep animals outside. Give away pets.



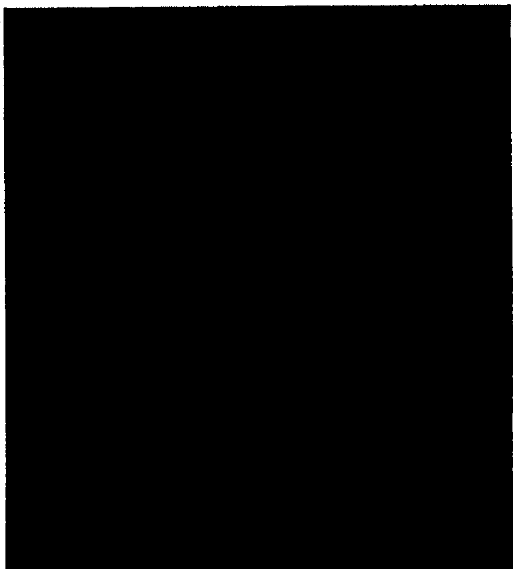
- No smoking inside.
  Get help to quit smoking.

- Keep strong smells out of the home. No soap, shampoo, or lotion that smells like perfume.
  No incense.

Make special changes to the room where the person with asthma sleeps.

- Take out rugs and carpets.
  They get dusty and moldy.

- Take out soft chairs, cushions and extra pillows.
  They collect dust.

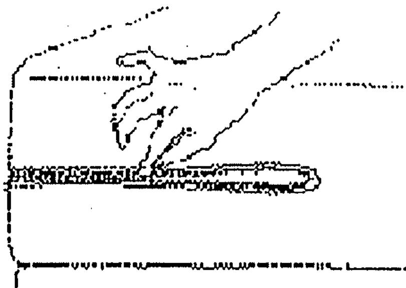


- Do not let animals on the bed or in the bedroom.

- No smoking or strong smells in the bedroom.

Keep the bed simple.

Dust collects in the mattress, blankets and pillows.
This dust bothers most people with asthma.



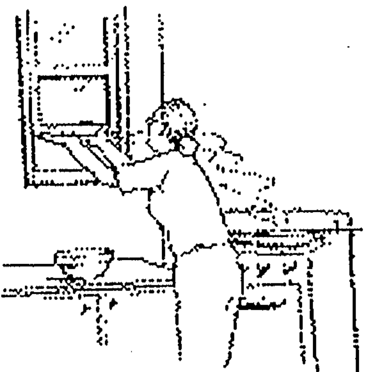
- Put special dust-proof covers with zippers on the mattress and pillow.

- Do not use a pillow or a mattress made of straw.

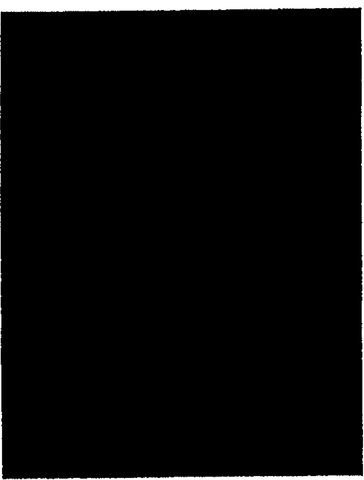
- A simple sleeping mat may be better than a mattress.

- Wash sheets and blankets often in very hot water.
  Put them in the sun to dry.

Use windows to keep the air fresh and clean.



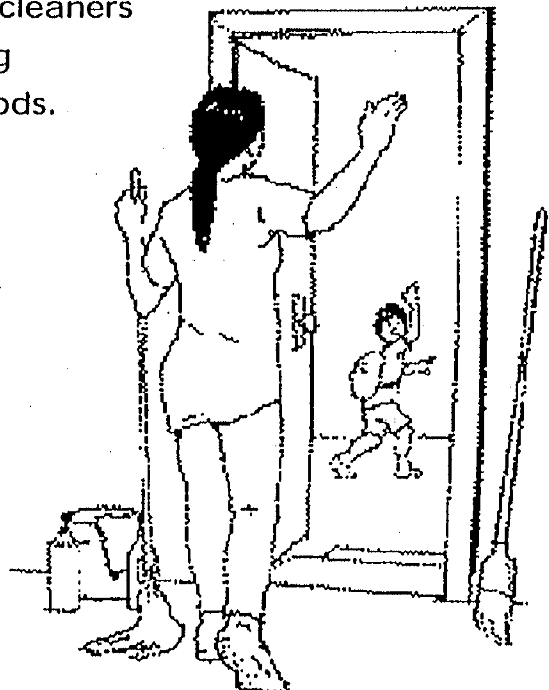
- Open windows wide when it is hot or stuffy, when there is smoke from cooking, and when there are strong smells.
- If you heat with wood or kerosene, keep a window open a little to get rid of fumes.



- Close windows when the air outside is full of exhaust from cars, pollution from factories, dust, or pollen from flowers and trees.

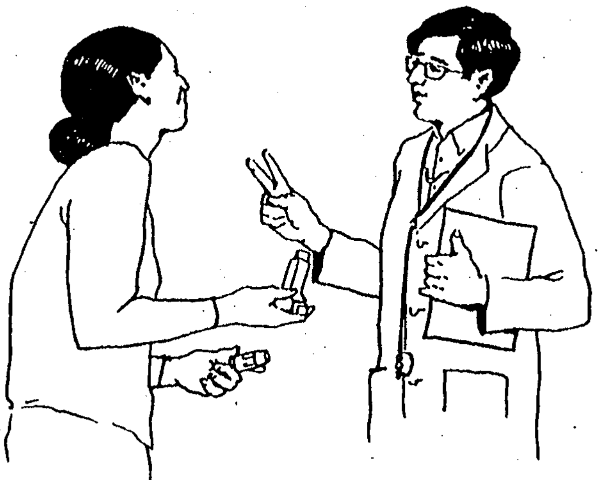
Plan to do these chores when the person with asthma is not there:

- Sweep, vacuum, or dust
- Paint
- Spray for insects
- Use strong cleaners
- Cook strong smelling foods.

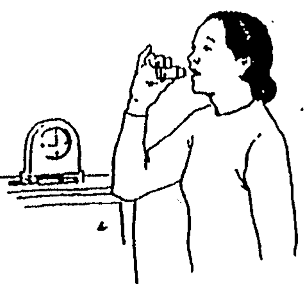


- Air out the house before the person with asthma returns.
- If there is no one to help, people with asthma can use a mask or scarf when they sweep or dust.

Most people with asthma need two kinds of asthma medicine.



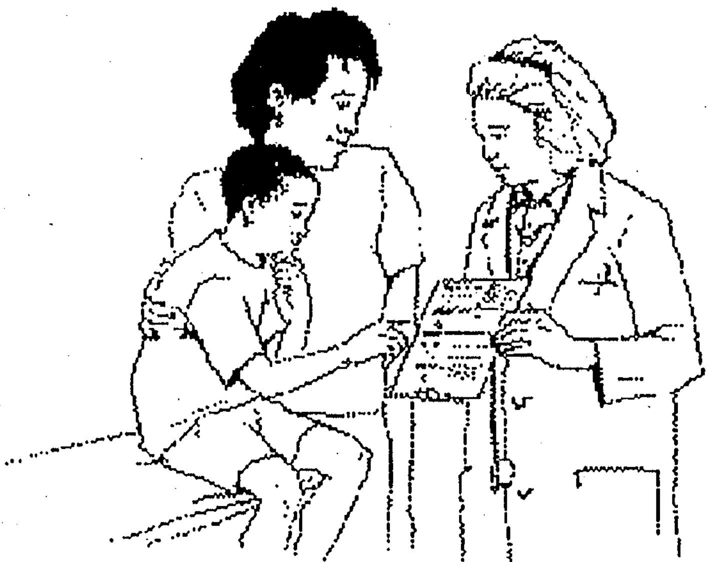
1. Everyone with asthma needs a quick-relief medicine to stop asthma attacks.



2. Many people also need a preventive medicine every day to protect the lungs and keep asthma attacks from starting.

Ask the doctor to write down what asthma medicines to take and when to take them.

- The doctor may use a medicine plan like the one in this book.
- Use the medicine plan to know what quick-relief medicines to take when you have an asthma attack.
- Use the medicine plan to help remember what preventive medicines to take every day.
- Use the medicine plan to see if you should take asthma medicine just before sports or working hard.



Preventive medicines for asthma are safe to use every day.

- You can not become addicted to preventive medicines for asthma even if you use them for many years.
- Preventive medicine makes the swelling of the airways in the lungs go away.

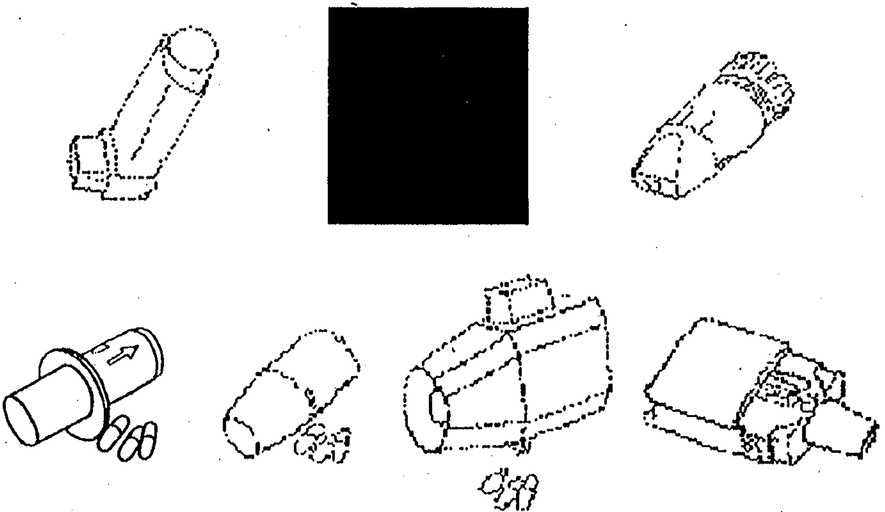
- The doctor may tell you to take preventive medicine every day:
    - If you cough, wheeze, or have a tight chest more than once a week
    - If you wake up at night because of asthma
    - If you have many asthma attacks
    - If you have to use quick-relief medicine every day to stop asthma attacks.

Tell the doctor about any problems with your asthma medicines.

- The doctor can change the asthma medicine or change how much you take. There are many asthma medicines.
- Go to the doctor 2 or 3 times a year for check-ups so the doctor can see how well the asthma medicine works.
- Asthma may get better or it may get worse over the years. Your doctor may need to change your asthma medicines.

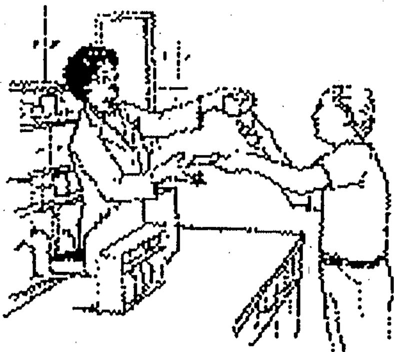
Asthma medicine can be taken in different ways.

When asthma medicine is breathed in, it goes right to the airways in the lungs where it is needed. Inhalers for asthma come in many shapes. Most are sprays. Some use powder.

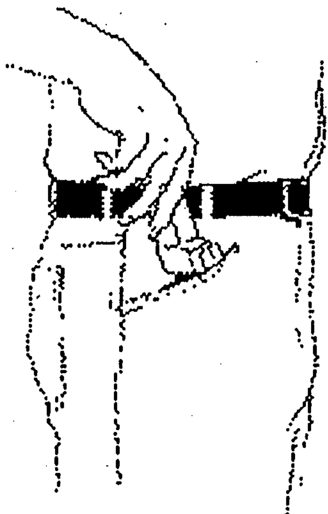


Asthma medicine also comes as pills and syrups.

Be prepared.
Always have asthma medicine.



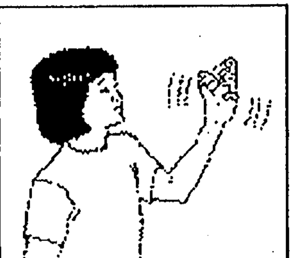
Set aside money for asthma medicine. Buy more before you run out.



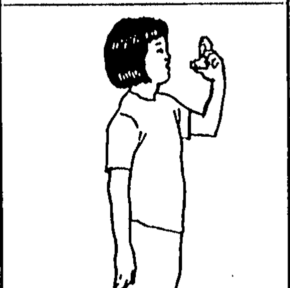
Always carry your quick-relief asthma medicine with you when you leave home.

How to use a spray inhaler.

Remember to breathe in slowly.

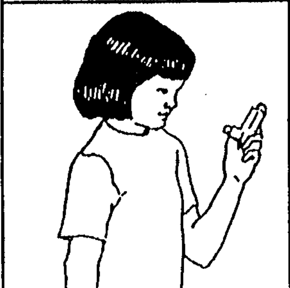


1. Take off the cap.
   Shake the inhaler.



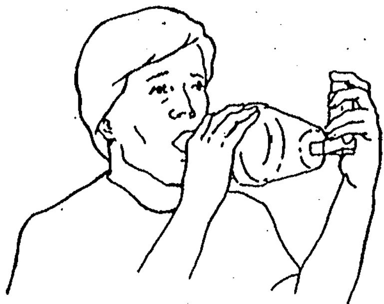
2. Stand up.
   Breathe out.

3. Put the inhaler in your mouth or put it just in front of your mouth. As you start to breathe in, push down on the top of the inhaler and keep breathing in slowly.

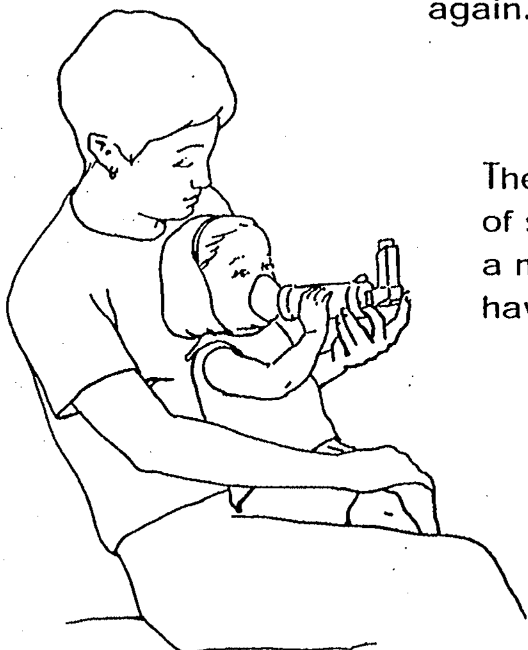


4. Hold your breath for 10 seconds.
   Breathe out.

A spacer or a holding chamber makes it easier to use a spray inhaler.



1. Spray the asthma medicine into the spacer one time.
2. Then take a deep breath and hold it for 10 seconds.
3. Breathe out into the spacer.
4. Breathe in again, but do not spray the medicine again.



There are many kinds of spacers. Some have a mouth piece. Some have a face mask.

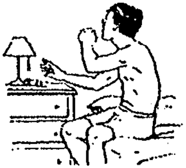
Act fast if an asthma attack starts.

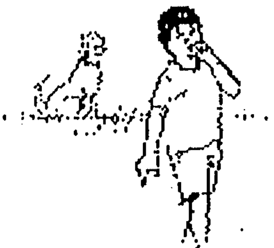
- Know the signs that an asthma attack is starting.

Cough

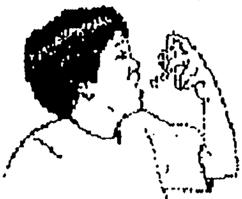
Wheeze

Tight chest


Wake up at night



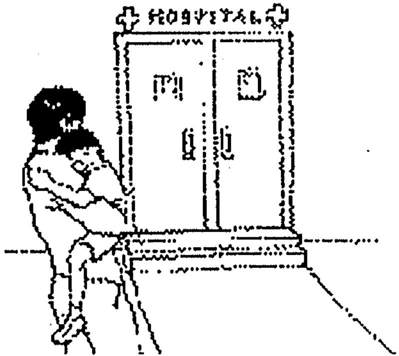
- Move away from the thing that started the attack.



- Take a quick-relief asthma medicine.

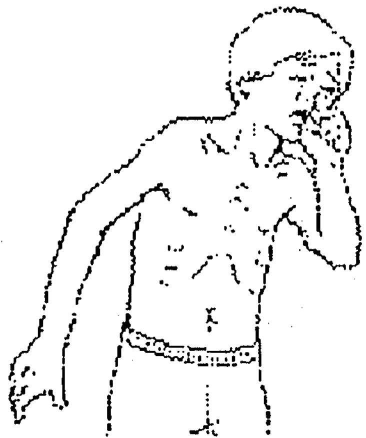
- Stay calm for 1 hour to be sure breathing gets better.

Get emergency help from a doctor if you do not get better.



Get help if you see any of these asthma danger signs:

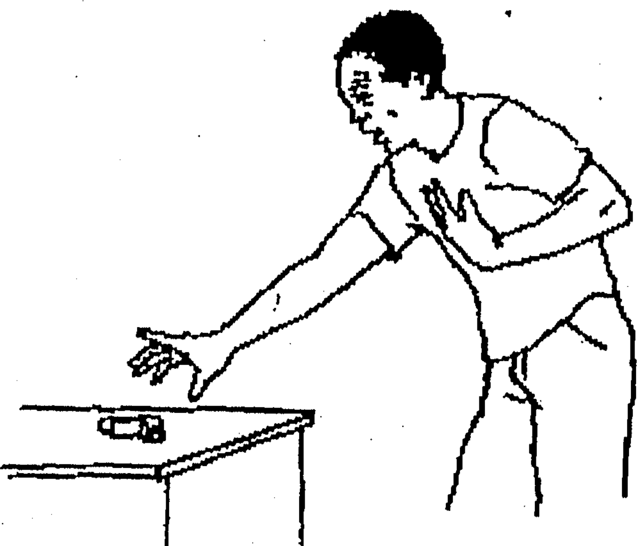
- Your quick-relief medicine does not help for very long or it does not help at all. Breathing is still fast and hard.
- It is hard to talk.
- Lips or fingernails turn grey or blue.
- The nose opens wide when the person breathes.
- Skin is pulled in around the ribs and neck when the person breathes.
- The heartbeat or pulse is very fast.
- It is hard to walk.



Be careful! Using too much quick-relief medicine for asthma attacks can hurt you.

Quick-relief medicine for asthma makes you feel better for a little while. It may stop the attack. With some attacks, you may think you are getting better but the airways are getting more and more swollen. Then you are in danger of having a very bad asthma attack that could kill you.

- If you use quick-relief medicine every single day to stop asthma attacks, this means you need a preventive medicine for asthma.
- If you need quick-relief medicine more than 4 times in 1 day to stop asthma attacks, you need help from a doctor today.

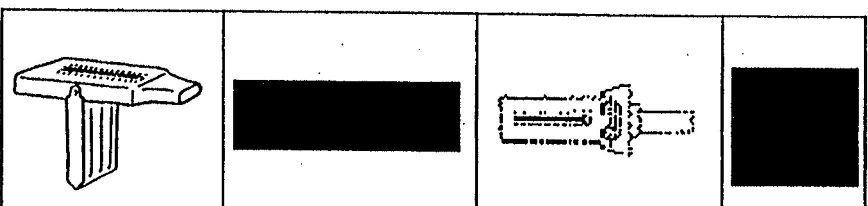


A peak flow meter can be used at a clinic or at home to measure how well a person is breathing.

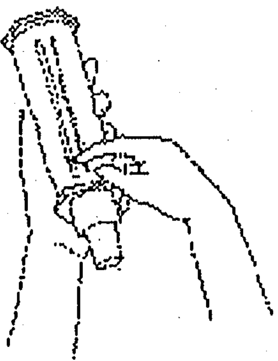
- It helps the doctor decide if someone has asthma.
- It helps to see how bad an asthma attack is.
- It helps the doctor see how well asthma is controlled over time.

If a peak flow meter is used every day at home, people can find breathing problems even before they start to wheeze or cough. Then people know when more asthma medicine is needed.

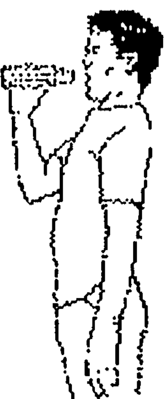
There are many kinds of peak flow meters.



How to use a peak flow meter

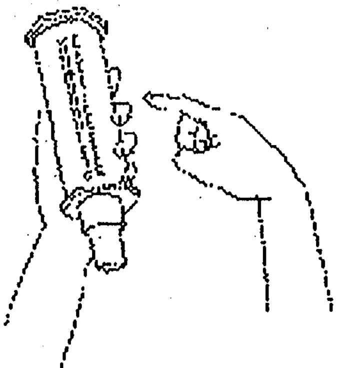


1. Slide the little marker down as far as it will go. This sets the meter to zero.



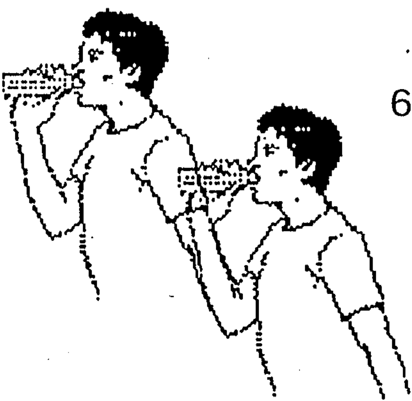
2. Stand up. Take a big breath with your mouth open. Hold the meter in one hand. Keep your fingers away from the numbers.

3. Quickly close your lips firmly around the tube. Do not put your tongue in the hole. Blow one time as fast and hard as you can.



4. The marker will go up and stay up. Do not touch the marker. Find the number where the marker stopped.

5. Write the number on a piece of paper or on a chart.



6. Blow 2 more times. Push the button down each time. Write the number down each time.

Name: ______________________

Doctor: ______________________

Date: ______________________

How to use a peak flow chart at home.

1. Find your peak flow number in the morning and evening.
2. Each morning and each evening blo 3 times.
3. After each blow, mark the spot where the marker stopped.
4. Put the meter next to the peak flow chart to help you find the spot to mar
5. Circle the highest of the 3 numbers. That is your peak flow number.

morning	evening	morning	evening	morning	evening	morning	evening	morning	evening	morning	evening	morning	evening	morning	evening
800	800	800	800	800	800	800	800	800	800	800	800	800	800	800	800
750	750	750	750	750	750	750	750	750	750	750	750	750	750	750	750
700	700	700	700	700	700	700	700	700	700	700	700	700	700	700	700
650	650	650	650	650	650	650	650	650	650	650	650	650	650	650	650
600	600	600	600	600	600	600	600	600	600	600	600	600	600	600	600
550	550	550	550	550	550	550	550	550	550	550	550	550	550	550	550
500	500	500	500	500	500	500	500	500	500	500	500	500	500	500	500
450	450	450	450	450	450	450	450	450	450	450	450	450	450	450	450
400	400	400	400	400	400	400	400	400	400	400	400	400	400	400	400
350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350
300	300	300	300	300	300	300	300	300	300	300	300	300	300	300	300
250	250	250	250	250	250	250	250	250	250	250	250	250	250	250	250
200	200	200	200	200	200	200	200	200	200	200	200	200	200	200	200
150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150
100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
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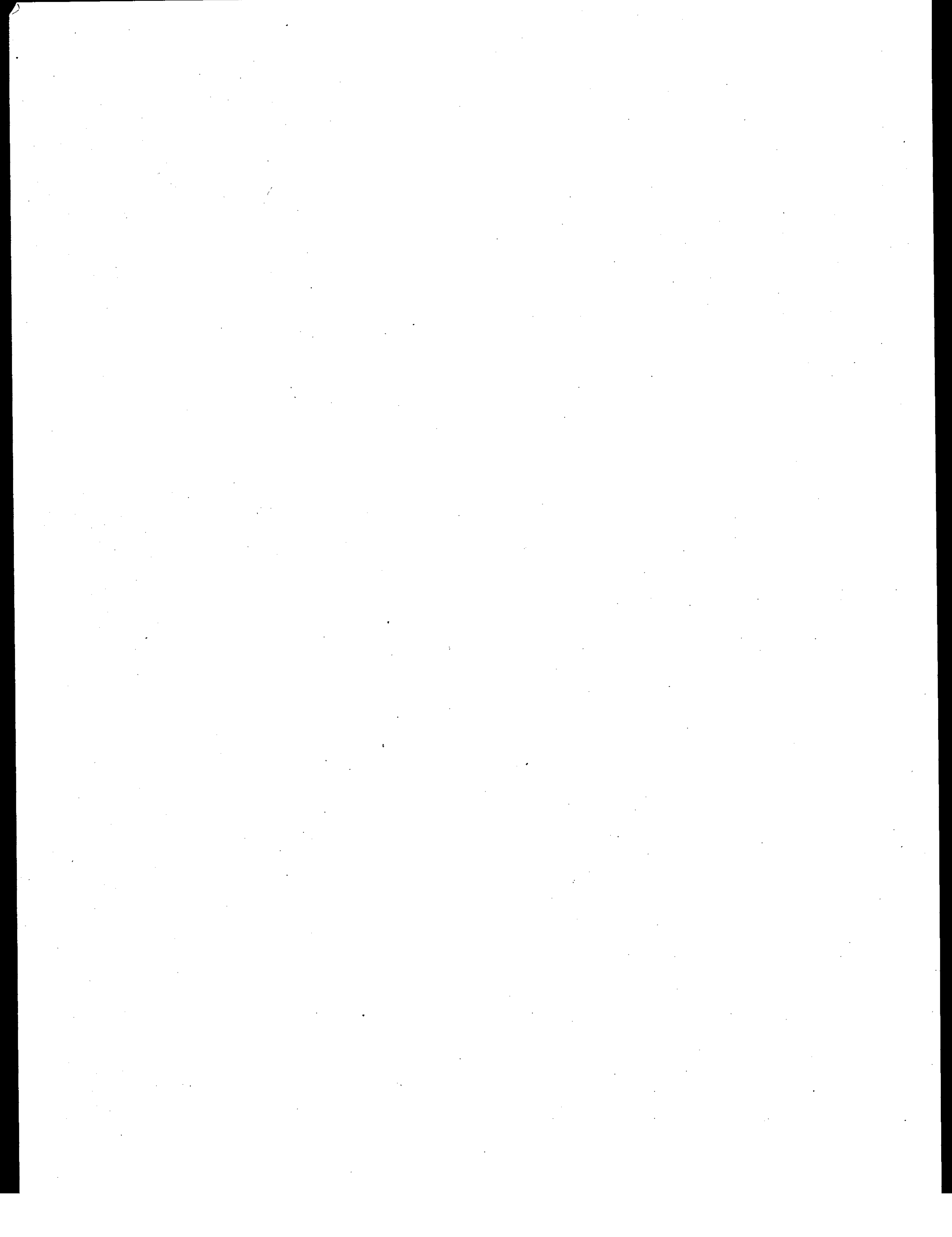


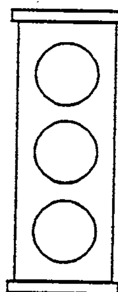
Name: ______________

Doctor: ______________ **Date:** ________

Phone for doctor or clinic: ______________

Phone for taxi or friend: ______________

help learn about your asthma medicines.



1. **Green** means **Go.** Use preventive medicine.
2. **Yellow** means **Caution.** Use quick-relief medicine.
3. **Red** means **Stop.** Get help from a doctor.

- Breathing is good
- No cough or wheeze
- Can work and play

Peak Flow Number

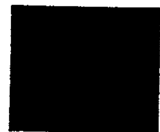
_____ to _____

Use preventive medicine.

Medicine	How much to take	When to take it

20 minutes before sports, use this medicine:

____



Cough

Wheeze

Tight chest

Wake up at night

Peak Flow Number

_____ to _____

Take quick-relief medicine to keep an asthma attack from getting bad

Medicine	How much to take	When to take it

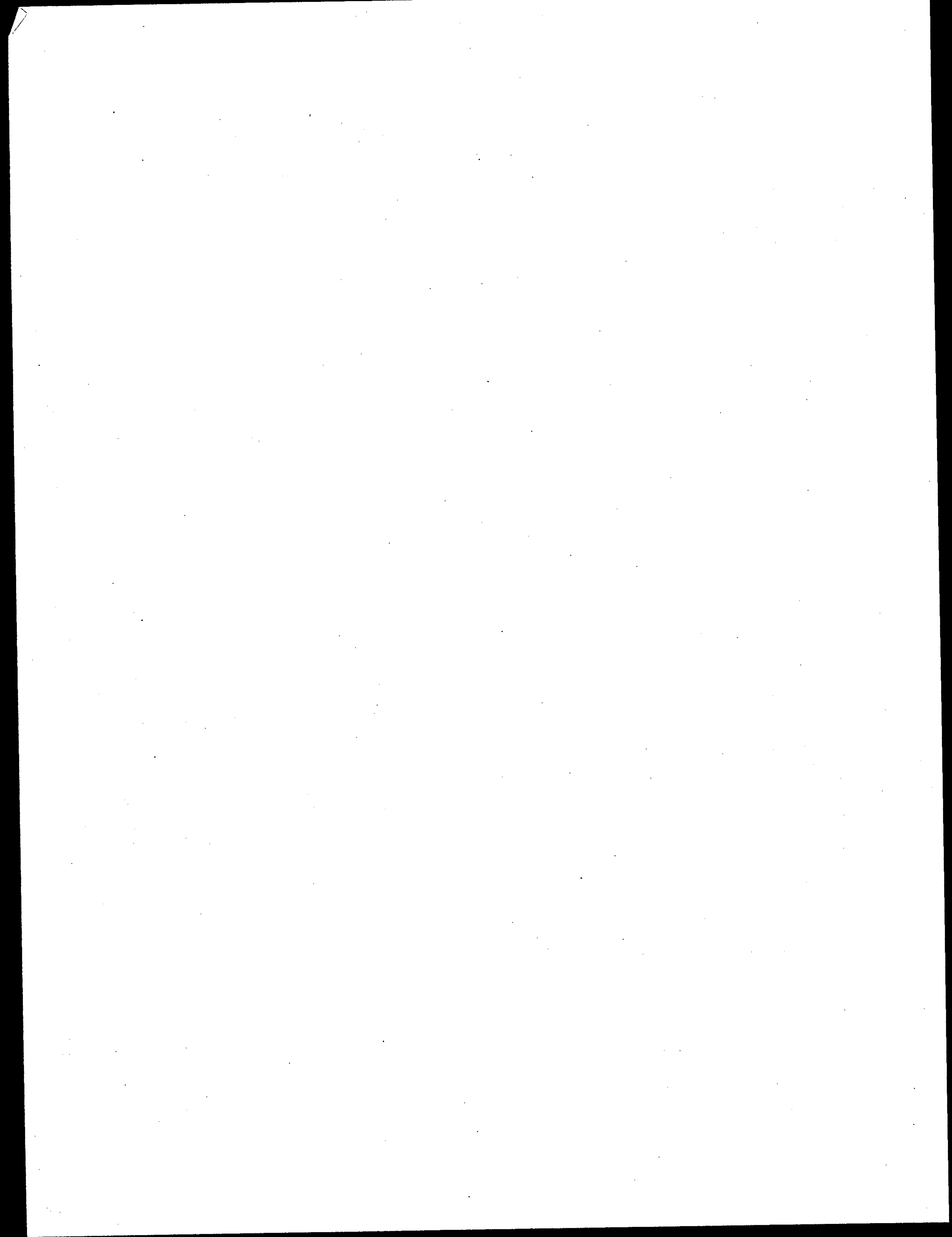
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't walk
- Ribs show
- Can't talk well

Peak Flow Number

Get help from a doctor now!

Take these medicines until you talk with the doctor.

Medicine	How much to take	When to take it



Clinic information:

The Global Initiative for Asthma is a joint effort of the National Heart, Lung, and Blood Institute and the World Health Organization with the following publications: Global Strategy for Asthma Management and Prevention, NHLBI/WHO Workshop Report, scientific information and recommendations for asthma programs; Asthma Management and Prevention: A Practical Guide for Public Health Officials and Health Care Professionals, highlights from the workshop report; Pocket Guide For Asthma Management and Prevention, a summary of patient care information for doctors and nurses; What You and Your Family Can Do About Asthma, a patient information booklet. All publications are available from the National Heart, Lung, and Blood Institute, National Institutes of Health, Bethesda, MD, USA 20892 and the Global Initiative for Asthma Secretariate, Department of Respiratory Diseases, University Hospital, Ghent, Belgium. The publications are also available through Internet (http:\\www.ginasthma.com).

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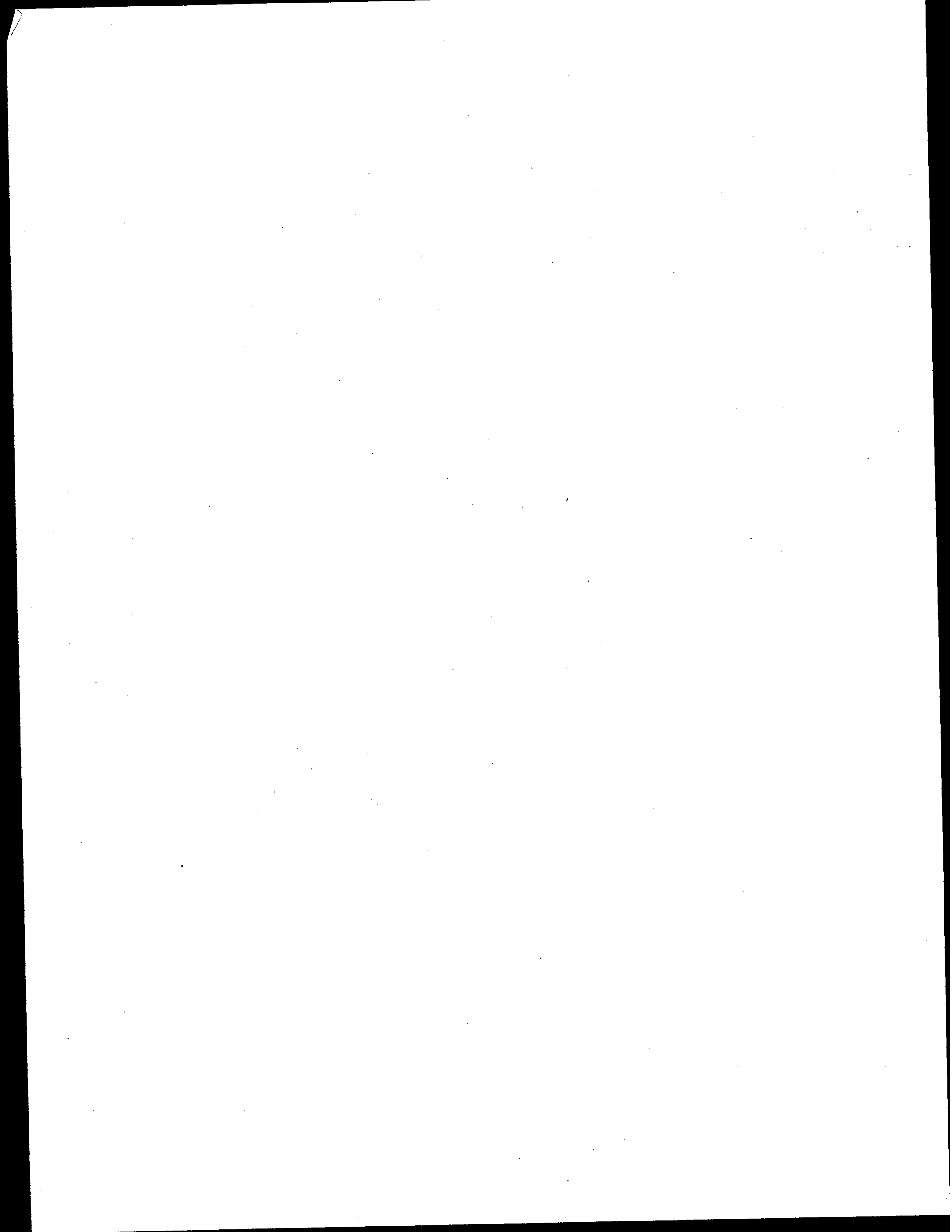

■ Basics of asthma
■ What triggers asthma?
■ New approaches
■ Warning signs
■ Allergy Avoidance
■ Asthma Severity
■ Special Conditions

Asthma Action Plan

Name____________________________________

Date______________________

It is important in managing asthma to keep track of your symptoms, medications, and peak expiratory flow (PEF). You can use the colors of a traffic light to help learn your asthma medications:

A. GREEN means GO - use preventive (anti-inflammatory) medicine
B. YELLOW means CAUTION - use quick-relief (short-acting bronchodilator) medicine in addition to preventive medicine
C. RED means STOP! - get help from a doctor

a. Your GREEN ZONE is ________ 80 to 100% of your personal best.
GO!

Breathing is good with no cough, wheeze, or chest tightness during work, school, exercise, or play.

ACTION:

☐ Continue with medications listed in your daily treatment plan.

b. Your YELLOW ZONE is ________ 50 to less than 80% of your personal best. CAUTION!

Asthma symptoms are present (cough, wheeze, chest tightness).

Your peak flow number drops below ________ or you notice:

- ☐ Increased need for inhaled quick-relief medicine
- ☐ Increased asthma symptoms upon awakening
- ☐ Awakening at night with asthma symptoms
- ☐ ____

ACTIONS:

- ☐ Take ______ puffs of your quick-relief (bronchodilator) medicine ____________________________. Repeat ______ times.
- ☐ Take ______ puffs of ______________ (anti-inflammatory) _____________ times/day.
- ☐ Begin/increase treatment with oral steroids: Take ______mg of _______________every a.m. ______p.m. _______.
- ☐ Call your doctor (phone) ______________ or emergency room __________.

c. Your RED ZONE is ________ 50% or less of your best. DANGER!!

Your peak flow number drops below _____, or you continue to get worse after increasing treatment according to the directions above.

ACTIONS:

³ Take ______ puffs of your quick-relief (bronchodilator) medicine

Repeat ______ times.

³ Begin/increase treatment with oral steroids: Take ______mg now.

³ Call your doctor now (phone) _______________. If you cannot contact your doctor, go directly to the emergency room (phone) _________________.

Other important phone numbers for transportation ____________________________.

AT ANY TIME, CALL YOUR DOCTOR IF:

- ☐ Asthma symptoms worsen while you are taking oral steroids, or
- ☐ Inhaled bronchodilator treatments are not lasting 4 hours, or
- ☐ Your peak flow number remains or falls below _______ in spite of following the plan.

Physician Signature ____

Patient's/Family Member's Signature ______________________________

This plan is provided as an example to clinicians

From:
Understanding Asthma Health Management Bulletin
Information for asthma patients and their friends
Medical Writer: Claudia Morain, Davis, CA
Contributing Editors: R. Mark Evans, PhD, American Medical Association
Mary Jane Brakl, Valhalla, NY
Medical Editor: Helene Cole, MD, Des Moines, IA
Consultant: Ronald Ferdman, MD
Division of Clinical Immunology & Allergy, Childrens Hospital Los Angeles
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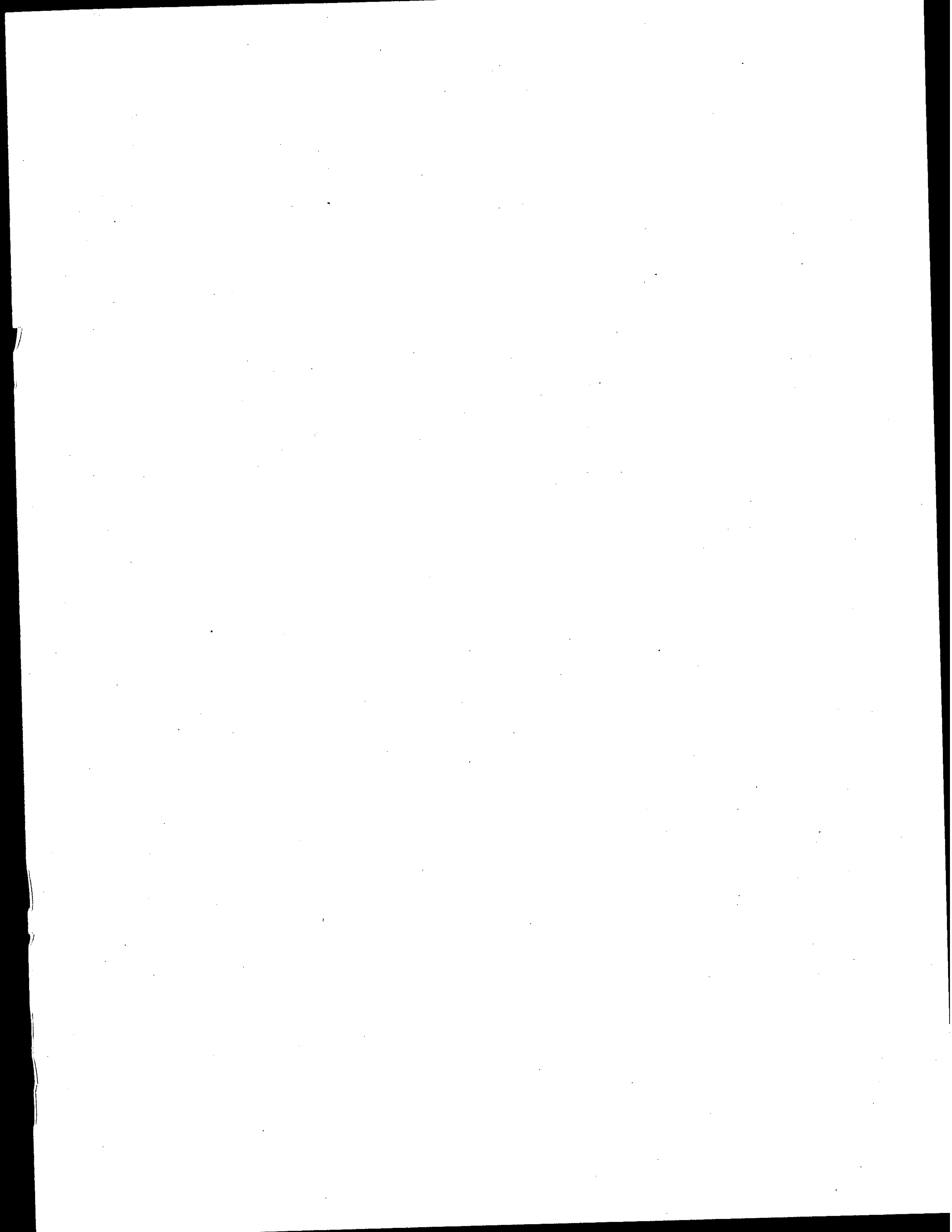

Concurrent Planning/Partnering with Families for Permanency

The OIG is wrapping up a three year project to design and test a series of best practice strategies for achieving timely permanency in a less adversarial manner for children under age 12 who either: 1) based on significant family strengths, should be able to return home quickly; or 2) are unlikely ever to be returned home. This latter assessment is made based on the seriousness of the abuse, conditions which are generally unamenable to treatment, or previous failures to make progress despite reasonable efforts by a child welfare agency. For the group assessed unlikely to reunify, we tested a model of concurrent planning for children in home of relative foster care. The project, entitled "Partnering with Families for Permanency", was a collaborative effort of the OIG, the Child Care Association, and four private agencies in Cook County: Lifelink/ Bensenville Home Society, Lutheran Social Services of Illinois, Volunteers of America, and Catholic Charities.

Description of the Project

The first group of thirty workers and supervisors were trained in May and June of 1997. Agencies began receiving cases on July 1, 1997, a date which coincided with the effective date of legislation mandating concurrent planning.

The project attempted to test a matrix and interview protocol designed by the Child Care Association to help workers assess the likelihood of reunification early in the case, to avoid a "one size fits all" approach to families. For families identified as strong candidates for early reunification, the extended family was invited to participate in a meeting, called a *permanency conference,* whose purpose was to make the agencies intentions clear and to enlist the whole family's support of a reunification plan.

For families who were assessed as unlikely to ever reunify, a distinction was made between those for whom reunification services should not be provided, and those where a reasonable cause exists offering families a final opportunity to make progress in services. For the former group, the agency attempted to screen the case for expedited termination. For the latter group, concurrent planning was employed as follows:

- Parents were offered services with a clearly stated preferred goal of return home, but at the same time, asked to help develop a backup plan for permanence.

- As part of the development of a backup plan for permanence, every effort was made to place the child in a potential permanent home should reunification efforts fail. In most cases, the home in which the child was placed was determined to be the appropriate permanency option and the family was willing to accept this responsibility. In cases in which the relative was not prepared to make a long term commitment to the child, the family was asked to identify other potential permanent homes within the extended family. At each step in the process, the parents were kept fully informed and invited to participate in discussions.

- Parents were given the option to decide to have their children grow up in another permanent home (through, for example, executing specific consents for adoption in appropriate cases).

- Parents' progress was closely monitored. The child welfare worker and supervisor shared their assessment of this progress with the parent and the extended family during regular case contacts and, where possible, in regularly scheduled permanency conferences.

- Families were informed from the beginning of the case of the need to make substantial progress within six to nine months or face a possible hearing to terminate parental rights.

Results

The project faced a number of difficulties, including a small number of referrals, significant worker and supervisor turnover, and some difficulties in negotiating the legal system. A total of 23 families with 54 children were served; the mean age of the children was 4.6 years. We attribute referral difficulties to timing: across the board, intake of new home of relative cases was significantly down, thus affecting our referrals. In addition, many of the new children who came into the project agencies were "add-on" cases, that is, later-born children with siblings already in the system. While we expected this group of cases to be a significant portion of our concurrent planning group, all but one of the agencies decided, understandably, to assign these children to their siblings' caseworker, whether or not the caseworker was in the specially trained project group.

The start date of our project also coincided with the beginning of performance contracting with private agencies and was simultaneous to the first year of implementation of the subsidized guardianship waiver. The participating agencies reported that these initiatives and their reward structures placed emphasis on moving older cases through the system and thus competed with our project which focuses on new cases. Now that many of the older cases are reaching legal permanency, it may be a better time to implement concurrent planning and early reunification strategies.

Worker and supervisor turnover was also a significant problem. Of the original group of 30 trainees, one year later only three were available to the project. Of the 27 who were no longer involved, 17 left the agency or were on leave, three were promoted to new positions within the agency, and an additional seven were made unavailable because their agency withdrew due to agency restructuring. The OIG trained an additional 61 workers and supervisors over the life of the project, as of November, 1998, sixty-four percent of all of those trained were no longer available to the project.

Turnover impacted not only project implementation but also the families served. The number of caseworkers assigned to the cases was 2.2 caseworkers per family. Only eight families had the same caseworker throughout the project; eleven families had three caseworkers during this period. The number of supervisors assigned to the families also ranged from 1 to 4, with a mean of 2.8.

Turnover in court personnel (including parent's attorneys) also contributed to some permanency delays for our project families. Nine of the 23 families experienced court delays which were in part attributable to court personnel turnover, worker turnover, or both.

Another set of issues related to barriers to legal permanency are cases that appear poor candidates for reunification but for which adjudication was delayed. One adjudication was delayed because the father was in jail awaiting trial for the murder of the children's sibling. This case was judged by caseworkers to be appropriate for expedited termination of rights but could not proceed because of a decision to wait for the outcome of the criminal trial. As concurrent planning and expedited termination is more widely implemented, this barrier to permanency needs to be addressed.

Despite the difficulties described above, early data analysis of our project suggests that the casework strategies we tested hold promise both for the early reunification and concurrent planning cases where children reside in home of relative care. First, the matrix ratings appeared to be fairly accurate with respect to case outcomes:

- Among the 5 "early reunification" cases, 3 children were returned to a parent and 2 children are pending reunification.
- Among the 13 "concurrent planning" cases, adoption is pending in 4; private guardianship was awarded in 1; adoption is planned in 3; reunification is pending in 2, and caseworkers have reached no permanency decision in 2 (data unavailable in one case)
- Among the 3 "reunification unlikely/seek consultation regarding expedited termination" cases, adoption has been completed in one and is pending in the other two.

The mean length of time of the children in the project was 18 months, with a range of between 7 and 23 months. Of the 48 children for whom final status information was available, either reunification or adoption had been achieved or appeared likely to be achieved for 31 (65%) of the children. Adoption was planned for 4 children but no legal action had been initiated. One child achieved permanency through private guardianship. Reunification was planned for 2 additional children but progress was not good; one child had a goal of independent living. No permanency decision had been made for 9 (19%) of the children.

Lessons Learned

We believe that the strategies of early differential assessment, full disclosure to families, and involving the extended family in the case plan are entirely compatible with the Department's permanency initiatives, including performance contracting. Timing is important, however, and as the Department implements concurrent planning more broadly it will benefit from having these other initiatives well underway.

This project was unique in that it tested concurrent planning with relatives as opposed to specially recruited and trained foster parents which were studied in the initial small study in Washington state. Acknowledging our small sample size and the developmental nature of our field test, we nonetheless answer the question "can concurrent planning be done with relatives?" with a cautious "yes". This is an important first step as so many of the children DCFS serves are in relative placement.

Caseworker access to legal consultation at key decision points in the case is critical to successful concurrent planning. Other states which have implemented concurrent planning report that courts need to be involved in the implementation plan. As Illinois broadly implements concurrent planning, local jurisdictions should be encouraged to develop advisory boards comprised of judges and attorneys representing the various parties in juvenile court.

Across the country, we have observed somewhat of a backlash regarding concurrent planning, as people in many quarters equate it with expedited termination of rights. In fact, concurrent planning has reunification at its core, and all training about concurrent planning should take this into account. Family reunification is the *preferred* permanent home for the child. To be effective, concurrent planning training must stress this point, and concurrent planning practice must involve well-timed and diligent efforts to reunify the family while at the same time planning for the contingency that the parents' efforts may be unsuccessful.